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## **Mind Your Health: The physical and mental health of looked after children and young people in Northern Ireland**

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# *Mind Your Health -* **The Physical and Mental Health of Looked After Children and Young people in Northern Ireland**



Dominic McSherry  
Montserrat Fargas Malet  
Katrina McLaughlin  
Catherine Adams  
Nina O'Neill  
Judith Cole  
Colm Walsh

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**Disclaimer:** This research forms part of a programme of independent research commissioned by OFMDFM to inform the policy development process, and consequently the views expressed and conclusions drawn are those of the author and not necessarily those of OFMDFM or DHSSPS.

## Acknowledgements

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Of course, no study would be possible without the involvement of research participants, of which there were many across the four phases of the study. We want to thank all those professionals either within social work (Phase 1), or across the professional groups involved in meeting the health needs of LACYP (Phase 4), for taking the time to participate in the study and for providing the information and professional reflection necessary to comprehensively describe the current system in Northern Ireland for meeting the health needs of LACYP, reflecting on the progressive aspects of this work, and flagging up where there may be room for further development. We also want to express our deep gratitude to the several hundred carers (fostering, kinship, and residential) for participating in telephone interviews, and enabling such a comprehensive account of the health of LACYP in Northern Ireland to be developed. This process also required considerable logistical support, and we want to thank all those people within the five HSC Trusts, and the Fostering Network, who supported this process. Last but by no means least, we want to express our profound appreciation to all those young people who took the time and had the courage to speak to the research team about their physical and mental health. The findings that emerged provide a very real sense of what it is like to be a young person living in care in Northern Ireland and the type of health issues that they face, often on a daily basis. These are messages that practitioners and policy-makers need and want to hear.

We would also like to acknowledge the input of the Office for Research Ethics Committees in Northern Ireland (ORECNI) for providing ethical guidance and assurance across all aspects of the study. Finally, we want to express our thanks to our secretary, Louise Moss, for providing administrative and logistical support throughout the study.

## Executive Summary

The Mind Your Health study is a Queen's University study, supported by a grant from the Office of the First Minister and Deputy First Minister (OFMDFM). The research study, which ran from May 2012 to April 2015 (three years), set out to profile the health needs of the Looked After children and young people (LACYP) population in Northern Ireland, and to explore how these needs were currently being met. The study used a mixed-methods approach, which included: a review of policy and practice documents; five focus group interviews with senior social work managers in each of the Health and Social Care Trusts; 233 telephone interviews with carers (foster, kinship, and residential); 25 semi-structured interviews with young people; and multi-disciplinary focus group interviews with professionals in four HSC Trusts.



## Key findings

- ◆ Behavioural and mental/emotional health problems were found to be the most common health issues suffered by LACYP in Northern Ireland, with 40 per cent having been diagnosed with behavioural problems, 35 per cent with emotional problems, and 21 per cent with depression or anxiety. In addition, nearly one third of LACYP surveyed were believed to suffer from a long-standing illness and/or disability (according to their current carers).
- ◆ A number of factors emerged that were related to health. LACYP in residential care had a much more negative physical and mental health profile than those in foster or kinship care, particularly kinship care. A smaller percentage of females displayed behavioural difficulties than males (as measured by the SDQ). Behavioural problems, as well as depression and anxiety, increased from early childhood through to the late teenage years, dissipating in early adulthood (18 years and over), whereas emotional problems increased with age but did not show any sign of dissipating at the early adulthood stage. Hyperactivity problems were more prevalent in the pre-and early teenage years, becoming less of an issue in the mid to late teenage years. Risk-taking behaviour increased through the teenage years, with the 16-17 age category showing the largest percentages of risk-taking and self-harming behaviours.
- ◆ Despite the high percentages of LACYP displaying behavioural and emotional problems, most carers surveyed in this study rated them as being 'very healthy' (60%), and the young people interviewed viewed themselves as physically 'healthy' (86%) and mentally 'healthy' (67%). This indicated that carers' perception of health is physically orientated.
- ◆ Young people employed different strategies to deal with their health issues, and one third felt unable to seek help when feeling down or anxious, often due to feelings of embarrassment, insecurity, stigma, or guilt.
- ◆ Some similarities and differences between HSC Trust practices were found. Regionally, statutory medical health assessments were being carried out for LACYP, with similar procedures being applied. In all HSC Trusts, LACYP had access to CAMHS and to targeted

mental health services, but the extent and nature of these varied between the different Trust areas. There were also a range of health promotion initiatives in each of the Trusts.

- ◆ Young people's engagement with services, particularly mental health services, was considered challenging by professionals, carers and the young people themselves across Northern Ireland. Some of the reasons for these challenges were outlined, and respondents provided a range of suggestions on how to better engage young people.
- ◆ Many LACYP had difficulties in accessing the services they needed, due to a range of issues, including: long waiting lists; lack in availability of local services; difficulties in accessing the appropriate service; and a lack of available information.
- ◆ Some positive factors were identified as currently helping meet the health needs of LACYP, including: priority status for LACYP in their referral to particular services; professional cooperation; delegated authority for carers; placement stability and good quality foster placements/positive caring environment; young people being able to open up to somebody they trusted; support services from particular voluntary and statutory organisations; and training around health issues for carers.
- ◆ Gaps in service provision were also identified, some having to do with a lack of resources and capacity issues, but others concerned with the organisation and coordination of services. A range of suggestions as to how services might be improved were also provided by professionals, carers and young people.



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## Introduction

Social inequalities have been associated with poor health for particular vulnerable social groups. Looked After children and young people (LACYP) are considered such a group. They often come from extremely disadvantaged families and are at major risk of having poor physical and mental health.



To date, there has been no systematic assessment of the types of health problems that LACYP in Northern Ireland are experiencing, or of the range of initiatives being undertaken to improve health outcomes. Neither has there been an exploration of the barriers to implementation of health services, or of their acceptability and likely impact. This study addresses this deficit, and establishes a foundation against which progress in addressing the health needs of LACYP in Northern Ireland can be assessed.

## Purpose of the study

This study aimed to compile a profile of the health of a representative sample of LACYP in Northern Ireland (10% of population), and use this to explore how the care system is meeting their needs, as well as what helps and hinders the implementation of initiatives designed to improve their health. There were five research questions:

1. What is the health profile for a sample of LACYP in Northern Ireland?
2. What approaches and interventions have been developed to identify and meet the physical and mental health needs of LACYP in Northern Ireland?
3. How effective are these, and what are the factors that help or hinder implementation?
4. To what extent are LACYP, and their carers, involved in these approaches and interventions, and what are their experiences of them?
5. How do health professionals (social workers, GPs, CAMHS psychologists, specialist nurses for LACYP) view their contribution to identifying and meeting the physical and mental health needs of LACYP?

## How the study was carried out

The study was conducted in four phases:

**Phase 1: Outline of the policies, procedures and service provision for LACYP, designed to address their health needs across the five Health and Social Care (HSC) Trusts in Northern Ireland.** During this phase, policy documentation across the five HSC Trusts was reviewed, and five focus group interviews were conducted, one in each HSC Trust, with senior managers for Looked After Children, fostering, and residential care services.

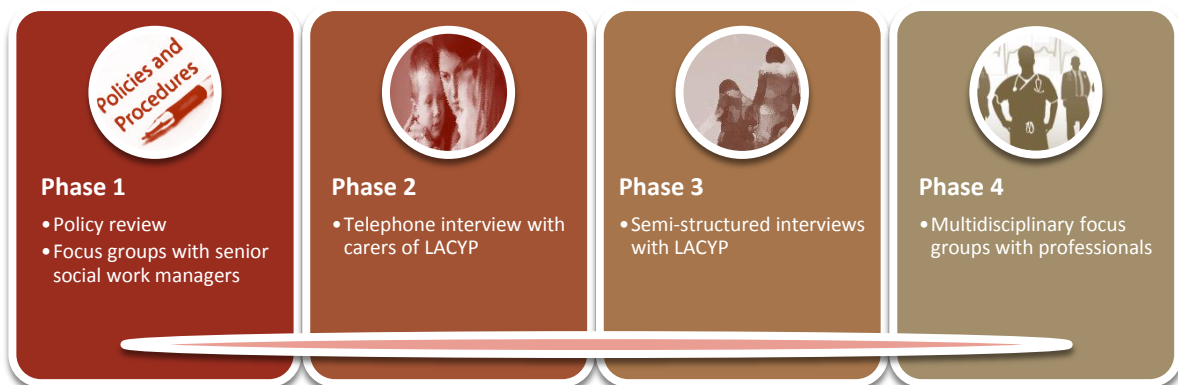
**Phase 2: Profile of the physical and mental health of LACYP in Northern Ireland.** During this phase, foster, kinship, and residential carers of LACYP across Northern Ireland were asked to



complete a telephone questionnaire containing both quantitative and qualitative questions. In total, 233 interviews were completed.

**Phase 3: Exploration of the young people's perspectives on their health.** During this phase, a sub-sample of young people (aged over 12 years old) were interviewed to gain their own perspectives on their physical and mental health needs, and how these were being met. In total, 25 young people were interviewed.

**Phase 4: Exploration of the professionals' perspectives on the health of LACYP.** During this phase, four multidisciplinary focus group interviews were conducted in four different HSC Trusts. In one Trust it was not possible to arrange such an interview due to logistical issues and project time constraints. These focus groups included social workers, GPs, CAMHS clinical psychologists experienced in working with LAC, specialist nurses for LAC, and school



nurses (n=30).

### Structure of this report

Chapter 1 provides a review of the academic literature on the health of LACYP, in addition to a review of policy and procedural documentation relevant to the health of LACYP in Northern Ireland, and set within a UK and international context.

Chapter 2 provides information regarding the research methodology used in the study. Chapters 3 to 6 present the findings of each of the study phases. Summaries of main findings are provided at the end of each chapter.

Chapter 3 concentrates on the findings extracted from the Phase 1 focus group interviews with senior social work managers within each of the HSC Trusts. The results deal with the different approaches applied in the Trusts to meeting the health needs of LACYP, the enabling and disabling factors related to their capacity to meet these needs, the gaps in service provision, and suggestions as to how the current system might be improved upon.

Chapter 4 is focused on the results from the Phase 2 telephone interviews with foster, kinship, and residential carers of LACYP. Findings from both the quantitative and qualitative interview data are described, and summaries of both are provided.

Chapter 5 explores the themes extracted from the analysis of the Phase 3 semi-structured interviews with the young people. These centred around the young peoples' perceptions of

health in general and of their own health in particular, their help-seeking behaviours, their views on how their health needs were being met, and how the system might be improved upon.

Chapter 6 presents the findings of the multi-disciplinary focus groups of Phase 4. The analysis concentrates on explaining the specific roles of the different professionals involved in meeting the health needs of LACYP, as well as the interventions and resources available in the different HSC Trusts. The chapter also highlights professionals' views on how effective these services are in meeting the health needs of LACYP, and suggestions offered to improve service provision.

Finally, Chapter 7 presents the conclusions of the study, bringing together the findings from each phase of the study; and attempting to answer the questions posed in the introduction. In addition, a list of recommendations is outlined.

**outcomes**

child needs  
order  
agencies  
reviews  
developed  
placement  
Trust  
assessment  
residential information  
service  
Act  
children's  
young  
Ireland  
wellbeing

care  
services  
health  
children  
policy  
provision  
support  
assessment  
placement  
trust  
reviews  
developed  
order  
agencies  
carers  
improving  
social  
Health  
ensure  
also  
need  
mental  
strategy  
local  
national  
LACYP  
quality  
rights  
families  
children  
service  
Northern  
HSC  
Ireland  
wellbeing

The information that informed the background review was derived from a number of sources. Firstly, a professional advisory group was established to inform the conduct of the study incorporating representatives from HSC Trusts, voluntary agencies, and academia, and these provided helpful assistance in terms of facts and figures. Secondly, a series of external meetings were organised by the research team with both statutory and non-statutory agencies. Key individuals within each HSC Trust provided the research team with copies of policy documents, as well as explaining procedural guidelines. Thirdly, the research team also met with representatives from the HSC Board, Voice of Young People in Care (VOYPIC), and the Northern Ireland Commissioner for Children and Young People (NICCY). Finally, the team was represented on the Public Health Agency (PHA)-led ‘Health and Wellbeing of LAC Working Group’, which brings together members from each HSC Trust and the HSC Board, in addition to representatives from the non-statutory agencies VOYPIC, the Fostering Network, and the National Children’s Bureau (NCB).

<sup>1</sup> The term 'looked after' refers to those children or young people looked after by the state where the Children's (1995) Order 1995 applies, whether subject to a Care Order or voluntarily accommodated by the local Health and Social Care Trust. A child may be looked after in residential care, foster care, secure institution care, or with their birth family (kinship care) or family or carers. This can be from birth and ends at the age of 18, unless the young person is deemed eligible for continued LAC support on the basis of ongoing education or training.

## Background

The relationship between health and social inequalities is well documented, in that inequalities in social conditions are associated with poor health for particular vulnerable social groups (Leon & Walt, 2001; Wilkinson & Pickett, 2006; Marmot, 2010). Both nationally and internationally, children in care are considered one such group (Mather, 2010). They tend to be drawn from families who experience considerable social disadvantage and deprivation (Bamford & Wolkind, 1988, Bradshaw & Millar, 1991; McSherry et al., 2008; 2010). Most of those who enter the care system have experienced abuse or neglect (DH, 2009), which may have adverse consequences for their cognitive development, educational attainment, self-efficacy, capacity to form secure attachments, and social competencies (Tanner & Turney, 2003).



## Physical Health

Research evidence suggests that children in care have a greater degree of physical health problems and risks than their peers (Williams et al., 2001; Ward et al., 2002; Hill & Thompson, 2003; Leslie et al., 2003; Mooney et al., 2009). Compared with children of the same age and social status who live with birth parents, children in care are more likely to have incomplete immunisations; lower health surveillance; worse dental health; poorer nutrition; make unhealthier lifestyle choices (Mather, 2010; Williams et al., 2011), and may leave care with unidentified physical health needs (Hill & Watkins, 2003). A longitudinal study of children in care in England (Skuse & Ward, 2003) found that 52 per cent had a health problem which required outpatient treatment, with 26 per cent having more than one problem requiring treatment. The study estimated that 15 per cent of children were likely to have required treatment from a specialist. Similarly, Williams et al. (2001) found that the 'overall health care of children who have been established in care for more than six months is significantly worse than for those living in their own homes, particularly with regard to emotional and behavioural health, and health promotion' (p. 280).

These health problems might be caused by early abuse and neglect, or poor parenting, but there may also be a deterioration of the child's health while in care (Gallagher, 1999). In fact, a study that focused on statutory health assessments for children in care in England suggested that the system might be failing to address identified health problems, since nearly 'half of all health recommendations had not been acted on by the time of the follow-up review' (Hill and Watkins, 2003, p. 10). On the other hand, more recently, Croft (2014) indicated that although LACYP displayed poor physical health at entry to care, many issues are resolved with appropriate intervention within a few months. It has also been noted that there is 'an absence of accurate, up-to-date data concerning children's health needs and their access to health care on social services case files' (Ward et al., 2002, p.20). This is often due to regular changes in social workers and children's placement moves. In addition, 'there is poor access to health records or liaison between health professionals' (Anderson et al., 2004, p. 31).

## Mental health

In the 1990's, a few studies (McCann et al., 1996; Dimigen et al., 1999) attempted to explore the mental health of children in care. These were hampered to some extent by small sample size, geographical area, and the lack of comparison groups in the general population. However, studies did highlight the high level of need experienced by these children on entry into care and when living in foster and residential care. In 2000 and 2004, Meltzer and colleagues conducted the child and adolescent mental health study in Great Britain, and in 2003 conducted the first national survey of the mental health needs of looked after children in England, with surveys following for Wales and Scotland (Meltzer et al., 2003; 2004a; 2004b).



Meltzer et al. (2003) found that as many as 36 per cent, 46 per cent and 44 per cent of children respectively in care in England, Wales, and Scotland had conduct disorders compared with five per cent, six per cent, and four per cent of children in private households. As many as 11 per cent, six per cent and 14 per cent respectively had emotional disorders compared with three per cent, two per cent, and four per cent of children in private households. In addition, 11 per cent, 12 per cent, and 11 per cent of these children were found to have hyperkinetic disorders (ADHD) compared to three per cent, two per cent and one per cent of children in private households (Meltzer *et al.*, 2003, 2004a; 2004b). Furthermore, it was found that 45 per cent of 5-17 years old children in care had a mental health disorder, compared to 10 per cent of the general population (Meltzer et al., 2003). The rate of mental disorder for 5-10 year olds in care was over five times higher than the general population (42% to 8%), whilst for those children aged 11-17 years old, the rate was four times higher (49% compared to 11%). These older children were also seven times more likely to have conduct disorders. Children in residential care were much more likely to have a mental disorder than those in foster care, or placed with family or friends (72% compared with 40% and 32%). They were also more likely to have other problems, with over 75 per cent having at least one physical complaint, and they were twice as likely as children with no mental disorder to have difficulties with reading, mathematics, and spelling. They were also twice as likely to play truant and four times more likely not to spend time with friends. Elsewhere, it has been found that significant majorities of children in foster care fall within the clinical range of behavioural and emotional problems (Achenbach, 1993; Minnis & Devine, 2001).

More recently, researchers have attempted to compare the mental health profile of children in care with that of children from a range of socio-economic backgrounds. The British epidemiological study undertaken by Ford et al. (2007) compared the mental health of children in care with that of children living in deprived and non-deprived private households. They found that children in care had a significantly higher prevalence for most psychiatric disorders, after controlling for age and gender, in comparison to all children from private households, and importantly from an equitable comparison perspective, to the most disadvantaged children from private households.

### Children's behaviour

Significant majorities of children in foster care have been found to fall into the borderline or abnormal range on the SDQ 'total difficulties' score (Goodman, 1997) based on parent/carer reports. This has been found to include as many as up to half (Egelund & Lausten, 2009; Dunne & Kettler, 2008) and as much as three quarters (Milburn, Lynch & Jackson, 2008) of the populations under investigation, suggesting that these difficulties may be having a significant impact on these children's lives. Research has also indicated that children in care experience some, or significant, difficulties in all of the subscales of the SDQ. For example, Whyte and Campbell (2008) found that 56 per cent of Northern Irish carers, 39 per cent of teachers, and 30 per cent of children aged 11 and older considered that there were some or significant difficulties in all of the domains of the SDQ. Furthermore, 40 per cent of carers, 37 per cent of teachers, and nine per cent of children indicated that these difficulties were definite or severe; with 33 per cent of carers, and 30 per cent of teachers indicating that these difficulties were having a significant impact on the child's life. Another Northern Irish study found that children in care had higher levels of emotional symptoms, conduct problems, hyperactivity/inattention, and peer relationship problems, and fewer prosocial behaviours, relative to age appropriate norms for parent, teacher, and self-reports (Teggart & Menary, 2005).

In addition, Callaghan et al. (2004) found that their sample of children in care were experiencing significant difficulties with emotional, conduct, and peer relationships problems, and Millward et al. (2006) found that children in care scored significantly higher than a non-care sample on conduct problems, emotional problems (anxiety and depression), hyperactivity, and problems with peer relationships. Other research has indicated that children in care score more frequently within the pathological range especially for hyperactivity and conduct problems (Egelund & Lausten, 2009) and are more likely to score within the abnormal and borderline range for the SDQ prosocial behaviour scale (Dunne & Kettler, 2008).

### International legislation

#### **UNCRC (1989) United Nations Convention on the Rights of the Child. United Nations**

The UNCRC is an international agreement on the rights of children. It sets out the basic rights to which all children are entitled, in order to have a safe, happy and fulfilled childhood regardless of gender, religion, social origin, and where and to whom they were born. In 1991, the UK Government ratified the Convention, thereby committing itself to the promotion of children's rights, through the provision of services as well as other means.

The Convention assigns more than 40 rights to children and young people including the right to survival and development, formation and preservation of identity, respect for the views of the child, freedom of thought and expression, access to information and education, and protection from violence, exploitation, punishment and trafficking. Various articles in the Convention also make reference to particularly vulnerable groups, such as children who have refugee status, children in care and those with disabilities. The Westminster Government is responsible for the co-ordination of the Convention across the United Kingdom, with the Department for Education (DfE) taking the lead in the implementation of the UNCRC and the co-ordination of reports.

## UK Government legislation and policy reviews, strategies and reports

### The Children Act 1989

The Act was a piece of legislation which reformed the law relating to children, in England and Wales. The primary aims of the Act were: to amalgamate private and public law in one comprehensive framework; to balance the protection of children with the ability for parents to challenge state intervention; to encourage partnership between statutory parents and authorities; to promote utilisation of voluntary arrangements; and to restructure the framework of the courts to enable the management of family proceedings. The Act was based on the premises that the welfare of the child is paramount and the best place for a child to be looked after is within their own home. This legislation also highlighted the need for parental contact during legal proceedings and the consideration of the child's needs arising from race, culture, religion, and language.



The changes implemented through this legislation significantly affected parents, other individuals with responsibilities for children, and local authorities. In relation to parents, the Children Act 1989 replaced parental rights with the concept of parental responsibility, defined as "all the rights, duties, powers, responsibilities and authorities which by law a parent of a child has in relation to the child and his [sic] property." Parental responsibility could be allocated to one or both biological parents, a guardian, or a local authority in the event of a Care Order or Emergency Protection Order being granted. The Act placed a duty on local authorities to provide services for children and their families, and to safeguard and promote the welfare of children in need.

### DH (2000) Framework for the Assessment of Children in Need and their Families

This was aimed at Children's Services to assist the assessment of all children in need, including those in need of protection. This statutory guidance was issued under Section 7 of The Local Authority Social Services Act 1970, and was aimed at professionals and other staff involved in the assessment of children across all agencies. Those working within health, education, and youth services should also be familiar with this guidance. The publication built on the DH's (1988) earlier guidance for assessment: *Protecting Children: A Guide for Social Workers undertaking a Comprehensive Assessment*.

This policy outlined a framework designed to assist in the systematic collection and analysis of information to support professional judgments. Such judgements included whether the child is in need, and if the child is, or is likely to suffer, significant harm, and determining whether a referral is responded to as a child in need of support (Section 17, Children Act 1989), or as a child in need of protection (Section 47, Children Act 1989). Throughout the assessment process, the safety of the child was to be paramount.

The guidance described the assessment process in detail. However, the policy did not outline step-by-step procedures to be followed. Rather, the guidance was to be perceived as a framework to be adapted and used as individual circumstances dictated. It referred to the needs of children in general, but also considered children who may have specific requirements, such as children in care, young carers, children being placed for adoption, and



children leaving care. It provided advice on how to evaluate information gathered through assessments, specifically in terms of the child's developmental needs, parents/carers capacity to respond appropriately and the impact of wider family, and environmental factors on the child and parental capacity.

The holistic design of the assessment requires the collection of information from all agencies involved with the child and family, and the framework outlines the roles and responsibilities of the various agencies. Consideration is also given to the organisational arrangements which should be in place to support effective practice in assessing children in need and their families.

### **The Care Standards Act 2000**

This Act replaced the Registered Homes Act 1984, and was intended to reform the regulatory system for care services in England and Wales. The range of care services to which the Act applied included residential care and nursing homes, children's homes, domiciliary care agencies, fostering agencies, voluntary adoption and healthcare agencies, and private care agencies. The Act introduced a number of changes to the 1984 Act, including the establishment of the National Care Standards Commission and Independent Councils for social care workers, the establishment of an office for the Children's Commissioner in Wales, and the reformation of regulations applicable to childminders. It also provided for the Secretary of State to maintain an accurate list of individuals who were deemed unsuitable to work with vulnerable adults.

### **Department for Children, Schools and Families (DCSF) (2003) Every Child Matters (Green Paper)**

This paper was produced in response to Lord Laming's inquiry into the death of Victoria Climbié (DCSF, 2003). The policies outlined in the report applied to children (from birth to 19 years) in England and were designed to protect them and maximise their potential. This Green Paper addressed the needs of children at risk within the context of services provided for all children. The overarching aim of the policy was to enable children and young people to reach their full potential by reducing levels of educational failure, ill-health, substance misuse, abuse and neglect, teenage pregnancy, crime, and anti-social behaviour.

Consultations with families and children and young people revealed five priority outcomes, including: being healthy; staying safe; enjoying and achieving; contributing positively to community and society; and reaching a state of economic wellbeing. The policy proposed that the Government built on the foundations that were already in place and progress towards improving these outcomes through: the creation of more Sure Start centres; the promotion of full service extended schools; investment in activities for young people and Child and Adolescent Mental Health Services; improvement in speech and language therapy; addressing homelessness; and reforming the youth justice system.

It further proposed progression towards achieving these outcomes for children by ensuring the necessary arrangements were in place to support parents and carers, provide early intervention and effective protection, facilitate integrated working and accountability within children's services, and to encourage reform to ensure a high-quality workforce for children's services.



### **DfES and DH (2004) National Service Framework (NSF) for Children, Young People and Maternity Services**

This framework was part of the then Labour Government's overall plan to tackle child poverty and improve the lives of children and families. The policy was jointly produced by the DfES and the DH, and was aimed at raising standards in hospitals, GP's surgeries, schools, nurseries, maternity units, and Sure Start centres. The NSF was a ten-year strategy which aimed to improve the lives and wellbeing of children and young people on a long-term basis. It aimed to ensure the provision of equal, high quality and integrated health and social care, from pregnancy through to adulthood.

The NSF was closely aligned with the *Every Child Matters* policy and shared the vision that children be healthy, safe, enjoy and achieve, contribute positively to society, and achieve economic wellbeing. Outlined in the NSF were a number of standards which apply to services for all children and young people, services for specific groups of children and young people, and maternity services. The first five standards were aimed at the NHS, local authorities, and partner agencies to achieve high quality service provision for all children and their families. The policy called for the promotion of health and wellbeing of all children and young people through a co-ordinated plan of action, such as prevention and early intervention to ensure long-term gain. Parents and carers were to receive the relevant information, services and support to help them care for their children, develop life-skills, and remain healthy and safe. These services were to be of the highest quality and tailored to the individual needs of the family. The NSF proposed that all young people should have access to services which are age-appropriate and responsive to their specific needs as they made the transition into adulthood. All agencies were to work to promote children's welfare and prevent harm through the provision of services and safeguarding.

The following four standards addressed children and young people who had particular needs. All children who were ill, suspected to be ill, or were injured would have timely access to appropriate advice and adequate services to address their health, social, educational, and emotional needs for the duration of their illness. Children and young people were to receive hospital care which was high quality, evidence-based, developed through clinical governance, and delivered in appropriate settings. Children with disabilities or complex health needs were to receive services which were co-ordinated, child and family-centred, and of the highest quality. All children and young people with mental health problems were to have access to timely, integrated, multidisciplinary, high quality mental health services. The NSF stated that children, young people, and their carers should base decisions about medicines on sound information about risk and benefit. The final standard pertained to maternity services, and addressed the needs and choices of women before, during, and after pregnancy. The NSF stated that women should have easy access to supportive, high quality maternity services, tailored to their needs and the needs of their baby.

This policy pioneers the development of national standards for children and young people's health and social care which promote high quality, women and child-centred services and tailored care that meets the needs of children, parents, and their families.

### **Care Matters Programme (2006)**

The *Care Matters* programme was developed to secure improved and sustainable outcomes for children in care and their families. Its aim was to narrow the gap and address disparities between children in care and their peers through successful corporate parenting: “The corporate parent’s aspirations for children in care should be exactly the same as any parent’s aspirations for their own child.”

### **DfES (2006) (Green Paper) Care Matters: Transforming the Lives of Children and Young People in Care**

This strategy was developed in England by the Department for Education and Skills (DfES) to address disparities in outcomes for looked after children and their peers. Johnson (2006) highlighted these inequalities in the foreword to the document and stated that: “our goals for children in care should be exactly the same as our goals for our own children: we want their childhoods to be secure, healthy and enjoyable – rich and valuable in themselves as well as providing stable foundations for the rest of their lives” (p.3).

The paper aimed to transform the operation of the care system and improve the quality of experience for children and young people in or on the edge of care. It recognised the importance of including children on the edge of care in their strategy, and proposed a number of interventions to prevent children needing to come into care, and assist in resettling children with their families after being in care.

It outlined the roles and responsibilities of the State as corporate parent. In order to strengthen this role, the policy proposed piloting schemes which advocated consistency by enabling the child’s social worker to adopt the role of corporate parent. The strategy highlighted the need for better placements, including fewer moves and a tailored approach to placement decisions, according to each child’s needs. The merits of high quality education were discussed and the policy proposed a number of strategies to improve the education of children in care, including direct admission for LACYP, even if the school is fully subscribed, and a dedicated budget for each social worker to spend on improving the educational experience of children and young people in care. The policy also highlighted the importance of “life outside school” (p.8) and proposed free access for children in care to a number of facilities, including leisure centres, sports grounds, and youth clubs. Finally, the policy addressed the transition to adult life for young people in care, and highlighted the challenges they can face in terms of employment and outcomes. The strategy stressed the need for continuous support for young people leaving care, and proposed raising the age at which young people can leave care from 16 to 18 years.

Listening to the voice of the child or young person was the fundamental basis of this Green Paper as Johnson (2006) explained: “we are determined to put the voice of the child in care at the centre both of our reforms and of day-to-day practice. It is only by listening to these children that we can understand their concerns and know whether or not we are meeting their needs” (p.4).

### **National Care Advisory Service (NCAS) and National Leaving Care Advisory Service (2006) National Standards in Leaving Care**

These standards were developed as an update of the original First Key Standards in Leaving Care (1996). The revised standards reflected changes in legislation, policy, and practice, and

were loosely based around the outcomes detailed in *Every Child Matters* and the *Care Matters* programme. The policy included eight standards, accompanied by action outcome criteria, which were developed to enable young people to make a successful transition to adulthood and proceed to live a healthy and productive life.

The standards addressed corporate parenting responsibilities, the health and safety of the child or young person, enjoyment of life and achievement of potential, positive contribution to society, achievement of economic wellbeing, consideration of fairness and diversity in service provision, and preparation in care planning. These are specified below:

1. Structures and processes exist to ensure that the local authority acts in the manner of a good corporate parent;
2. Every young person is entitled to good healthcare and to receive information and support to maintain a healthy lifestyle, which respects their right to confidentiality;
3. Every young person has suitable and affordable accommodation and there are processes that ensure they stay safe;
4. Every young person is encouraged and supported to achieve their potential in education and to enjoy leisure and recreational activities;
5. Every young person is encouraged and supported to make a positive contribution to the development and delivery of services, to the planning and decision-making that affects their lives, and to their local communities;
6. Every young person is encouraged and supported to achieve economic wellbeing through employment and receives appropriate financial support throughout their transition to adult life;
7. Every young person receives a service that values diversity, promotes fairness, and challenges discrimination; and
8. Every young person has a plan that accurately reflects how their short, medium and long-term needs will be met, and that young people are sufficiently prepared for adult life before leaving care in a way that reflects their individual needs.

#### **DfES (2007) (White Paper) Care Matters: Time for Change**

This White Paper built on responses to the Green Paper *Care Matters: Transforming the Lives of Children and Young People in Care*. Similar to the Green Paper, the focus of the policy was to address disparities in the quality of outcomes for looked after children, in comparison with their peers: “The aspiration that the State has for these children should be no less than each parent would have for their own child” (p.3). This White Paper outlined the government’s plans across seven key areas for improving the outcomes of children and young people in care. The seven themes are discussed in turn below, accompanied by some recommendations.

First, the policy stated that improving the role of the corporate parent is key to improving outcomes for children in care. The DfES suggested improving this role within each local authority through the establishment of a ‘Children in Care Council’; the development of each

local authority's 'Pledge' to children in care; clear understanding of who is responsible for leading improvements in corporate parenting; and reviews of progress in improving outcomes for children in care.

Second, the policy emphasised the need to support children within their own families. A change in legislation was recommended to enable carers who are related to the child to apply for a Residence Order, if the child has lived with the carer for at least one year continuously. The DfES also recommended effective care planning to ensure that work with birth parents was continuous whilst the child was in care, and delivery of appropriate services, to support the child or young person's safe return home.

Third, the White Paper emphasised the importance of stable placements and called for improvements in the quality of placements for children in care through improved commissioning; strengthening statutory guidance to prevent out-of-authority placements; and revising National Minimum Standards for foster and residential care.

Fourth, the importance of high-quality education was emphasised, and there was a recommendation of early years provision for children in care under the age of five, and high priority for children in care in school admission arrangements.

Fifth, the strategy highlighted the importance of health promotion in improving outcomes for children in care. In order to promote health, the DfES recommended sharpening the focus on the needs of children in care; developing new standards for service provision to pregnant young women and mothers in care or leaving care; and transforming the availability of positive activities for children and young people in care.

In the sixth key theme, the policy aimed to improve the transition to adulthood for young people in care by: preventing their premature discharge from care; extending the age to which care leavers can avail of support from a personal adviser; and the introduction of a national bursary for all young people in care who go on to higher education.

Finally, it was acknowledged that the role of the corporate parent is embodied by the work of practitioners. The policy recommended improving the role of the practitioner by addressing issues of recruitment and retention of social workers; remodelling the social care workforce to enable social workers to spend more time with the child; and improving the skills and training of social workers. It was hoped that this revised framework would enable children and young people to receive high quality care and support, and drive forward improvements in services.

### **DCSF (2007) The Children's Plan: Building brighter futures**

This was developed by the DCSF with the aim of making England the best place in which children and young people can grow up. Underpinning the plan were a number of key principles, including: the need for the Government to recognise and support the important role of parents; the need to encourage all children to succeed and reach their full potential; finding a balance whereby children can enjoy their childhood whilst also being prepared for the transition to adulthood; recognising that services best meet children's needs when they are shaped by children rather than professionals; and realising that "it is always better to prevent failure than tackle a crisis later".

The document provided a ten year plan which addressed six strategic objectives identified by the DCSF. The first one was to secure the wellbeing and health of children and young people through investment and improvements in service provision. The second objective was to safeguard young and vulnerable children. The plan also outlined the Government's responsibility for ensuring that adequate frameworks and systems are in place for safeguarding children and young people. The third objective was for individual progress in achieving world class standards and closing the gap in educational achievement for disadvantaged children through investing in family learning and free education for two-year-olds from the most disadvantaged areas. The fourth objective was system reform to achieve world class standards, and close the gap in educational attainment for disadvantaged children by investing to improve the quality and capacity of teachers; promoting diversity; and creating enabling school environments. The fifth objective was to ensure that young people achieve their potential (by 18 years old and beyond) by investing in schemes to encourage young people to stay on in education. The final sixth objective was keeping children and young people on the path to success by investing in positive activities and producing action plans to tackle risk behaviour.

The policy also outlined goals to be achieved for children by 2020. These included: the enhancement of children's wellbeing; Early Years developments to ensure that every child is ready for success in school; every child is ready for secondary school; every young person is equipped with the skills to deal with adult life and further study; parents are satisfied with the level of support they receive; young people participate in positive activities; employers are satisfied with young people's readiness to enter the employment market; improved child health; child poverty is halved by 2010 and eradicated by 2020; and a significant reduction in the number of young people receiving convictions for first-time offences.

#### **DCSF (2008) *Care Matters: Time to Deliver for Children in Care – An Implementation Plan***

This implementation plan was a joint publication by the Government and the Children's Inter-Agency Group. The policy followed on from the *Care Matters* White and Green Papers and marked a shift from policy development at a national level to delivering change at a local level. The implementation plan focused on the national framework for change, provided guidance for local implementation of change, and offered suggestions as to how progress could be monitored and evaluated.

The shared vision outlined emphasised the need for successful corporate parenting, listening to the voice of children in care, and developing stable relationships. The policy highlighted a number of aspirations, including that shared by *The Children's Plan*, to make England the best place in which children can grow up, whether they are in care or living with their birth families. Other ambitions included: narrowing the gap between children in care and all children; providing access to sufficient positive leisure activities; and developing opportunities for volunteering, work experience, and employment for older children in care.

The policy proposed that Children's Trust partners progressed towards these ambitions through systematic planning for children in care, based on high-quality assessments for children entering care, effective management, greater choice of placement, and improved support. Sector-led development was also key in making progress to achieve the vision outlined. The implementation plan included a list of tools and resources designed to enable Children's Trust Partners to improve practice within specific areas. The plan proposed

monitoring and evaluating progress using feedback from children and young people, input from Ofsted following regulatory inspections, analysis and evaluation of pilot intervention data, and an amalgamation of the above.

### **The Children and Young Persons Act 2008**

This Act amended the Children Act 1989 and was intended to reform the statutory framework for the care system in England and Wales, by implementing the proposals in the *Care Matters White Paper* (DfES, 2007). The purpose of the Act was to ensure that children and young people in care received high quality care and services which were focused on and tailored to their needs. The Act was also intended to improve the stability of placements and improve the educational achievements of children and young people in care. The legislation also sought to ensure that young people are not forced out of care before they are ready through the provision of support and services.

In summary, the Act dealt with: the delegation of authority; respite services; the promotion of wellbeing for children in England; appropriate placements for looked after children; the appointment of independent reviewing officers (IROs); the designation of individuals to ensure that each looked after child's needs are being met; and payment of bursaries for a former relevant child who goes on to higher education and respite services. The legislation also extended the rights of relatives who are entitled to apply for a Residence Order or Special Guardianship Order.

### **CAMHS (2008) Children and young people in mind: the final report of the National CAMHS review**

This independent review was commissioned by Government in 2008 to investigate the way in which children's health, education and social care services contribute to the mental health and psychological wellbeing of children and young people. The review tracked changes across nine areas in England between 2004 and 2008, and highlighted positive development in services contributing to mental health and psychological wellbeing. These progressive changes included: reduced waiting lists for CAMHS; the introduction of new programmes to support infant mental health; vulnerable children and children in care; as well as the development of the Behaviour and Attendance programme<sup>2</sup> in schools. The review noted that local organisations have also played an important role in developing innovative approaches to improving the skills of families and those who work with children. Whilst these changes marked progress towards improving mental health and psychological wellbeing, the review called for more consistent and progressive change, proposed through the consideration of 20 key recommendations.

These recommendations pertained to changes required at local, regional and national levels to improve the mental health and psychological wellbeing of children and young people. First, the review called for the establishment of a National Advisory Council with the

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<sup>2</sup> The Behaviour and Attendance Strategy was introduced in 2003 in a bid to encourage schools to adopt a holistic approach to tackling behavioural issues and provide targeted multi-agency support to a number of local authorities through the development of Behaviour and Education Support teams.

responsibility of promoting mental health as a national priority, addressing the recommendations outlined in the review, and holding Government accountable for progress in this area. Second, it recommended fortification of the Government's national support programme in order to facilitate consistency, improvement, and sustainability in service delivery. Third, the children's workforce was to be supported in meeting the challenges faced through the development and implementation of minimum standards and accessibility to training programmes. Finally, the report recommended the delivery of high quality practice through national outcome measurement, monitoring and evaluation of children's services, and accessible knowledge about children's mental health and psychological wellbeing.

Whilst most of the recommendations were aimed at children's services, the review highlighted the need for an all-round shift in perspectives of mental health. Stigma and negative attitudes towards children and young people with mental health-related issues can act as barriers which prevent the improvement of mental health and psychological wellbeing. It was suggested that consideration of the recommendations, coupled with a shift in cultural attitude, could facilitate important improvements in children's mental health and psychological wellbeing.

### **Co-operation and Working Together (CAWT) (2008) Framework for Integrated Planning for Outcomes for Children and Families**

Reviews of current policy in relation to health service provision for children and young people often emphasise the need for collaborative/partnership working across various agencies, but few offer guidance on procedures for working collaboratively. This framework provided an overview of strategies and tactics for achieving outcomes through integrative planning and collaborative working. It was aimed at policy-makers, service providers, and practitioners who worked with and for children on a daily basis. "Integrated planning is the formulation of plans by and between agencies for the provision of services" (p. 15). It was noted that adopting an integrated approach to planning could be beneficial in a number of ways, including: effective use of resources; identification of inefficient or overlap of services; and reduction of stigma associated with using specific services. Successful integrated service planning requires recognition of the importance of content *and* delivery in the provision of health services and the ability to reflect on practice. This involves policy-makers and practitioners engaging in a process which describes and questions their actions, in order to improve the experience for children and young people.

This framework offered clear guidance on how to use an integrated planning approach which focused on outcomes for children and families. The document provided examples of action points to ensure that organisations maintained focus on outcomes for children and families, as well as indicators to measure the degree to which identified outcomes were being achieved.

### **DH and DCSF (2009) Healthy Children, Safer Communities**

This policy was jointly developed in 2009 by the Department of Health (DH) and the Department for Children, Schools and Families (DCSF). It pertained to children in England, and aimed to improve the health and wellbeing of young people at risk of offending and re-offending. The strategy was specifically aimed at those individuals responsible for directing services for vulnerable children, at a local and regional level. It was also important for



managers, commissioners, and practitioners involved with services for children and families. The vision was that “all children and young people will be safer and healthier and stay away from crime, and that communities will be safer too” (p.6).

The DH and DCSF proposed to deliver this vision through a three-tier approach, described in sections one, two, and three of the strategy. Section one referred to the vision for improving the wellbeing of children in the Youth Justice System (YJS), and proposed harnessing mainstream services to reduce offending and re-offending. The key objectives associated with this principle included early intervention to address emerging health needs, ensuring children in the YJS access services used by all children, underpinning interventions with holistic assessments, and acknowledging the importance of supportive family and community relationships.

Section two focused on addressing health and wellbeing, based on the vision that contact with the YJS should contribute to positive health outcomes for children. Identifying and addressing needs at an early stage was viewed as integral for reducing youth crime. This principle aimed to ensure that more children experienced diversions from the YJS; to improve the provision of services to young offenders; to ensure the courts received accurate health information; to promote health and wellbeing in the secure estate; and to achieve continuity of care when children completed a sentence.

Section three referred to ‘Making it happen’, and was based on the vision that decision-makers at all levels should respond to the health inequalities experienced by young people at risk of offending behaviour. This section of the strategy aimed to achieve a co-ordinated approach to improving health and wellbeing, to provide services that made a difference, and to ensure high-quality service provision and improved outcomes for children, their families, and communities.

### **DCSF and DH (2009) Healthy lives, brighter futures – The strategy for children and young people’s health**

This was a long-term strategy, jointly produced by the DCSF and the DH, which presented the Government’s vision for children and young people’s health and wellbeing. The strategy highlighted the progress which had led to children and young people being healthier than ever. However, the policy outlined the 2020 ambition of making England the best place for children to grow up by supporting families “in securing world-class health and wellbeing outcomes for their children” (p. 8). The strategy proposed progressive steps towards this ambition through the achievement of world-class health outcomes, services of the highest quality, excellent experiences in using services, and minimising health inequalities. The recommendations outlined in this strategy cemented the standards set through the *National Service Framework for Children, Young People and Maternity Services* and the *Every Child Matters* programme for improving outcomes for children.

The strategy highlighted the important role which parents play in achieving the best physical and mental health and wellbeing outcomes for their children. It outlined a number of outcomes which parents and children could expect from their services. Firstly, parents ought to be provided with the information required to help their children lead healthy lives, as well as details of local services and organisations which could assist them. Secondly, adequate services ought to be in place to meet specific health needs of children and young



people; they ought to provide healthy environments and encourage young people to make healthy choices. Finally, parents could expect that those from the most disadvantaged backgrounds would have access to extra support and services. This strategy outlined the plans for universal, targeted, and specialist support across three life stages; early years and pregnancy; school age children; and young people. It also set out how the delivery system could be supported in implementing the recommendations, with a particular focus on collaborative working between services in contact with children and young people, in order to achieve common aims. The policy set out ambitions for children's health and wellbeing, as well as proposals for realising these ambitions.

**The Centre for Excellence and Outcomes in Children and Young People's Services (C4EO) (2009) Improving the emotional and behavioural health of looked after children and young people**

This knowledge review, published by the C4EO, is one of three reviews which aimed to improve the life chances of LAC. The report was based on a systematic review of research evidence on successful means of improving the emotional and behavioural health of LACYP. The review focused specifically on interventions, with the aim of providing evidence to help service providers improve services and outcomes for LAC and their families. The review set out to answer three specific questions:

1. What is known about the importance of relationships for LACYP?
2. What is known about accessibility, acceptability, and effectiveness of enhanced foster care, multi-systemic therapy and mentoring?
3. What is known about the role of professionals and birth families in supporting looked after children and young people's emotional and behavioural health?

Findings from the knowledge review revealed that: a sense of belonging is key to emotional wellbeing; accessible interventions and support enhance placement stability; LACYP require continuity of support; challenging negative stereotypes of being 'in care' can improve children's emotional health and wellbeing; improved access to support and more information on services is important to foster carers and birth parents; treatment foster care may be effective in reducing offending behaviour and number of care placement moves; multi-systemic therapy can result in improved emotional health; mentoring can have a positive impact; and more extensive evaluation research into therapeutic interventions is required.

**DCSF and DH (2009) Statutory Guidance on Promoting the Health and Well-being of Looked After Children**

This statutory guidance concerned the delivery of services to promote the health and wellbeing of LACYP. It only applied to England and was issued to local authorities, Primary Care Trusts (PCTs), and Strategic Health Authorities (SHAs) under sections 10 and 11 of the Children Act 2004. The guidance superseded the document 'Promoting the health of looked after children,' published by the Department of Health in 2002.

The aim of this guidance was to ensure that "all looked after children and young people are physically, mentally, emotionally and sexually healthy, that they will not take illegal drugs and that they will enjoy healthy lifestyles"(p. 5). It aspired to achieve this aim by promoting

collaborative working between local authorities, PCTs and SHAs, and outlining clearly the roles of local authorities and the National Health Service (NHS).

Although the guidance outlined separately the responsibilities of local authorities and the NHS, many of these could only be delivered through the co-operation of different agencies. In terms of working collaboratively, the guidance stated that local authorities, PCTs, and SHAs should work together to commission health services. Local authorities should also have systems in place to notify PCTs of placement changes and ensure that the health needs of children placed out-of-authority are being met. Such systems included the identification of the responsible commissioner and adherence to the guidance thereof. Staff working with LACYP were responsible for liaising with professional colleagues to ensure that health and care planning was meeting the child's needs. Whilst health assessments and health plans were the responsibility of the local authority, PCTs had to comply to ensure that these were conducted effectively. Local authorities, PCTs, and SHAs needed to collectively build awareness of the high level of mental health needs among LACYP into their strategic planning.

It was the responsibility of local authorities to ensure that a health assessment was conducted for every child. They had also to ensure that every child had a health plan, which was reviewed every six months in accordance with the regulations; this was usually the responsibility of the child's social worker. The local authority should act as a parent and advocate for each child and ensure that the child's voice is heard and informs the commissioning, planning, delivery, and evaluation of services. Local authorities, usually through the medium of social workers, should ensure that carers have means of contacting and accessing the lead professionals and relevant services for children in their care. Looked after children should have free access to positive activities and related facilities owned, delivered, and commissioned by local authorities. The NHS was expected to contribute to meeting the health needs of LACYP through the commission of effective services, the delivery of these services through provider organisations, and the provision of co-ordinated care by individual practitioners.

### **NICE and SCIE (2010) Promoting the quality of life of looked-after children and young people**

This guidance was jointly produced by the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) with the aim of improving the quality of life (i.e. the physical health and social, educational and emotional wellbeing) of LACYP. It was not statutory guidance, but was relevant to individuals across a wide range of professions and agencies, and it was hoped that this would help in meeting obligations to improve the health and wellbeing of LACYP. The recommendations also reinforced statutory guidance and minimum standards.

The guidance outlined the ways in which organisations, professionals, and carers can work collaboratively to improve the quality of life of LACYP by enabling them to reach their full potential and enjoy similar life-opportunities as their peers. The recommendations covered local strategy and commissioning, multi-agency working, care planning and placements, and timely access to appropriate health and mental health services. They specifically sought to promote stable placements and nurturing relationships; support the full range of placements, including those with family and friends; encourage educational achievement;

support the transition to independent living; meeting the specific needs of LACYP, including those from marginalised populations; and place LACYP at the heart of decision-making processes. Each recommendation was accompanied by action points detailing which course of action should be taken and by whom, in order to address each of the key issues raised.

### **Department of Health (2011) Quality Criteria for young people friendly health services**

This guidance was developed in England to help commissioners and health service providers improve NHS and community-based services for young people. The DH outlined a range of principles, covering ten topic areas, which would enable health services to become 'young people friendly'. It was hoped that the quality criteria specified would assist in the provision of a framework to change the way in which resources were allocated, thus helping to ensure better health outcomes.

The ten topic areas which were identified as significant in making health services young people friendly included: accessibility of health services; effective publicity of these services; the need for confidentiality and informed consent in the provision of health services; and consideration of the environment and atmosphere in service settings. Staff should also receive adequate training to understand and engage with young people, as well as adequate support and supervision in the delivery of health services. Consideration should be given to the issues faced by young people during the transition to adulthood. Health services should reflect consideration of these issues and include consultations on smoking cessation, healthy eating, alcohol and drug misuse, mental health, and sexual and reproductive health. Sexual-health-related work should be informed by NICE guidance, and a range of sexual health services should be offered, including: screening and treatment for Sexually Transmitted Infections (STI), contraception, and appropriate information on sexual health. The final topic area identified related to specialist child and adolescent mental health services (CAMHS) and specialist services. Specifically, it was argued that young people and parents and carers should be presented with appropriate and sufficient information to make informed decisions.

It was hoped that the application of this policy would contribute to improving the quality and availability of health services provided to adolescents in England, as well as reducing inequalities in accessing health services.

### **APS Group Scotland (2011) Nutritional guidance for children and young people in residential care settings**

This guidance, developed by Healthy Scotland, covered children who were accommodated in residential homes, school care accommodation, and secure accommodation. It adopted a health promotion model and a holistic approach to health and wellbeing to "help care providers to plan and provide food and drink that meets the dietary needs of children and young people in their care" (p. 2). It was developed in response to a consultation with children and young people in residential care, from which five key themes emerged: young people seeing food as an unknown quantity; staff and establishments responding to young people as individuals; the importance to young people of being involved in food issues; improving quality, quantity, variety, and availability of food; and flexible and alternative eating arrangements. A number of recommendations were made, including preparation of food in-house and additional staff training. This guidance highlighted the importance of a healthy-balanced diet in preventing diet-related diseases, childhood obesity, and promoting

dental health. An increase in fruit and vegetables, offering a variety of food, suitable portion sizes, reducing sugar, and fat and salt intake were just some of the recommendations made. Practical advice on how to achieve these suggestions was also provided. At present, there is no similar guidance available in the rest of the UK, including Northern Ireland.

**The Royal College of Nursing (2012). Looked after children: Knowledge, skills and competences of health care staff. Intercollegiate role framework.**

The Royal Colleges (the Royal College of Nursing, the Royal College of Paediatrics and Child Health, and the Royal College of General Practitioners) published this framework in recognition of the importance of education and training to prepare practitioners for the roles and responsibilities entailed in working with looked after children in the UK. This framework outlined key roles, and the knowledge and skills required of professionals working with LACYP. More specifically, it identified five levels of competence (i.e. a combination of skills, knowledge, attitudes and values required to effectively protect and promote the welfare of LACYP), giving examples of groups of professionals that fell within each. The levels were:

- ◆ Level 1: Non-clinical staff working in health care settings;
- ◆ Level 2: Minimum required for clinical staff who have some degree of contact with children and young people and/or parents/carers;
- ◆ Level 3: Clinical staff working with LACYP and/ or their parents/carers, and who could potentially contribute to assessing, planning, intervening and evaluating the needs of the LACYP;
- ◆ Level 4: Specialist roles, such as Medical, Nursing and Health advisors, including lead health professionals; and
- ◆ Level 5: Designated professionals

The framework also identified key issues related to acquiring and maintaining knowledge and skills.

**DH (2015). Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing.**

This document reported on the work undertaken by the Children and Young People's Mental Health and Wellbeing Taskforce in England, and offered a vision on the way to improve how children and young people's mental health services were organised, commissioned, and provided. In this report, a set of challenges facing child and adolescent mental health services (CAMHS) were identified, including:

- ◆ Significant gaps in data and information, and delays in the development of payment and other incentive systems;
- ◆ The treatment gap (only a small percentage of those with a diagnosable mental health condition access support);
- ◆ Difficulties in access (increases in referrals and waiting times, and growing complexity and severity of presenting problems);
- ◆ Complexity of commissioning arrangements, with a lack of clear leadership and accountability for children's mental health across agencies (leading to the potential for children and young people to fall through the net);

- ◆ Regional inconsistencies in the access to crisis, out-of-hours, and liaison psychiatry services; and
- ◆ Specific issues facing highly vulnerable groups of children and young people and their families, who may find it particularly difficult to access appropriate services.

The report established a set of goals for the Government to accomplish by 2020, including:

- ◆ Improved public awareness and understanding;
- ◆ In any locality in the country, timely access to clinically effective mental health support for children and young people when they need it;
- ◆ A shift from a system defined in terms of the services provided (the ‘tiered’ model) towards one created around the needs of children, young people, and their families (leading to easy access to the right support from the right service at the right time);
- ◆ Greater use of evidence-based treatments with services strictly focused on outcomes;
- ◆ More visible and easily accessible mental health support for children and young people (i.e. “one-stop-shop” services in each local area; named points of contact in specialist mental health services and schools);
- ◆ Improved care for children and young people in crisis (treated in the right place at the right time, and as local as possible);
- ◆ Greater delivery of evidence-based programmes of intervention and support for parents to strengthen attachment and avoid trauma;
- ◆ Easy and timely access to the appropriate supports for the most vulnerable children and young people;
- ◆ Improved transparency and accountability across the whole system; and
- ◆ Ensuring that all professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support.

#### **DoE and DoH (2015). Promoting the health and well-being of looked-after children.**

##### **Statutory guidance for local authorities, clinical commissioning groups and NHS England.**

This was joint statutory guidance (from the Department for Education and the Department of Health) for local authorities, clinical commissioning groups (CCGs), and NHS England, and it replaced the *Statutory Guidance on Promoting the Health and Well-being of Looked After Children*, issued in November 2009. It was divided into two main parts: one regarding joint responsibilities in terms of supporting all LACYP, and the other one regarding planning and providing services for individual LACYP.

The main points established in this guidance document were:

- ◆ The corporate parenting responsibilities of local authorities comprise the duty to safeguard and promote the welfare of the children they look after, including the promotion of the child’s physical, emotional, and mental health, and acting on any early signs of health issues;
- ◆ Local authorities should arrange for their LACYP to have a health assessment. The initial health assessment must be done by a registered medical practitioner, whereas review health assessments can be carried out by a registered nurse or registered midwife;

- ◆ Local authorities must ensure that every child/young person they look after has an up-to-date individual health plan, which should be developed based on the written report of the health assessment. The health plan is part of the child's overall care plan;
- ◆ When a child starts to be looked after, moves placement, or stops to be looked after, the responsible local authority must inform (among others) the CCG and the child's GP. If the child is moved in an emergency, the notifications must occur within five working days;
- ◆ LACYP should never be refused a service (including for mental health) because of their placement being short-term or unplanned;
- ◆ CCGs and NHS England are required to cooperate with requests from local authorities to conduct health assessments and help them ensure services to LACYP are provided without unjustified delay;
- ◆ Local authorities, CCGs, NHS England, and Public Health England should cooperate to commission health services for all children in their area;
- ◆ The health needs of LACYP should be taken into consideration in developing the local Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS);
- ◆ Local authorities need to agree local mechanisms with CCGs to make sure that they comply with NHS England's guidance on establishing the responsible commissioner in relation to secondary health care when making placement decisions for LACYP;
- ◆ If a young person leaving care moves out of the CCG area, arrangements must be made through discussion between the 'originating CCG', those currently providing the child's healthcare, and the new providers, in order to ensure continuity of healthcare;
- ◆ Local authorities, CCGs, and NHS England must make sure that plans are in place to support children leaving care to continue to obtain the healthcare they need; and
- ◆ LACYP must be able to take part in decisions about their health care. Arrangements need to be made in order to promote a culture where LACYP are listened to; a culture that takes into consideration their views in identifying and meeting their physical, emotional, and mental health needs; and a culture that enables others to understand the importance of listening to and taking account of the child's wishes and feelings about how to be healthy.

### **The Times (2015). Time to Mind: A manifesto for child and adolescent mental health services**

This is a recent campaign launched on the 13<sup>th</sup> March 2015 by the Times and the Sunday Times calling on the Government to do more for children and adolescents suffering mental ill-health. The manifesto was produced by Professor Tanya Byron, government advisor and one of the UK's leading clinical psychologists, and backed by three more of the country's top experts in the field: Sarah Brennan, CE Young Minds; Dr Peter Hindley, Child & Adolescent Psychiatrist, RCPsych; and Professor Isobel Heyman, Child & Adolescent Psychiatrist GOSH and Chair, London Child Mental Health SCN. The manifesto includes ten action points:

1. A new prevalence study to be commissioned by the government of child and adolescent mental health, which should be repeated every five years;

2. The referral and treatment for children and young people with mental health problems should be evidence-based and carried out by a properly trained clinician, and NICE guidelines must be followed;
3. The focus of investment in CAMHS should be on early intervention and prevention, in order to identify and treat problems before they become severe or chronic;
4. Funding outpatient and community outreach services with access to early intervention should be a priority; while certain other practices (i.e. young people suffering a crisis being held in police cells, taking them onto adult wards, or being sent miles from home) must end;
5. Better and timely access is needed to all services (e.g. out-of-hours crisis services, paediatric liaison teams within acute hospitals, community-based assertive outreach teams, etc.): waiting times for treatments for non-urgent cases should be a maximum of 18 weeks, while front line support services should be available 24 hours a day, seven days a week;
6. Local authorities should urgently assess the mental health needs of the children and adolescents living in their area;
7. The transition from CAMHS to adult mental health services require local coordination of services across the system with a well-coordinated system-wide commissioning framework;
8. There needs to be better training for professionals at Tier 1 (i.e. GPs, health visitors and school nurses): “A telephone access system to a senior mental health clinician should be considered and piloted as a model of good practice for the support of Tier 1 staff, where via a mass telephone system GPs and paediatricians can contact a consultant child and adolescent mental health professional within 30 minutes”;
9. There also needs to be better training and guidance for teachers and schools: “The Department for Education should include a mandatory module on mental health in initial teacher training, with mental health modules forming a mandatory part of ongoing professional development in schools for all staff. Ofsted should also include routine assessments of emotional support and mental health provision in schools as part of their inspection. Implementation of the guidance issued to schools should inform these assessments”; and
10. “There must be a clear national policy directive for CAMHS, underpinned by adequate funding and driven by accurate and up-to-date data on the regional and national mental health needs of children and young people.”



**Children and Young People's Mental Health Coalition (2015). Children and young people's mental health: The policy, the progress made, the challenge.**

This recent report summarises some of the more relevant policies relating to children and young people's mental health in England, highlighting the progress that has been made in this area, and identifying gaps and weaknesses in current policy in order to pinpoint the current challenges. According to this report, progress has been made in terms of investment in CAMHS: increased focus on mental health promotion; recognition of the importance of joined-up working within policy and through the development of Children's Trusts; increased focus on the early years; and the Think Family Agenda (recognizing the importance of seeing the child within the context of his or her wider family network). However, many challenges are also identified:

- ◆ A need for increased focus and commitment around perinatal and infant mental health;
- ◆ Because of the stigma and discrimination still existent around mental health, young people being less likely to identify, manage and seek support for their mental ill-health;
- ◆ A lack of mental health promotion actually occurring at an individual, community, and societal level;
- ◆ A lack of recognition by the general public (including children and young people) of the role that nutrition and exercise play in mental health;
- ◆ Lack of training around child emotional development for the children's workforce;
- ◆ The need for a greater focus on identifying issues as they emerge across a variety of settings and intervening before issues become more serious;
- ◆ Significant problems with the interface between CAMHS and early intervention in psychosis teams;
- ◆ Transition between CAMHS and other adult services is the biggest area of concern for children and young people, their families, and service providers;
- ◆ A gap in provision for young adults with very little policy focusing purely on 19-25 year old young adults;
- ◆ Variable quality of specialist CAMHS with many children with mental health concerns not always meeting the threshold for access to services;
- ◆ Not enough focus on the needs of children from BME backgrounds;
- ◆ Taking into account poverty and health inequalities;
- ◆ Current underdevelopment of joint commissioning for families and mental health, and the need to involve children, young people and families in needs assessment and service design; and
- ◆ Short-term or project-based funding for projects and treatments (not suitable to children and young people's needs).



## Children in Care in Northern Ireland

When efforts to secure children's safety and wellbeing within their own families fail, the law in Northern Ireland makes provision for the responsible Health and Social Care (HSC) Trust (equivalent to local authorities in Great Britain), of which there are five in Northern Ireland, to share parental responsibility with the parents through a Care Order (Children Order 1995, Article 50). In these cases, children are placed in substitute care placements, including: kinship care, foster care, and residential care (primarily for teenagers).

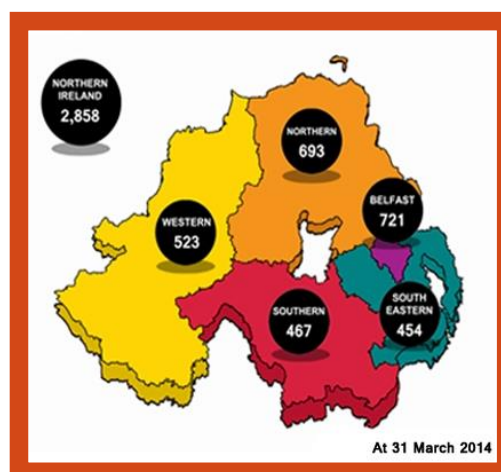


A child can also be accommodated by an HSC Trust on a voluntary basis. In such instances, birth parents retain full parental responsibility, and may resume care of their child at any time. When reunification with the birth family is thought possible, children subject to Care Orders may be placed with their birth parents, pending the birth parents making satisfactory progress in terms of addressing the HSC Trust's concerns, with a consequent revocation of the Care Order. Some children also remain living with their birth parents while the HSC Trust makes an application for a Care Order through the courts, and on some occasions thereafter, even when a Care Order is granted.

Children may remain in kinship and foster care for a short period of time before returning home, or on a longer-term basis if the parents' difficulties remain unresolved. In some instances, kinship and foster carers may choose to apply to have the Care Order superseded by a Residence Order (Children Order 1995, Article 8), which effectively takes the child out of the care system and affords the carers shared parental responsibility with the birth parents. In effect, the shared parental responsibility held by the Trust when a Care Order is in place is transferred to the carers when a Residence Order is granted.

## Northern Ireland Statistics on Children in Care

Around the time the study began, on 31<sup>st</sup> March 2012, 2644 children were being looked after by the five HSC Trusts in Northern Ireland. Of these, 52 per cent were boys and 48 per cent were girls; 22 per cent were aged under four years, and 18 per cent were 16 years or older. During 2011/12, there were 865 admissions into care, an increase of four per cent from the previous year, 745 discharges from care, and 932 respite placements (DHSSPS, 2012). During the course of the study, the LAC population grew substantially. In fact, the number of looked after children in Northern Ireland rose by 14 per cent between 2011 and 2014, with 2,858 looked after children and on 31<sup>st</sup> March 2014, representing 66.2 children per 10,000 of the child population. Of these, 51 per cent were boys and 49 per cent were girls; 23 per cent were under five years, and 19 per cent were 16 years or older. The proportion of children in each placement was similar, with around three quarters being placed in foster care (Table 1), although the percentage of children being in care for less than one year decreased between 2012 and 2014, from 25 per cent to 14 per cent (Table 2).



Changes in each Trust's number of looked after children between 2012/13 and 2013/14 ranged from increases of 12 per cent and 8 per cent in the Western and Belfast Trusts to a decrease of 12 per cent in the South Eastern Trust. The Northern and Southern HSC Trusts had similar numbers of looked after children both years. During the 2013/14 year, there were 910 admissions into care, 798 discharges from care, and 10,147 episodes of respite care. The Northern HSC Trust accounted for the largest proportion of admissions (26%), followed by the Southern HSC Trust (20%), the South Eastern and Belfast HSC Trusts (19%), and the Western Trust (16%) (DHSSPS, 2014a).

**Table 1: Placement type and legal status of looked after children in Northern Ireland (%) 2012-2014**

Placement & legal status	31/03/2012	31/03/2014
<b>Foster care</b>	74	75
<b>Placed with family/parents*</b>	11	12
<b>Residential</b>	9	7
<b>Other placements</b>	5	5
<b>Care Order (Article 50/59)</b>	51	58

\* This refers to children for whom a Care Order exists and who are placed with their parents, a person who is not a parent but who has parental responsibility for the child, or where a child is in care and there was a Residence Order in force with respect to him/her immediately before the Care Order was made, a person in whose favour the Residence Order was made.

Source: DHSSPS, 2012; and DHSSPS, 2014a

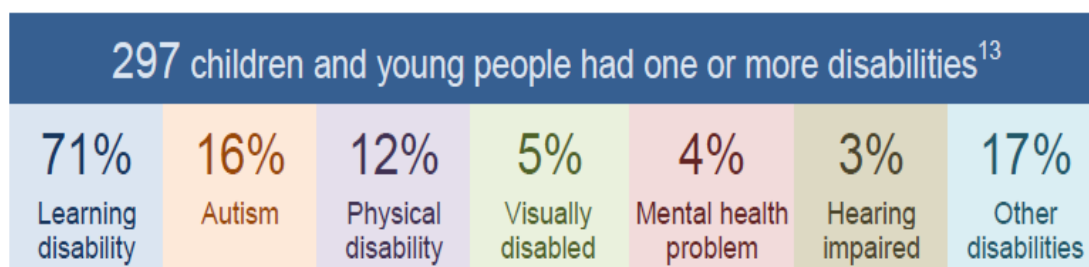
**Table 2: Duration in care (%) 2012-2014**

Duration in care	31/03/2012	31/03/2014
<b>Less than one year</b>	25	23
<b>1-9 years</b>	65	68
<b>10 years +</b>	9	9

At 30<sup>th</sup> September 2013, 2,071 children in Northern Ireland had been continuously in care for a period of at least 12 months, and 23 per cent had experienced a placement change during the previous 12 months. The largest proportion of LAC was in the Belfast HSC Trust, closely followed by the Northern HSC Trust. In 2012/13, 14 per cent of LAC were reported as disabled, the same as previous years; but this varied in relation to gender, with 17 per cent of males being disabled compared to 12 per cent of females. The Belfast HSC Trust had the highest proportion of disabled children in their LAC population (16% compared to 10% of the LAC population in the Southern Trust). Nearly all children under five were up-to-date with their six-monthly assessment (97%), and 87 per cent of children aged five and over were up-to-date with their annual statutory medical; 99 per cent of LAC were up-to-date with their immunisations; and 96 per cent had their teeth checked the previous year. Nearly three quarters of children in care for a period of at least 12 months were of school age (73%). Of

those, over three quarters had a Personal Education Plan (PEP) (77%), one quarter had a statement of SEN (compared to 5% in the general school population), six per cent had been suspended from school (compared to 1.3% of the general school population), and eight per cent had missed at least 25 school days within the relevant school year. In addition, the proportion of eligible LAC attaining key stage one to three was more than a third less than the general school population. Almost three quarters (73%) of LAC achieved at least one GCSE compared to 100 per cent of the general school population. In addition, ten per cent of children aged 10 or over who had been in care for a continuous period of 12 months or more had been cautioned or convicted of an offence while in care (DHSSPS, 2014b). Overall, these figures indicate that many important health and related outcomes for children in care differ when compared to that of their peers.

**Figure 1: Looked after children with a disability and type of disability (2012/13) (extracted from DHSSPS, 2014a, p. 13)<sup>3</sup>**



During the year ending 31<sup>st</sup> March 2014, 268 young people aged 16-18 left care in Northern Ireland, 53 per cent were boys and 47 per cent were girls. The majority of care leavers were aged 18. In terms of health, 12 per cent of care leavers were disabled, over half (53%) of which had a learning disability, one fifth (22%) were on the autistic spectrum, and nine per cent had a mental health condition. Nineteen per cent of care leavers had a statement of Special Educational Need (SEN). In terms of last placement type, 52 per cent of care leavers were in foster care (25% in kinship and 26% in fostering), 13 per cent had been in residential care, 14 per cent in independent living arrangement, and 12 per cent placed 'with parent'. The percentage of care leavers leaving school with no qualifications was 28 per cent, a large difference compared to the general school population in which only one per cent leaves with no qualifications. Young people whose placement prior to leaving care had been foster care achieved more or higher qualifications than care leavers in all other placement types. Children who had been in care for a period of more than 10 years, performed better in educational terms than those who had been in care for less than 10 years. The percentage of care leavers in unemployment fell by five percentage points from 18 per cent to 13 per cent from the previous reporting year. Most care leavers were in education or training (29% and 30% respectively), and nine per cent were employed (DHSSPS, 2015).

<sup>3</sup> These figures refer to children looked after for 12 months or longer. It also should be noted that 22 percent of the children had more than one disability and were therefore included in more than one category.

## Northern Ireland Government Commissioned Reports, Legislation and Strategies

### The Children (Northern Ireland) Order 1995

The Children (Northern Ireland) Order 1995 is the main legislative framework providing the foundation for policy and procedural guidelines relating to children and families in Northern Ireland. All matters concerned with children's lives are covered including children looked after, Legal Orders, parental responsibility, day care provision, education, children's homes, and child protection. The necessity of local Health and Social Care (HSC) Trusts promoting and safeguarding the welfare of children in need is emphasised with children in need defined in the following way, "if his health or development is likely to be significantly impaired or further impaired without the provision for him of such services".



In relation to health care, the Order stipulates that Trusts are required to undertake medical examinations of children in need, particularly where the Court makes an Interim Care Order (ICO), Supervision Order (SO) or Emergency Protection Order (EPO). In such cases, the Court may instruct Trusts with regard to the medical or psychiatric examination or other assessment of the child. However, "if a child is deemed to be of sufficient understanding to make an informed decision he may refuse to submit to the examination or other assessment". It must be noted that if a child subject to an EPO refuses medical examination, the Court can rule that the examination must take place. EPOs also authorise "the prevention of the child's removal from any hospital, or other place, in which he was being accommodated immediately before the making of the Order". The Department of Health, Social Services and Public Safety Northern Ireland (DHSSPSNI) may also impose requirements for arrangements to be made for protecting the health of children in voluntary and registered children's homes or in foster care. The policy and procedural handbooks written by the legacy HSC Boards and HSC Trusts are derived from this Order.

### The Arrangements for Placement of Children (General) Regulations (Northern Ireland) 1996

These regulations form an addendum to the Children (NI) Order 1995 and outline the arrangements for the placement of children by social services, a voluntary organisation, or in a private residential home. They refer to more general considerations as well as health and education of children in care. In relation to health, it states that social services shall ensure arrangements for medical examination and written health assessments, outlining the child's health needs, prior to placement or as soon as possible after. Also, the onus lies with social services to ensure that health service provision is available to the child for the duration of the placement. The authority should also have regard to the state of the child's health and health history, and the effect of this on their development, the existing health provision, and possible need for preventative measures.

### **HPA (2001) Minds matter: Exploring the mental wellbeing of young people in Northern Ireland**

This report was based on secondary analysis of the data gathered from the 1997/1998 Health Behaviour of School Children survey (HBSC<sup>4</sup>). The report explored the ways in which young people assess their health, appearance, satisfaction with life, confidence, and social relationships. It highlighted the range of concerns which young people have, which can impact on their emotional wellbeing in a positive or negative way. It was revealed that most of the young people who participated in the HBSC regarded themselves as healthy. However, perceptions of feeling healthy decreased as children got older, particularly among girls. The data revealed that boys were also less likely to feel lonely and/or worry about their body image. Young people who participated in frequent physical activity were more likely to consider themselves healthy and happy. The report outlined the benefit of emotional wellbeing in improving capacity to accept challenges in life in a positive manner.

### **The Children (Leaving Care) Act (Northern Ireland) 2002**

This Act was an addition to the Children (NI) Order 1995 for the purpose of specifying the duties of Trusts for children leaving care. It specified that “for each eligible child, the authority shall carry out an assessment of his needs with a view to determining what advice, assistance and support it would be appropriate for the authority to provide him under this Order (a) while it is still looking after him; and (b) after it ceases to look after him, and shall then prepare a pathway plan for him.”

### **The Children’s Homes Regulations (Northern Ireland) 2005**

These regulations outlined the arrangements for the running of children’s homes and requirement of and for staff who are employed in them. Of utmost importance was the promotion of the child’s welfare which included the basics of provision of food, clothing, etc. In relation to health, the registered person in the home must promote and protect the health of all children accommodated therein. They must ensure that all children are registered with a GP, and are offered referrals to additional services as needed, such as dental or therapeutic services. In addition, each child must be provided with guidance, support, and advice on health and personal care issues. Further to this, the home was tasked with the safekeeping and administration of all children’s medicines.

### **OFMDFM (2006) Our children and young people: Our pledge**

In 2006, the Office of the First Minister and Deputy First Minister (OFMDFM) produced a ten-year strategy entitled *Our Children and Young People, Our Pledge*. This identified tasks for the Northern Ireland Office, Northern Ireland administration, and the Northern Ireland Court Service, to bring about improvements in the lives of children and young people in Northern Ireland. The strategy was based on six key outcomes, which aimed for all children to be: healthy; live in safety and with stability; enjoy; learn and achieve; make a positive contribution; achieve economic and environmental wellbeing; contribute positively to

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<sup>4</sup> The HBSC is a cross-national quantitative study conducted in collaboration with the European Region of the World Health Organization. The study aims to provide contextual insight into the health behaviours and lifestyles of young people across 26 European countries.

community and society; and live in a society which respects their rights. It proposed to deliver these outcomes through the provision of high quality universal services, as well as targeted interventions for particularly vulnerable groups of children, to ensure that all young people have the opportunity to fulfil their potential.

The overall pledge was to deliver a shared vision for all children and young people over the following ten years (to 2016). The vision was “that all children and young people living in Northern Ireland will thrive and look forward with confidence to the future”. The outcomes framework was underpinned by a number of supporting themes, including: adopting a ‘whole-child’ approach; working in partnership; securing the support of parents, carers and communities; responding to the challenges of a society emerging from conflict; shifting to preventative and early intervention; seeking the views of children; assessing children’s needs comprehensively; and driving towards a culture which respects the rights of the child.

The strategy proposed to measure success through implementation structures, such as the development of action plans and advisory groups, as well as a set of indicators. The indicators were directly related to the six key outcomes and were accompanied by ‘drivers for change’ which the strategy deemed key in delivering the vision outlined in the pledge.

### **The Bamford Review of Mental Health and Learning Disability (Northern Ireland) (2006) A vision of a comprehensive child and adolescent mental health service**

In 2002, the DHSSPS commissioned an independent review of law, policy, and service provision affecting individuals with mental health needs or learning disability in Northern Ireland. This review was led by Professor David Bamford (who sadly has since deceased). The Bamford review formed the basis of a number of reports which presented a vision for reform. The recommendations presented in the review called for: the promotion and protection of the whole community’s mental health through preventative action; those with mental health needs or learning disabilities to be valued and assigned equal rights and opportunities; and the reform and modernisation of services for those with mental health needs or learning disabilities, and their families.

The Bamford Review highlighted the importance of a comprehensive Child and Adolescent Mental Health Service, involving statutory, voluntary, and community services, with a shared goal of safeguarding the mental health of children in Northern Ireland. It outlined the importance of adopting a holistic view of the child, and proposed 51 recommendations, based on principles which promote comprehensive and individualised services and advocate a focus on inclusivity, family, and minimum restriction of services. The principles also promoted the need for early intervention in CAMHS, smooth service transition, cultural competence among service providers, and an organisational structure of services based on case management.

It was noted that a comprehensive CAMH service should promote mental health, prevent mental ill-health, and provide accessible and effective treatment services to those who have developed mental ill-health. Children should have access to a comprehensive array of services that address the child’s physical, emotional, social, and educational needs in order to promote positive mental health. Agencies need to establish collaborative links and develop a model that prioritises and meets the needs of LAC. “Clinical aspects of LAC should include the liaison with and consultation to the network surrounding the child,



comprehensive assessment of need, intervention with the child and carers, supervision and training, audit, research and evaluation” (p. 56).

### **DHSSPS (2007) Care Matters in Northern Ireland – A Bridge to a Better Future**

Building on the Department for Education and Skills’ (DfES) Green paper (2006), this document outlined a strategic vision for improving services for children and young people in care or on the edge of care in Northern Ireland. It was aimed at key stakeholders in the statutory and voluntary sectors, as well as carers. The document stated that the vision to improve the experiences and outcomes of children and young people in care rested on a number of key features, including: a focus on family support; partnership working among key stakeholders; improving quality of care; striving to achieve the best outcomes for children in care; reshaping services to become integrated and multi-disciplinary; ensuring children and young people’s voices were heard; promoting an integrated approach among agencies; using targets to achieve outcomes; and developing structures to improve pathways through care.

The strategy outlined specific goals which included reducing the number of children and young people in care by 20 per cent and improving “outcomes for young people in care so that we at least double the proportion of care leavers who are in employment, education or training at age 19” (p. 16). The document highlighted a range of areas around which actions/outcomes were required to meet these goals and progress towards the vision outlined above.

The strategy proposed to increase support for vulnerable children, and improve outcomes for children and young people in care by:

1. Improving services and support to help vulnerable families stay together;
2. Developing the range, quality, and stability of placement options for children in care;
3. Ensuring that Health and Social Care Trusts have the necessary arrangements in place to act as effective corporate parents for children in care;
4. Improving educational opportunities for children in care;
5. Providing children in care with opportunities to take part in activities outside of school and care; and
6. Developing the level of support available to young people leaving care as they make the transition to adulthood.

Central to this strategy was the focus on the welfare of the child: “the welfare of the child must always be paramount and this over-rides all other considerations. This principle must be at the heart of any strategies, policies, procedures and services to safeguard children and must be at the heart of this strategy” (p. 22). The strategy sought to improve service provision for children and young people in care, or on the edge of care, by “setting new challenges and encouraging new and innovative ways of working in a cohesive and collaborative manner in the future to improve their outcomes and quality of life” (p. 112).

### **Northern Ireland Children's Services Plan 2008-2011**

This document outlined regional planning services priorities for vulnerable children and young people between 2008 and 2011. The plan was jointly produced by the Eastern, Northern, Southern, and Western Area Children and Young People's Committees (ACYPCs). It detailed a number of outcomes and indicators which could be used to measure the effectiveness of children's services provided in the statutory, voluntary, or community sector.

The plan was based on the six outcomes outlined in *Our Children and Young People – Our Pledge* (OFMDFM, 2006). It outlined the foundations necessary for effective planning and commissioning of services for children and young people. The foundations included: the participation of children and young people; outcomes which are based on needs and rights; a model which centres on the child, i.e. 'the whole child model'; support for families and communities; adequate structures to support integrated planning; and effective means for monitoring and evaluation.

The plan provided a comprehensive list of core indicators, relative to each of the six outcomes outlined in *Our Children and Young People – Our Pledge* (OFMDFM, 2006). These could be analysed to track change over time, compare data from different areas, and measure the wellbeing of groups of vulnerable children. Data gathered using these indicators could be complemented with qualitative local knowledge to build rich profiles of children and young people, which could then inform future policy and action plans.

The document indicated that it is the responsibility of the four ACYPCs to work towards improving the health and wellbeing of vulnerable children, including those at risk of harm or abuse, children in need, and looked after children and young people. The plan outlined further indicators and priority themes for specific groups of children and young people who are particularly vulnerable including: those from ethnic minorities; young offenders; children with emotional, psychological, and behavioural difficulties; those with disabilities; young carers; children affected by domestic violence or drug and alcohol use; and looked after children or those leaving care.

The Annual Review (2008-2009) and Outcome Monitoring Report (2009) presented findings which demonstrated whether services are improving outcomes for particular groups of children. These reports documented progress made between 2008 and 2009, which formed the basis of action plans set out for 2009/2010.

### **NICCY (2008) Sexual Health Policy Paper**

A focus on young people's sexual health was one of fifteen priority areas identified in *Children's Rights in Northern Ireland*. The Northern Ireland Commissioner for Children and Young People (NICCY) supported the World Health Organisation's (2002) definition of sexual health, which states that "Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled".



This policy paper outlined key issues in the provision of sexual health information and services in Northern Ireland. Section 5 (1) of the Criminal Law Act (1967) states that it is an offence to fail to disclose an offence to the police, thereby placing a requirement on professionals to report young people under the age of 14 who are engaging in sexual activity. This piece of legislation has obvious implications for young people, particularly if they fail to seek medical advice or support due to fears of confidentiality breaches. As such, NICCY called for a review of current legislation regarding mandatory reporting.

NICCY also called for a comprehensive sexual health strategy, which would provide a framework for service delivery across all HSC Trusts. It was recommended that the DHSSPS urgently develop protocols to assess risk when a young person presents with sexual health needs, in order to arrange the provision of appropriate advice and support. It was also recommended that the DHSSPS expand service provision at Genito-Urinary Medicine (GUM) clinics across Northern Ireland. A call was made for the delivery of appropriate sexual health education in all schools and the development of a common code of ethics for those delivering sexual health information and services to young people. It was recommended that Trusts introduce appropriate training for foster carers and residential staff to aid in the delivery of sexual health information to young people in the care system. NICCY also endorsed a review of sexual health services and information for young people with disabilities. Finally, a recommendation was made that the DHSSPS conduct a regional study on the views and experiences of young people in relation to their sexual health needs and the services available to them.

#### **DHSSPS (2009) Families Matter: Supporting Families in Northern Ireland**

This document was a regional family and parenting strategy produced by the DHSSPS (2009). The aim was to place parents in a central position in terms of policy, and to provide strategic direction and detailed initiatives on the way in which the government could best assist parents in Northern Ireland. It complemented the aims of Care Matters NI (2007), which focused on providing support for families in crisis.

The strategy was fundamentally based on the merits of prevention and early intervention when supporting parents who were experiencing difficulties. The vision in the strategy was that “All children and young people are valued during childhood. Children and young people reach their potential and have the opportunity to lead full, healthy and satisfying lives by becoming active contributors to their community through participating socially, educationally and economically in the life of the community”(p. 16).

In order to facilitate prevention and early intervention, the strategy promoted integrated planning in service provision at government, regional, and local levels. The policy endorsed a ‘whole child’ approach and considered this model a core map for integrated planning. As this policy is a supporting pillar of the OFMDFM Children and Young People's Strategy, the proposed outcomes are linked, and include: being healthy; keeping safe; enjoying learning and achieving; making a positive contribution; economic wellbeing; and enjoyment of rights. It was proposed that these outcomes could be attained through implementing a model of family support. This model served to identify various levels of need in the population, as well as the support that was required to address these needs. It featured four levels of services, which ascended according to greater need and higher levels of support. The aims

of the higher levels of support, i.e. levels three and four, were to impact positively on the family situation so the child and family would no longer require specialist services.

The policy proposed that the provision of prevention and early intervention approaches through *Families Matter* would impact positively on families who might otherwise require higher needs-based intervention. The overall pledge was to deliver a shared vision “that all children and young people living in Northern Ireland will thrive and look forward with confidence to the future” (p. 8).

**Northern Ireland Commissioner for Children and Young People (NICCY) (2009), *Children’s Rights: Rhetoric or Reality. A Review of Children’s Rights in Northern Ireland 2007/08*, Belfast: NICCY**

This report provided an update of Kilkelly et al.’s (2004) study on children’s rights in Northern Ireland. The initial study was commissioned in 2003 by the first Northern Ireland Commissioner for Children and Young people (NICCY). The aim of the 2009 review was to determine the state of children’s rights in Northern Ireland in 2007/8 within the framework of the rights outlined in the UNCRC, in order to inform the future work of NICCY, and others concerned with children’s rights within Northern Ireland.

The review was based on primary data collected from young people, carers, and professionals, as well as a review of secondary data. The report began with an overview of the way in which the Convention is implemented as a whole, and recognised in Northern Ireland. Subsequent sections of the report are structured thematically, according to related rights which are relevant to all children and young people under the UNCRC. These sections focused on: civil rights and personal protections; family life and alternative care; health and welfare; education; leisure, play and culture; and children in conflict with the law and the administration of juvenile justice.

Regarding the findings on family life and alternative care, it was found that the majority of children and young people tended to view positively their relationship with their parents and the care provided to them within the family, although many appeared to feel that their views were not listened to/respected within the family home. In terms of LAC, it was found that “placement stability and continuity of care are raised time and time again when looked after children and young people are given the opportunity to comment on their experience of care, as something that is both important to them and frequently missing in their lives” (p. 168). In addition, care planning was found not to be a participative approach, as LAC are not effectively and meaningfully engaged in decision-making processes relating to their lives (which is a breach of children’s article 12). In view of these findings, the report included the following recommendations:

- “Investment in the development of a range of placement options for looked after children to ensure that adequate placements are available to suit the needs of all children/ young people in care. All placement decisions should take account of the views of the child and be informed by the article 3 best interests principle, with familial placements being given preferential consideration and adequate resourcing and recognition.”

- “Restructuring of looked after children reviews to make them more flexible, child friendly and support the participation and involvement of children in decision making as recommended by the NICCY review of the care planning process.”
- “Targeted inter-departmental investment in tackling the current patterns of disadvantage experienced by looked after children, including those associated with their health and education.” (p. 191)

It was hoped that this report would be used to inform the future work of NICCY and others concerned with children’s rights, as well as being a useful resource for anyone concerned with improving the rights of children and young people in Northern Ireland, through effective realisation of their rights.

### **DHSSPS (2010) Healthy Child, Healthy Future**

This is the framework document for the Universal Child Health Promotion Programme in Northern Ireland. This document was envisioned to strengthen the already existing Child Health Promotion Programme (introduced in 2006). The *Healthy Child, Healthy Future* programme was a universal public health provision for children and young people aged 0-19 years, irrespective of need, with some children and families receiving a targeted service (e.g. LACYP or children with special educational needs). It “offers every family with children a programme of screening, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices so that children and families achieve their optimum health and wellbeing”. The programme entailed a number of set contacts to be made with each family to identify the children’s health needs through a holistic assessment, and where necessary it was to provide early intervention to alleviate the potential early negative impact of any physical, social, or emotional issues. The programme was delivered to families from Level 1 to Level 4 of the ‘Understanding the Needs of Children in Northern Ireland’ (UNOCINI) Thresholds of Need Mode. The initial family health assessment carried out by the health visitor was to be regularly updated during the period of working with the family. The document detailed the objectives and principles of such programme, as well as its delivery.

### **ICCR and PHA (2011) Improving the Mental Health of Northern Ireland’s Children and Young People: Priorities for Research**

This report was one of a number of reviews, commissioned by the Public Health Agency (PHA), which focused on the priorities identified in the Bamford Review. It presented a systematic overview of research around the mental health of children and young people in Northern Ireland. The review centred around five priority areas of research identified by the PHA which included: early interventions; mental health of looked after children; and development of resilience. The report covered two additional areas of importance identified in the Bamford report, including children with autism spectrum disorders and complex needs, and gay, lesbian, bisexual, and transgender youth.

The report identified a significant number of gaps in the research, including: the need for a prevalence survey of children and young people’s mental health in Northern Ireland; research on effective interventions to assist in the identification of help-seeking behaviour; adequate reporting on factors that contribute to poor mental health; research on preventing attachment and other behavioural disorders; evaluations of parenting interventions; further studies on looked after and maltreated children; exploratory studies on the effectiveness of

multi-agency and multi-disciplinary working; research on resilience; studies which address the needs of gay, lesbian, bisexual, and transgendered young people; interventions on preventing suicide and self-harm; interventions and support for parents with mental health problems; studies on alternatives to inpatient care; and interventions for children with autistic spectrum disorders.

### **Children and Young People's Strategic Partnership Northern Ireland, Children and Young People's Plan 2011-2014**

The CYPSP is a cross-sectoral, strategic partnership, consisting of the leadership of all key agencies who have responsibility for improving outcomes for all children and young people in Northern Ireland. It is stated that the purpose of the CYPSP is to put in place integrated planning and commissioning across agencies and sectors, aimed at improving wellbeing and the realisation of rights of children in Northern Ireland, in relation to OFMDFM's six outcomes for children. The CYPSP follows recommendations as outlined in the UNCRC, and in alignment with OFMDFM's ten-year strategy promotes a whole child model in which early intervention is a key priority. Children are encouraged to be active participants, not passive recipients of services. The partnership is divided into five outcome groups which are aligned with the five HSC Trusts. These groups can implement changes at the local level. However, the partnership aims to "lead the strategic campaign to change policy and remove obstacles in the overall context which prevent better outcomes for children and young people being achieved" (p. 18).

### **HSCB (2011) Transforming Your Care: A Review of Health and Social Care in Northern Ireland**

A review of the provision of Health and Social Care Services in Northern Ireland was requested by the Minister for Health, Social Services and Public Safety in 2011. This review was completed in the same year by the Health and Social Care Board (HSCB), with input from an independent panel appointed by the Minister. The key objectives of the review included: the provision of a strategic assessment across all aspects of Health and Social Care Services; examination of the present quality of services and their accessibility; measurement of the extent to which the needs of patients, clients, carers, and communities are being met; recommendations for future delivery of services to the Minister; and development of a specific implementation plan to address the changes required in health and social care.

The review concluded that there was an irrefutable need for change, due to: population growth, particularly ageing populations; poorer health and growth in chronic conditions; and instability in the Health and Social Care System. Twelve major principles for change were identified, to underpin the future model proposed for health and social care. These principles were the foundation of 99 recommendations outlined in the review to improve future configuration and delivery of Health and Social Care Services.

The key themes emerging from the recommendations included: recognition of quality and outcomes as determining factors in shaping services; prevention and promotion of individual responsibility for health; provision of services in close proximity to the home; greater choice of service provision; a major review of inpatient paediatrics; reduction in the number of acute hospitals; establishment of a clinical forum; and the development of community based services for individuals with learning disability or mental health issues. The review outlined a specific implementation plan to make changes over a five year period. The HSCB have

subsequently developed a new model of integrated health and social care, which places the individual at the centre, with the various Health and Social Care Services built around them.

### **Understanding the Needs of Children in Northern Ireland (UNOCINI) (2011)**

This assessment framework was designed to improve the processes used to identify and assess the needs of vulnerable children in Northern Ireland. It promotes an inter-agency and holistic assessment model which is balanced and consistent, thus, offering “a logical process within which children and their family’s circumstances can be considered, analysed and understood in order to develop robust plans that lead to action with the aim of improving outcomes for the child” (p. 10). The UNOCINI framework should be considered “whenever an individual practitioner identifies that a child may have needs that are additional to those of a similar aged child living in similar circumstances” (p. 14).

More specifically, this assessment framework has been developed in order to “improve the quality of assessment within stakeholder agencies, assist in communicating the needs of children across agencies and avoid the escalation of children’s needs through early identification of need and effective intervention” (p. 8). It focuses on three areas of assessment which include: the needs of the child or young person; the capacity of parents/carers to meet the child/young person’s needs; and the impact of external factors (e.g. wider family and environmental factors) on parental capacity and children’s needs. Within this framework, the child’s needs are categorised into four main areas: health and development; education and learning; self-esteem and self-care; and family and social relationships. It is not only concerned with the child’s needs, but the identification of strengths in situations which may support and/or protect the child. Fundamental to the UNOCINI assessment framework is a child-centred approach which considers the perspective and wishes of the child by involving them in the assessment process.

The UNOCINI assessment process consists of four phases: agency appraisal and preliminary assessment; referral; initial assessment; and preliminary assessment. Some children will experience all four phases of the assessment, whilst others may only experience one. Each level of the assessment is intended to build on the previous level to ensure continuity of assessment and avoid duplication.

In relation LACYP, the Looked After Child Pathway (LAC2) is used with those children who are being cared for by one of the five Health & Social Care (HSC) Trusts. The children may be the subject of a Legal Order, or they may be voluntarily accommodated. The assessment framework is intended to facilitate robust and balanced assessments of LAC which will “inform recommendations about future plans” and “enable better placement matching in foster and residential care” (p. 76).

LAC2 is a comprehensive assessment of a child and families’ circumstances and is undertaken in full consultation with the parents and child/young person, incorporating the views of multi-agency professionals working alongside the child and their family. For children in placement, LAC2 includes a section which examines the placement’s contribution to meeting the child or young person’s needs. In terms of health, it is informed by the outcomes from the annual health assessment (or six monthly assessment for children under five years), the annual dental assessment, the annual optical assessment (where required),

and the annual emotional health and well-being consultation (pending). LAC2 is then used to inform the LAC review.

### **DHSSPS (2012) Child and Adolescent Mental Health Services: a Service Model**

This DHSSPS policy document endorses and describes the preferred model for the organisation of CAMHS in Northern Ireland, and was developed as a response to a specific recommendation of the 2011 report of the Regulation and Quality Improvement Authority (RQIA) Independent Review of CAMHS in Northern Ireland. The service model promotes a person-centred needs-led, rights-based approach/delivery of service, and consistency of CAMHS delivery across the region.

The document describes a stepped-care approach: “The stepped care model aims to enable children and young people to achieve their full potential by reducing the impact of mental health and emotional problems through improved provision of co-ordinated care across child health, social care and specialist CAMHS care services.” (p. 14). This approach consists of five steps, which are: Step 1 – targeted prevention; Step 2 – Early intervention; Step 3 – specialised intervention service; Step 4 – integrated crisis intervention child and family services; and Step 5 – inpatient and regional specialist services.

The document also set up the way it envisaged this model would be taken forward: “Guiding the transition process as services move towards implementation of this model will be the responsibility of the HSC Board/PHA as service commissioners. The existing Bamford Child and Adolescent Mental Health Service subgroup, which has broad representation from stakeholders and is linked in to the Children and Young People’s Strategic Partnership, is seen as an appropriate vehicle for taking this work forward collaboratively” (p. 19).

### **SCIE (2012) Therapeutic approaches to social work in residential child care settings**

This report was based on an evaluation of therapeutic approaches in residential care, across the five HSC Trusts in Northern Ireland. These approaches were already being used in a number of children’s homes and regional secure units in the different HSC Trusts, and this study aimed to evaluate them. In the report, ‘therapeutic approaches’ refer to means of helping staff to understand how trauma affects children and young people, reasons for maladaptive coping, and rationale for the responses of agencies.

In order to facilitate the evaluative component of the study, each HSC piloted a different model of therapeutic approach, including: social pedagogy; the Children and Residential Experiences (CARE) model; the Sanctuary model; the Attachment, Self-Regulation and Competency (ARC) model; and the Model of Attachment Practice (MAP). These models focus on various areas of practice, including non-confrontational approaches to working with young people, maximising development and wellbeing, modelling positive behaviours and skills, and building competency in executive functions and social skills.

Findings revealed that staff who had received training for a number of therapeutic approaches reported improved practice, particularly around relationships with young people, which they attributed to this training. Young people also often noticed an improved ‘atmosphere’. It was also noted that training and support appeared to assist in the implementation of therapeutic approaches. The report concluded that such approaches may complement specialist therapeutic interventions, but not replace them.

### DHSSPS (2014c). Making life better. A whole system strategic framework for public health 2013-2023

This ten-year public health strategy document builds on the *Investing for Health Strategy* (2002/12), and it provides direction for policies and actions aimed to improve the health and wellbeing of people in Northern Ireland (by identifying actions at government level and directions to implement them at regional and local level). The framework is structured around six different themes: giving every child the best start; equipped throughout life; empowering healthy living; creating the conditions; empowering communities; and developing collaboration. Long-term outcomes with strategic supporting actions and commitments are specified for each theme. The document recognises the need to improve universal as well as targeted services for those in greater need, and it identifies some particularly vulnerable groups, including children in care.

The key long-term outcomes specified for the theme “Giving Every Child the Best Start” are: 1) good quality parenting and family support; 2) healthy and confident children and young people; and 3) children and young people skilled for life. Some of the actions and commitments that were detailed in the document for 2013-2015 as aiming to achieve these outcomes were:

- ◆ Establishment of Family Support Hubs and expansion of initiatives and evidence-based parenting support programmes;
- ◆ Establishment of an Early Intervention Transformation Programme;
- ◆ Roll-out of Family Nurse Partnership Programme;
- ◆ Improved safeguarding outcomes for children;
- ◆ Implementation of an infant mental health training plan;
- ◆ Establishment of 20 new Nurture Units within primary schools to address early emotional and behavioural difficulties among children in Years 1-3;
- ◆ For LACYP ensure:
  - Greater involvement in the preparation of their care plans and their PEPs (Personal Education Plans);
  - Better and increased engagement in special interests, culture and leisure, and extra-curriculum activities; and
  - Regular school attendance;
- ◆ Increase the proportion of school leavers from disadvantaged backgrounds achieving at least 5 GCSEs at A\*-C or equivalent, including English and Maths;
- ◆ Provide early support to children and young people up to age 19 with special or additional educational needs through:
  - Pilot approaches and building capacity in line with the Review of SEN & Inclusion;
  - Full roll out of PEPs process for all LACYP in school and training; and
  - Development of guidance for schools on promoting attendance.



## Northern Ireland Regional Policies and Guidance

### Handbook of policies and procedures, volume 2 children looked after (1998)



This regional handbook was developed by a collaborative project between the HSC Boards and Trusts across Northern Ireland in 1996. Volume two of the handbook outlines policies and procedures specific to LACYP, and along with the other three volumes, Family Support, Court work, and Childminding and Day care, is derived from the Children (NI) Order (1995). The handbook was developed prior to the amalgamation of the legacy HSC Trusts and each HSC Trust or grouping of Trusts was empowered to customise the handbook dependent on the specific requirements of their locality. It was to be used in conjunction with the Area Child Protection Committee (ACPC) policies and the Adoption handbook, and was accompanied by a collection of universal forms including the Children Looked After (CLA) forms.

The areas covered in volume two of the handbook are as follows: planning and placement; health care; education; contact; independent visitors; reviews; placements with relatives/friends; placement with foster carers; placement in Trust residential units; placement with parents; placement outside the Trust area; secure accommodation; arrangements to live abroad; refugees; fostering services; residential care; and leaving and aftercare.

The handbook sets out the main principles to which the Trusts have subscribed. In relation to health, the principle states that “children looked after have a right to a high standard of health care and the Trust will promote the physical and mental health of all children looked after”. It also emphasises regulations for the Arrangements for Placement of Children (General) Regulations, and the Review of Children’s Cases Regulations (NI), such as medical and health assessments needing to be completed upon entering care, and that each child in care must be provided with health services, including medical care, dental care and treatment.

Health promotion, training, and education were also highlighted so that children can make informed choices about their health needs. The Trusts are expected to act proactively for each child’s health, including monitoring health and development, promoting preventative measures, and provision of access to an array of services. As highlighted in the government reports above, close collaboration between health professionals and parents, carers, and children is deemed necessary for the provision of high quality health care.

The actions to be taken by HSC Trust staff when children first enter care and throughout their time in care are provided, including: recording of medical history; updating of these records over time; and making of arrangements for registration with a GP. The health assessment and needs are to be recorded on the regionally used BAAF forms and all notifications about the child within the HSC Trusts are to be made using the CLA forms provided in the handbook. The health needs of the child should be reviewed at every LAC review meeting.

Procedures for LACYP from ethnic minority groups or those who have disabilities and special health care needs are also outlined. Details for children who are voluntarily accommodated are specified including details of consent for emergency and routine medical treatment. The policy for delegated authority has since been updated and implemented in all HSC Trusts and is described below.

### **Area Child Protection Committees' Regional Policy and Procedures (2005)**

The ACPC has recognised that the wellbeing of children is significantly affected by their vulnerability owing to disability, abuse, substance misuse, violence at home, or bullying. This document provides the key elements in the child protection process, but also provides an outline of the role of staff in the various agencies involved, and guidance on how to recognise child abuse. The necessity for inter-agency collaboration to support families in safeguarding children is also highlighted. "The vision of the ACPC is that children should be brought up in a safe environment that promotes their welfare and protects them from significant harm" (p. 18, section 1.3).

The HSC Trust is required to take the lead in investigating child protection concerns, but other statutory and non-statutory agencies must also be committed to safeguarding and be involved in the decision-making process, resulting in a strategic approach to child protection. It is the responsibility of each HSC trust to appoint a named nurse for child protection. Similar to volume two of the handbook of policies and procedures, a child must undergo a medical assessment if referred to Social Services or if concerns are raised about child abuse. As per policy, parents or carers should provide consent for the medical assessment and accompany the child to the assessment.

### **Guidance on Delegated Authority to Foster Carers in Northern Ireland (2010)**

The guidance on delegated authority was developed in response to recommendations in the strategy: *Care Matters in Northern Ireland: a Bridge to a Better Future* (2007). Specifically, it was proposed that "approved foster carers should have more autonomy in relation to the everyday decisions about children in their care" (p. 1). The document named above outlines the guidance that HSC Trusts are required to follow when considering the delegation of authority to foster carers (including kinship and respite carers). It states that: "The delegated authority to foster carers will be individually agreed for each child. The guiding principle is that authority is delegated to foster carers in order that they can provide the child with a normal family experience. The extent of the delegation will vary depending on the type of placement, the legal status, the views of the child and their parents, and the experience of the foster carers" (p. 2).

The table below briefly outlines the areas of delegated authority, which should be considered for each child or young person in care.

<b>Foster carers should generally hold delegated authority for:</b>	<b>In particular circumstances and following discussion they may hold delegated authority for:</b>	<b>Trusts will generally be responsible for:</b>
Routine medical visits to GP	Immunisations	Passports
Overnight stays	Body piercings	Decisions re contact
Holidays within the UK and Ireland	Non Routine medical treatment including general anaesthetic	Alcohol use
Regular trips to Republic of Ireland	Holidays/trips abroad	Smoking
Haircuts	Change of school	National Insurance Number
Visiting friends	Wider media activity	Use of contraception
School medical	Church and religious ceremonies	
Optician	Participating in hazardous activities	
Dentist		
School day trips*		
Meeting with school staff		
Sports clubs/organisations		
School photographs*		
Sex education		
Mobile telephones		
Consent to educational initiatives e.g. Fostering Achievement *		
* Responsibility for these areas should be delegated as soon as possible after placement		

Source: DHSSPS (2010)

The overriding principles of delegated authority are that all decisions must be made in accordance with the Care Planning process, and in the case of an emergency or unexpected event, the foster carer should act as 'a reasonable, prudent parent' (p.5).

#### **Health needs of LAC Inter-Agency Group: Action Plan 2012-2015**

This multi-agency working group developed an action plan regarding the health needs of LAC to be addressed over a three year period. A number of action points were specified:

1. The development of regional practice that requires LACYP to be involved as much as possible in health assessments and plans;
2. A participation event for young people, carers, and practitioners to improve user understanding of health is being organised;
3. The development of regionally-consistent policy for the prompt response to the health needs of LACYP. This is to ensure that children in care will have prompt access to specialist health assessments and services;

4. Annual training programmes for carers of LACYP to include training events to support carers meet the health needs of children;
5. Health improvement interventions to be prioritised, planned, and implemented. This aims to encourage and facilitate LACYP to participate in a range of sport, hobbies, and leisure activities, as well as promoting smoking cessation and arts-based support programmes;
6. Support and promote the Mind Your Health study in QUB, and improve the relationships between researchers, practitioners, carers, and LACYP; and
7. To respond to the Children's Services Framework standard regarding the health needs of LAC consultation.

### **Policies and procedures specific to Health and Social Care Trusts**

Notification of a child becoming looked after and subsequent changes in circumstances is currently under review and guidelines and standards are being developed for the notification of changes. Currently, a CLA1 form is used, and this includes the child or young person's details, parental information, legal status, persons with parental responsibility, GP details, address before placement, placement dates, reason for placement, and school details. Upon completion, the form is to be sent to the Child Health Department and the child's school.

The 'Admission to Care' medical is a medical examination and written health assessment of the child at the time of becoming looked after. Part A of this document, which includes a detailed medical history and consent form for medical examination, is completed by the child's social worker in consultation with the parent/carer. Part B of the form is completed by a GP or community paediatrician after they have received part A from the social worker. Part B mainly constitutes a physical examination.

A statutory medical is completed at either six monthly or yearly intervals, comprising a medical examination and written health assessment of the child. This is completed by a GP or community paediatrician, and focuses mainly on physical health.

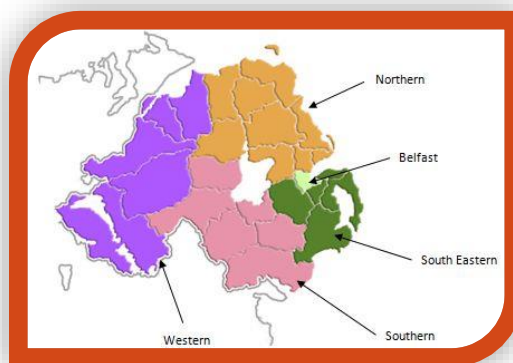
### **The 16+ Multi-Agency Partnership**

The 16 Plus Service is designed to support young people with a care background across a range of areas in their lives, including health, education, training and employment, accommodation, finance, and social support. The 16 Plus Service promotes independent living, and encourages young people with a background in care to take responsibility for their own health and wellbeing. The service is available for young people with a care background aged between 16 and 21 years. For those who remain in education, the 16 Plus Service is extended to 24 years. The service is comprised of individuals from a range of professions, including social workers, therapeutic workers, personal advisers, employability staff, and project workers. Members from this team work collaboratively to ensure that young people with a background in care are supported in achieving their full potential.

## HSC Trust-specific approaches

### Belfast HSC Trust

Within the Belfast HSC Trust, the Volume 2 handbook and associated CLA documents provide the foundation of policies and procedures for LAC. In addition, the admission to care medical is completed prior to a child or young person entering care and the statutory medicals are completed as per policy. Upon leaving care and entering adoption, the BAAF medical assessment is completed. The Belfast HSC Trust also follows the practice of delegated authority as outlined in the regional documentation described above. A LAC specialist nurse was appointed to the Belfast HSC Trust during the timeframe of the 'Mind Your Health' study.



The health needs of all LACYP are monitored through the LAC review process. Additional support is available for all LACYP from the Therapeutic Support Service (TSS). This service is available to children and young people in residential care, foster children over the age of 11 (recently extended to include children aged 7 and over), and adopted children and young people. Referrals are accepted from LAC teams /adoption team. If the child or young person is actively suicidal or experiencing psychosis, request is that they should be seen by CAMHS in the first instance. Following initial consultation, an agreed plan is formulated, and this could take many forms, e.g. the child or young person is offered therapy (e.g. long term psychotherapy/DDP/CBT); a psychometric assessment is carried out of the young person; the foster carers/residential carers are offered regular consultation; on-going consultation is given to the professional team or a combination of the aforementioned; the young person is signposted or given an onward referral; or the young person is discharged. For urgent mental health assessments, referrals can be made to The Crisis Assessment and Intervention Team (CAIT). For non-urgent cases, referral pathway is to the CAMHS team.

Additionally, LACYP can be referred into universal services, e.g. child development clinic, DAMHS (drugs and alcohol mental health service); DAISY; FASA; HYPE (which promotes the sexual health of young people by increasing their access to education, information and relevant services); family nurse partnership for (young parents under 19 years); Autism Intervention Service; and Family Trauma Centre.

### South Eastern HSC Trust

In addition to completion of statutory medicals and CLA forms as per the Volume 2 handbook of policies and procedures, comprehensive health assessments are carried out by the specialist nurse for LAC, health visitor and school nurses. In addition, health and wellbeing questionnaires (i.e. "About Me" questionnaires) are used as a tool to engage the young people to inform the health assessment. The '*About Me Health and Wellbeing Questionnaire for Young People*' or '*About Me Health and Wellbeing Questionnaire for 8-12 year olds*' are completed when a child enters care by either the health visitor or the specialist nurse for LAC. Both questionnaires cover topics such as physical health, eating, identity, self-esteem and emotional wellbeing, school life, and keeping safe. The questionnaire for 8-12 year olds also asks about puberty and growing up, whereas the

questionnaire for young people asks about puberty, sexuality and relationships, and also provides an opportunity for additional comments on health. These questionnaires provide a tool to engage children and young people in addressing their health needs. The Public Health Agency has provided funding for the development of a health journal for Looked After young people, and the “About Me” questionnaire is included in the journal.

The ‘*Health Assessment form for Looked After Child 0-10 years*’ and the ‘*Health Assessment form for Looked After Young Person 11-18 years*’ follow outlines from the UNOCINI guidance and were in draft form when this study was carried out. As per statutory medical guidelines, health assessments are completed upon entering care, prior to the three month LAC review and are reviewed every six months for the under-fives and yearly for the over-fives, or when a child moves placement. In addition, nursing staff (LAC Nurse, Health visitor, School Nurse) complete a separate assessment that provides a more holistic approach to meeting the health needs of these child and young people. The health assessments follow the recommendations made in ‘Promoting the health and well-being of Looked after Children’ (DH, 2009). As well as information on physical and emotional health and development, immunisations, vision and oral health, these forms incorporate contact details for other personnel and agencies involved in the health care of the child. Once the health assessment has been completed and any health needs have been identified, a health plan will be generated which details the health need, the action required to address the health need, and by whom. If health needs are identified, the nurse will present this plan at the LAC review. A sub group of the regional “Health and Well-being of LAC” group was working on revising the current health assessment documentation with a view to having a regional approach.

An ‘*Emergency Department Protocol for Looked After Children who Self-Harm*’ has been developed by the *Cared For Children Programme* and was due to be reviewed in May 2013. By the time of the writing up of this report, it was not being formally implemented, and was due for review in summer 2015. This protocol is an appendix to the ‘*Self-harm Integrated Care Pathway for Children and Young People*’. It provides actions required in the event of an incident of self-harm occurring in a residential unit or foster placement and the personnel roles and responsibilities.

A specialist nurse for LAC had been in post in the South Eastern HSC Trust for approximately seven years. The role of the LAC nurse has been defined in the Care Matters programme as encouraging “the inclusion of young people in decision making regarding their health and well-being, enhance multidisciplinary and interagency working by proactively working across disciplines, agencies and boundaries, and promote an understanding of the health needs of LACYP”. In addition, the LAC nurse aims to provide support, advice and training for other professionals such as nurses, midwives and social workers, and for children and young people and their carers. The core competencies, knowledge, and skills of the specialist nurse for LAC and all other health care providers associated with the health of LACYP are outlined in the *Looked After Children Knowledge, skills and competencies of healthcare staff* (Royal College of Nursing and Royal College of Paediatrics and Child Health, 2015).

The LAC directory provides details of all the services offered by the South Eastern Trust. It was over five years old at the time of publication of this report, and might have then been out of date. The Trust has a therapeutic support and advice service entitled SET Connects,



which is available to LACYP and those involved in their care. The service utilises multi-disciplinary consultation of all professionals involved in the care of LACYP. The service provides consultations/therapeutic support with foster carers, families, residential staff, and other professionals involved in the care of a child or young person. SET Connects receives referrals from social workers by means of an on-line referral form and a recent UNOCINI or LAC documentation. The Trust also makes use of a number of specialised services through referral processes, such as: the Forum for Action on Substance Abuse (FASA); an Impact of Alcohol Programme (ASCERT); a Drugs and Alcohol Intervention Service for Youth (DAISY); the Voice of Young People in Care (VOYPIC) advocacy organisation; and Drug and Alcohol Mental Health Services (DAMHS).

### **Southern HSC Trust**

In the Southern HSC Trust, statutory medicals are completed within 14 days of placement, and either six-monthly or yearly, as per statutory guidance, depending on the age of the child or young person. Comprehensive health assessments are conducted as an adjunct to the statutory medical. This process has been in place from November 2010, in which children receive a health assessment upon entering care prior to the three month LAC review, which is then updated when there is a change in circumstances. The health assessment is completed by a health visitor, a Band 6 school nurse, or the Specialist Nurse for LAC, depending on the age of the child and their circumstances. In addition, the health visitor, school nurse or the Specialist Nurse for LAC completes either the “About Me Health and Wellbeing Questionnaire for 8-12 year olds” or the “About Me Health and Wellbeing Questionnaire for Young People” (depending on age of the young person). Both questionnaires are useful tools to engage children and young people in addressing their health needs. Information gathered from the questionnaires is incorporated into the health assessment. The health assessment provides a baseline. There are two health assessments developed for use depending on age of the young person (0-11 years old; and 12-18 years old). From the completed health assessment, a health plan is devised to address outstanding and current health issues/needs. A leaflet on health assessment has also been developed for LAC, which details information on the processes and who to contact for more information.

As per the Volume 2 Handbook of Policies and Procedures for Looked After Children, the social workers complete the CLA1 form when a child or young person is admitted into care or there is a change in circumstances. The CLA1 forms are forwarded to the Specialist Nurse for LAC for distribution to the relevant health visitor or School Nurse Manager, who will subsequently allocate a health visitor and school nurse to LACYP. This process ensures that LAC are seen as early as possible by a health professional and their health assessments are commenced in a timely manner.

The Southern HSC Trust appointed a Specialist Nurse for LAC in 2008, whose role is defined in the Care Matters Programme as encouraging “the inclusion of young people in decision making regarding their health and wellbeing, enhancing multidisciplinary and interagency working by proactively working across disciplines, agencies and boundaries, and promoting an understanding of the health needs of LACYP”. The core competencies, knowledge and skills of the Specialist Nurse for Looked After Children are outlined in the *Looked After*



*Children Knowledge, Skills and Competencies of Health Care Staff* (Royal College of Nursing and Royal College of Paediatricians and Child Health, 2012).

A Personal Development Guidance for LACYP, carers, and staff in Children and Young People Services Directorate was developed in 2011, and became operational in 2012. This guidance document aims to provide Children and Young People's Services staff and foster carers with a framework for the delivery of personal development work with LAC and management of personal and relationship issues. The guidance covers physical, emotional, and social parameters for a breakdown of age ranges, and highlights the role of the LAC review in the personal development of LACYP. The guidance document provides examples of personal or relationship issues, and how to manage them in practice in relation to areas, such as self-harm or suicide and various parameters associated with sexual behaviours. In addition, information is provided on smoking cessation, physical activity, child safety online, and drugs and alcohol. This document was originally intended to be implemented locally, and it was later considered for adoption regionally by the PHA. An audit of the Personal Development Guidance was being undertaken in-house.

In 2012, in-house policies were developed for health visitors, school nurses, and the Specialist Nurse for LAC to promote the health of LAC. This follows the guidance set out by NICE and SCIE (2010) on promoting the health and well-being of LACYP. The aim of the policy is to "ensure that health visitors and school nurses working within the Southern Trust understand their responsibilities in relation to promoting the health and wellbeing of looked after children, and, have advice, support, supervision and training in order to practice competently" (p. 3). It sets out seven standards to which health visitors, school nurses, and the specialist nurse for LAC must adhere:

1. Family health assessment and the development of health plans for Looked After Children in foster placements;
2. Health assessment and the development of health plans for Looked After Children in residential care;
3. Inter-agency collaboration;
4. Supporting carers;
5. Transfer of health visiting and school nursing responsibility following change of foster placement;
6. Storage of records relating to school-aged Looked After Children; and
7. Advice, support and supervision for health visitors, school nurses, and Specialist Nurses regarding Looked After Children.

There is a separate LAC Scaffold service headed up by a Consultant Psychologist. This service provides input to the residential LAC sector. In addition, there are CAMH practitioners with each of the leaving and aftercare teams, and the CAMH teams co-work and provide consultation to these teams in respect of young people up to their 18th birthday.

### Western HSC Trust

The Western HSC Trust follows the Volume 2 handbook and associated documentation. Delegated authority is completed with each new placement and was being updated at the time this study was being conducted. The Trust offers a number of additional services which LACYP may be referred to, including: the LAC Therapeutic Service; the Area Mental health child and family team; the Drug and Alcohol Service; ZEST (help for self-harm and suicide); young people's therapeutic project (for adolescents who abuse); and the NSPCC FEDUP program (Family Environment: Drug Using Parents). A specialist nurse for LAC has been in post in the Trust since 2012. Children with special health needs may attend the child development clinic which includes dental, dietetics, speech and language, physiotherapy, and paediatrics. Their needs are assessed in all areas, and referrals for further treatment are made if necessary. CAMHS referrals are usually through the LAC Therapeutic Service, but the Clinical Psychologist will often conduct an assessment first rather than direct referral by social workers. If a child or young person is treated in hospital for self-harm or attempted suicide, they are provided with a leaving card on discharge from hospital which provides a route to the CAMHS service.

### Northern Health and Social Care Trust

Within the Northern HSC Trust, the Volume 2 handbook and associated documentation lay the foundations for policies and procedures for LAC. Health assessments are conducted upon entering care and followed up annually or bi-annually, depending on the child's age. A specific team is responsible for dealing with and overseeing the development of services in relation to the health of LAC.

The Trust offer a number of services to which LAC may be referred, including the Therapeutic LAC team (referred to as TTLAC) and the CAMHS (Tier 3) team. Prior to referral to these services, social workers are encouraged to consult with both teams to ascertain which service is best suited to the child's needs. In instances where a child in foster care presents complex needs, support is available for carers from the TTLAC team, as well as through the Behaviour Clinic within the Family Centre.

Based on the principles of the Children Act (1989), the Northern Trust operates under the premise that the best place for a child to grow up is within their own home. The Trust is currently developing a unit and team which deal specifically with children on the edge of care. Children who have been removed from the family home but are expected to be rehabilitated, are currently placed in Linden Homes, offered to the Trust by Barnardo's. During the time that this study was being carried out, the Trust was in the process of developing an Intensive Support Residential Unit and team to deal specifically with emergency respite, whilst advocating the continuum of family support services, to ensure the child returns home to a safe and stable environment.

The Trust advocates the use of Transitional Carers for LAC who are between placements, often due to complex needs. The Trust is involved in the project 'Supportive Board and Lodgings', which seeks to develop residential properties in Mid Ulster and East Antrim, which can house 12 young people in each area. The Trust also aims to redesign the fostering structure in place at present by increasing the number of fee-paid foster carers and reducing the number of independent placements. Fee-paid foster carers will be supported by the TTLAC team, Intensive Support Team, and the CAMHS team.

The Trust also offers the GEM scheme to older LAC. This initiative promotes continuity and stability of living arrangements in post-care life for young people between the ages of 18 and 21. The scheme seeks to achieve better outcomes for young people in care in relation to health, safety, training, education, and employment.

## Conclusion

This chapter details the policy and procedural context for professionals working with LACYP in Northern Ireland, particularly in terms of meeting their health needs. In recent years, government across the UK has set out to address the poor health of LACYP. *'Every Child Matters'* (DCSF, 2003) has served as an overarching framework from which subsequent policies have been developed. In Northern Ireland, *'Our Children and Young People – Our Pledge'* (OFMDFM, 2006) aims for all children to be healthy, stay safe, enjoy and achieve, make a positive contribution, and achieve economic wellbeing. Other national policies specifically related to driving forward the LACYP agenda include: *'Care matters: Time for Change'* (DFES, 2007); *'Care matters: Time to deliver for children in care'* (DCSF, 2008); and *'Healthy lives, brighter futures: The strategy for children and young people's health'* (DoH, 2009).

These policy and strategy documents identify the need to improve health outcomes for LACYP, and set out what children and carers should be able to expect from services. The UK Government has also produced statutory guidance on promoting the health and well-being of LACYP, aimed at removing inconsistencies in delivery, and promoting better coordinated care (DCSF, 2008; DoH 2009). However, despite these policy drivers for improvement, there remains a lack of effective performance monitoring, and *'more needs to be done to ensure that children, young people and families are involved in designing services'* (NICE, 2010, p.13).

A number of recurrent themes emerged from the main legislative and policy documents in the UK and Northern Ireland profiled in this review, with the foremost recommendation being the operation of multi-disciplinary and inter-agency collaboration. This would appear to be essential considering the range of professionals involved in the care of LACYP. Collaborative working across teams would facilitate efficient care planning and aid referral between services. Other key messages within the documentation reviewed include early intervention and health promotion for LACYP, with a focus on listening to the voice of the child/young person. The information gathered from each of the HSC Trusts details the range of procedures in place and the array of services available to Looked After Children and their carers. Discussions with key individuals from each Trust highlighted the importance of a holistic approach to health assessment in relation to LACYP. They also stressed the need for timely access to services for children in care, using fast-track approaches when necessary.

This chapter documents the plethora of UK and NI legislation and policy pertaining to the health of children, including those in care. However, in England and Wales, policy specific to LAC is further developed than in Northern Ireland. HSC Trusts in Northern Ireland rely quite heavily on the Volume 2 Handbook of Policies and Procedures (1998), which is in need of updating in order to reflect changes in legislation, policy and procedure since 1998.

It might be argued that the similarity of the legislative frameworks between England, Scotland, Wales and Northern Ireland, render the need for specific LACYP policy for Northern Ireland redundant. There is, however, a strong case for Northern Irish specific policy development. For example, according to the Health Survey Northern Ireland 2013/14, about one-fifth of the 4,509 respondents showed signs of a possible psychiatric disorder; and of these (individuals scoring four or more on the GHQ12 scale), 45 per cent of women and 29 per cent of men were taking medication for stress/anxiety or depression. In fact, Northern Ireland spends more on medicines than anywhere else in the UK, and is the second highest in Europe (and one of the highest in the world) for dispensing anti-depressants (BBC news, 2/12/2010; 16/11/2014). Moreover, the number of anti-depressant tablets prescribed by doctors and GPs in 2013 increased by six per cent to more than 100 million from the previous year (BBC news, 26/09/2014); with GPs prescribing them two and a half times more often than their English counterparts (BBC news, 16/11/2014). The estimated higher incidence of psychological morbidity in Northern Ireland has been associated with the high number of areas of social deprivation (DSD, 2007), and the impact of the conflict (O'Reilly & Stevenson, 2003). These findings suggest that it would be unwise to assume that policies developed for LACYP in England and Wales will generalise to the Northern Irish context.

It would appear that Northern Ireland may benefit from the development of bespoke statutory guidance on promoting the health of looked after children, as used in England (DCSF and DH, 2009). Such guidance would delineate the roles and responsibilities of HSC Trusts and voluntary organisations, in relation to the health promotion of LACYP, and in principle assist the range of professionals involved to efficiently and effectively meet the health needs of this vulnerable group.



## Chapter 2: Methodology

This chapter provides a description of how this study was conducted, including the design, sample, methods of data collection and analysis used.

### Phases

This study was conducted in four phases, using a mixed-method approach:



**Phase 1:** It profiled the policies, procedures and service provision for LACYP, designed to address their health needs across the five Health and Social Care (HSC) Trusts in Northern Ireland.

**Sample and Method:** In addition to a review of policy documentation across the five HSC Trusts, five focus interviews were conducted, one in each HSC Trust, with senior managers for Looked After Children, fostering, and residential care services. The purpose of the focus groups was to gather information on adherence to statutory health standards, policy and procedures, and service provision, including targeted interventions.

**Phase 2:** This profiled the physical and mental health of LACYP in Northern Ireland. It also explored the effectiveness of policies, strategies and interventions, and carers and birth parents views of these in relation to a particular child in their care - the designated child. This data was collected via interviews with carers in foster, kinship, and residential care, as well as birth parents where a child or young person was living at home on a Care Order. It is important to note that the term 'kinship care' in this report is used to describe children who are being formally Looked After by the HSC Trust, and are placed in the care of relatives, as opposed to informal settings where a relative may be caring for children and young people, possibly without the involvement/knowledge of social services. This interview asked carers/birth parents to describe the physical and mental health of a designated child, and this was used to explore their views on how appropriately and effectively these have been addressed, the extent to which they or the child/young person have been involved, and their experiences of the service provided. A telephone interview was utilised to minimise the burden of data collection for carers/birth parents.

**Sample:** On any one day in Northern Ireland, there are some 2,500 children and young people in care, ranging in age from one day to 18 years old. In order to achieve a representative sample for the study, we aimed to interview at least 10 per cent of all carers and birth parents (where there is a Care Order at home) of LACYP across Northern Ireland (approximately 250). Each HSC Trust was asked to specify its population of LACYP as of the 31<sup>st</sup> August 2013, using the Social Services Client and Administration Retrieval Environment (SOSCARE). It was also necessary to engage the support of the Fostering Network to supplement the telephone interview sample.

**Method:** Carers were asked to take part in a telephone interview, involving the collection of both quantitative and qualitative data (see Appendix 1). This lasted approximately 45

minutes, and focused on: i) the medical information they received when the child/young person was placed with them (including historical health information); ii) the child/young person's health needs, as they perceived them; iii) the impact of previous and ongoing assessments to address these needs; and iv) any other health services offered and provided. The *Strengths and Difficulties Questionnaire* (SDQ) (Goodman, 1997), an adapted version of the *Warwick Child Health and Morbidity Profile* (WCHMP) (Anderson et al., 2004), and questions from the *Young People's Behaviour and Attitude Survey* (YPBAS) (NISRA, 2014), were also incorporated into the telephone questionnaire. The use of the SDQ with the child/young person's 'main carer' reflects guidance on assessing the mental health of LACYP issued by the Department of Education in England and Wales (DCSF, 2011). Carers were also asked to talk about their experiences of interventions relating to the child/young person's health, in terms of their perceived relevance, acceptability – including the extent to which the child/young person and carer/birth parents were involved – and impact. Research collaborators identified in each of the HSC Trusts facilitated the consent process for gaining the telephone numbers of carers/birth parents who were agreeable to participate in a telephone interview. Carers were initially sent an information pack informing them about the study, and what the proposed telephone interview would entail. Each participating carers/birth parents received a £10 gift voucher, as a token of appreciation of their time.

Table 3 shows the total number of telephone interviews completed across the five HSC Trusts. In total, 246 interviews were conducted. However, data had to be excluded from the analysis in 10 cases, when it transpired that these children had recently been adopted at the time of the interview. Furthermore, three interviews were conducted with the carers of children in foster placements being provided by independent fostering organisations, and due to the low number within this specific category, these cases were also excluded from the analysis. Consequently, there were 233 interviews conducted for children/young people in care across the five HSC Trusts in Northern Ireland. The highest proportion of children/young people in the sample were from the South Eastern HSC Trust area (n=84, 36%), whilst the lowest percentage came from the Belfast HSC Trust (n=29, 12%).

**Table 3: Telephone interviews conducted with carers in each Trust**

HSC Trust	N	%
South Eastern Trust	84	36
Western Trust	46	20
Southern Trust	37	16
Northern Trust	37	16
Belfast Trust	29	12
<b>Total:</b>	<b>233</b>	<b>100</b>

**Phase 3:** This examined young people's perspectives. A sub-sample of young people was interviewed to gain their own perspectives on their physical and mental health needs, and



how these were being met. This was important because research suggests that the views of young people in care may differ from those of professionals and caregivers (Holland, 2009), and the need to involve the perspective of LACYP themselves was flagged up as crucially important within a literature review of the mental health needs of LACYP. This was developed as part of the Northern Ireland CASPAR project, a regional multi-agency working group of voluntary and statutory providers, academics, and carers concerned about the mental health need of LACYP (Mullan & Fitzsimons, 2006).

**Sample:** Due to recent research governance decisions taken by the HSC Trusts in Northern Ireland regarding the appropriate age for direct research with LACYP, only children/young people aged 12 years and over were included. In total, 25 young people were interviewed.

**Method:** The interview focused on: their understanding of their physical and mental health; their experiences of health education; how well they thought their health needs have been addressed; and their recommendations for how to best meet the health needs of LACYP (see Appendix 2). Interviews were conducted at a convenient time at their home. They lasted approximately 45 minutes, were recorded with the young person's permission, and transcribed. Participating young people received a £20 gift voucher, as a token of appreciation of their time.

**Phase 4:** Explored professionals' perspectives.

**Sample:** A sample of social workers, GPs, CAMHS clinical psychologists experienced in working with LAC, specialist nurses for LAC, and school nurses.

**Method:** Multidisciplinary focus group interviews were conducted in four of the five HSC Trusts. The interview schedule covered issues such as: what their respective roles were in addressing the health needs of LACYP; interventions/resources used to assess and support these needs; their perspectives on how effectively these needs were being met; their role in multi-disciplinary co-ordination of meeting these needs; and their views on how service provision regarding the physical and mental health of LACYP could be improved (see Appendix 3).

## Measures

As indicated above, two measures were incorporated into the telephone questionnaire, i.e. the SDQ (Goodman, 1997) and a modified version of the WCHMP (Anderson et al., 2004), in addition to a selection of questions adapted from the WPBAS (NISRA, 2014).

### Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire - SDQ (Goodman, 1997) is a commonly used behavioural screening questionnaire for assessing psychological morbidity in children and adolescents, as perceived by their parents/carers. It is composed of 25 items divided into five scales of five items each. These are: emotional symptoms; conduct problems; peer problems; hyperactivity/inattention; peer relationship problems; and pro-social behaviour. With the exception of the pro-social score, these dimensions are combined to provide a total difficulties score. Scores across all domains can be classified as normal, borderline, or abnormal. Approximately 10 per cent of a community sample will score within the abnormal band on any given domain, with a further 10 per cent within the borderline band. Higher



scores are indicative of problematic areas, with the exception of the pro-social scale, wherein lower scores are suggestive of concerns.

### **Warwick Child Health and Morbidity Profile (WCHMP)**

This is an easy-to-administer research and service planning instrument developed initially by Spencer and Coe (2000), and slightly modified by Anderson et al. (2004), to facilitate cross-sectional and longitudinal recording of parent/carer-reported health and morbidity of individual children and child populations. The modified version was applied in the current study. The measure incorporates 10 domains: general health status; acute minor illness status; behavioural status; accident status; acute significant illness status; hospital admission status; immunisation status; chronic illness status; functional health status; and health-related quality of life.

### **Young Person's Behaviour and Attitude Survey (YPBAS)**

A consortium of Northern Ireland governmental departments commissioned the Central Survey Unit (CSU) of the Northern Ireland Statistics and Research Unit (NISRA) to design and conduct a study on the behaviour and attitudes of young people in post-primary education in Northern Ireland. The Young Persons Behaviour and Attitudes Survey (YPBAS) is a school-based survey conducted among 11-16 year-olds. The research covers a range of topics, relevant to the lives of young people today such as demographics, social support, school, subject choices and next steps, nutrition, sport and physical activity, play and leisure, libraries, museums and arts, sun protection, the environment, travelling to school, road safety, attitudes towards domestic and sexual violence, personal safety, smoking, alcohol, solvents and drugs, and sexual experience and knowledge. Five rounds of the survey have taken place to date: the first in 2000, the second in 2003, the third in 2007, the fourth in 2010, and the fifth in autumn 2013 (NISRA, 2014). A number of questions were adapted from the YPBAS for use in the telephone interview questionnaire.

## **Recruitment and consent**

### **Phase One: Focus group interviews with senior social care managers**

Information packs were sent to senior managers of LACYP, fostering, and residential care in the five HSC Trusts requesting them to participate in a focus group interview. If willing to take part, potential participants were asked to contact the research team via the contact details provided on the participant information sheet. Those who had not responded after a two-week period were contacted for a second time to ascertain their willingness to participate. Prior to commencement of the interview, members of the research team guided participants through the information sheet and answered any questions they may have had. After this, all participants were asked to sign the consent form.

### **Phase Two: Telephone interviews with carers/birth parents**

The five HSC Trusts across Northern Ireland were contacted and asked to identify their LACYP population as of the 31<sup>st</sup> August 2013. The HSC Trusts compiled a list to contain: the child/young person's SOSCARE number; their date of birth, and their gender. This list was then forwarded to the research team by the respective HSC Trusts. The research team randomly selected their study sample (at 50% of population), stratifying for age and gender, and then forwarded invitation letters and information sheets for the selected sample of carers/birth parents to the HSC Trusts. At this point, the HSC Trusts forwarded the invitation

letters and information sheets to the selected sample. After a two-week period, the HSC Trusts contacted these carers/birth parents (by home visit or telephone call) to see if they were agreeable to participate in the proposed telephone interview regarding a child/young person they were caring for.

Where carers/birth parents were agreeable to participate in the interview, the HSC Trust ascertained whether they were happy or not for their telephone number to be forwarded to the research team, so that they could be contacted directly to arrange a suitable time to conduct the interview. They also sought their consent to send their first name to the research team so that a named person could be requested when the initial telephone call was made. The HSC Trusts then contacted the research team to confirm which carers/birth parents had either agreed or declined to take part in the telephone interview, and to provide telephone numbers and names for those that had agreed for these to be shared with the research team. HSC Trusts also informed the research team of the status of the placement, i.e. either foster/residential or with birth parents, so that the researcher knew whether they were speaking to a carer or a birth parent. This process was replicated with the Fostering Network in terms of the additional cases that were identified to supplement the study sample.

The research team telephoned carers/birth parents to arrange a suitable time for a telephone interview, and then subsequently conducted the interview at an agreed time, obtaining verbal consent for the interview at the start of the telephone call. The telephone interview was recorded to act as evidence of consent and to assist in data collection. Upon completion of the interview, the researcher requested the carer/birth parent's address to send the gift voucher.

### **Phase Three: Face-to-face interviews with children/young people**

During the telephone interview with the carer/birth parent (phase two), if the young person was 12 years or older, researchers asked the carer/birth parent if they were agreeable for the child/young person to be sent an information sheet and invitation letter to take part in a face-to-face interview. In total, 80 carers agreed that this information could be sent to the young person they were caring for. After a two-week period, the research team telephoned the carers/birth parents to see if the young person had stated to them that they were agreeable to participate in a face-to-face interview. In total, 25 young people agreed to be interviewed, and the research team arranged the interview to take place at their home. Two researchers went to the young person's home to conduct the face-to-face interview. The young person was given the opportunity to ask any questions that they had, and written informed consent was obtained prior to commencement of the interview.

### **Phase Four: Focus groups with professionals and carers**

A list of health and social care professionals was compiled by senior social care managers in each of the five HSC Trusts. With two Trusts, the research team forwarded information sheets and invitation letters to these health and social care professionals. If willing to take part in a focus group interview, potential participants were asked to contact the research team via the contact details provided on the participant information sheet. After a two-week period, the research team contacted those who had not responded to ascertain their willingness to participate. The researchers then arranged a suitable time for the participants to attend a focus group interview. Prior to commencement, each participant signed a

consent form. With another two Trusts, the senior social care managers identified the key professionals to attend the meeting, send the information sheets on our behalf, and identified a date to meet that suited the participants and the research team. Again, prior to commencement of the interview, each participant signed a consent form.

### **Research governance and ethics**

Prior to commencement of data collection, research governance approval was granted by each of the five HSC Trusts, with the South Eastern HSC Trust acting as the lead Trust in this regard, and ethical approval was granted by the Office of Research Ethics Committee in Northern Ireland (ORECNI).

### **Analysis**

For Phase One and Phase Four, focus groups were conducted with professionals. These were digitally recorded and transcribed, and analysed using content analysis. In other words, the transcriptions were examined for recurring themes, thematic coding categories were identified, and detailed codes developed, and input in excel sheets.

For Phase Two, telephone interviews with carers were recorded. The quantitative data were input into an SPSS file, and a series of descriptive statistics (i.e. cross-tabulations, frequencies, means and standard deviations) were conducted in order to analyse the data. Pearson Chi-Square tests and one-way Analysis of Variance (ANOVA) were utilised to examine the relationship between background variables and health profile variables. The qualitative data was transcribed verbatim, and analysed using content analysis. Phase Three face-to-face interviews with young people were also transcribed and analysed using content analysis.

## Chapter 3: Social work managers' perspectives

A focus group interview was conducted in each of the five HSC Trusts. These were conducted at the initial stages of the study between October 2012 and May 2013. The focus groups included a range of social work managers, senior practitioners, and senior social workers. The focus group interview aimed to get the participants' perspectives on the approaches used in their Trust in terms of meeting the health needs of LACYP, the factors that helped or hindered implementation, gaps in service provision, and suggestions on how to improve the health of LACYP. This chapter describes the findings from this first phase of the study.



### Practical approaches to meeting health needs

In each of the HSC Trusts, focus group participants were asked about the approach they took to meeting the health needs of LACYP. Social work managers outlined a range of policies and procedures.



**Statutory medical assessments** were mentioned within all five Trust focus groups. Participants explained that these were completed by the General Practitioner (GP) once a child entered care, and every six months after that for children under five, and annually for older children. However, in all the HSC Trusts, participants mentioned the fact that older children (i.e. teenagers and adolescents) were less keen to engage in them, and many young people over 15 years of age would refuse to attend. A number of reasons were identified as to why this might be the case, such as seeing it as very basic, as assessing “only” physical health, and feelings of difference to the rest of their peer group:

*I think some of the recent feedback I've had from some of our young people who go for their medicals, they feel it's more of a tick box exercise for the GP rather than an actual medical assessment because it's a standard form that goes out, the GP sits with the young people, bang bang bang bang and that's it done, and ... don't feel there's that great need ... other 16+ young people are also getting to the stage where they're saying 'look I go to the doctor when I'm sick, you know why do I have to go to the doctor because I am in a foster placement?'*

*... a lot of the young people aged 16-17 will not consent to the medical. They associate that with children in care and having to follow a norm – some do, some don't, but that's their choice. They're encouraged to, but it's their choice.*

*... it's really just a general check-up, they're not taking bloods or anything significant that would identify any underlying issue ... It's very basic.*

*... a lot of young people in our world would say that they are reluctant to attend a statutory medical organised on behalf of the Trust, but they would be very clear and say – but I go to the doctor when I have to – when there's something not right, I'll go to the doctor. And you know that because they are quite happy mostly for the social worker to make a short call to the GP and you can see over the course of the previous six months or a year, they've had ongoing appointments for whatever ailment they had – but it's the statutory medical is an emotional block to them.*

Some participants posed a dilemma regarding these assessments, while they recognised these above-mentioned issues, they also saw the need to assess children and young people's health in order to be able to meet their needs:

*... is there a more meaningful way of capturing the health needs of a looked after young person? How many do – everybody's young children – take their under-five's every six months and then once a year? It's kind of stigmatising and what's that saying to people – to go to the doctor once a year whenever there is no need – and yet it's important that we know about their health needs in that assessment and there is work ongoing to look to see how that could be developed. That regional health group, and looking at sub groups out of that, maybe a recognition – do maybe need to look at that and how meaningful it is as a blanket for all young people, as opposed to looking at a needs assessment of their health. I think it does make them stand out from the rest of the population and I'm sure it's hard to understand why you have to go – if you're not well you go to the doctor ...*

It was also felt that for children who were going through the adoption route, assessments can be more thorough and accurate.

*... in terms of our looked after children who have an adoption care plan, we have very good systems and processes in place in terms of capturing a holistic picture for the young people when we are presenting them to our adoption panel. We do have our statutory medical provision but alongside that our child development clinics are very good at ring fencing appointments, particularly for pre-adoption medicals – that's a multi-disciplinary assessment, so you get a very detailed comprehensive report in terms of all aspects of the young person's health and development. It's also an opportunity for issues to be flagged up early and any concerns in relation to genetics.*

In addition to the statutory assessments, participants in all five HSC Trusts mentioned the **LAC review meetings** and their forms as another forum to assess children's health needs. One of the sections of the LAC Review specifically targets health.

*The reviews themselves, the LAC reviews would have a particular section that looks at health and development within a multi-disciplinary forum – would have input from health visiting, we might also have our LAC nurse ... So the whole LAC process would have a section looking at that on a regular basis and look to see other particular health needs and if there needs to be referrals made for speech and language, occupational health, specialist assessments – so that would be part of the review process.*

There was also some discussion about the UNOCINI (Understanding the needs of Children in Northern Ireland) assessment framework. Some participants did not find it a particularly useful tool, and gave their reasons why:

*It's not one report and it's not sent out as it was meant to have done, it's still the social work report, the UNOCINI is a social work document, it's not a multi-disciplinary document.*

*Most people would say the UNOCINI is quite a complicated document, and whoever thought it out wasn't actually thinking logically.*

*... it's not being used instead of a court report, you know it's part of discovery and experts are looked for and a social worker court report as well as the care plan alongside that, so loads of paper.*

*I think the thinking behind the UNOCINI was that it would be the comprehensive assessment and that it would be used in terms of a court allocation as opposed to doing a court report, but ... that's as much our fault as it is the court's fault for not accepting it, because ... it's not logical in terms of actually saying what I want here, this is the situation, this is what we've done and an outcome, it's not ...*

*... And that in itself will stop that ever becoming an initial social work statement because that's not what judges are saying they're looking for, they want very clear concise information and they want it as a read-alone document and it's there for them to look at, they would rather have two pages of good concise analysis than have 15 pages of blurb really.*

**Specialist nurses for LAC** had been appointed in the HSC Trusts, except for the Northern HSC Trust. However, one had only been in post for a short time. Their role was seen as important in meeting the health needs of LAC. However, at times their involvement was perceived to be primarily about physical health.









In the Belfast Trust, in terms of health promotion focusing on **sexual health**, participants mentioned the HYPE scheme (Health for Youth through Peer Education), which is a peer-mentoring scheme that deals mainly with sexual health and relationships. In the Northern Trust focus group, the Rainbow Project in Belfast was mentioned regarding sexual health for all children on a Care Order. In the Southern Trust, there was a pilot for a sexual health clinic (GUM clinic), specifically allocated to young people, with a proviso that young people in care would be given priority:

*The HYPE Scheme would have been around now for a long time – maybe 10 years. Works in sexual health and relationships, particularly doing a lot of peer mentoring ... HYPE is a long established, very valuable one in terms of sexual health, particularly with the profiles. Then it was a North and West legacy service – that was predicated on with statistics that were coming in, e.g. teenage pregnancy, unprotected sex – it was wrapped up in sexual health.*

In the Western Trust focus group, participants also referred to training for foster carers regarding different health issues and conditions (e.g. Foetal Alcohol Syndrome; mental health; First Aid; etc.):

*Training is in my head as well about the foster carers because again foster carers would have like first aid training, they would have particular training around foetal alcohol syndrome, training around mental stages in adolescence and that sort of thing, so again it's trying to support the unit you know, trying to support the families so that they have the right information to be able to help the child at that particular time in the sense of health ...*

Finally, another initiative that was mentioned by participants in the Southern and Western Trusts is the Family Nurse Partnership, which is a long-term project aimed at helping teenage mothers to parent their children. It is running in three (S, W and N) of the five HSC Trusts:

*... putting in very, very concentrated dedicated health professional time, be it a health visitor or school nurse ..., somebody that works with the teenage mother for two years, when she first finds out she's pregnant until the child is 18 months old, quite a concentrated amount of time to help her to parent, and the benefits of that and it's proven to be very, very successful, so they've tried to implement it over here, because we do have high teenage rates in comparison to England, Scotland and Wales ...*

## Mental health needs and service provision

Mental health was one of the main themes discussed within each of the five focus groups. Participants discussed the prevalence of mental health problems, as well as alcohol and drug misuse difficulties, for children and young people in care, particularly for those in residential care, and the perceived complications and gaps in service provision that exist in addressing these particular needs.



*... a significant number of our young people, we have completed a scoping exercise in transition and roughly about 30% give or take a couple of percentage points, are showing that young people who have emotional needs – I use that in the broadest terms, some have a diagnosis of mental illness, the vast majority don't – it's roughly about one in two in the transition world.*

*... in terms of the young people who come into care, I mean the vast majority of them have mental health issues and I suppose it's about trying to get access to a service that is completely overrun and is very, very difficult.*

*I suppose for us in the 16+ team we find it difficult with the increased drug culture and the alcohol and the mental health issues that arise from that ...*

Despite problems and gaps (which will be discussed in a following section), participants in the focus groups referred to a range of therapeutic and psychological services available:

- ◆ CAMHS (Child and Adolescent Mental Health Services);
- ◆ LAC Therapeutic (Western); Therapeutic Support Service (TSS) (Belfast); Therapeutic Team for LAC (Northern); SET Connects (South Eastern); and LAC Scaffold Service (Southern);
- ◆ The CAIT Team (Crisis Assessment and Intervention Team) (Belfast & South Eastern);
- ◆ Beechcroft (Regional Child and Adolescent In-Patient Unit - Belfast);
- ◆ Plans for emotional screening at entry into care - but not developed yet (Western and Northern Trusts);
- ◆ Specific services for drug and alcohol misuse – Dunlewey (Northern Trust);
- ◆ Related services: 16+ team (all Trusts);
- ◆ Non Trust-run services (all Trusts): the SEAL (Social and Emotional Aspects of Learning) project (programme used widely in schools in NI) and the Dina project (delivered by Barnardo's to 4-8 year olds including Looked After Children, as part of the Incredible Years Series) (South Eastern); DAISY (South Eastern and Western) (a service for young people who need confidential advice and help for alcohol or drug use, available in the South Eastern, Western and Belfast HSC Trust areas); and other agencies meeting health needs of LAC, including support for drug/alcohol abuse: Surestart, Divert, Nexus and Barnardo's, Extern, VOYPIC and Fostering Network.

Some examples of participants talking about these are displayed below:

*We have our LAC Therapeutic Service ... and there's CAMHS of course, you know, the local CAMHS teams as well too and some of our young people, now they could be referred on from LAC Therapeutic Service if that's identified.*

*... we have a service within the Trust called SET Connects and we do refer a lot of our young people to that service, whether that be through consultation with foster carers about managing particular behaviours or whether that be direct work with children, that tends to be a service that we use quite a lot within the looked after population ... we would also have, parallel to the SET Connects, called the Therapeutic Support Service ... And we have a CAIT Team as well we can access. The CAIT Team, they're like the crisis team, if somebody is concerned about a child, they can assess the child immediately so it's additional to the CAMHS.*

*On a wider level you have the CAMHS service – but that's accessible to all children and young people up to the age of 18, slightly over because sometimes they'll maintain the service for the care leavers ... It's a significant service ... you have the young people's centre which will be by appointment. Young people can get emergency appointments, a lot of the time through the GP, but you can have an emergency at the young person's centre. Then you have the inpatient site which is Beechcroft, which is what, years old now? Maybe two years ... It's a regional provision. Then for – I suppose we move more into the emotional wellbeing of the young people, then you have the Therapeutic Support Service (TSS) – and that is primarily LAC. That's really a psychology service ... So that can be open to individual therapeutic work for young people as well as consultation for carers and you can get a consultation within a few weeks.*

### Factors hindering implementation

Participants in the focus groups were asked about the factors that they believed helped or hindered their capacity to meet the health needs of Looked After children. They listed a range of challenges, which can be summarised as:

- ◆ Difficulties in accessing services, due to:
  - Young people moving Trusts or jurisdictions:



*On occasions when a child is placed outside of the Trust area it can be difficult accessing available resources for the young person, travelling can also take up a lot of time and impact on the amount of times you get to review the young person. Each Trust will have case responsibility, until the young person is seen and accepted by the other Trust, but again restraints can lead to a less robust handover and transition. The difficulty with this is that many of the young people lack motivation to engage and without a consistent approach this can lead to them disengaging from the service they require.*

*You don't have that local knowledge and I suppose if there is an issue as well it takes a day then to get to a city in England or wherever and you're just not as available to the young person so they're not getting a good enough service really ...*

- The geography of the particular HSC Trust (less services in rural areas – having to travel long distances and taking them out of the community):

*The other thing is access to services. It can depend on geographical location, services that they can access and that can be very difficult as well.*

- ◆ Difficulties in the transition to adult mental health services – adult health services not meeting the needs of the care leaver population:

*Adult services, particularly in mental health, is very fragmented and doesn't really meet the needs of the care leaver population, particularly in respect of the histories of some of the young people, their lack of engagement – it lacks a social work approach to it – three strikes and you're out. Particularly in the mental health service where you are offered your appointments, you don't keep them, you're offered again and you'll be re-referred through a GP service. That's where social workers are a very vital link to that. So there is potential argument that somewhere along the line, that possibly the CAMHS service should be extended to reflect that. If we're offering a service, why should other services cease at 18? I think that's a very important interface, particularly with the high percentage of young people with mental health problems.*

*That's an interesting point in terms of the three strikes and you're out. If you are not proactive about attending appointments, there isn't that follow-up at all. As you know yourself, young people are difficult to engage, it takes a while for them to come around and they need to be pulled gently into the process, and that really does become problematic at that particular aging out of the care system. You see young people who would need that encouragement consistently and it's not there.*

- ◆ Young people's lack of engagement with services:

*I think there are services out there but it's just the young people are not engaging because of the culture that they're in, but once they do start engaging you know it's working for them, so ... there are a lot of good services ... a lot of it is down to their involvement and engagement ...*

- ◆ Drug and alcohol culture, including difficulties in containing new trends on substance misuse (e.g. aerosols, and availability of prescription drugs and legal highs);
- ◆ Resource issues (i.e. lack of resources) – e.g. difficulties in accessing care placements for young children with complex needs; challenges in placing the young people in the appropriate place; long waiting lists for psychological services (i.e. CAMHS, LAC Therapeutic, etc.);
- ◆ Gaps in children's health information (affecting carers' capacity to meet the child's needs), due to:
  - some children not being registered with GPs when coming into care; or moved GPs and health records did not travel;
  - some families not sharing information; and

- information systems not being properly linked.
- ◆ Differences of assessment views between social workers and CAMHS professionals:

*I suppose historically the CAMHS sort of relationships sometimes can be a wee bit fraught and that's really because we are coming from a place where we're very worried about the youngster and you know maybe within our risk assessment we believe that they're very high risk whereas the risk assessment carried out maybe by a professional in CAMHS might be slightly different. They mightn't feel that they're just at the same level of risk or might feel that we should carry on as we're going and sometimes that really can leave our social workers and our foster families quite concerned so I think there is something about joint working in the future to understand where we are coming from both sides because I think it's been going on now for as long as I'm in practice, like 20 years. We've always had these wee issues.*

- ◆ Court delay in securing permanent placements for looked after children;
- ◆ Difficulties in assessing the mental and emotional wellbeing of children in care:

*... social workers have to make an assessment on social and emotional wellbeing, and to be honest that's a fairly elusive commodity in that there isn't kind of a singular benchmark or key performance indicators that you can measure against and I think it's a very inconsistent application ... you can see it in all the reports because it is very elusive, that alone measuring the emotional and social wellbeing of some of the children who have had adverse childhood experiences and multiple deprivations, so sometimes I think social workers meddle in a lot of assessment areas which they're not actually capable of assessing, but they'll couple together a couple of meaningful words ... it's fine when the children are young, the developmental milestones but once you go on ... we have to assess whether a child in need is 16 or 17, but I haven't actually seen a creditable framework to make a determination when a 17 year old is in need against the developmental milestones of a 17 ... it doesn't exist, so ... everyone talks about it meaningfully but I haven't really seen any evidential framework to kind of inform our practice about it.*

- ◆ Occasional poor representation of health professionals in LAC review meetings:

*... and sometimes for whatever reason when you turn up at a LAC review, there might only be the social work staff and maybe one representative ... so your decision-making then can be diminished, holistic decision making if that's the right word, because what you're actually doing you're only ending up with two disciplines rather than a wider range ...*

## Factors helping implementation

Focus group participants also identified a range of supporting factors, which were believed to aid their capacity to meet the health needs of Looked After children within their particular HSC Trust:



- ◆ LAC being a priority group when referred to certain services:

*I suppose for Looked After Children what we try to do is always prioritise them, whatever way we can, even if there are boundaries or there are things like that, that come up, we always try and say 'well can you make an exception because this child is Looked After ...'*

*I think the other thing that we need to mention are things like for speech and language therapy, our health colleagues in those areas providing those services, looked after children are on a priority list, now I am not entirely sure what the reality of that is in terms of making referrals but certainly the Trust recognises in looking at, you know when it looks at AHP area that looked after children and child protection registered as well, that looked after children are a priority grouping, so referrals there will get fast tracked, it still doesn't mean if they miss three appointment they're going to get any more but at the same time it's recognised as a priority.*

- ◆ Sharing buildings among professional teams:

*... the other thing from a very positive perspective, where we are in 16+ we share a building with CAMHS so for the young people ... It was historical in terms of we had an old building which then a new building was put in, so the two services were there. For the young people who would come under the consultant in our building, it's really very good, the person is very approachable, we can scoot down the corridor and have a chat about this, you can put a referral in, I mean you still have to go through the same processes in terms of when a referral comes through, but ... that actually works really well, the young people may not necessarily engage ... but for those who do, it's actually very good, so we're probably the only team though in the Trust that are fortunate in that, that actually when it works, it works well.*

- ◆ Having links with hospitals ("just in terms of following up very complex medical issues relating to LAC while there are care proceedings ongoing to try and speed things up and avoid delay");
- ◆ New support scheme for kinship care;
- ◆ Change of structures, which aid communication between different services/departments/professionals:

*I think the way we are structured now in terms of our new health and wellbeing centres, where we are co-located with allied health professionals, we are in the same room in The Mental Health Care Centre, eg with health visitors and children's community nursing. Aids that communication ...*



- ◆ Giving delegated authority to foster carers;
- ◆ Encouraging more participation of young people in meetings and in dealing with their own health needs:

*I think we would be conscious of making services more accessible to young people and clearly building in to the way the service operates to ensure the young person feels they are being valued and listened to and that there is meaning in attending these boring meetings – a lot of young people in the past felt that they were more or less there as part of the furniture and discussion that was going on between the professionals to the exclusion of some of these young people – I think we've moved on from that. Most of the LAC reviews tend to focus – and the chair of the LAC review will address their remarks to the young person as opposed to other professionals.*

*I found what works for us is having the regular support or the regular risk strategy meetings with the young person there and bringing them on board into them short clear calls, it doesn't work for all of them but certainly it helps.*

- ◆ The geography of the particular HSC Trust – services accessible locally;
- ◆ Good quality foster placements;
- ◆ Having a support post which bridges children from Beechcroft into other placements:

*I used to find it really difficult when some of the young people were in the children's homes and the risks were really high and staff got very anxious, and since we've put in, I'm not saying it's all great, but we now have members of staff who worked in Beechcroft, who bridge those children from Beechcroft to the homes or into foster care, it's probably more going back into their homes in 16+ than going into foster homes, but that post has been invaluable I think, hasn't it? I don't get the calls I used to get and the meetings. I think there's been a lot of training with staff and support and understanding, I'm not saying it's still not high risk, but that post seems to have really helped.*

- ◆ Linking the Supporting Carers Scheme with the psychological service for LAC (as a means to support "carers and skill them up to be able to deal with the traumatic events that the young person has been through and help them work through it");
- ◆ LAC Therapeutic ("has made a huge difference to us in the sense of being able to manage the emotional health of these youngsters"; and
- ◆ Health promotion initiatives:

*... would do sessions around smoking and around cannabis and around drugs and alcohol that is very ... youth orientated so it's not heavy, heavy sessions. It's to try and keep them engaged at some level you know so that they would use the art ... really the messages that are going across are educational you know. It's been very, very successful.*



## Gaps in service provision

Participants in the focus groups were also asked to identify gaps that made it more difficult to address the health needs of children and young people in care. Those identified were:



- ◆ Lack of mental health services available for young adults (over 16 years old);
- ◆ Lack of therapeutic services for children under the age of 11<sup>5</sup>:

*Therapeutic service starts at age 11 so we would have young people younger than that who are not eligible for that service and it's about where do we refer these young children to?*

- ◆ Lack of specific services for young people with ASD:

*One of the other services, just to say that it's becoming more necessary is ASD, there's an ASD diagnostic service but there's actually no specific services for young people with ASD, that's difficult for young people with recent diagnosis ...*

- ◆ Lack of continuity between the CAMHS teams in the HSC Trust and the CAMHS service in Belfast:

*... I think there could be somebody linked to some of the teams from the CAMHS service, or you know a bit like SET Connects has, certain staff linked to some of the children's homes, I think there needs to be some continuity ...*

- ◆ Lack of support in terms of behavioural difficulties for young children:

*One of the other gaps that consistently would be about ... behavioural difficulties in that younger age group. You see that time and again in terms of looked after reviews and carers maybe needing a wee bit more help around behaviour and knowing the first contact for health is health visitor ... but if it has got to be more than that, then that's where you are stuck in relation to where you go next. It's not quite up to the next tier of services but, might need a bit more extra support and health.*

- ◆ No inpatient treatment (i.e. detoxification facilities) in Northern Ireland for young people's struggling with drug abuse:

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<sup>5</sup> The Belfast HSC Trust did extend the age range to provide service to LAC aged seven years and over during the timeframe of the research study, and developed specific training for foster carers in promoting the emotional health of LACYP.

*I would like to see inpatient treatment offered to young people with severe drug and alcohol addictions under 18, some kind of an option in Northern Ireland, I think there used to be one but I think it closed years ago, and they're really risky young people.*

*The sort of barriers that we tend to deal with more ... are the young people who are engaged in serious drug abuse, solvents and whatever ... There's discussion around the need for a detoxification service, which doesn't exist yet but would be something you could probably access across the water. So we don't have that provision here. The drug dependency issue is worked through the basic CAMHS service ...*

*I suppose for us in the 16+ team we find it difficult with the increased drug culture and the alcohol and the mental health issues that arise from that ... there's no units or rehab within Northern Ireland where we can allow these young people to get the supports, you're really relying on the people on the ground developing positive relationships ... to try and slowly pull them away from the drug culture, that's the main difficulties that we have at this stage.*

- ◆ No service for young people when discharged from Beechcroft:

*There's also an issue if you have a young person going to be discharged from Beechcroft, sometimes if they don't have a recognised mental illness and they discharge themselves, the only place that there is for those young people to be placed is in our children's homes, and the staff aren't equipped and able to deal with that level of risk really, in terms of what those young people present. So that's a gap really, it's where those young people move on from if they're discharged ...*

- ◆ Lack of a regional assessment framework (including key performance indicators) against which to assess the social and emotional wellbeing of children in care;
- ◆ No regional policy and procedure for transferring/sharing health information when a child moves HSC Trust between specialist nurses for LAC.
- ◆ Gap in service provision for children with complex needs requiring 24/7 care:

*... very young children with very, very complex needs that need looked after, and I mean I think that's a massive gap because it's a wing and a prayer to try and find a carer that can maybe take children like that, and you know you're asking people to give up work, you're asking for 24/7 care and I just think there needs to be a regional kind of approach to how those young children, you know, they're drifting in hospital placements for months and years. So at the very extreme end, there's those children ... they're drifting ... and we're not knowledgeable at all at how to meet their needs in a holistic long-term way.*

- ◆ No secure beds within a particular HSC Trust; and lack of a regional secure mental health facility and assessment centre for children with risk-taking behaviour and severe mental health issues:

*... we don't have secure beds within the Trust, certainly any secure beds we would be looking down towards the South Eastern Trust or the Belfast Trust, and usually that's lengthy negotiations there to see even if there is ... if it's not a possibility, then we have to kind of rethink our strategy with it at that stage, meanwhile trying to keep that young person safe, and some of them do put themselves in horrendous situations, horrendous danger ... the legal highs, with the aerosol back in trend, with the drinking ...*

*There's something specific too that we have encountered is when young people are admitted to Beechcroft and the experience that is there ... they're in with adults ... There's no facility here. They have to travel ... I know of one young person that said they didn't get the service that they needed when they were there. Now that's a gap for us in terms of how we know that is the right place for them at that time ...*

*It's like a secure mental health facility that's necessary when kids risk taking behaviour and their mental health has been impacted so much that safety is a concern ...*

- ◆ No centralised information system storing all the health information gathered by different professionals about each child in the care system:

*... we have a wealth of information systems within the Trust but our systems don't talk to each other, and if there is a lot of information on the child health system about Joe Bloggs, and Joe Bloggs becomes looked after and it goes onto our system, the information doesn't automatically recognise him and help us to populate that process, so our systems, no matter how good they are, aren't talking to each other.*

## Recommendations and suggestions to improve service provision

Focus group participants were asked to forward suggestions as to how the system might be improved in order to address the health needs of Looked After children and young people. A range of suggestions were offered, often in relation to attempting to fill the gaps previously identified. Most of the suggestions were focused on trying to better meet the mental health needs of Looked After children:



- ◆ Early intervention - Earlier screening of younger children to pick up on emotional vulnerabilities:

*I think if we begin to screen the way we're talking about doing ... screening those younger children whenever they come in, so that we can pick up on any emotional vulnerabilities, so that then you can just work on your assessment early rather than, you know, towards the end of their career but it is about ... adolescence is going to kick in, it's going to be difficult and we know it's going to be challenging.*

- ◆ Mental health and therapeutic services specific for younger children (under 11s), including behavioural problems support (e.g. behavioural nurses), play therapy, art therapy, etc., in order to ensure that the signs of impact of neglect and abuse are picked up as soon as they become apparent;
- ◆ A wider therapeutic service to meet the needs of all LAC, in terms of low self-esteem, etc., but not serious enough to go to CAMHS:

*... some of them do have like wee eating issues that have come from their trauma too and sometimes it's very difficult for foster carers to manage, and they'd be thinking who do you go to for that? It's not exactly CAMHS because it's not serious enough for CAMHS but there are issues there ... That's where you're saying that a wider therapeutic service would probably be better to meet those needs you know.*

- ◆ More provision of alternative therapies and art therapy (rather than talking therapy – which did not appear to work very well with children and young people), with a consultative team able to decide what is best for the particular young person at the time:

*I think for me it's that emotional, not physical element ... health and wellbeing and ... having access to resources – to have to source out, could be within the Trust, play therapy, art therapy – being able to access that because I think that's the bit we have to catch up on ...*

- ◆ CAMHS service extended to include young people up to the age of 21 and possibly older, to reflect 16+ service:

*The one area of discussion, it's around the CAMHS service – our service, the 16-21 and possibly older for people in full-time training or education – so there could be an argument made that the CAMHS service – social services still involved until the care leavers are at least 21 – the CAMHS service is not ... it is essentially up to 18 years of age, at which point adult services, if required, become involved ... So there is potential argument that ... possibly the CAMHS service should be extended to reflect that. If social services offering a service, why should other services cease at 18? I think that's a very important interface, particularly with the high percentage of young people with mental health problems.*

- ◆ A multi-disciplinary mental health team (OT specialists, clinical psychologists, specialist nurse, and educational psychologists) working in a one-stop shop for all children in care:

*I would like to see a multi-disciplinary team with OT specialists because the OT fits so well with attachment that the sensory issues that our young people, our wee kids experience and all, I would love to see the attachment focused OT sitting alongside your clinical psychologists, sitting alongside your specialist nurse, and it could be achieved like a one-stop shop so that all children in care had direct access ...*

- ◆ A 'dedicated CAMHS person' (somebody you can phone for advice, and be able to consult):

*What I would really love to see is a dedicated CAMHS person ... someone actually if you're presented with an issue you can phone, you can actually phone for advice and you can actually get somebody on the other end of the phone, whilst you go through the process of obviously putting the form in but actually somebody when you need them on the day.*

*... it's those complex cases where children are presenting even from an earlier age, with either physical disability, global, delayed, or addiction, and it's about we don't appear to have the services to meet those needs in a timely fashion and that's basically it in a nutshell, because if we did, if we had somebody who we could contact particularly in CAMHS and consult in relation to how this child is presenting and what would you think would be a good way to go forward, I mean sometimes it takes us four years to get to that point ...*

Various professionals in different HSC Trusts also referred to the gap previously mentioned regarding alcohol and drug abuse, and argued for the need to have an inpatient treatment unit or detoxification service offered to young people with severe drug and alcohol addictions.

A range of suggestions was also given around better communication and coordination between professionals:

- ◆ Good communication between all of the agencies responsible for the child/young person;
- ◆ a multi-agency response, and a "joined-up approach", with somebody that would coordinate their health needs:

*... it's about that joined up approach really you know and I suppose we don't often feel that we kind of get that from our health colleagues, even just back to the health visiting, where we're based we're pretty lucky because most of our health visitors are all on site and we know them so we have that relationship you know, but it must be very difficult whenever you're at a distance ...*

*It has to be a multi-agency response, it can't be in isolation, can it? Because, as you say [name], there are other things impacting and sometimes you have to stop the other things to do the mental health issues or the emotional support, and then you have to swap to something else, so it needs timing and agreement and a proper plan, these ad hoc services coming in, it doesn't really work, does it?*

- ◆ More consistency, in terms of children/young people having a relationship with the same professional (so they feel they can invest in the relationship).
- ◆ Having health professionals at LAC reviews:

*I think even just actually to have health professionals at LAC reviews, we don't have that and certainly even CAMHS because I think those specialist kind of teams are fairly small as well, I mean like our therapeutic LAC, that's Trust-wide, and there's a handful of workers, so even just having who does what, if everybody is at a LAC review and everybody's voice is heard I think that would be a good start in the right direction really, but you'll find the longer a young person is in the looked after system, those LAC reviews just get smaller or the attendance gets smaller and smaller and you've just got a very select few around the table and maybe not always the key personnel who really should be there.*

◆ Good assessment:

*I think it's about good assessment as well, in terms of being able to identify the young person's needs at as early a stage as possible and then to identify the best service to meet them and the best people to help the young person address those needs, and that might be helping the parent in the early preventative edge of care stage, or it could be the foster carer or the residential worker, or it could be the individual health visitor or school nurse, depending on who knows the young person best and who is best placed to do that.*

Other suggestions were for more investment in certain areas:

- ◆ In-house resources ("sometimes we have to buy those in and it's expensive") - access to resources that could be within the Trust (e.g. play therapy, art therapy, etc.);
- ◆ More focus on the mental health needs of the birth parents before children come into care (prevention);
- ◆ More prevention services / early intervention practices:

*... if there was more prevention services, especially for some of the young children that we're getting into the service, early intervention, by the time patterns are set, we're getting young people who are out of control and what do we do when we bring them into the children's home and they're taking drugs?*

- ◆ More effort being made to engage LACYP in social activities and exercise and hobbies in their local communities:

*... if we had more resources, I would like to see more effort being made to engage our young people in social activities and exercise and hobbies in their local communities ... young people tend to go mix with groups of other Looked After Children, and not necessarily with other young people in their local communities, and I think it would be hugely beneficial to try and encourage that ... so that you're attending your local rugby club or swimming club or whatever ...*

- ◆ More support to be put in place in order to ensure that placements do not break down:

*Stability is the biggest thing and that touches on what we've just said as well, for me, stability is key for everything, so I think more provision needs to be put in place in order to ensure that placements don't break down, ... the carer is not being given as much information as they possibly could in order to make an informed decision as to what is right for them or not, and a couple of carers would be very upset and feel a little bit let down that they had children in their care that they weren't given absolutely all the information that they possibly could, so for me I think if we get that right sharing of information, good communication and lots of support, that ultimately should improve the health needs of looked after children.*



## Summary

- ◆ According to the social work managers interviewed, HSC Trusts appeared to follow similar procedures when dealing with the health needs of the LACYP. Professionals talked about statutory health assessments, the LAC review process, specialist nurses for LAC, health promotion practices (especially regarding alcohol and drug use, and sexual health), and mental health provision (i.e. CAMHS, therapeutic services for LAC, and other psychological services offered by different organisations).
- ◆ Participants identified a range of factors hindering their capacity to meet the health needs of LACYP, including lack of resources, young people moving Trusts, and young people not engaging with services (mentioned by professionals in different Trusts), and lack of representation of health professionals in LAC meetings (although this was mentioned within only one of the focus groups).
- ◆ Participants identified a range of factors that increased their capacity to meet the health needs of LACYP: Prioritization of LACYP for some services; change of structures; new support scheme for kinship carers; and giving delegated authority to foster carers.
- ◆ In relation to gaps in addressing the health needs of LACYP, professionals in different Trusts identified particular services and aspects that were lacking at both a local and a regional level, such as inpatient treatment (i.e. detoxification facilities) for young people's drug abuse in Northern Ireland, and appropriate mental health services for young adults (over 16). Other gaps identified were: service provision for children with complex needs; and a centralized information system.
- ◆ Most of the suggestions and recommendations made were focused on improving mental health service provision for LACYP, particularly in relation to early intervention and prevention. Others related to the gap in services for drug and alcohol users, and others were aimed at improving communication and coordination between health professionals.

## Chapter 4: Carers' perspectives

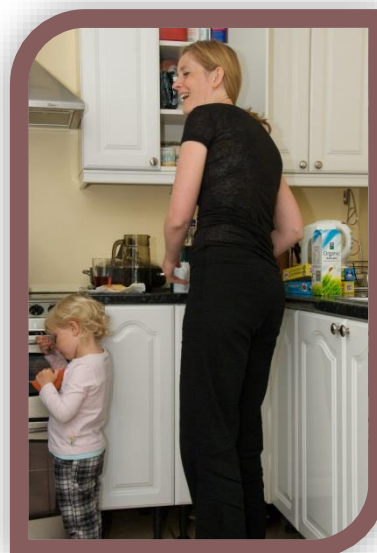
### Introduction

A telephone questionnaire was used to gather information for a sample of 233 looked after children/young people across the five HSC Trusts in Northern Ireland through speaking to their parent/carer. This was designed to facilitate the collection of both quantitative and qualitative data regarding the health of LACYP.

### Quantitative Data

#### Background Characteristics

There were slightly more girls (52%) than boys (48%) in the study sample. The vast majority of children/young people were designated as either Catholic (51%) or Protestant (40%), with small percentages being described as having no religion (5%), or having mixed religion (4%). Most of the children/young people were described by their carers as being either 'white British' (44%) or 'white Irish' (39%). A range of other ethnicities were suggested by a minority of carers, such as: 'White' (9%); 'Traveller' (3%); 'Mixed Ethnicity' (2%); 'Other' (2%); 'White Northern Irish' (1%); and 'Black' (<1%). These reflect the religious and ethnic distribution of looked after children and young people in Northern Ireland as a whole (DHSSPS, 2014a).



**Table 4: Placement of the children/young people included in the sample and in the NI LACYP population 2013/14**

Placement types	N	%	% LACYP NI 2013/14
Foster care	158	68	44
Kinship care	53	22	32
Residential care	16	7	7
With parents	6	3	12
Other	0	0	5
Total	233	100	100

The vast majority of children/young people were in long-term placements (81%), with a much smaller proportion of children in short-term placements (14%). However, some carers stated that they did not know if the placement was long or short-term (5%). In terms of the status of the placements, the vast majority of children/young people were in foster care (68%), followed by kinship care (22%), residential care (7%), and living at home on a Care Order (3%). This is in contrast with the most recent statistics available for the full population of LACYP in Northern Ireland, described in Chapter 1, which indicate that 32 per cent of LACYP are in kinship care and 44 per cent in foster care (DHSSPS, 2014a) (see Table 4). Thus, the study sample has a much larger proportion of children/young people in foster care than

the overall figure for Northern Ireland. This may be explained by the lower percentage of children/young people in the sample living with parents (3% as opposed to a regional 12%), or 'other' types of placements. This may be to some extent an artefact of the selection process and the necessity to seek the assistance of the Fostering Network to recruit additional carers to the study, with these being primarily foster carers.

Table 5 shows the age range of the children/young people at the time of the telephone interviews. This distribution is very similar to the population of looked after children and young people across Northern Ireland. Most of the children/young people in the study population were over the age of 11 (54%), and only a small percentage were under five (15%). Only twelve were 18 years old and over (5%).

**Table 5: Age of the children/young people included in the sample and in the NI LACYP population 2013/14 (DHSSPS, 2014a)**

Years	Age at Interview			
	N	%	Cumul %	% LACYP NI 2013/14
<1 yr	8	3	3	3
1-4 yrs	28	12	15	20
5-11 yrs	72	31	46	33
12-15 yrs	74	32	78	25
16+	51	22	100	19
<b>Total</b>	<b>233</b>	<b>100</b>		<b>100</b>

As regards legal status, most were subject to a Care Order (63%), with a smaller percentage being on an Interim Care Order (15%). A smaller proportion of the children/young people were on other Orders: Freed for adoption (5%); and Ward of Court (1%). Some children/young people were voluntarily accommodated (12%), whilst a few carers did not know the child/young person's legal status (4%), and two young people had no legal Order in place due to the fact that they were 18 years old. Compared with the population of looked after children and young people across Northern Ireland, the study sample under-represents those who are voluntarily accommodated, with this being 26 per cent at the regional level.

As indicated in Table 6, approximately one third of the sample had been in care for less than three years (38%). This differs from the statistical figures provided by government for the population of LACYP in Northern Ireland, with this cited as 56 per cent (DHSSPS, 2014a). This may be explained to some extent by the nature of the research study, and the difficulty that is experienced recruiting participants from placements where children and young people have just recently entered the care system. In contrast with government statistical figures (DHSSPS, 2014a), 16 per cent of the sample had been in care for 10 years or more at the point of interview (compared to 10% for the total population of LACYP in Northern Ireland). These figures reflect the fact that in 81 per cent of cases, the carers described the placement as 'long-term', with 15 per cent describing it as 'short-term', and 5 per cent were unsure if the placement was long-term or short-term. In terms of the children/young people's current placements, 55 per cent had been in placement for less than three years, with 45 per cent in placement for longer than three years, and 7 per cent in placement for 10 years or more.

Table 6: Length of time in care of the children/young people in the sample

Years	Length of Time in Care		
	<i>N</i>	%	<i>Cumul %</i>
<3 mts	3	1	1
3 mts – 1 yr	29	13	14
1 - 2 yrs	56	24	38
3 - 5 yrs	53	23	61
6 - 9 yrs	54	23	84
10+ yrs	38	16	100
<b>Total</b>	233	100	

### Strengths and Difficulties Questionnaire Profile (n=204)

It is common practice when applying the SDQ that usage is exclusive to children over three years old, and this was applied within the current study. Consequently, SDQ data was collected for 204 children/young people. As shown in Table 7, high percentages of children/young people in the current study sample scored with the abnormal range across the different dimensions of the SDQ: emotional symptoms (36%); conduct problems (40%); peer problems (38%); hyperactivity (41%); and total difficulties (40%). In terms of pro-social behaviour, the level of children/young people in the abnormal range was much lower than the other dimensions at 21 per cent, but this is still twice the level that would be expected from a community sample.

Table 7: SDQ scores

Range	SDQ Scores (%)					
	Emotional Symptoms	Conduct Problems	Peer Problems	Hyperactive	Prosocial Behaviour	Total Difficulties
<b>Normal (cs 80%)</b>	51	52	53	49	68	49
<b>Borderline (cs 10%)</b>	13	8	9	10	11	11
<b>Abnormal (cs 10%)</b>	36	40	38	41	21	40

Carers were also asked if the rating they had given for the children/young people would have been different in the past. A large proportion of carers (46%) indicated that the profile would have been poorer in the past, indicating an improvement in behaviour over the time that the children/young people had been placed with them. On the other hand, a smaller proportion (15%) suggested that it would have been better, indicating a deterioration in behaviour. Many carers (40%) believed that there had been no change.

## Warwick Child Health and Morbidity Profile

### General Health

Most children/young people were described by their carers as being either 'very healthy' (60%), or 'healthy' (33%). Only a small proportion of the children/young people were described as being either 'not very healthy' (5%) or 'unhealthy' (2%).

Most carers (88%) indicated that the children/young people did not have minor illnesses more often than other children of similar age. A small minority of carers (n=28; 12%) indicated that the children/young people had: a few more illnesses (5%); a lot more illnesses (4%); or were never free of them (3%).



### Behaviour

Most carers (60%) commented that the children/young people did not display any behaviour that was a problem for them or their family, with a smaller, but sizeable, proportion (40%) indicating that the child/young person's behaviour was problematic. This percentage of carers who indicated the presence of problematic behaviour is the same as that percentage of parents whose child/young person was scored in the abnormal range on the SDQ for conduct problems, indicating a strong correlation on this aspect of child/young person health between the two measures. Of those carers who indicated that the child/young person's behaviour was a problem, most believed this to be a 'big problem' (51%), whilst smaller proportions suggested this was either a 'moderate' (34%) or 'small' (15%) problem. The vast majority of carers (90%) had sought professional help for these behavioural problems.

### Hospital Admission

A minority of carers indicated that the child/young person they were caring for had an accident (18%) or serious illness (20%) in the last year which required medical attention, including being hospitalised for one night or more (12%).

### Longstanding illness and disability

Almost a third of carers (32%) commented that the child/young person they were caring for had a long-standing illness or disability. Most of these carers believed that this illness/disability affected the children/young people's activities (63%), but fewer considered that their own activities were affected (38%). Of those who indicated that the child/young person's long-standing illness/disability affected their own activities, over half suggested that this was a 'big' (53%) as opposed to a 'small' (47%) effect. Just less than one in five carers (16%) commented that they considered the child/young person to have health problems that would prevent them from leading a normal life.

### Scoping Health Conditions

The study questionnaire was designed to allow for a comprehensive scoping of health conditions, past and present, for this population of children/young people, and these are illustrated in Table 8. For display purposes, those conditions that are, or have been, present for more than 10 per cent of the study sample are depicted in bold.

Table 8: Health conditions (%)

<b>Acne</b>	<b>13</b>	<b>Emotional problems - undiagnosed</b>	<b>15</b>
<b>ADHD/ADD - diagnosed</b>	<b>17</b>	Epilepsy	2
ADHD / ADD - undiagnosed	8	<b>Eye/sight problems</b>	<b>29</b>
<b>Allergies/rashes</b>	<b>14</b>	Foetal alcohol syndrome - diagnosed	2
<b>Asthma</b>	<b>18</b>	Food allergy	4
Autism - diagnosed	3	<b>Glue ear</b>	<b>11</b>
Autism - undiagnosed	6	<b>Hay fever</b>	<b>12</b>
<b>Behavioural prob. - diagnosed</b>	<b>40</b>	<b>Health condition since birth</b>	<b>14</b>
Behavioural prob. – undiagn.	7	Hearing problems	7
Bed wetting	<b>16</b>	Heart problem	5
Blood disorder	1	Kidney/ urinary tract problems	7
Cerebral palsy	2	<b>Learning difficulties - diagnosed</b>	<b>22</b>
<b>Chest infection</b>	<b>10</b>	Learning difficulties - undiagnosed	7
<b>Co-ordination problems</b>	<b>12</b>	<b>Migraine / severe headaches</b>	<b>11</b>
<b>Depression or anxiety – diagn.</b>	<b>21</b>	Muscle disease / weakness	4
<b>Depression or anxiety – und.</b>	<b>14</b>	Obesity	5
Diabetes	1	<b>Soiling pants</b>	<b>14</b>
Dyslexia	4	<b>Speech / language problems - diagnosed</b>	<b>18</b>
Eating disorder - diagnosed	5	Speech / language problems – undiagn.	2
Eating disorder - undiagnosed	6	<b>Stiffness / deformity of limbs</b>	<b>10</b>
<b>Eczema</b>	<b>12</b>	<b>Stomach / digestive problems</b>	<b>13</b>
<b>Emotional problems – diagn.</b>	<b>35</b>	Any other condition / disorder	3

As shown in the table, 40 per cent of children have diagnosed behavioural problems. This is very similar to the findings from the SDQ, wherein 40 per cent of children/young people were found to be in the abnormal range on the total difficulties measure. If the figure for undiagnosed behavioural problems is included (7%), the overall figure rises to 47 per cent.

Other notable problems included: emotional problems (35% diagnosed and 15% undiagnosed – combined 50%); eye/sight problems (29%); learning difficulties (22%)

diagnosed and 7% undiagnosed - combined 29%); depression or anxiety (21% diagnosed and 14% undiagnosed – combined 35%); speech/ language problems (18% diagnosed and 2% undiagnosed – combined 20%); asthma (18%); wetting the bed (16%); and allergies and rashes (14%).



### Generic Health-Related Questions

The telephone interview questionnaire also contained a number of questions that were deemed relevant to understanding the general health of children/young people in care. It was found that almost all were registered with a GP (99%), and were up to date with their immunisations (97%). A small proportion (9%) was registered disabled, and this was found to be consistent with governmental statistics for the total population of LACYP across Northern Ireland, with the 10 per cent being recorded as having a disability (DHSSPS, 2014a). Almost one in five children (19%) had a statement of 'Special Educational Need'.

### Young Person's Behaviour and Attitude Survey (YPBAS) Questions

Excluding children under the age of three and who may not have commenced school (12%), a sizeable minority of carers indicated that the child/young person they were caring for had been expelled or suspended from school (16% compared to 6% of YPBAS respondents in 2013 in NI). In terms of healthy eating, it was found that one in four children/young people were eating five or more portions of fruit and vegetables each day (26% compared to 16% of YPBAS respondents in 2013), with only a very small proportion not eating any (6% compared to 4% of YPBAS respondents). Carers also indicated that most children/young people ate breakfast every school day (67%), with a much small proportion (14% compared to 19% of YPBAS) never eating breakfast on school days. As regards enjoying sport or physical activity, the vast majority of carers indicated that the child/young person did enjoy this (71%), whereas a smaller proportion (19%) believed that they did not.

It was also possible to examine more sensitive issues relating to substance use and sexual behaviour. These were only asked of carers in instances where children/young people were over the age of seven (n=186, 80%). Table 9 illustrates the percentages of children/young people who were believed to be smoking, drinking alcohol, using solvents, or using illegal drugs on a weekly basis or to have ever done so.

**Table 9: Alcohol and drug use**

Substance	Weekly (%)		Ever (%)	
	MYH	YPBAS 2013	MYH	YPBAS 2013
Tobacco	14	4	21	13
Alcohol	7	4	33	38
Solvents	<1	5	8	12
Drugs	5	<1	13	8

Table 9 shows that one in five of the study population had ever smoked. This is nearly twice as high as that found for 11 – 16 year olds in the general YPBAS sample across Northern Ireland (n=7,076). One third of the children/young people had taken an alcoholic drink at some stage, but only seven per cent had done in the last week. This is similar to the YPBAS



figures for young people in Northern Ireland as a whole. Smaller proportions of young people had ever used solvents (8%) or illegal drugs (13%). Again, these figures were similar to the findings from the YPBAS for young people in Northern Ireland as a whole (NISRA, 2014). It was also found that 40 per cent of children/young people had had either a boyfriend or a girlfriend (compared to 68% of YPBAS respondents) and carers believed that in 38 per cent of cases, the child/young person had some sexual experience (in comparison with 10% of YPBAS respondents).

### **Background factors and health profile**

In addition to profiling the physical and mental health of LACYP, a number of background factors were explored in terms of how this profile was represented across the study sample. In this regard, three key factors were examined: placement type; age; and gender. This study did not set out to examine health profile differences at the HSC Trust level, so this form of analysis was excluded from the current report. However, the data set does provide an opportunity for this type of analysis to be conducted at some point in the future.

### ***Relationship between placement and health profile***

The type of placement that the children/young people were living in was found to be significantly related to a range of health profile variables.

Figure 2 displays variation in profile across the three domains of the SDQ (normal, borderline, and abnormal) on total difficulties score, across the three main placements types of foster care, kinship care, and residential care. The sample did include six cases where a child/young person was living at home on a Care Order. However, this was deemed too small a sub-sample for comparative purposes, and consequently these cases were excluded from the placement-specific analysis. Although 40 per cent of the total sample scored within the abnormal range on total difficulties score, this ranged from a low of 23 per cent in kinship care to 81 per cent in residential care.

A Pearson Chi-Square test of independence was performed to examine the relation between placement type and SDQ total difficulties score. The relationship between these variables was significant:  $X^2(9, N = 200) = 18.73, p < .03$ . A one-way analysis of variance (ANOVA) was also calculated on SDQ total difficulties score across placement type. The analysis was significant:  $F(2, 197) = 6.90, p = .00$ . Post-hoc tests (Tukey HSD) indicated that across the three placement types, there were a number of significant differences between mean scores: between residential (mean score = 20.88) and kinship care (mean score = 12.55) ( $p = .00$ ); and residential and foster care (mean score = 15.08) ( $p = .02$ ).



Figure 2: Placement type with SDQ total difficulties score (%)

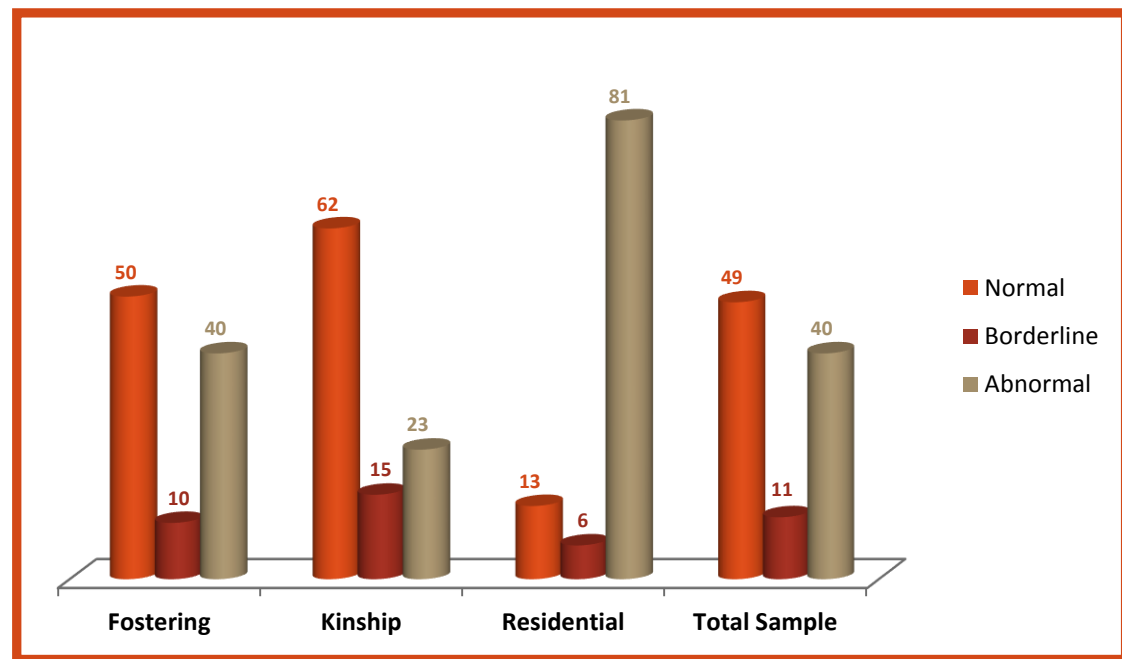
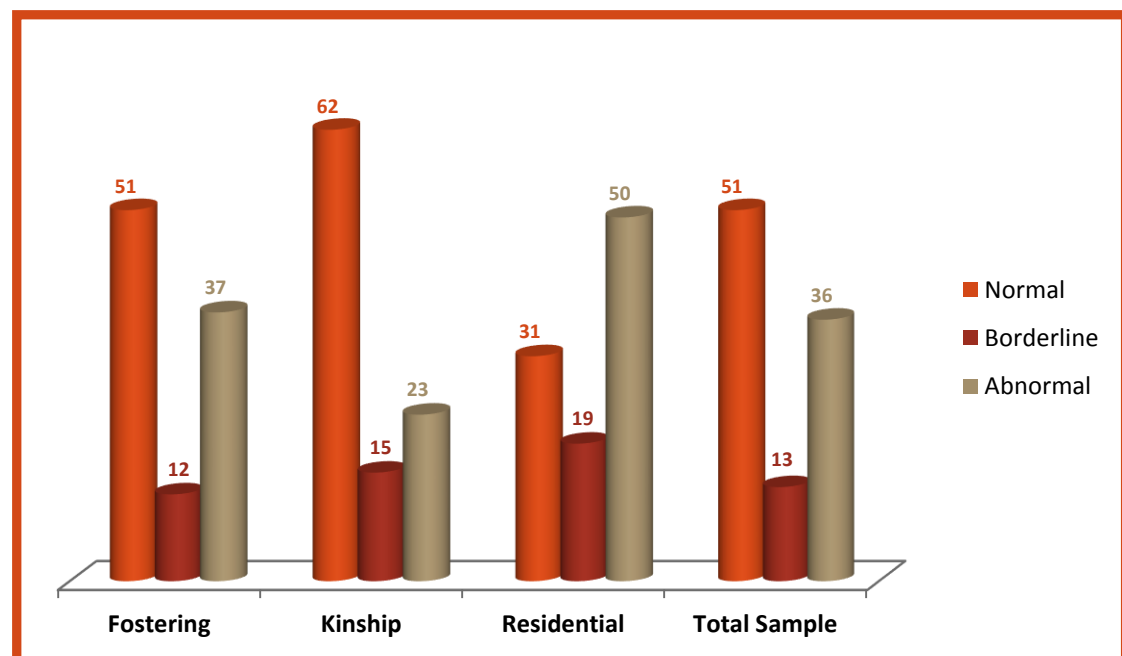


Figure 3 illustrates variation in profile across the three domains of the SDQ (normal, borderline, and abnormal) on emotional symptoms score, across the three main placement types of foster care, kinship care, and residential care. As illustrated in the chart, although 36 per cent of the total sample scored within the abnormal range on emotional symptoms score, this ranged from 23 per cent in kinship care to 50 per cent in residential care.

Figure 3: Placement type with SDQ emotional symptoms score (%)



A one-way analysis of variance (ANOVA) was also calculated on SDQ emotional symptoms score across placement type. The analysis was significant:  $F(2, 197) = 3.24, p = .04$ . Post-hoc tests (Tukey HSD) indicated that there was a significant difference between mean scores for children/young people in residential care (mean score = 5.13) and kinship care (mean score =

3.15) ( $p = .03$ ). There was also a near significant difference between mean scores for children/young people in residential care and foster care (mean score = 3.60) ( $p = .08$ ).

Figure 4 shows variation in profile over the three domains of the SDQ (normal, borderline, and abnormal) on conduct problems score, across the three main placement types of foster care, kinship care, and residential care. As shown in the chart, although 40 per cent of the total sample scored within the abnormal range on conduct problems score, this ranged from 27 per cent in kinship care to 75 per cent in residential care.

A Pearson Chi-Square test of independence was performed to examine the relation between placement type and SDQ conduct problems score. The relationship between these variables was near significant:  $\chi^2(9, N = 200) = 15.86, p < .07$ . A one-way analysis of variance (ANOVA) was also calculated on SDQ conduct problems score across placement type. The analysis was significant:  $F(2, 197) = 9.13, p = .00$ . Post-hoc tests (Tukey HSD) indicated that there were significant differences between mean scores for children/young people in residential care (mean score = 5.63) and kinship care (mean score = 2.43) ( $p = .00$ ); and also residential care and foster care (mean score = 3.13) ( $p = .00$ ).

**Figure 4: Placement type with SDQ conduct problems score (%)**

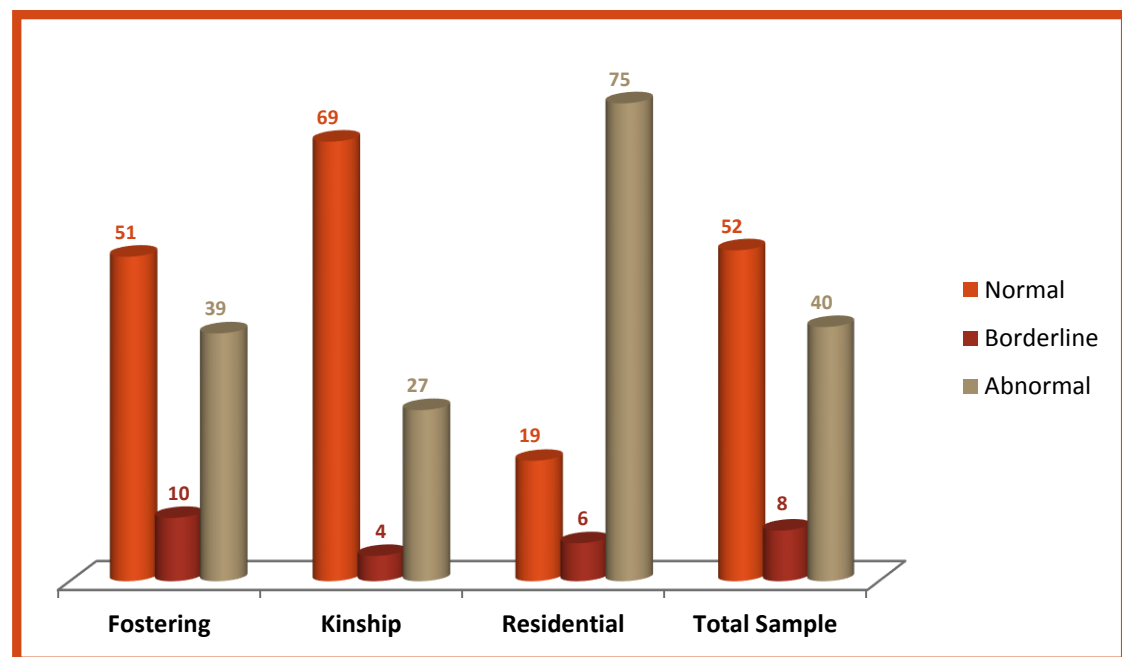
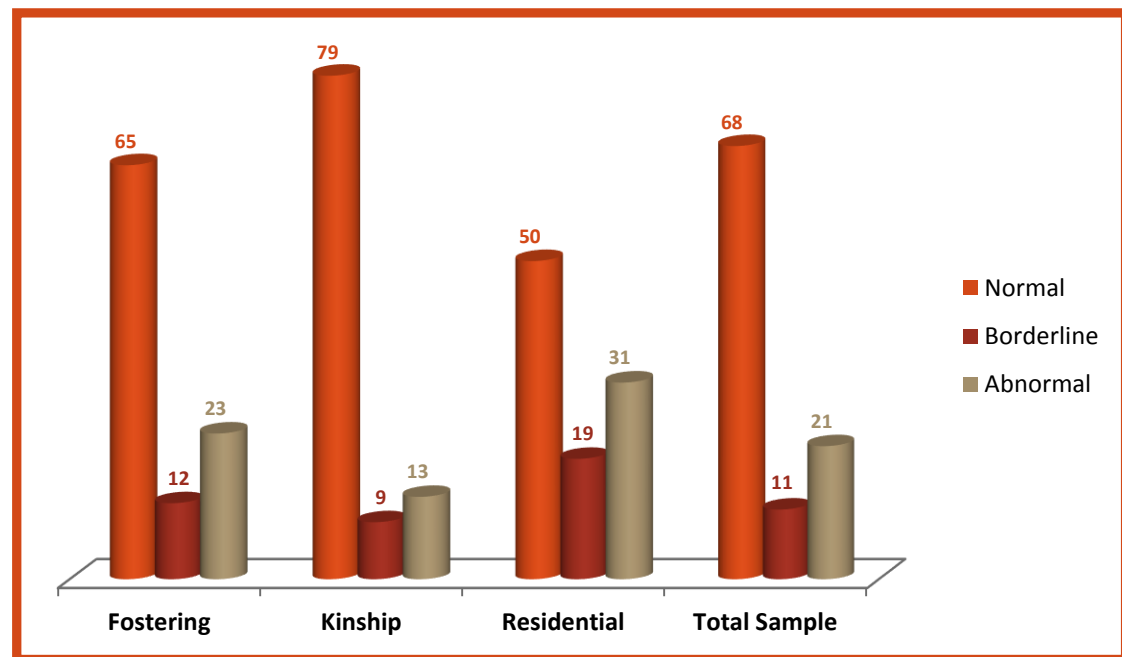


Figure 5 illustrates variation in profile over the three domains of the SDQ (normal, borderline, and abnormal) on prosocial behaviour score, across the three main placement types of foster care, kinship care, and residential care. The chart shows that although 21 per cent of the total sample scored within the abnormal range on prosocial behaviour score, this ranged from 13 per cent in kinship care to 31 per cent in residential care.

Figure 5: Placement type with SDQ prosocial behaviour score (%)



A one-way analysis of variance (ANOVA) was also calculated on SDQ prosocial behaviour score across placement type. The analysis was significant:  $F(2, 197) = 6.26, p = .00$ . Post-hoc tests (Tukey HSD) indicated that there were significant differences between mean scores for children/young people in kinship care (mean score = 7.89) and residential care (mean score = 5.56) ( $p = .01$ ); and also between kinship care and foster care (mean score = 6.67) ( $p = .01$ ). It should be noted that unlike with other dimension of the SDQ, higher means are indicative of a higher degree of prosocial behaviour.

Figure 6: Placement type and WCHMP overall state of health

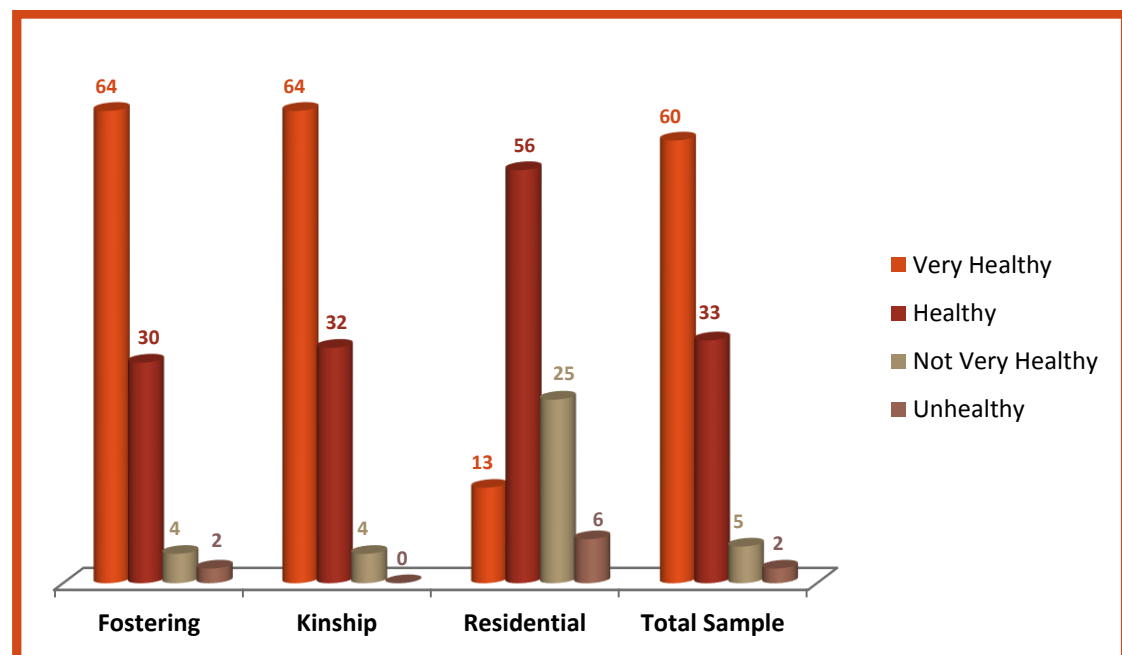


Figure 6 shows the percentage distribution of responses given by carers across the three placement types when asked to rate the children/young people's overall state of health. As the chart indicates, although 60 per cent of the overall sample of carers rated the

children/young people's health as 'very healthy', this was only specified for 13 per cent of children/young people in residential care. In addition, five per cent of the total sample of carers rated the children/young people as 'not very healthy'. However, this was as high as 25 per cent in residential care.

A Pearson Chi-Square test of independence was performed to examine the relation between placement type and WCHMP overall state of health. The relationship between these variables was significant:  $\chi^2(9, N = 230) = 26.41, p < .00$ .

Table 10 shows a range of health related variables that were found to be significantly related to placement type. As described in the table, a number of statistically significant differences were observed regarding placement type (as measured by Pearson Chi-Square tests of independence):

- ◆ The percentage of residential carers citing problematic behaviours for the young person's family was markedly higher (81%) than for foster (38%) and kinship (31%) care;
- ◆ A relatively low percentage of children/young people in kinship care (6%) was admitted overnight to hospital in the past year relative to foster care (13%), and residential care (31%) in particular;
- ◆ In relation to diagnosed behavioural problems, kinship care showed the lowest percentage (23%), followed by foster care (41%), with residential care showing a markedly higher percentage (81%);
- ◆ In terms of diagnosed emotional problems, the percentage of children/young people for whom this applied was very similar in both foster (32%) and kinship (30%) care, but much higher in residential care (81%);
- ◆ Low percentages in kinship care (9%) and foster care (16%) were ever suspended from school, in comparison with a much higher percentage of those in residential care (50%);
- ◆ A markedly higher percentage of young people in residential care (50%) never ate breakfast on a school day than in the other two placement types; and this was equally true of those who did not enjoy sport/physical activity (31%), were not in a sport club outside of school (69%), and who spent no time on homework (58%);
- ◆ In terms of the variables that dealt with substance use and risky behaviour (i.e. smoked, taken alcohol, in trouble with family due to alcohol, in trouble with locals due to alcohol, in trouble with police due to alcohol, in trouble with friends due to alcohol, used solvents, used illegal drugs, engaged in behaviour that is harmful to themselves, and have had some sexual experience), a pattern emerged of very high percentages of young people in residential care engaging in this risky behaviour, relative to children/young people in kinship and foster care.

Table 10: Placement type with other health related variables (%)

Condition/Issue Present	Fostering	Kinship	Residential
Behaviour problematic for family <sup>1</sup>	38	31	81
Admitted to hospital <sup>2</sup>	13	6	31
Diagnosed behaviour problems <sup>3</sup>	41	23	81
Diagnosed emotional problems <sup>4</sup>	32	30	81
Suspended from school <sup>5</sup>	16	9	50
Never eats breakfast <sup>6</sup>	11	13	50
Don't enjoy sport/physical activity <sup>7</sup>	18	17	31
Not in sport club outside school <sup>8</sup>	40	45	69
No time on homework <sup>9</sup>	14	13	58
Smoked <sup>10</sup>	18	11	69
Taken alcohol <sup>11</sup>	34	23	75
In trouble with family due to alcohol <sup>12</sup>	8	7	69
In trouble with locals due to alcohol <sup>13</sup>	3	0	44
In trouble with police due to alcohol <sup>14</sup>	8	2	56
In trouble with friends due to alcohol <sup>15</sup>	4	0	31
Use solvents <sup>16</sup>	3	2	62
Use illegal drugs <sup>17</sup>	7	7	69
Harmful behaviours <sup>18</sup>	29	9	69
Sexual experience <sup>19</sup>	44	25	75

<sup>1</sup>  $\chi^2 (3, N = 230) = 15.23, p < .01$ .

<sup>2</sup>  $\chi^2 (3, N = 230) = 8.50, p < .04$ .

<sup>3</sup>  $\chi^2 (9, N = 230) = 19.82, p < .02$ .

<sup>4</sup>  $\chi^2 (9, N = 230) = 19.00, p < .03$ .

<sup>5</sup>  $\chi^2 (9, N = 230) = 18.61, p < .03$ .

<sup>6</sup>  $\chi^2 (9, N = 230) = 42.46, p < .001$ .

<sup>7</sup>  $\chi^2 (12, N = 230) = 22.85, p < .03$ .

<sup>8</sup>  $\chi^2 (9, N = 230) = 49.16, p < .001$ .

<sup>9</sup>  $\chi^2 (15, N = 230) = 64.37, p < .001$ .

<sup>10</sup>  $\chi^2 (12, N = 182) = 37.80, p < .001$ .

<sup>11</sup>  $\chi^2 (15, N = 182) = 43.96, p < .001$ .

<sup>12</sup>  $\chi^2 (9, N = 182) = 64.75, p < .001$ .

<sup>13</sup>  $\chi^2 (9, N = 182) = 55.67, p < .001$ .

<sup>14</sup>  $\chi^2 (15, N = 182) = 56.41, p < .001$ .

<sup>15</sup>  $\chi^2 (12, N = 182) = 36.54, p < .001$ .

<sup>16</sup>  $\chi^2 (12, N = 182) = 83.13, p < .001$ .

<sup>17</sup>  $\chi^2 (12, N = 182) = 82.39, p < .001$ .

<sup>18</sup>  $\chi^2 (9, N = 182) = 24.71, p < .01$ .

<sup>19</sup>  $\chi^2 (15, N = 182) = 53.90, p < .001$ .

### Relationship between age and health profile

The age of the children/young people at the time the telephone interview was conducted with carers was found to be significantly related to a range of health profile variables.

Figure 7 displays variation in profile over the three domains of the SDQ (normal, borderline, and abnormal) on emotional symptoms score, across the different age ranges of the children/young people in the study sample. The two youngest categories (less than one year and 1-4 years) were excluded due to age restriction of the SDQ. The figure shows that although 36 per cent of the total sample scored within the abnormal range on emotional symptoms score, this ranged from 30 per cent in the 5 – 11 age category, to 50 per cent in the 18 years and older category. As shown by the chart, the percentage of children/young people within the abnormal range increased with age.

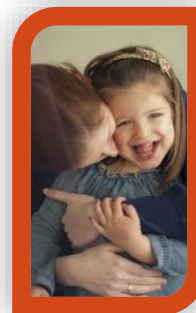
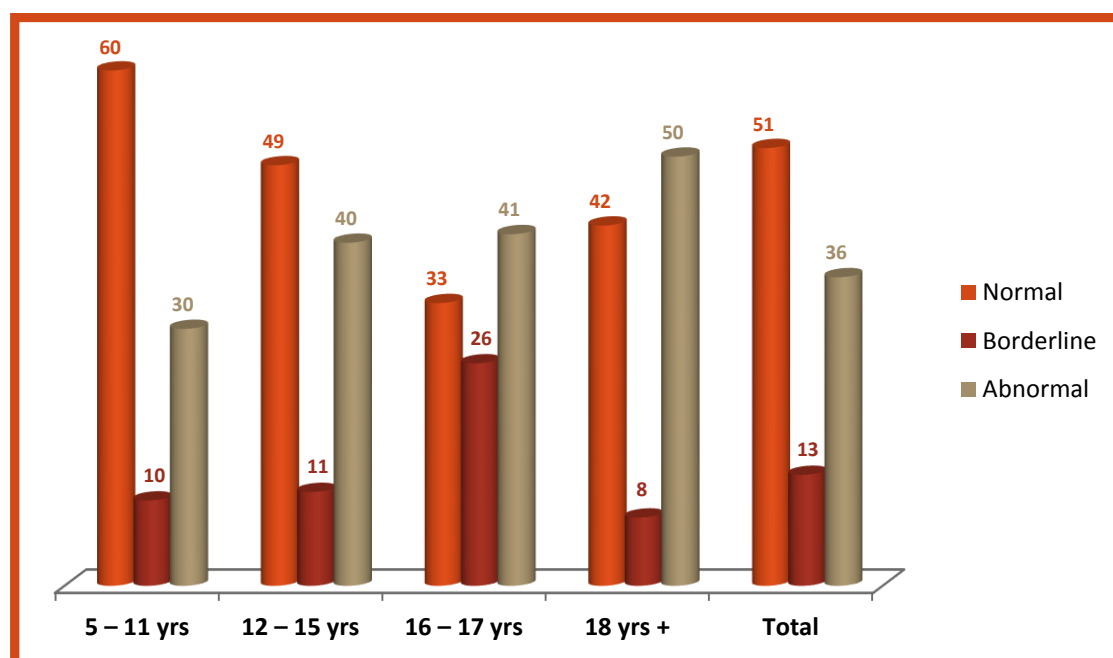


Figure 7: Age with SDQ emotional symptoms score (%)

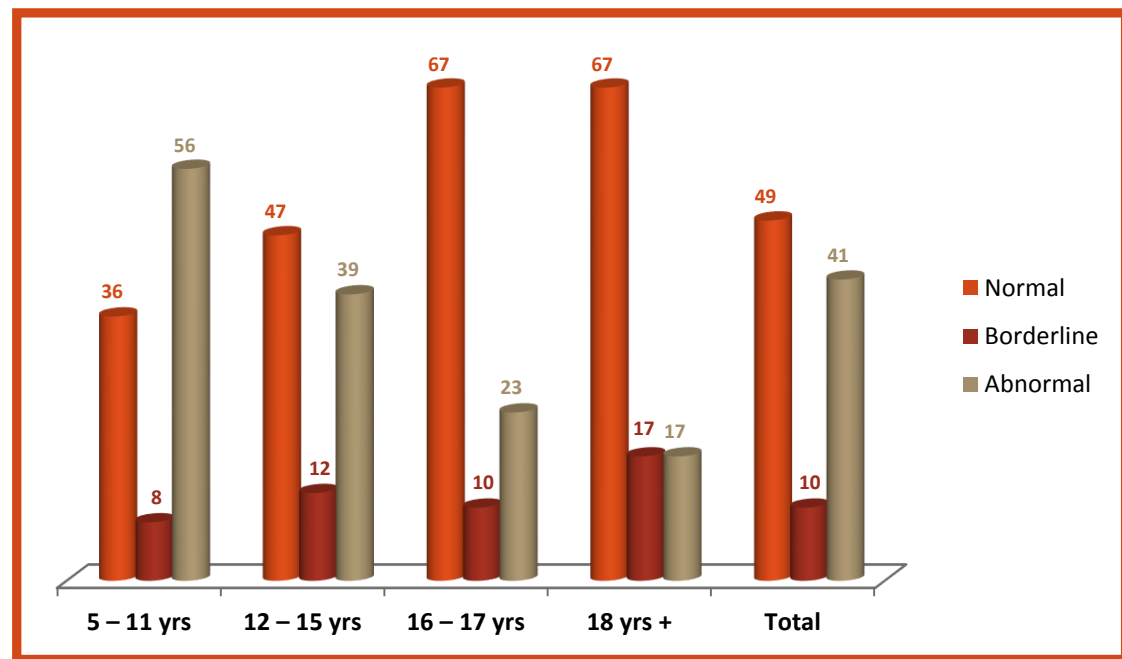


A Pearson Chi-Square test of independence was performed to examine the relationship between age at interview and SDQ emotional symptoms score. The relationship between these variables was significant:  $X^2(12, N = 206) = 29.37, p < .01$ . A one-way analysis of variance (ANOVA) was also calculated on SDQ emotional symptoms score across the different age ranges. The analysis was not significant.

Figure 8 shows variation in profile over the three domains of the SDQ (normal, borderline, and abnormal) on hyperactivity/inattention score, across the different age ranges of the children/young people. The figure shows that although 41 per cent of the total sample scored within the abnormal range on hyperactivity/inattention score, this ranged from 17 per cent in the 18 years and older age category, to 56 per cent in the 5 – 11 years group. The chart also illustrates the opposite pattern to that depicted in Figure 6, with the percentage of children/young people within the abnormal range decreasing with age.



Figure 8: Age with SDQ hyperactivity/inattention score (%)



A Pearson Chi-Square test of independence was performed to examine the relation between age at interview and SDQ hyperactivity/inattention score. The relationship between these variables was significant:  $X^2(12, N = 206) = 27.46, p < .01$ . A one-way analysis of variance (ANOVA) was also calculated on SDQ hyperactivity/inattention score across age range. The analysis was significant:  $F(3, 195) = 4.08, p = .01$ . Post-hoc tests (Tukey HSD) indicated that there was a significant difference in mean scores between the 5 – 11 age group (mean score = 6.24) and the 16 – 17 (mean score = 4.26) age group ( $p = .01$ ).

Figure 9: Age with SDQ peer relationship problems score (%)

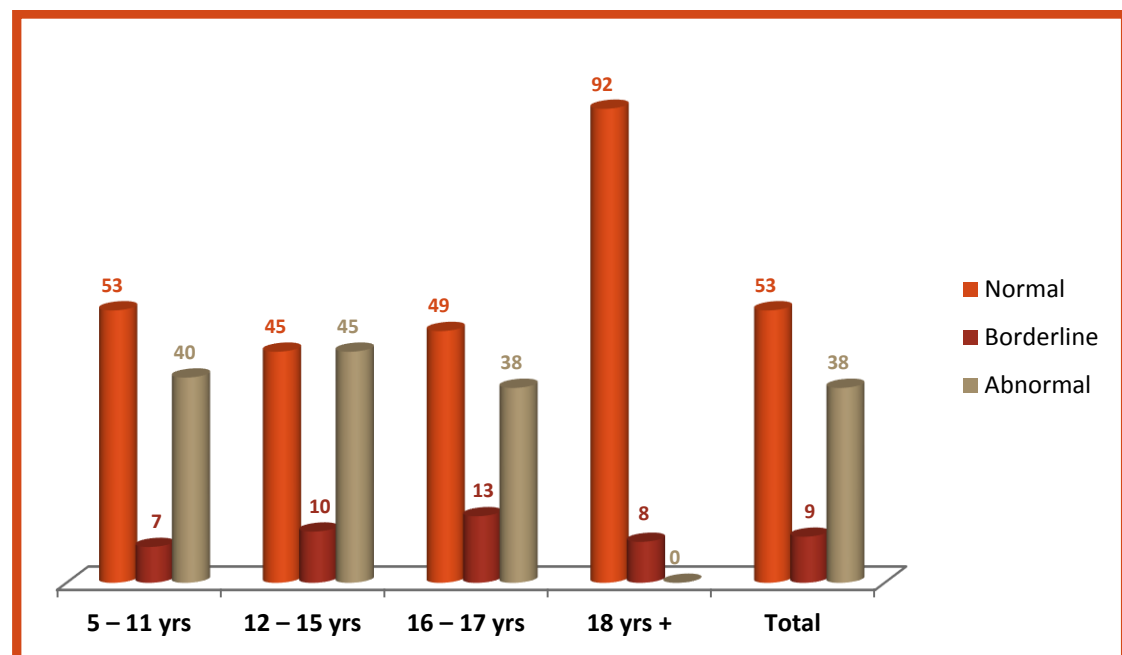


Figure 9 shows variation in profile over the three domains of the SDQ (normal, borderline, and abnormal) on peer relationship problems score, across the different age ranges of the children/young people in the study. Although 38 per cent of the total sample scored within the abnormal range on peer relationship problems score, this ranged from zero in the 18 years and older age category, to 45 per cent in the 12 – 15 age group. On this occasion, the chart illustrates that peer relationship problems appear to peak in the 12 – 15 age category and then begin to decline thereafter.

A Pearson Chi-Square test of independence was performed to examine the relationship between age at interview and SDQ peer relationship problems score. The relationship between these variables was significant:  $X^2(12, N = 206) = 25.52, p < .02$ . A one-way analysis of variance (ANOVA) was also calculated on SDQ peer relationship problems score across age range. The analysis was significant:  $F(3, 195) = 3.51, p = .02$ . Post-hoc tests (Tukey HSD) indicated that there was a significant difference in mean scores between the 18 years and older (mean score = 0.83) age group, and all three other age categories: 5 – 11 years (mean score = 3.11,  $p = .02$ ); 12 – 15 years (mean score = 3.21,  $p = .01$ ); and 16 – 17 years (mean score = 3.23,  $p = .02$ ).

Figure 10 shows the percentage distribution of responses given by carers across the six age ranges when asked to rate the children/young people's overall state of health. Although 60 per cent of the overall sample of carers rated the children/young people's health as 'very healthy', this drops to 54 and 51 per cent in the 12 – 15 and 16 – 17 age categories, suggesting that the teenage years are more concerning for carers regarding LACYP health.

A Pearson Chi-Square test of independence was performed to examine the relationship between age at interview and WCHMP overall state of health. The relationship between these variables was significant:  $X^2(15, N = 233) = 30.26, p < .02$ .

**Figure 10: Age at interview and WCHMP overall state of health (%)**

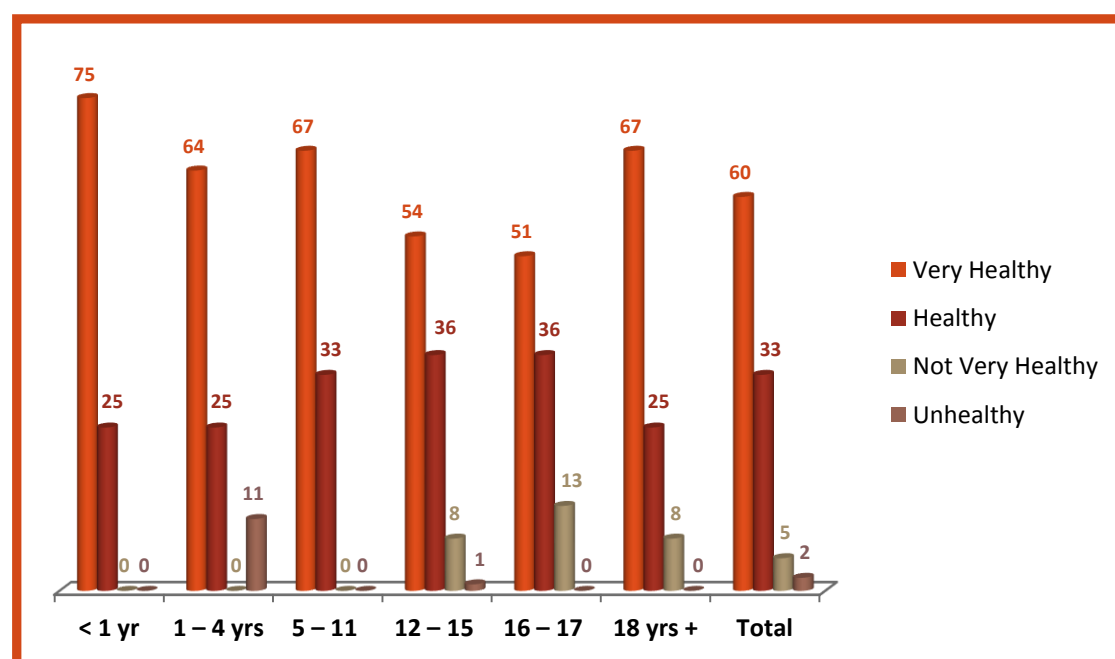


Table 11: Age at interview with other health related variables (%)

Condition/Issue Present	< 1 yr	1-4	5-11	12-15	16-17	18+
Diagnosed behaviour problems <sup>1</sup>	0	18	42	46	49	33
Diagnosed depression/anxiety <sup>2</sup>	0	7	13	30	31	25
Diagnosed emotional problems <sup>3</sup>	0	11	29	41	51	58
Diagnosed hyperactivity <sup>4</sup>	0	7	21	20	15	17
Suspended from school <sup>5</sup>			4	22	46	8
Never eats breakfast <sup>6</sup>			6	22	28	17
Don't enjoy sport/physical activity <sup>7</sup>			10	27	28	25
Smoked <sup>8</sup>			2	20	46	25
Taken alcohol <sup>9</sup>			5	30	72	75
Use solvents <sup>10</sup>			0	8	20	8
Use illegal drugs <sup>11</sup>			0	8	36	25
Harmful behaviours <sup>12</sup>			19	24	54	8
Sexual experience <sup>13</sup>			8	42	82	83

<sup>1</sup>  $\chi^2 (15, N = 233) = 51.87, p < .001.$

<sup>2</sup>  $\chi^2 (15, N = 233) = 53.42, p < .001.$

<sup>3</sup>  $\chi^2 (15, N = 233) = 50.45, p < .001.$

<sup>4</sup>  $\chi^2 (15, N = 233) = 39.36, p < .01.$

<sup>5</sup>  $\chi^2 (15, N = 233) = 191.29, p < .001.$

<sup>6</sup>  $\chi^2 (25, N = 233) = 39.36, p < .001.$

<sup>7</sup>  $\chi^2 (20, N = 233) = 135.20, p < .001.$

<sup>8</sup>  $\chi^2 (12, N = 184) = 39.36, p < .001.$

<sup>9</sup>  $\chi^2 (15, N = 184) = 75.30, p < .001.$

<sup>10</sup>  $\chi^2 (12, N = 184) = 25.18, p < .02.$

<sup>11</sup>  $\chi^2 (12, N = 184) = 47.14, p < .001.$

<sup>12</sup>  $\chi^2 (9, N = 184) = 26.73, p < .01.$

<sup>13</sup>  $\chi^2 (15, N = 184) = 91.87, p < .001.$

Table 11 shows a range of health related variables that were found to be significantly related to age at interview. As described in the table, a number of statistically significant differences were observed regarding the child's/young person's age (as measured by Pearson Chi-Square tests of independence):

- ◆ Almost one in five of the 1-4 age category had diagnosed behaviour problems, increasing to half the 16-17 age group, and then reducing to 33 per cent for the 18 and over category. This suggests that the presence of behavioural problems increases with age through to the late teens, when this begins to dissipate.
- ◆ A small percentage of children in the 1-4 age category exhibited depression/anxiety, with this increasing steadily to a peak of 31 per cent in the 16-17 age group, and then declining to 25 per cent in the 18 and older category. This indicates that in addition to behavioural problems, symptoms of depression or anxiety appear to increase through the teenage years, reducing in early adulthood.
- ◆ Diagnosed emotional problems appeared to increase with age, with the 18 years and over category having the highest percentage for the group as a whole. This suggests that where behavioural problems and depression/anxiety may begin to dissipate in early adulthood, this is not the case in relation to emotional problems.

- ◆ The percentage of children/young people with diagnosed hyperactivity increased from seven per cent in the 1-4 age category, through to 21 per cent in the 5-11 age group. However, unlike with behavioural problems, depression/anxiety, and emotional problems, the percentage of children/young people displaying symptoms of hyperactivity did not increase through the teenage years, but began to reduce through the older age ranges. This suggests that hyperactivity is a particular problem in the pre- and early teenage years, and becomes less prevalent as children/young people move through their teenage years into early adulthood.
- ◆ The remaining nine variables in Table 1 show a consistent pattern, with small percentages of children/young people in the 5-11 age category presenting these concerns, with this rising steadily and peaking in the 16-17 age group, and then reducing in the 18 years and over category. This suggests that LACYP in the mid to late teenage years are at greatest risk of behaviours that are adverse to their health.

### *Relationship between gender and health profile*

The gender of the children/young people was found to be significantly related to a range of health profile variables.



Figure 11 displays variation in gender profile on SDQ conduct problems score for male and female children/young people in the study sample. Although 40 per cent of the total sample scored within the abnormal range on conduct problems score, there was a seven percentage point difference between girls (36%) and boys (43%), indicating that this type of behavioural problem was a particular issue with boys. A Pearson Chi-Square test of independence was performed to examine the relation between gender and SDQ conduct problems score. The relationship between these variables was significant:  $X^2 (2, N = 204) = 7.26, p < .03$ .

**Figure 11: Gender with SDQ conduct problems score (%)**

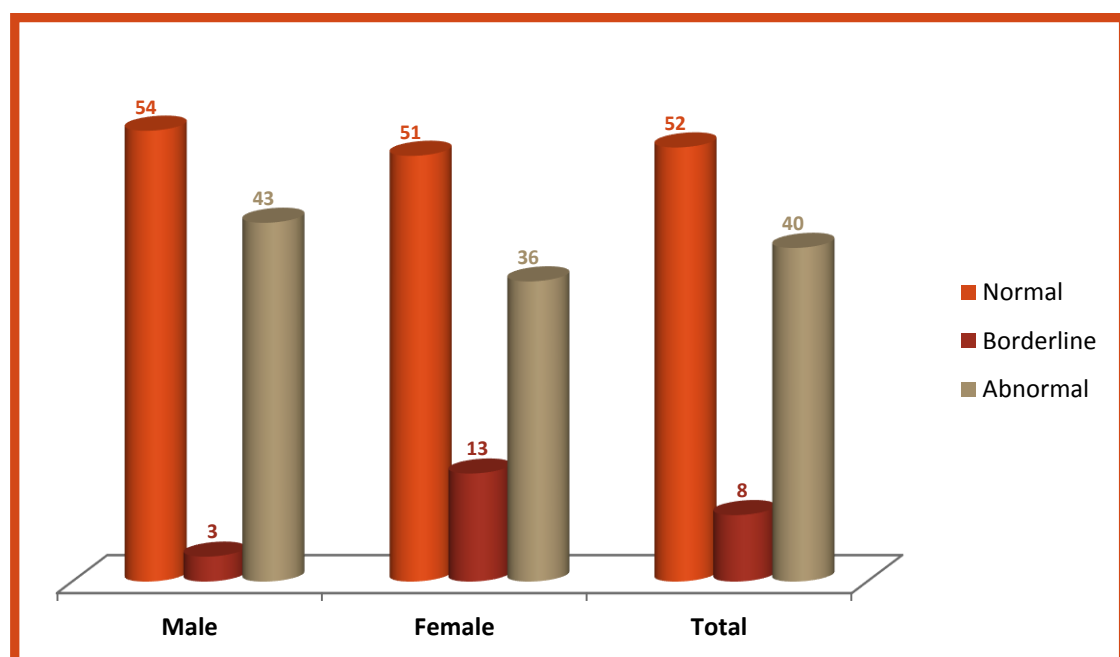


Figure 12: Gender with SDQ hyperactivity/inattention score (%)

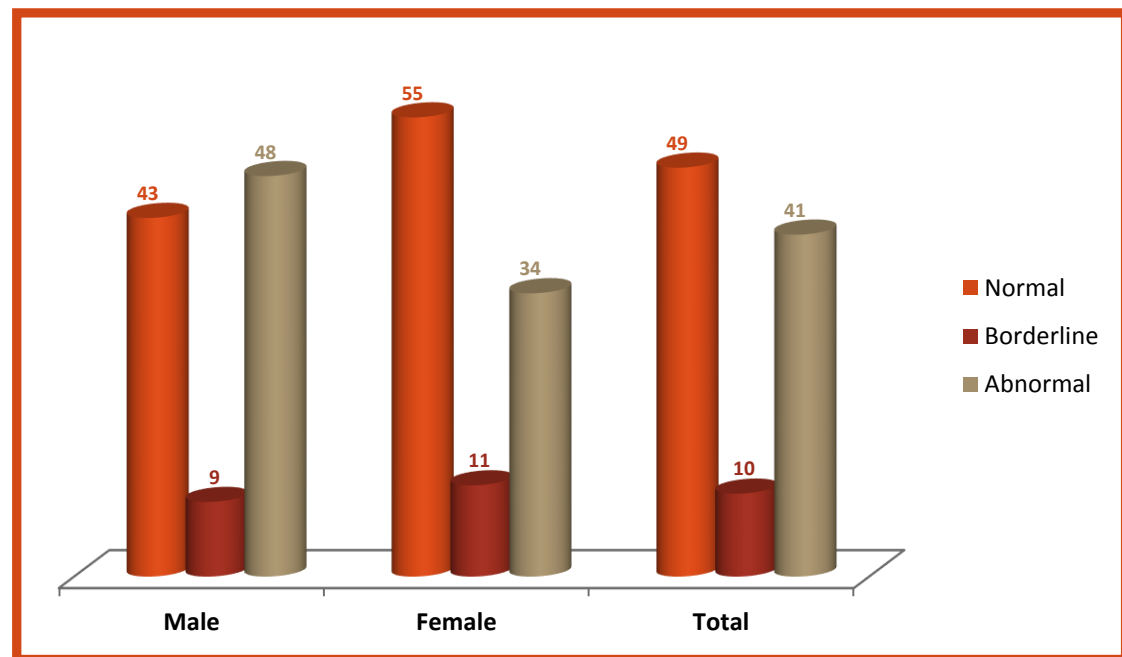


Figure 12 displays variation in gender profile on SDQ hyperactivity/inattention score for male and female children/young people in the study sample. Although 41 per cent of the total sample scored within the abnormal range on hyperactivity/inattention score, there was a 14 percentage point difference between girls (34%) and boys (48%), indicating that this type of behavioural problem, as with conduct, was a particular issue with boys. A one-way analysis of variance (ANOVA) was also calculated on SDQ hyperactivity/inattention score across gender. The analysis was significant:  $F(1, 203) = 5.31, p = .02$ .

Figure 13: Gender with SDQ peer relationship problems score (%)

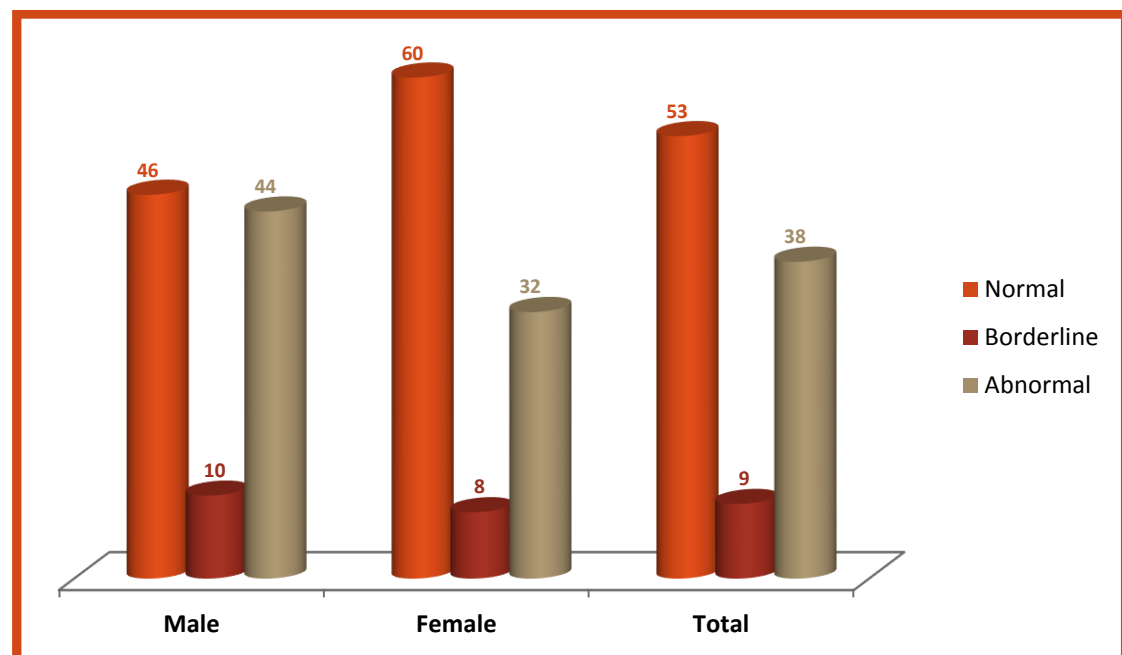


Figure 13 displays variation in gender profile on SDQ peer relationship problems score for male and female children/young people in the study sample. Although 38 per cent of the total sample scored within the abnormal range on peer relationship problems score, there

was a 12 percentage point difference between girls (32%) and boys (44%), indicating that this type of relationship problem, as with conduct problems and hyperactivity/inattention, was a particular feature of male LACYP. A one-way analysis of variance (ANOVA) was also calculated on SDQ peer relationship problems score across gender. The analysis was significant:  $F(1, 203) = 5.23, p = .02$ .

Table 12 shows three health-related variables that were found to be significantly related to gender. As displayed in the table, the percentage of boys with diagnosed hyperactivity was two and a half times that for girls. In terms of having a statement of 'Special Educational Needs', just over twice as many boys were statemented compared with girls. In relation to having ever been suspended or expelled from school, this was the case for just over three times as many boys as girls. All the findings presented in relation to the relationship between gender and health profile indicate that boys are much more likely than girls to have a poor health profile.

**Table 12: Child's/young person's gender with other health related variables (%)**

Condition/Issue Present	Boys	Girls
Diagnosed hyperactivity <sup>1</sup>	25	10
Statement SEN <sup>2</sup>	27	12
Suspended/expelled from school <sup>3</sup>	25	8

<sup>1</sup>  $\chi^2 (3, N = 233) = 10.74, p < .02$ .

<sup>2</sup>  $\chi^2 (3, N = 233) = 9.16, p < .03$ .

<sup>3</sup>  $\chi^2 (3, N = 233) = 13.60, p < .01$ .

## Summary

Key messages that emerged from the quantitative analysis of the interviews were:

- ◆ High proportions of LACYP in the study sample scored within the abnormal range on the SDQ: Emotional symptoms (36%); conduct problems (40%); peer problems (38%); hyperactivity (41%); pro-social behaviour (21%); and total difficulties (40%).
- ◆ Despite the high percentages of LACYP displaying behavioural and emotional problems, most carers rated them as being 'very healthy' (60%). This suggests that carers tend to associate 'health' with 'physical health', and may not consider behavioural and emotional concerns as health-related.
- ◆ LACYP were found to have a range of simple and complex health issues and conditions: diagnosed behavioural problems (40%); diagnosed emotional problems (35%); eye/sight problems (29%); diagnosed learning difficulties (22%); diagnosed speech and language problems (18%); asthma (18%); diagnosed ADHD/ADD (17%); diagnosed depression/anxiety (14%); health condition since birth (14%); and soiling pants (14%).
- ◆ Almost all LACYP in the study sample were registered with a GP (99%) and were fully up-to-date with their immunisations (97%).
- ◆ LACYP in residential care had a much more negative physical and mental health profile than those in foster or kinship care, particularly kinship care.
- ◆ The percentage of children and young people with behavioural problems, as well as depression and anxiety, increased across the study sample from early childhood through to the late teenage years, dissipating in early adulthood (18 years and over), whereas the percentage with emotional problems increased with age, but did not reduce at the early adulthood stage. Percentages of children with Hyperactivity problems were highest in the pre-and early teenage years, reducing through the mid to late teenage years.
- ◆ The percentage of young people engaged in risk-taking behaviour increased through the teenage years, with the 16-17 age category showing the largest percentages of risk-taking and self-harming behaviours.
- ◆ Female LACYP had a much more positive mental health profile (SDQ scores) than males, at least regarding externalising behaviours.



## Qualitative Data

Given the difficulty that could at times be experienced by a carer to sustain the full telephone interview over 45 minutes, especially where they were caring for young children, carers were offered the opportunity to end the interview after the collection of the quantitative data, or continue through to the qualitative questions. Although the quantitative section was completed for all 233 LACYP, in 120 interviews, carers also completed the qualitative section of the telephone questionnaire. These were the foster carers of 75 children/young people, the kinship carers of 31, the residential staff of 12, and the birth parents of two children. Most of the LACYP were being cared for within the South Eastern (n=47), Western (n=35), and Southern (n=21) Trusts, and less within either the Belfast (n=9) or Northern (n=7) Trusts. This section presents the findings that emerged from the analysis of these 120 qualitative interviews with carers.

### Medical information received

Respondents were asked about the medical information they received when the child arrived in the current placement. Only a few carers received a full medical history, and the majority received basic information regarding particular conditions the young person had, immunisations, medication and appointments. Information on mental health issues was less commonly provided. Sometimes, the information was passed on verbally, rather than in writing:



*Practically nothing, practically nothing, very little, whatever we got was verbally and that was things about milk and stuff. (Foster carer of a five-year old)*

*I think on her sheet it said that her immunisations were up to date and she was in good health – that was it. (Foster carer of a six-year old)*

A considerable number of respondents reported receiving no information at the start, and these were likely to be kinship carers (as it was expected they would already know the child), and/or those whose child came through an emergency placement. Kinship carers often claimed that they already knew most medical information about the child. However, others believed more information at the start would have been useful to them, particularly in relation to their past background:

*... this was just all thrust upon us ... we didn't know which direction we were going in. One day we got a phone call and two hours later [child] arrived ... I would like to have known a bit more about the past ... obviously, the social workers have been on mum's case for years. Obviously, [child] has been under the spotlight – they know a certain amount of what has been going on. But [my husband] and I have never been told – has [child] been mentally or physically abused? It's a bit tricky for us to understand all this but obviously when [child] was placed with us, they never said about medical conditions, or that the home life was pretty bad, or [child's] needs or this or that. There was nothing. (Kinship carer of a ten-year old)*

A number of the carers felt that they wanted more information about the child initially, so that they could make an informed decision about whether to go ahead with the placement. Many took the child to a medical statutory assessment at the start, and found out about the child's state of health that way. Some had to request information such as the name of the child's GP or whether the immunisations were up to date or not:

*Shortly after [child] had come to me, that's when [child] took that sore throat and chest infection, within a week or two, I just more or less had to find out who [child's] GP was to make the appointment to take [child] to it. Then once the forms went through then for [child] to be in with me, [child] had to get a full medical done then and everything was fine. (Kinship carer of eight-year old)*

*Very little when [child] was first placed with me, then a few weeks after when I kept on asking about it, I eventually got the medical information ... basically just to say that [child] had a hearing test but immunisations were up to date – basically that was it. (Foster carer of a three-year old)*

Some foster and kinship carers found out about children's health as placements progressed. For instance, some respondents reported that they did not receive any information on behavioural issues and drug misuse, but found this out over time. They also mentioned their concern over the impact on their own family:

*We were not told all that when we took [child] into placement, it was peeling the skin of an onion ... Forewarned is forearmed and to find out as you go along is terrible because although we are not in that situation now that our own children live with us, you have to consider the impact on your own family and very much decide if you want to take that risk on board ... I think it is very unfair that there isn't more disclosure, because I think if you are bringing that young person into your own home and you certainly should be well informed. (Foster carer of a teenager)*

*I know it was confessed to us when we took [child] on board, the [social worker] wouldn't let me have his file, you know and then we met with [child] and already had sort of committed to [child] and then eventually [social worker] told me that [child's] place of residence was Young People Offender Unit ... and I also feel very strongly that when they are making the placement and they know that there are certain things that will impact on your family, as we have had sexual abuse and drugs and everything, then they should be saying well what we are going to do is offer you support in relation to this ... (Foster carer of a teenager)*

However, a few carers acknowledged that there were things that were unknown even to social services:

*[Child] had just been discharged from hospital so – was in hospital one night before [child] came to us because the way the police found [child]. I don't know if we got a lot of knowledge – [child] had got a rash or something like that when was taken to hospital. There was very little knowledge given to us because I don't think they knew very much. (Foster carer of a four-year old)*

*... we got like a 12 o'clock emergency phone call 'would we take all the kids on?', so we weren't told anything. And then even whenever it came to 'well could you hold onto these until we do further investigation?', I don't even think social services knew the full extent of what the kids were going through .... It is only now since they've been attending all their doctors' appointments and specialists' appointments, they're kind of getting a better idea of where the kids were at, and what they have been going through ... (Kinship carer of a three-year old)*

Similarly, one carer explained how the young person's sexual abuse only surfaced after the young person disclosed it recently:

*I don't think we got any medical information, I don't think we had any kind at all ... Well it's only ever been [child's] behaviours and history from [child] came into care and first came into the placement with us, you know, in the last six years, regarding sexual health that has only come to the fore lately, from [child's] own disclosure, regarding sort of health we knew [child] came into care because of neglect ... no one did know (about the sexual abuse), that's only been disclosed lately, [child] had only disclosed that lately. (Foster carer of teenager)*

Residential carers were more likely to be satisfied with the information received about the young person they were looking after, especially if they were coming from another residential home:

*We got a history medical report that had been completed by [child's] GP ... we would have had, from children's homes previous to here so we had quite a comprehensive medical history. (Residential carer)*

*[Child's] immunisations, what GP registered with, opticians, anything [child] attended in the sort of six months prior to that, we got quite a lot of information because [child] came to us from another children's home. (Residential carer)*

To sum up, there was no coherence in terms of information received by carers at the start of the placement, and in the majority of cases, a full medical history was not provided.

### Health needs

Just over a third of children and young people (34%), including some of those with particular health conditions (e.g. Foetal Alcohol Syndrome, epilepsy) or with learning disabilities, were believed to have no health needs. These included a higher proportion of the children in kinship care (65%, n=20 of the kinship care sample) than those in foster care (41%, n=31 of the foster care sample). Over half of the respondents were concerned about the children's/young people's mental health needs, including emotional and behavioural difficulties. These issues were more often reported than physical health needs, especially in older children, teenagers, and young people. These issues were also more likely to be reported for young people in residential care (75%, n=9), and those living in foster care (56%, n=42), compared to those in kinship care (26%, n=8).



Respondents often referred to diet and exercise, as well as hygiene issues, when talking about physical health needs. Some of the children were overweight, and carers highlighted how that could affect their self-esteem:

*I would say [child] is healthy apart from over-eating problem ... I would say that [child] has low self-esteem because of the weight. We have tried to build up [child's] confidence. (Foster carer of teenager)*

Others had a problematic relationship with food due to their earlier experiences of neglect:

*There's overeating and hiding the food as well. The first month of going to Grammar School [child] wanted to go to dinner every day but I don't like the children going to dinners every day because they eat junk everyday then and it's not healthy, especially with the way [child] was eating so [child] was getting a full pack lunch and [child] was hiding it under the bed in order to try and force the issue to let [child] go and there was about sixty rounds of sandwiches under the bed and yogurt and you can imagine what it was like. (Foster carer of a teenager)*

Dental health problems were also quite common, or had been an issue at the start of the placement (16%). These problems were often blamed on the unhealthy diets that children had followed prior to the placement and having never acquired the habit of brushing their teeth regularly. Most of these children had never been to the dentist prior to entering care.



*[Child's] dental health is important because they were never taught to brush their teeth. Have had a lot of problems – teeth having to come out already. Had a lot of problems with the teeth. [Child's] brushing them every morning and night now – a lot more than what it was. (Kinship carer of teenager)*

*[Child] drinks those energy drinks, which I am very much against. I've tried to speak to mum and dad about that but they totally ignore me and no matter what [child] wants, [child] gets. [Child] would eat a lot of sweets, again mum and dad provide, because I'm too mean or too strict to give a lot of sweets. Even though the older half-brother is due to have 16 teeth removed at the age of 21, I've explained that – look at (name) ... this is a result of those sugary drinks, very, very high in sugar. But I might as well talk to the wall because obviously when they were growing up this was the way the family ran - if you wanted sugary drinks you got as much as you wanted. (Foster carer of a twelve-year old)*

*As far as I am aware, they had never been to the dentist ... it definitely did look like it. None of their teeth had been treated ... Yes, and they didn't brush their teeth or anything. They didn't have tooth brushes ... a lot of [child's] teeth are rotten. Like [child's] sister had to have seven teeth removed because of neglect. (Foster carer of a teenager)*

When asked about mental health needs, many talked about contact with birth parents and family members, and also about past traumas that the children experienced. In terms of contact, carers reported difficulties in children's behaviour after contact, but also when visits were cancelled or when parents did not fulfil their 'promises':

*[Child's] usually fine but, I suppose more emotional – just when contact is cancelled and things like that ... will do the opposite of everything I ask [child] to do – there'll be a row or argument, temper tantrum. (Foster carer of a three-year old)*

*She (mum) tells [child] things that she can't follow through. She tells [child] things that she shouldn't be saying, then you get the fall back. This impacts on [child's] emotional health after the contact – [child's] upset. (Foster carer of an eight-year old)*

Similarly, a few carers described an emotional spill over, whereby the parents' feelings and worries were transmitted to the young person, or whatever was said during the contact visits negatively affected the young person:



*I have found that if mum is well, [child] is well mentally too. In the past, when mum is not so well, it affects [child] as well. Takes on the role of the parent. (Foster carer of an older teenager)*

*[Birth mother] can sometimes talk about things that are wrong with her and her illnesses and worry [child] and also will pick up on things like I say the agoraphobia or just different things, if she has something else wrong with her, like something to do with her breathing or something like that, then [child] said had that as well, [child] did when first came to me, had panic attacks ... (Foster carer of a teenager)*

*[Child] seems happy enough to go, but then can be upset by the situation that goes on at contact ... Things that are said or you know one of the other kids bullying one of the other ones, what have you. And then [child] takes it all on board, and thinks it's their own fault even though [child] may not even be in the same room. (Foster carer of a nine-year old)*

Young people had a variety of contact arrangements, which changed with time (usually reducing in frequency). Apart from affecting the children's emotional health (i.e. behaviours, self-esteem, mood, etc.), some carers also noticed some issues in terms of potentially affecting the child's physical health (e.g. weight issues – parents offering sweets/fatty foods):

*Prior to [child] coming to us, the diet that mum would have had was so, so very bad – for the first seven years of [child's] life the eating patterns were so bad it is very difficult to change them. On contact, mum would give [child] the wrong things ... (Foster carer of teenager)*

*... Sometimes if [child] is spending time with my mum, she would maybe take [child] to the shop and offer to buy like a chippie or make something that's really not what [child's] meant to be eating. I have had to have discussions with social services and I've spoken about it in the last meeting and I've spoke to her about it and sometimes she doesn't want to listen to me so social services will tell her ... It's only just because it's not fair on [child] because [child's] trying to eat healthy and do well and obviously as soon as someone offers [child] like a chocolate bar, [child's] going to want it. (Kinship carer – older sibling of an eleven-year old)*

A few carers also pointed out at the difficulties stemming from children not being told the reasons why they entered care. A foster carer of a teenager felt that social workers should inform children/young people about these issues, so they can better cope with their situations:

*I think maybe the children themselves need spoken to more about what's happening in their lives because ... whenever these two children came to me, they didn't really understand why they had been put into care, and it took a long, long time, you know, it took years for someone to actually tell them, because there was a time they thought it was because their mum had hurt her arm, and ... I think maybe that if something might have helped them earlier on if they had have been told...*

In all these contexts, in terms of their mental health, carers talked about children/young people needing constant reassurance, encouragement, and affection:



*... if [child] thinks their having a visit and mum doesn't turn up ... I think [child] knows that mum might forget [child]. I just keep reassuring [child] that mummy is sick and she won't forget [child], she'll always be there – it might be a couple of weeks from she's here, but [child's] always delighted to see them. As long as you sit down and explain to [child], you'll find can take it in. (Foster carer of a ten-year old)*

*... when they [two siblings] went for adoption, [child] was very heartbroken and that, but when [child] was told would see them again, and we were able to get a date to meet up with them, it kind of settled [child] and has been very settled and has got the next date to meet up with them and got pictures of them, so that settles [child]. So I think if you tell [child] the truth all the time and give a date of when things are happening, then that settles [child] and is looking forward to that date. (Foster carer of an eleven-year old)*

*[Child] needs reassurance and plenty of praising and just TLC. And involving [child] in everything that goes on in the placement, and basically that's it, just involvement, making them feel safe and making sure that they've got their stability and also you have to put your boundaries and your ground rules down, sitting down and talking to them and explaining to them. (Foster carer of a five-year old)*

Sometimes, carers explained that children and young people found it hard to talk about their feelings and their past, and they stressed the importance for the children and young people to 'open up' to somebody they felt comfortable with, in order to address their mental health needs:

*I think [child] needs to be able to express themselves a little bit more, I think [child] needs to be comfortable enough to be able to come to us, that's what the art therapy is for, for [child] to open up a little bit more and really just needs reassurance, things like that ... if there's something bothering [child], I don't think [child] would have the confidence to come to us. (Kinship carer of an eleven year old)*

*[Child] is very emotionally damaged ... needs help around the sexual abuse and to stop being so secretive. [Child] needs some sort of help to be taken out of that, to help [child] open up a bit. (Foster carer of a seven-year old)*

*... sometimes we need to have a wee talk with [child] because sometimes gets very low and would mentally think about things that have happened in the past and there's a lot of things [child] doesn't even want to talk to anyone who even knows [child] at all, won't talk about things from when they were a child. (Kinship carer of a young woman)*

Carers also stressed the importance of having somebody to talk to when sensitive issues, like sexual health, needed to be addressed, as it was felt that the young people would not be comfortable discussing those issues with them:



*It's just I don't want [child] to be embarrassed in front of other children in school and coming out with something, you know? If [child] has any concerns, if [child] met a boyfriend/girlfriend and wanted to talk to someone rather than us, if you understand me. [Child] is 17, I'm just trying to think what I was like when I was 17! That's a worry – coming from a parent now. (Foster carer of an older teenager)*

On the other hand, other carers felt that the young people were able to communicate well with them, which was beneficial for their health:

*We're a very open family and we talk about everything and if I thought there was something worrying [child] we would sit down and we would talk. (Kinship carer of a teenager)*

A few children and young people had very complex health needs, as they were profoundly disabled, and needed constant caring and monitoring:

*... [Child's] prone to sudden deterioration in medical condition so does need you to be very vigilant and alert to sudden changes in [child's] condition ... oxygen levels are monitored overnight by a wee monitor. (Foster carer of a four-year old)*

Young people in residential care tended to have more problems regarding alcohol and drug consumption, which in turn affected their mental health (50%). Residential carers claimed that mental health issues were extremely common particularly for this group of young people (in comparison to their peers):

*Certainly the substance misuses will continue to have an impact on [child's] mental health if it continues being as it is presently. Some of the very dangerous substances that (child) would use would certainly have very adverse effects on [child's] mental health. (Residential carer)*

In summary, children and young people displayed a range of health needs, and mental health concerns and behavioural problems were common, more so than physical health needs.

### **Meeting the children's/young people's health needs: Who is involved?**

The majority of foster/kinship carers believed the primary responsibility for addressing the child's health needs was theirs, very often together with social workers, health visitors and other professionals. Residential carers suggested that the responsibility laid with them, field social workers, the HSC Trust, birth parents and the young person themselves. Some stressed the fact that these children and young people



had many professionals involved in their lives, and attended a wide range of appointments or were seen by a variety of people (e.g. paediatricians, dentists, GPs, health visitors, social workers, counsellors, psychiatrists, LAC nurses, school nurses, etc.).

Despite this, in terms of meeting the child's health needs, some carers (particularly foster and kinship carers) claimed that they treated the children they cared for the same way as they would do 'for their own children', and followed the same procedures:

*I would take [child] to the doctors. Obviously that would be the first port of call. If I need to I will call in on the social worker, the school is very good, you know, they do any assessments and things like that so they're very good that way. Basically it's just like what you would do with any other child, your own child, you do what you have to do. (Foster carer of a twelve-year old with learning disabilities)*

*Well like any four-year-old, [child] needs supervision when outside playing because [child] will climb and jump, typically what four-year-olds will do, but other than normal supervision that I would have gave my own children and the same with regards to health, [child] gets the same treatment, if a doctor is needed, [child] goes to the doctor, and if not, then not, I rare [child] the same as I rare my own, in fact I probably be a wee bit more protective because of the situation ... if [child] gets a black mark, there's nothing particular, just a normal four-year-old. (Foster carer of a four-year old)*

The term 'delegated authority' appeared to be confusing for many carers, as they often did not know or misunderstood what it meant (60%). Carers were often confused about the type of decisions they were allowed to take by themselves, and had to constantly check with their social workers:

*I've contacted them now for surgery to get this tooth out and the orthodontist asked me, have I parental ...? you know, could I sign the form? I didn't know that, so I had to come back and ask the social worker. (Kinship carer of a teenager)*

*Appointment with the doctor – if I think [child] needs to be brought – rather than go through the whole process of the social worker, mum and dad have to give their permission that I bring [child]. Sometimes you think, is it ok to bring [child]?, am I doing the right thing or the wrong thing? ... First thing on a Monday morning was the first time I had to bring [child] –had a really bad throat. Wasn't sure what I was allowed and not allowed to do – didn't have a clue. (Foster carer of a three-year old)*

*... it's more sussing out what we can do and what we can't do, and what would have to be negotiated with parents and social workers and stuff. It's more of a you've to ask the questions, it's not normally always as clear, so then quite often social workers are coming back to you "yes you can do that" and "no you can't do that, but you can do that" (Foster carer of a seven-year old)*

Others did know what delegated authority was (40%), although not all of them had it in place for the child that was the focus of the interview, and some only acquired it very recently:

*I literally got the letter in only about a month ago. They sent me the letter signing the health care over to me. When I say the health care over to me, that I can take him to appointments and get things done, without ringing them to ask their permission – and for them to write letters and things like that. That I now have the authority to say, yes I can do that. I couldn't have taken them to the doctor to get an injection without social services knowing about it – now I can do that – simple things like that. (Foster carer of a four-year old)*

Less than half of the carers (46%) claimed to have delegated authority for the child/young person they were discussing in the interview. These were more likely to be those living in the Southern Trust (57%) or the South Eastern Trust (47%), and kinship carers were less likely to hold delegated authority (29%, compared to 53% of those in foster care). These carers had been provided with a list of things that they could and could not give authority for, and many stressed its advantages:



*Delegated authority has been extremely useful for us. When [child] came first was under an Interim Order – if needed injections, I couldn't give permission ... So delegated authority gave us control day-to-day on [child's] behalf. Made life more normal for [child].... I have a sheet with all the different things listed. Mum just has to give permission for [child] to travel outside the country. Basically I can make all the decisions day-to-day. (Foster carer of a ten-year old)*

*On this young person, I have received forms as to what I can sign for and what I couldn't sign for and that was returned back, but again that has only happened in maybe the last sort of year. Prior to that, it was really going back to the social worker for them to sign off or it was possibly mum. (Foster carer of a teenager)*

*Given that we don't actually live in our Trust's area, we live quite away so actually getting forms signed by the parent was always a problem for us because it was so far away, since delegated authority it's been great because I can just now say yes that's ok you can do that. I think it's been great, just even letting them go and choose their own haircut, go to the dentist, go to the doctors, without having to constantly phone up the social worker and say I've got to go here and I've got to go there. (Foster carer of an older teenager)*

Other carers highlighted the difficulties of not having delegated authority, and the detrimental impact that it had on the child/young person, as well as the carer themselves:

*I went and sat 40 minutes with [child] to get last injection and I went into the room and they said oh we couldn't deal with you and then they phoned social services and because my social worker was off they wouldn't give authority for it. (Kinship carer of a three-year old)*

*... we don't have any parental responsibility for the children and you are sort of relying on social workers organising a senior social worker to attend this and then turn up again to sign for something else, so that can be a wee bit of a – kind of delays things ever so slightly – and I have a lot of running about to do, taking forms from the school dentist up to maybe the social services in local town, get it signed and get back down – a lot of to-ing and fro-ing. (Foster carer of a twelve-year old)*

Kinship carers were less likely to have delegated authority, as birth parents were often still very much involved in the lives of the young people:

*When it comes to the signing of anything legal, my mum and dad they still have their say in it. Mine is kinship care. Unless I went for a different kind of care plan, I don't have the right to sign a lot of forms. If I want to go down the road of having more say with the children, I am able to take it to court and apply for it. I'm happy enough at the minute. My mum and dad always agree to anything that they know is right for the children. (Kinship carer – child's older sibling)*

*There were some things – going to the new school and that, I would take anything I had to the meetings where mum was there and social workers were there – I didn't want to be just signing everything – mum was still mum and I felt she needed to know what was going on ... (Kinship carer of an eleven-year old)*

Whereas the benefits of having delegated authority were highlighted by some, a few had some concerns and fears about it:

*It's still down to the Trust. You are there but at the end of the day it is all 'with the approval and consent of the Trust'. Really it's only what it is on paper. If something happened they would hang you out to dry! (Foster carer of a teenager)*

*We still feel that even with the delegated authority we still have to go back to social services and check things out, do you know what I mean? So you don't really get delegated authority, and the downside of delegated authority is what happens if something goes wrong, that would be our biggest concern. (Foster carer of a teenager)*

*... it is beneficial for the normal day to day things like if you are going on a school trip, if you are making a routine dental appointment, if you are making a routine eye appointment, but I would still be very wary of signing anything were there's any danger at all to a child maybe where there's an anaesthetic. Going on a dangerous school trip, maybe canoeing or rock climbing. It's not even that I wouldn't want the responsibility. It's just the fact that when you ask somebody to sign something for you on a child's behalf they are more aware of what they are signing ... (Foster carer of a teenager)*

Although most carers were happy with the level of involvement they had in the child's health, others felt they should have been more involved. This was the case of a foster carer of a five-year old, who recently acquired delegated authority, but prior to that, she was not permitted to attend the statutory medical assessments of the child she was caring for:

*... until [child] was in long-term care with me officially through the courts I wasn't allowed to attend the medical and like a lot of the things they would have been asking, as [child] was living with me, I would have been the one that would have been able to answer them, I wasn't allowed to attend appointments, the mother didn't want me there, I'm getting it third hand by the time I hear it, I think that is an important thing too, the carers should be allowed to go unless it is a protected placement or something, but the carers should be allowed to go.*

Birth parents were usually informed about the decisions of their child/young person's health but often not involved. However, over a quarter (28%) was perceived to be involved regarding the young person's health. This was more likely to be the case when contact was regular and frequent, particularly when the care plan was reunification or/and children were placed in kinship care or residential care. Birth parents' involvement was sometimes perceived in a positive light (as a partnership between carers and birth parents), whereas other times, it appeared less positive:

*If something happened I would take [child] to the doctor or hospital and then tell mum, or whoever needs to be told. Mum and dad look after [child's] dental appointments and check-ups. I've taken [child] sometimes myself. We just sort it out between us. [Child] was up all night coughing one time and I rang the mum and asked her if she could get [child] another inhaler and she'll maybe say [child] has to see the doctor, so they'll take [child]. Parents are still very much involved in decisions about [child's] health. (Kinship carer of a seven-year old)*

*I suppose [child] would talk to her, is quite open with mum so would talk to her about feeling and then she would be contacting us and helping us to agree what path we'll take with [child] here ... (Residential carer – caring for an older teenager)*

*The mother still has quite a lot to say about whether [child] gets to the doctor or not. I can't actually take [child] to my doctor because [child's] not registered, so if I need to take [child] to the doctor I have to notify social services and they ask the mother to go along with them to the doctors, but I have arranged now that I can take [child] to my own doctor if I need to, otherwise it's stupid. (Foster carer of a two-year old)*

To sum up, children/young people had a range of people involved in meeting their health needs, but usually, the carers were the ones responsible for their day-to-day health care, and the ones who informed or referred the children to the social workers and/or their birth parents (if involved in the young people's lives), as well as the GPs/health visitors, who in turn referred them to other services and supports. Delegated authority was a confusing concept, and there appeared to be a wide variety of practice, with some carers unsure of the decisions they could take, others having some authorisation to sign off certain things, and others who had to constantly refer to social workers and birth parents.

## Carers' perception and satisfaction with the services provided/availed of

### Services

The majority of carers whose child did not have major physical or mental health issues appeared to be satisfied with the supports offered, as they did not have to avail of much:



*I'm quite happy with it now because the social worker I have has made me aware of things that I wasn't aware of, you know so maybe we're lucky because [child] is quite good but maybe if you had another child who wasn't and had behaviour problems and that maybe there should be more help in that way. (Kinship carer of a twelve-year old)*

*I've been happy enough with the supports we've had but again I suppose the child that we have is very easy to mind, you don't really need much support, you could probably have a situation where you have a child with all sorts of different conditions who are I suppose harder to work with and maybe you do need more supports. (Foster carer of a baby)*

Kinship carers were often unaware of the types of supports they could avail of, especially those who were new to fostering:

*[Are you aware of any supports out there?] Not really, no. This is my first time doing it and this was sort of sprung upon me, it wasn't something I was thinking about doing at the time but it was more or less just helping out at the start, thinking that it was only for a few weeks, and then ... we started to get to know the ins and outs of the background and what happened ... so it's sort of like a learning curve here for me as well as everybody. (Kinship carer of an eight-year old)*

Organisations often referred in the interviews as providing support services for the children/young people were: the Fostering Network (in particular the Fostering Achievement programme); SET Connects (in the South Eastern HSC Trust); VOYPIC; CAMHS; NSPCC; Barnado's; and Extern. Other services and supports offered were courses for foster carers, art therapy, play therapy, etc. For older young people, the 16+ team was a crucial support, and this was particularly pinpointed by residential home staff. This type of supports was often viewed in a very positive light, and thought of as helping the children and their carers:

*... the support from Fostering Achievement has been brilliant. They've given them reading and educational things and toys to work with coordination and stuff. They have been really supportive in swimming so that's been really good to help with coordination. Even to talk with them has been really good as in giving advice and guidance ... They've also met the children at the Fostering Achievement awards ... It boosts their confidence to get awards ... It helps with self-esteem big time and confidence ... (Foster carer of an eight-year old)*



*They both have mentors from VOYPIC ... I will tell you one thing, when VOYPIC were involved, it scared the life out of them. They had to sit up and take note because VOYPIC don't mess about. It was all for the child's benefit. (Foster carer of a teenager)*

*The 16+ Team is [child's] biggest support, they would be linking in maybe once or twice a week, they run a number of activities and [child] would usually get involved in activities, meant to be going to deep sea fishing tomorrow, was away on Tuesday doing activities in a rifle shooting thing, there's an away day between ourselves and 16+ on Monday, so there's loads of activities and loads of support constantly coming in from different organisations, the one on Monday was done through Divert, the two this week has been through 16+ team, last week it was the Education Board ... (Residential carer of an older teenager)*

Some foster/kinship carers were also satisfied and valued the services provided by social services, in particular the support provided by specific social workers. Carers stressed the importance of having someone (who knew the details of their particular case) immediately accessible (if and when they were needed), as well as having quick access to the services they required. Typical statements reflecting this were:

*I have to say that my own social worker, and their social worker, is brilliant. I'm not having bother with anything at all, it's just a matter of picking the phone up here and ringing and they are there at the other end to give me as much – and if I need the social worker she would just drop and come down and see what's going on. (Foster carer of a ten-year old)*

*We have social workers at the end of the phone anytime we want. If the social worker who is dealing with the child isn't available, there is always someone usually of a higher post there. At one stage, when the [child] was self-harming the senior LAC person said bring [child] down and I'll have a talk with [child] ... and straight down and he talked to [child]. (Foster carer of a teenager)*

*We get any help we need, as I say, we only have to ring and tell them anything at all that we're worried about and they would come out and chat it over with us or whatever like, they would be very good at supporting us with any concerns we have. (Kinship carer of a four-year old)*

*... anything that I have asked for, I got. Assessment from a paediatrician, asked for an optician appointment, I got that, asked for speech and language, I got that, asked for dental appointment, got that, health visitor comes out – really everything has been 100 per cent in that area. (Foster carer of a three-year old)*

While some carers had the above-mentioned positive experiences with the support and services offered to them, others highlighted negative aspects, and the difficulties they faced regarding social services support. In the latter cases, foster/kinship carers often complained about social work staff turnover, social workers not being available when needed (not returning phone calls, etc.), and lengthy waiting lists for services (thus not having the support when needed). Regarding the issue of staff turnover, some carers illustrated just how many social workers young people would have been assigned to in any given period of time:



*I find that it is very sad because in the year that [child] has lived with us, has had five different social workers, which is very sad. (Foster carer of an eleven-year old)*

Others not only highlighted the issue, but explained why they perceived this to be problematic. The main issue related to the building up of trust and the implications of this for the social worker/young person relationship. Carers reported that if the young person did not know the social worker or had little time to build up a relationship with them, this impacted on how much they would trust them, and in turn whether or not they would open up with them:

*... every time [child] gets a new one [social worker], they go, so it has been very difficult and very damaging on the child because they invest in these people and then they change, it's very disrespectful to them. It's not their fault they move to different places but I think the trust as a whole don't take enough acknowledgement of the damage that does to a child because it affects them, their social and emotional outlet, because they are like "why bother telling them things if they're not going to be around?" so therefore they hold more inside and they worry about more things. They think there is no point in telling them that, because they're not going to be about to care or to do anything about how I feel, and think and that's been a big issue, particularly for this child. [Child] would actually say 'there's no point', and has stopped investing in those relationships, and then that does have a big impact. (Foster carer of an eight-year old)*

In addition, staff turnover meant that for some young people, services could not be accessed or were accessed late. For instance, according to a foster carer of a young person, anger difficulties were never addressed:

*... as I've said because [child] had so many different social workers and every time it's been transferred onto the other social worker, by the time they get round to doing something, it was 14 before [child] got a social worker who actually started ... helping [child], and then they got [child] involved with a child psychologist and then in DAISY, but DAISY was basically for drugs and alcohol, nobody has actually dealt with [child's] anger issues, which [child] has had since being with me, and now the older [child's] getting, the worst it's getting, and now nobody really wants to do anything about it.*

Indeed, it was sometimes felt that access to services depended on the efficiency of social workers or the social work team that the child/young person had:

*You have to be prepared to fight for them (services for LAC) ... a lot can depend on the different teams that you're working with. But this team I feel is very good, but it is very varied, although there are systems in place, it varies depending on who you are working with. (Foster carer of a nine-year old)*

*The support from the field work staff has been very, very poor indeed. I have had ongoing issues with them. Fostering team is extremely good but that is not really their responsibility ... it has been a constant fighting match with them, all sorts of things. (Foster carer of a teenager)*

Other issues of concern regarding social workers were the perceptions that they did not know the children or that they did not listen to the carers:

*With their last social worker, I wasn't supported because she knew nothing about the children. She was talking at LAC reviews and you were thinking, 'what's this lady on about when she doesn't know the children?' ... we did an interview recently and said, 'Fostering is nothing – it's dealing with bureaucracy and social services that's the hard thing!'. (Foster carer of a teenager)*

Some carers also indicated the lack of availability of social workers, as they found it difficult at times to contact their social worker when they needed to, especially in emergency situations:

*... the social workers that I have had in the past, when I have tried to get them, they were on leave, in a meeting, on a call, and all I get is 'they'll ring you back', I could be sitting ... waiting on them ringing me back. (Kinship carer of a teenager)*

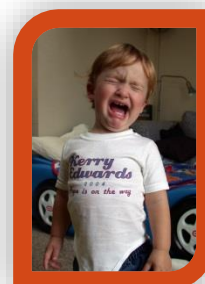
Another issue that many of the carers complained about was the length of waiting times – sometimes the young people had to wait a long time for the support/service that they needed, and in some cases, they never received the service at all. Statements reflective of this were:

*Takes a long time to wait for referrals. In my experience of this one time, there was too long a gap from knowing [child] was ready to talk about it, to getting an appointment. The notion would nearly leave [child] ... If I had to say that these services are fabulous, yes, they might well be, but I do think they have to have a quicker turnaround to be of benefit. Waiting list is too long. (Foster carer of an older teenager)*

*I think there is enough out there for looked after children. The problem is getting them to these professionals, and then there is also the waiting lists and problems getting appointments, drags things out. Sometimes you are looking at a month/six weeks for appointments. (Residential care worker)*

*I have had other children that needed a lot of input from mental health, etc, and it wasn't available ... I would have been pushing for it and the services weren't there, and the waiting lists were terrible ... I mean the social worker was trying their best and were referring it and referring it, and chasing it up, and trying to track it up and push it up to the top, but everybody is looking for their child to go to the top ... the waiting is terrible. (Foster carer of a teenager)*

As exemplified by the last quote above, mental health issues appeared to be more difficult to assess and address, and carers were often not happy with the level of support provided in these cases, especially in terms of the timing. Because of their experience of the difficulties in accessing mental health services, some carers were critical of these supports and talked about the impact of mental health needs not being addressed, as these quotes from two foster carers (of teenagers) exemplify:



*When you get the appointment which could be a long way down the line, the child has nearly got to the stage where it's irreparable damage, how can you repair something that you've been pushing for years and some are only getting as they reach puberty? and then at that stage it's so deep set there's nothing you can do.*

*I've fostered maybe 16 young people over the years and a lot of them I am still in contact with now. Did any of them have their emotional or mental health needs met? I would say no. I see young people now trying to lead normal adult lives and they're crippled by their past experiences. They leave care at 18 and they have so much baggage. It's very difficult for them to enter the adult world and meet the challenges they are going to face and cope with things. I think foster care can do a lot to help, but some of these youngsters will have been so traumatised that they need the best of help; and that best of help is not there, probably because the system is so over-laden. If you have a young person who makes a suicide attempt, or is self-harming on a regular basis, then the services kick in, but they have to be as bad as that.*

Carers were also concerned for young people who had been 'emotionally damaged' but turned down psychological help, and the lack of effort to make these young people engage with these services:

*I think that a lot of, especially older children 11-15, it's their choice if they want to go to counselling, if they want to take part. Which means that really a child is damaged and doesn't want to really talk – child does not want to do it – so they are allowed not to address the issue. I think it's a major problem, it's not healthy ... Something else needs to be put in place where the children are, maybe not made, but maybe in some sort of way, where they have to engage ... there should be some way of actually addressing those issues before they are too old to do anything about it. Early intervention is a major problem. (Foster carer of a seven-year old)*

In fact, carers in children's homes stressed the fact that CAMHS approach was not always an appropriate response (i.e. if young people miss appointments, they can be discharged).

They stressed the mental health difficulties that young people living in residential care face, and that not enough is being done to help them:

*It seems to be that young people who don't readily engage with CAMHS or find it difficult to engage with CAMHS can be quite quickly discharged, whereas these are the young people with the most complex difficulties, most in need of the service and there should be greater effort maybe in trying to engage them, if you miss three appointments, forget about it ... (Residential carer)*

*... they won't engage, CAMHS is what two/three strikes and you're out, if you don't attend your third appointment you're taken off the books, and they entice you to come by letter ... that's not how you communicate with these kids and it's not how you get these kids to engage in service provision, there's a lot more required. (Residential carer)*

In terms of services, schools and the education system were also mentioned by a few carers. Many of them reflected bad experiences with the education sector, as they considered that professionals had not displayed a supportive role towards the child (who had difficulties – e.g. autism, etc), and at times even an unhelpful one. Oftentimes, carers felt they had to battle with schools to get the supports needed:



*... you have that long to wait to try and get, especially if they've got problems, for them to be statemented and things like that I think it takes years for, [child] was never statemented in primary school because [child] didn't misbehave, was very placid and got on with things, and ... should have a classroom assistant there all the time, because [child] thrived since this was provided in new school. (Kinship carer of a teenager)*

*I have a lot of issues with what happened at the very last LAC meeting ... I was present and [child] and [child]'s social worker and the principal social worker and the vice principal was there, one of [child's] summer reports wasn't very good but it was intentional, [child] didn't want to have good reports so failed nearly all the exams ... reports at Christmas were excellent, had straight As in everything. On the summer, the reports were terrible because all that previous year [child] was having a really, really bad time, didn't care about nothing ... had lost everything, mother, father, home, friends ... had lost everything, and I would say [child] was spiralling out of control, and at that LAC meeting you would have thought [child] had killed somebody, [child] was on trial, it was disgraceful ... the vice principal sat there and read out the whole of that report, which wasn't very nice, [child] was sitting crying and they continued reading that out, when I got outside I hated myself, I hated myself. (Kinship care of a teenager)*

*I see so many young people put on the educational scrapheap because lots of people look at them and think 'oh there's trouble' - if they have difficulties, if they have challenges - they just didn't want to have to deal with them ... I've had a lot of battles over the years with the whole educational establishment. This young person that I have ... spent the whole day running around the town. [Child] has been moved to a much smaller school, they are much more on the ball, they regularly contact me. [Child's] attendance at school is now 100 per cent, and it's just because a different attitude, more support and all sorts of things ... But it took me to get [child] moved. The whole process was totally driven by myself. (Foster carer of a teenager)*

*The only place that doesn't listen is the Education Board, who are the biggest stumbling block for these children quite often. They are completely a law unto themselves. I was at a big forum recently for people with disabilities and they did lots of workshops. We all came out with the same thing - yes, social services are trying to break down walls and we do feel that even though budgets are tight, people are trying to move forward for people with autism and these different conditions. But the Education Board just shut down and nobody can do anything about it then. I felt that, with a different child, that I had an army of people behind me when I had social services, new teachers and a great headmaster, but I still had a child floundering for seven years in a school - and now even a special school ... This other child I'm talking about is 13 - was educated in a store room with a classroom assistant - [child's] last four years of primary school. The Education Board wouldn't move [child] to a school that was suitable - it was a budgetary thing. It is very very poor. That impacts on their emotional health as well. (Kinship carer of a five-year old)*

To summarise, there were a range of views and experiences regarding the health services provided to children and young people in the care system: while some carers were satisfied, others felt frustrated in relation to a series of issues, including staff turnover, gaps in service provision, and barriers to accessing appropriate services.

### Medicals

A considerable number of carers defined medicals as not being thorough enough, 'just weight and height', and inadequate in terms of assessing mental health needs:

*To my knowledge of them, it's about height and weight ... and that's really about it. As I say, the one person we look after physically is very fit and healthy, but it's the mental side of things really is our concern, and I don't think at these medicals they go into that in-depth. (Foster carer of a teenager)*



Often, the quality of the assessment appeared to depend on the individual doctor. A few carers thought they had to urge the GP to get things looked at properly or point things out to them, otherwise things would not be assessed:

*Unless you are highlighting things, 'he's like yeah fine, fine, fine, and you know sign the form', I get paid and away he goes. I think unless you are pushing 'I'm concerned about this', and going back and going back. I don't know, maybe there's not the same sort of commitment to look for things you know. It's really much dependent on the foster carer that things are picked up, because we went in to the medical literally the GP was tick boxing you were saying things you know, [child] would have been out of the surgery in no time. (Foster carer of an eight-year old)*

*... once I went and it wasn't [child's] own doctor, it was a local that was there, and he just talked to [child] about 'how are you feeling?' and [child] said 'well', and he looked on the computer and he said 'you haven't been for anything in a year now and oh well I think everything is fine', and I said 'no I'm sorry I want [child] checked, I want the full medical done, that what [child's] here for'. So for me personally, I wouldn't allow them to shortcut but I'm sure there are people that wouldn't speak out ... now my own GP would be very thorough, in the sense that he would check [child's] chest, lungs, ears, throat, he would ask [child] 'have you any problems in school, any problems outside school, any problems with the family that you're living with...?' (Foster carer of an older teenager)*

However, other carers were satisfied with how the medical statutory assessments worked, and a few even pointed out some benefits:

*We can't ask the child to take their shirt or trousers off, but the doctor can. He inspects for scratches and scrapes or anything that looks untoward. It's helping us – it gives us great peace of mind, having a professional opinion that says everything is 100 per cent, or this is what you have to watch out for. (Foster carer of a teenager)*

Older young people (over 16 years old) were more inclined to refuse medicals, as they did not see the usefulness of it, and chose to go to the doctor when they felt they needed to go:

*I think at one point refused to go to the statutory medical, couldn't be bothered – certainly if [child] had a specific need, would be happy for the appropriate appointment to be made. (Residential carer – caring for an older teenager)*

*[Child] has refused to go back for stat checks with the doctor because [child] feels it's a waste of time. So basically we go to the doctor if we need to. [Child] sees own Trust social worker on regular visits ... sees my social worker on her regular visits ... I do believe that in the past, they [medical assessments] would have addressed [child's] needs, but not now ... It's not something that I would push for [child], because I don't think it's necessary ... (Foster carer of an older teenager)*



### Perceived gap in services – what can be improved? What more is needed?

As previously noted, mental health services were crucial for these children and young people, due to the high level of mental health needs identified. A large number of carers who had young people with mental health difficulties under their care felt these services were often not available or not provided in a timely manner to address these issues. Carers advocated for early intervention and for services to be provided on a long-term basis (for as long as child needed them):



*... most kids would need to see a clinical psychologist to be assessed because if they are assessed early it means that the carers would not work years down the line ... You're fighting for two or three years and with a problem child, whereas if they could get them early and assess them then, you'd know which direction to go with them. (Foster carer of a teenager)*

*I really would like to see something for the kids' mental wellbeing ... there's just not enough funding for people out there for mental health ... Physically, children are very well taken care of, but mentally I think ... nobody wants to go into it in too much detail, but yet I think that's where the biggest problems are because you know, creating problems for the future ... if it's not a problem now, then we don't need to deal with it ... if there was more forward thinking, then the problems wouldn't arise ... it's crisis management. (Foster carer of a teenager)*

*I think [child] needs like the therapeutic LAC they're getting at the minute, could do with that probably for the next five years if not more, but we won't get that, if we're lucky we'll probably get six or eight sessions and then it's off you go, you know, carry on, but they're damaged kids, they are damaged kids and they need a lot more help and support. (Foster carer of a ten-year old)*

When young people were at risk of self-harming, the timing of the mental health service provision was indeed vital, as a residential carer in an intensive support unit explained:

*We would like to see more input with the mental health. It can be quite difficult if the young person is presenting as feeling very low and maybe is not due to have a Beechcroft appointment for another week, another two weeks, it can be very difficult to get them one there and then, and it can put a lot of pressure on you to ensure nothing happens to that young person, and that would be reflective throughout the team. At times, you feel you are helpless in that sort of situation.*

This issue was also mentioned in relation to a lack of out of hours support, especially in terms of issues with alcohol and drugs:



*The only problems that we would face at times is if we're phoning them out of hours, say something happens out of hours, maybe two or three o'clock in the morning, they're saying 'what can I do?', which they're right probably in a way, but in the meantime it doesn't help us with the problem we're sitting with, or if you're take them over and they're feeling depressed, not in [child] case now, but if they're cutting themselves or something like that, automatically we say it's the drink or the drugs and nobody wants to sort of do anything for them, but it's getting better I have to say, there seems to be a better understanding. (Residential carer)*

In addition, the approach taken by CAMHS was not perceived to be 'proactive in how they seek to support young people', and bigger efforts needed to be made to engage them. It was also noted that making these services more accessible (in terms of being in the local area) would help:

*I think if we could bring those services in an informal way into the local area, I mean where [child] has to go to access some of them services is 15 miles away, which means [child] has to commit to being here for us to take them over and commit to being away from friends for three hours, which [child] doesn't want to do, so access, if they were local in your GP surgery, [child] might go. (Residential carer)*

Because of the difficulties in identifying particular conditions, especially when it relates to problematic behaviours (i.e. confusion with autism, ADHD, etc.), another suggestion was to have a central point of referral for professionals:

*If you had a gut feeling – you might have someone out there – you might have social worker saying they think it's attachment, then I think it's autism – I think it would be great if there was something central where a child was referred and went into a central hub and professionals looked at all this information and maybe decided – we'll send [child] to such and such – that they are linked up and compare information. It might speed the whole process up, as opposed to being sent off to this place and that place – all separate, not maybe sharing information. I think that would be a great idea. (Kinship carer of a five-year old)*

In relation to having somebody with a more coordinating role which could 'speed the whole process', it was suggested that LAC nurses could fulfil this function:

*I think [LAC nurses] would be good link people in terms of accessing services quicker maybe. (Residential staff worker)*

In terms of social workers, as highlighted earlier, it was felt that there was a need to retain staff in the same cases, and to avoid if possible social worker staff turnover. Carers argued that strong relationships between the young people (as well as their carers) and social workers needed to be built, in order to identify what they needed and to ensure that the voice of the child was heard, and so children/young people would be better informed about the decisions taken affecting their lives.

A few carers believed that professionals did not listen to them regarding what the child needed. That was especially the case for mental health issues, and when the child did not overtly display any problematic behaviours or 'did not fit a box'. Thus, carers expressed their wish to be taken seriously and listened to by professionals, so children could be seen by the right professionals at the right time:

*... it's just getting access to them because sometimes you know they try and brush it under the carpet. Sort of like 'we will see how it goes in six months' or 'I don't think there really is a problem'. But they are not with the child day and daily. You know they are seeing a child for half an hour or an hour once a month. They can't tell what's going on in that child's life in that time. So they really do need to listen to the carers. (Foster carer of a nine-year old)*

When so many professionals are involved in a child's life (especially when staff turnover is included), communication between them is critical to being able to assess accurately and meet the child's needs. However, carers highlighted a lack of communication between services and professionals, and a lack of consistency in terms of having just somebody involved throughout:

*... really the lack of communication is dreadful between each department ... it's the main problem and children have a tendency to get lost in the system ... there's not a consistent member in this child's life, one member or even two members of a staff team that would be there to see a child through and support them through it, it's not there. (Foster carer of a teenager)*

Gaps were also identified regarding services for carers. In this regard, carers felt that there was not enough respite care provided that would give them a break, especially when they had to care for children with complex needs. Other suggestions in this area were support groups for foster carers, summer schemes for children, courses for carers delivered in the mornings (while children are at school), and events to bring together young people and carers:

*I think probably the area that I would say there would maybe be a wee bit of lack in would be respite kind of support. We don't have birth children but we do get a little bit of support through for babysitting once a fortnight, but the likes of a weekend or the likes of regular babysitting, there's not the set up for that, and if there was a set up, that would be quite good, because then it means that you're able to give so much more then to the children, because you're making sure you're filled up yourself. (Foster carer of a nine-year old)*

*... it would be nice if there were mother and toddler groups specifically for children in care – that sort of thing where people would have similar problems and similar issues that could be discussed ... because you have to be so careful what you say in general situations about the child, whereas it's a bit easier if it's other carers that you're with. (Foster carer of a four-year old)*

It was also felt that kinship carers in particular were less likely to have any supports:

*I don't think there is enough support for kinship carers. I don't think they should have to take the rubbish from parents or grandparents or their solicitors or anything else, because at the end of the day we didn't ask to be put in this place, social services came to me asking me 'would I take the kids on?'* (Kinship carer of a three-year old)

Another issue of concern was the needs of the birth children being overlooked, for example:

*My (birth) children if they were all here would say they didn't feel that they were considered. The focus is obviously on the young person and keeping that young person in placement, and at times, we had some very heated family discussions ... and our overarching concern was that our family came first, and we had to counsel them, and debrief them, and give them support, and I think more could have been done for them. My children would probably also say that this has been a very good experience overall, and they probably have a better appreciation about some of the very simple things in life.* (Foster carer of a teenager)

Finally, a number of carers discussed the lack of services for young people with behavioural problems or disabilities aged 16 and above. Statements reflecting this were:

*I think it really varies a lot. I think the child with ADHD, I think they are quite good at getting them to see a paediatrician and getting that initial referral done. I do think that their hands are tied - there are so many of these children coming through now. There isn't enough services. The gaps for me, is more like afterwards. Whenever you have a child with all of these problems and they are coming up to 16, there is really nothing at all out there for them.* (Kinship carer of a five-year old)

*... there is nowhere else they can put them. They talk about now transferring [child] to the disability team and that's going to open doors. But hopefully that will open doors, because at the minute, if it wasn't for me researching what even [child] could attend, or going with [child] to things... [Child] could sit here, there's nothing, you can't leave [child] to a youth club or to the ordinary clubs that's around ... I would like to see more things for children with special needs. In the sense of outside the foster home, things they could go to. Things where people would understand them.* (Foster carer of an eleven-year old)



## Summary

Key messages that emerged from the qualitative analysis of the interviews were:

- ◆ There was a lack of consistency regarding the level of information provided to carers at the start of a placement. Kinship carers and carers whose children were placed with them as an emergency placement were more likely to receive little or no medical information.
- ◆ Child's background information was felt to be very relevant when trying to deal with its impact on the young person's mental and emotional health. However, this type of information was often not provided to the children's carers, who found out more about these and other issues as the placement progressed.
- ◆ Mental health needs, including behavioural issues, were more widespread than physical health needs.
- ◆ In terms of physical health needs, diet, exercise, and hygiene were often mentioned. Dental health problems were commonplace, especially at the start of the placements, due to lack of adequate routines and unhealthy diets.
- ◆ The concept of "delegated authority" generated a lot of confusion, and there did not seem to be a clear, universal practice across placements and HSC Trusts. While some respondents appeared to have this in place, and had been provided with a list of what they could decide or sign off, many carers had not and were uncertain of the decisions they could take regarding the child/young person.
- ◆ Support from a range of voluntary and statutory organisations and their different schemes was usually viewed in a positive light, and found useful in addressing the young people's needs.
- ◆ The importance of having the support from social workers readily available when needed was deemed as crucial by the majority of carers. However, while some stated that they had this timely support, many complained about the lack of it, in addition to social work staff turnover, and long waiting lists for the services they needed. Mental health services were particularly considered to be fundamental (given the high level of mental health needs), but many carers had negative experiences regarding access to those services.
- ◆ The stigma that the children/young people felt because of being in care was recognised by some of the respondents, who suggested that these young people needed to feel 'normal'. Thus, going to statutory medical assessments was often deemed as increasing these feelings of being different, and respondents often claimed they were not really necessary, as young people go to the doctor when they need to. In fact, some of the older children/young people were refusing to go. However, for other children with complex health needs, these regular medical assessments were believed to be relevant, especially if their needs were thoroughly evaluated. The problem was that many carers did not perceive them as being comprehensive enough, especially in assessing mental health needs, but more of a 'tick-box exercise'.
- ◆ In terms of gaps to service provision, respondents wanted to see more support from mental health services, shortening waiting lists, and having the support available when most needed; better coordination of services; more effort in engaging young people with mental health services; and more support given to carers.

## Chapter 5: Young people's perspectives

### Introduction

Twenty-five face-to-face interviews were conducted with young people in care from across the five HSC Trusts in Northern Ireland. These interviews focused on: what it meant for them to be healthy and/or unhealthy; what their physical and mental health were like at the time of interview, and whether this had always been the case; who they speak to and sought help from, if at all, about their health; whether or not they thought help was available to them regarding their health; and how they thought that services could be improved for LACYP. The key themes that emerged are described and discussed below, and these are supported by direct quotations from the young people, with pseudonyms being used to protect their identity.



### Perceptions of health

#### Healthy living

Young people were asked about what being healthy means. Over half immediately referred to physical health, and only three (out of these 14) mentioned mental or social aspects of health when probed. These participants focused particularly on healthy diets and exercise. They recognised the benefits of being active, including being fit enough and able to be involved in activities; and some specified the type of foods that were considered healthy:



*It means you can do loads of exercise and you can take part in lots of things. (Abbie, in foster care, age 15)*

*That you eat fruit and veg, you do like a diet and you do loads of exercise, an hour a day and all. (Nina, in residential care, age 14)*

*To keep fit and to eat the right amount of food, and eat healthy food like salads, lettuce, tomatoes and all like that. (Adam, in kinship care, age 12)*

When asked for examples of people who they considered healthy, these young people mentioned elite athletes (e.g. Usain Bolt, world record holder at both 100m and 200m) or other famous sport personalities (e.g. Steven Gerrard), who are extreme examples of physical fitness, as well as general people involved in active professions:

*Like runners and fitness instructors, people who go to the gym a lot, people who swim, lifeguards, fireman. (Nina)*

A few of them proposed people in their families also as examples. For instance, Adam talked about his brother, who he saw as an inspiration as he lost weight through going out and being active:

*My brother, he's not like the weight of us, the fat on the rest of us, but he was when he was younger but he kept going outside and joining clubs and playing football with his friends, my sisters went out to see if he was okay and then I joined in with him playing football. (Adam)*

In contrast, for two young women, mental health took precedence. They described being healthy as mainly being free of worry and coping with change, and claimed that other aspects of health, such as diet, would fall into place as long as they felt well mentally. Both of them had experienced difficulties with their mental health in the past, and one of them was still trying to cope:

*... because my lifestyle seems to chop and change quite a lot and it's kind of hard to keep up with it, so I'm not really too fussed about my diet ... but for my mental health, I think it would definitely be important ... and that would be healthy as to have a clear mind and to know what you're going to do and to look after your mental health. (Anna, in foster care, age 17)*

*To be in your right mind is really what is about being healthy because that's where ... your mind is, what controls everything, so if you're in the right mind, then everything else will. (Bridget, in foster care, age 21)*

Like Adam, Bridget mentioned her own family members as examples of healthy people:

*My mum would be healthy, I would consider my foster mum to be healthy, I would consider the young ones that I look after to be healthy, because they're young, and at the minute, they don't have a lot to worry about or anything like that there, so they're quite free spirited at the minute.*

There were also a few young people (n=5) that had a broad understanding of health, as comprising different aspects, such as physical and mental health, as well as social and family life:

*Being able to solve problems and being physically fit like football ... so being healthy just means all round happy I think ... healthy like being around your friends and being happy and not really caring about life, but being happy in yourself like ... (Daniel, in foster care, age 15)*

*Well having a healthy lifestyle, you're eating healthy, you're exercising, you're actually socialising and all, you need to have a healthy mind too, your family ... (Nicole, in kinship care, age 19)*

*To be in shape, to have a good understanding of the world and to like people and to be nice, to be very open-minded about things (Tracy, in kinship care, age 15)*



### Unhealthy living

When asked about what they believed ‘unhealthy’ meant, mirroring their answer to the previous question, most young people focused on physical health, in terms of over-eating or eating the wrong foods, as well as a lack of exercise or being inactive (which a lot of them equalled to being lazy), or being physically sick:



*To be unhealthy would be to be malnourished or to be sick, like the flu or something, well that's not really that unhealthy, but there is different levels of illness. (Glen, in foster care, age 13)*

*To be lazy, not eating properly, and I'd say that's all. (Connor, living with birth parents, age 17)*

*Like you're lazy, you eat fast food without ever cooking dinner, you're trying to lose weight rather than gain it, you're looking unhealthy. (John, in kinship care, age 16)*

*To sit in the house, eat takeaways, don't eat healthy food when people are making it, just lay about and not doing anything, just being really lazy. (Adam)*

Three young people also talked about risk-taking behaviours, as making people unhealthy:

*... just going out and drinking and taking drugs and whatever that's kind of unhealthy for me. (Anna)*

The idea of not being able to look after oneself was also mentioned, in relation to both physical and mental health:

*Not being able to look after yourself is being unhealthy, if you can't look after yourself, you can't be healthy, so again that's to do with your mindset, if your mindset is not right you can't look after yourself and you can't always depend on somebody else to look after you because that doesn't make you healthy either. (Bridget)*

Those who had a broad notion about health incorporated it in their answer on what it means to be unhealthy:

*Not being able to live your day to day life sometimes ... if you were stressed or something or if you were ill. (Claire, in foster care, age 18)*

*Probably just the opposite, if you were struggling from mental health problems and you weren't physically active, or not eating the right things or nothing, none of that sort of stuff, just not looking after yourself. (Trevor, in residential care, age 19)*

Daniel also had a comprehensive idea, and talked about the difficulty of being healthy when you are not receiving appropriate care, and how that impacts on you:



*... if you have don't have a good family, you're getting hit and you're not getting the right food, like health, like say if you don't have a good social life and you're stuck inside, you're not really getting cared about, that's what I think unhealthy is about. ... Well if your parents don't provide for you, you know with food, you're scared, I would say you would feel unhealthy and not happy with yourself, scared ...*

Nicole talked about her parents and other people having mental health problems, which she attributed to living in disadvantaged areas:

*People who are poor aren't capable of certain things because they've restricted themselves. Situations have happened that have made them mentally that way ...*

### Sources of advice about health

When investigating the sources of information from which young people derive advice about how to be healthy, school was found to be a common source (76%). Foster parents and/or carers were another important source (62%), while professionals including social workers and doctors or nurses rarely were (38%). Some young people discussed health with their friends (52%), while others did not, sometimes because they did not feel comfortable discussing mental health issues with anybody. In addition, there were some young people who claimed that they did not get advice from anybody, some of them stating that it was 'common sense' or that they had a 'rough idea' already. However, when prompted about where they got this idea from, some of them would then refer to these common sources.

### School

The types of advice given at school were usually in relation to diet and exercise. In this regard, a few young people described the healthy options available to them at school cafeterias, and the sporting facilities available in their school, as well as the encouraging influence of teachers:

*... they have a tuck shop and it sells them healthy crisps you get, it starts with a v, like velvet or something, they sell them and bottles of water, I always get one packet of them and bottle of water. The big playground has about three football pitches so you have nets there so you can go out and play football. (Adam)*



However, a few children referred to other types of advice, such as mental health (specifically to do with reducing stress during the exam season, and teaching you 'to calm down'), and to be safe:

*They would calm you down, they would put you in an isolating room or something to let you cool down and stay away from the people you get angry at. (Morgan)*

*They tell you to keep safe when out and about in the streets and all so you don't get injured. (Glen)*

In terms of particular school agents, as previously noted, teachers (in particular PE and HE teachers) and the school nurse were mentioned:

*My PE teachers in school. Mr [name], they tell you the diets, muscle, vegetables and all that. (John)*

### Family

It was to be expected that family – including foster parents and/or carers had a strong influence – but this seemed to be particularly significant in some cases:

*My sister (carer) has loads of exercise stuff, she has football, we have a basketball net up there and badminton and she has to be strict with us about what we're eating. Like last night she made a nice homemade chicken curry and then she kept making nice dinners, she says the only treat we're allowed is on Saturday or have one thing like a chocolate bar on Friday. (Adam)*

*From my foster mum, she would keep me right in being healthy ... she tells me don't stress, she'll give me regular breaks, so if she sees me stressing, she'll tell me to go out for a walk ... she keeps me right. (Bridget)*

Foster carers, in particular, were mentioned by six young people; kinship carers (in particular the older sister for a set of siblings, and the grandparents for another young person) were referred to by four; and three young people in residential care specified the residential staff in the home. The advice given was mostly about keeping physically active and eating healthy foods while restricting sugary and fatty foods. However, mental health issues were also talked about, and young people claimed to have approachable carers who they could talk to. Daniel also stated that his foster carers encouraged him to do his homework, as well as to be physically active and socialise with peers:



*... our ma and da would always promote health ... you can have a certain amount on the phone or the PlayStation or whatever but that's all, get in and do some work, outside they wouldn't mind us going outside kicking a ball against the yard or going up to training or socialising but as long as you're doing the work and you're doing well at school they'd be happy enough.*

## Friends

Friends were said to be good sources of support by 11 young people. Some young people stated that their friends also liked to keep active and played sports together:



*... a lot of them [my friends] are addicted to going to the gym and stuff ... (Philip)*

For some young people, having close friends instilled a sense of confidence and belonging, as they knew they could discuss issues with them that they were facing:

*I'm lucky because I have great friends. If I was in trouble or if I needed help they would always be there for me and I would be there for them – we're a good bunch of lads. (Daniel)*

*Me and my friend group, we talk about a lot of things – even making healthy dinners because a lot of my friends are in university and I don't really want to be living off pot noodles (laughs) so I would be like what can I make for myself that I can't burn (laughs). But we talk about a lot of stuff – they're really good. (Anna)*

The influence of friends was not as strong for some young people, one of whom said that any decision was ultimately her own. This young person spoke throughout her interview of the support she received and valued from her foster mother, showing that this was a much stronger relationship than that which she had with her peers:

*My friends would maybe say 'you shouldn't be doing that, you should be doing this', but I'm quite strong minded in that I will do it my own way eventually. They might hinder me for a few seconds but normally I'm quite stubborn. (Bridget)*

A lack of trust of friends was revealed by another young person, who commented on whether she discussed mental health issues with her peer group:

*There's friends who don't like talking about it to other friends ... because if somebody did, they will probably go and say to someone and then before you know it, it will start getting rumours. (Morgan)*

## Professionals

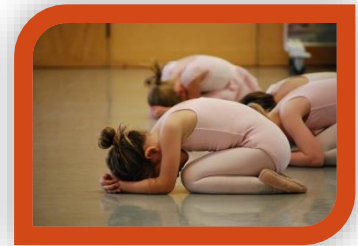
Young people were less likely to mention professionals as sources of advice. However, three young people mentioned GPs or doctors (getting advice about physical health); four talked about attending particular courses in youth organisations or receiving leaflets about health for children in care; two referred to their social workers; two mentioned specific psychological professionals (i.e. counsellor and CAMHS doctor); and one girl identified her health visitor. For a few of these young people, these professionals were quite important sources of support, while others just mentioned them when probed, in conjunction to others (that would have been felt to be more relevant):

*The social worker keeps tabs on me ... I organise how much I want them to contact me – they'll ring me or send me an email, that's the way I prefer because I don't like being invaded all the time. We've organised a routine so if I just send a message saying 'I'm doing okay', or they'll send me a message 'how's things, how are you doing?', so they keep tabs that way but they know that I don't like being constantly asked all the time 'am I okay?' because that will push me further and further back. (Bridget)*

## Perception of own health

### Physical health

Participants were asked how their physical health was at the minute, and whether there had been any change in it. Most young people believed their physical health to be “good”, “OK”, and “grand” (86%), and they sometimes talked about their diets and their ability to keep physically active:



*I'd say pretty good, yeah good. ... I suppose ever since I went to secondary school yeah, pretty good ... Because I exercise ... and I eat healthy as well. (Connor)*

*Grand, I haven't been able really to do any exercise because I had to go and see somebody in (hospital) ... so you can't really do any sports or nothing, I can only do walking ... until I'm 16 and then I'm going to get an operation. (Nina)*

Trevor claimed his physical health was “not great”, precisely because of a lack of exercise and poor diet:

*It's not great now but I keep it up to the best I can, I go out walking or maybe an odd jog if I could or something (laughs) ... It's just my eating and all wouldn't be the best at all, wouldn't be healthy stuff or nothing, it would just be fast food and junk food and all that sort of stuff.*

Two other young people discussed issues regarding their physical health, which were very much linked to their mental health, and these were quite complex. James had ADHD and numerous other health conditions, and Nicole believed that her problems with her stomach had to do with her anxiety issues.

*I can't even run. I can run but I can't run for ... I usually get bored or tired, usually both at the same time but other than that there, yeah I can do stuff, like I mean I can lift a chair, lift that chair for example, I can move stuff about if I need to. (James, in foster care, age 17)*

*I tend to catch anything like I've had some women problems, although I could be the only one in my family to do anything, that eats fruit and vegetables, I'm the one with the poor health which is weird ... If I manage to have loads of problems with my stomach and everything, I catch it all. ... ever since I was a child which is what caused my anxiety because of my poor health, I have my anxiety, worried about going out in places ... because of it, because I know having a bad stomach and all, I just can't control, and I could throw up and all at times ... (Nicole)*

A number of the young people raised their weight when asked about their health. For instance, while Anna believed that she was overweight at the time, John and Tracy claimed that they lost a lot of weight previously, and that made them "healthier" now than they had ever been before:

*Physical health seems to be fine, I am not at the weight I would like to be, and I think I could definitely be at a healthier weight, but apart from that, everything else seems to be okay, I have had no problems health wise, so yeah everything seems to be okay. (Anna, in foster care, age 17).*

*When we were young, I was a bit on the bigger side, but as I've grown up I've lost a lot of weight. ... it's been pretty good ... I started getting back into shape and growing up yeah. (John)*

*I used to be overweight and I don't think I'm fat or overweight now ... It kind of just happened itself, I didn't really realise and then I was told 'oh you look like you've lost a lot of weight' and all that, I went outside a lot more and that's when it started to come off I suppose. (Tracy)*

In total, five young people reported having ill health when they were younger, but were feeling considerably better at the time of the interview. Sometimes, they put the improvement in their physical health down to getting older, but some of them also felt that it was due to being in a more happy and healthy environment:

*I used to have asthma when I was younger and chronic bronchitis and that used to just play up in the winter and I used to be quite ill whenever I was younger, but I seem to have grown out of it now, so everything is fine now. (Anna)*

*I would say I'm the healthiest I've ever been, because I had a troubled kind of past, but now I'm the best I could be like, and I have my friends and family, so I'm happy and I'm healthy ... well I would say, this family here would be the best family for me, and I am happy with the way it is, and I wouldn't go back to my other, to past life so, so yeah I would say I'm the healthiest I've ever been. (Daniel)*

*It was not really good when I was living with my (birth) mum because my mum was neglecting me ... it's not her fault, it's because she had mental problems in her head, and she had a [physical disability], so she couldn't handle it, so she neglected us and then we had to go into care, and that's when we had to move to (older sibling). (Adam)*

## Mental health

Young people were asked about their own mental health, both at present and in the past. As expected, there was much variation in how they reported feeling. Two thirds of young people reported no problems at all in the present, or just talked about general day to day (normal) stress, like exams:



*Mentally all good, good education in school, as I said friends kind of help the mental thing, so yeah I'm happy and mentally strong. (Daniel)*

*It's good like. You maybe have stress because of like school but once them tests are over, you're all right. (Philip, in kinship care, 19)*

For Glen, to be mentally healthy was very important, as he identified poor mental health as a great stigma, for which people are marginalised:

*I think I'm mentally healthy, I'm not insane or anything (laughs), just like a normal teenager ... I would probably be an outcast, I would feel like if I wasn't like mentally healthy, I'd probably be an outcast from everyone else, they would stay away from me.*

Whilst some reported enjoying good mental health at the time of the interview, half of all the young people reflected on a time when they were not feeling as well, with some having suffered from serious mental health problems. For instance, half a year before his interview, Trevor was suicidal and struggling with his mental health difficulties. He then sought the help of a psychological service, which focuses on young people with addiction difficulties, and felt that his counsellor had a really positive influence, and helped him recover:

*It's a lot better than what it was like, say about a half a year ago there, I was really struggling but I just finally went and sought help, and then that's when I got myself into that [name of organisation] place, I was out in CAMHS, out in [place name] as well but I left that there when I turned 18, so I'm happy the way it's all turned around now definitely.*

Thus, the positive changes in these young people's mental health were attributed to their new circumstances and having more support around, having grown up, or to the help provided by certain services:

*... with better people, better environment as well. My friends and family now, they're good ones and I think they make you feel better as opposed to having like a bad family, bad friends I suppose ... It's just like better, isn't it? Plenty to do, plenty to see, fresh air. Sure you wouldn't get that if you were living in a city or somewhere. (Connor)*



*... it's back to normal now about a year, but I hadn't been at myself for the last two or three years before because I was getting shifted and moved and I was going from house to house and things weren't going well for me, that's why I just took it all the wrong way then ... It was in here, in here, that gave me a stepping stone to get back, then a few times when I felt like I was coming down it was like there's always a wee staff there just to throw a wee stone underneath to get you to stand back up again ...they're there and if they can see you falling downhill, they would let you know about it. (Kevin, residential care, age 18)*

A few (n=4) were still struggling with their mental health. Nina was in particular difficulty, as she had taken two overdoses recently, and described her mental health as “not good”. Anna was riddled by guilt because of the way she entered care, and had a complicated relationship with her mother and grandmother. She had also had an overdose and had been self-harming, but she felt she was working through her issues, and was in the pathway to recovery:

*I've had a few concerns about my mental health since about last summer, these past couple of months have been particularly difficult and where I would self-harm and recently I took an overdose and was in hospital for a while, just because my school was pressuring me and my social life and my family life was making it very, very difficult for me, but I'm pulling through and I'm working on it, I'm not better but I'm getting there ... I just need to work out myself, and that's just going to take some time because of my family situation ... so it's just me trying to adapt to that and find different ways to cope with it ... well, coping would have been cutting, but I don't do that anymore, but that would have been probably my main strategy, so it's finding those coping mechanisms just to deal with this changing lifestyle, because it happens so constantly, and it's just trying to keep up with it, but yeah apart from that, I'm just working on it.*

## Seeking help

### Physical help

When asked about feeling unwell physically and to whom they would turn, the vast majority of young people said they would tell their foster parents, parents, and/or carers (including home staff) (71%). They respected their advice because they were older, experienced, knew the young person well, and cared for them. Some of them also said they would contact the GP or doctor, and Glen and David mentioned friends and girlfriends.





*I tell my sister (carer) because she has been through some stuff when she was little, she knows what will happen and she'll just tell me the best way to do it ... she's the adult, she has done loads of good school work and would know most of the stuff. (Adam)*

*If I'm sick, I would tell my (foster) mum and dad and they would go out of their way to make it better ... they're so understanding and they would know, even if I didn't tell them, that something was wrong because they pay that much attention. (Daniel)*

*I tell my carer first and then the carer would pass it on to a doctor and let them know ... I tell her (carer) because she's there, and she's in the house and there's no one else. (Dylan, in foster care, age 17)*

*I speak to my foster mum because she is the one who is looking after me and I prefer talking to a girl than males. (Morgan)*

*I tell my (foster) dad and my mum because they would keep me company and make me feel safe and make me feel good about myself as well. (Abbie, in foster care, age 15)*

Five young people explained that they would not tell anyone because they expected their pain or sickness to disappear eventually:

*I normally try to hide it – I don't like being pitied around. If I am unwell, I'm just like 'I'll be fine'. I'm not very good with pain so whenever they finally realise what's wrong with me, I'm very bad with it, but again I like to deal with it myself, even a sore head – I'll be like 'I'll be fine' – but my mum would be like 'take painkillers, sit down' – I don't want to, but sometimes you literally have to tell me 'right, you need to do that'. (Bridget)*

*It's passing me you know, you just get on with it and do your own thing, it's not going to like bog you down. (James)*

General physical health problems seemed to be readily discussed between foster carers and young people, but one young person mentioned a specific concern which she explained she preferred to keep to herself:

*Sexual health I probably wouldn't talk to (foster parents) as much about, I mean (foster mother) I talk to openly, well we all talk openly about it, but some things I feel just are my own personal things and I don't tell anybody ... and that's just the way it is being a girl or being a woman, you just keep those things to yourself. I never had anything concerning that I would need to tell them but I would probably just keep some things like that to myself, but everything else I would share. (Anna)*

### Mental health

Telling others about mental health problems was a slightly different matter – while the majority were able to seek help, one third of the young people felt unable to talk about mental ill health (mainly because of the stigma), and spoke of feelings of embarrassment, insecurity, or guilt which was fuelled by previous life events. Some underplayed the

relevance of feeling mentally unwell, and how it is something that eventually goes away, and two believed they never felt mentally unwell. These young people were often also those who did not seek help for their physical health:

*I usually wouldn't tell anyone about mental health issues because it's triggered by a lot of guilt, I have a lot of guilt so I don't really want to tell people. I'm a smart person so if I knew something was up and something was bad then yeah I would definitely tell them, but usually I just kind of deal with it myself because it passes, so usually I just keep on top of it. (Anna)*

*You don't feel mentally unwell for that long, well I haven't. I just get over it. Bottle it up for a couple of days and it will go away ... What stops me telling people? It's just not knowing what other people would think. It must just be a young person thing. I don't know, they keep to themselves probably and avoid embarrassment I suppose. For some, it might be embarrassing, for some it wouldn't. (Connor)*

*... it's one of those passing things. I mean you can't stay depressed forever, can you? I mean you can stay depressed but... it's not fun because I've had my fair share of doing that ... I do get down sometimes, but I usually pick myself back up within a period of time. (James)*

Some young people employed different coping mechanisms in order to make themselves feel better:

*I just would put the earphones on and that's my therapy there, I used to write it down, like just sit and write and then I would scrumple it up, and that was my way of telling somebody, as I'm older now I would tell 'such and such was annoying me', or my mum would realise what's wrong and she would just openly ask, somebody normally has to ask me before I'll tell them. (Bridget)*

*I do get down sometimes, but I usually pick myself back up within a period of time ... sometimes I watch funny videos and they're funny so that works out. (James)*

*I have a busy social life, I never really used to go out ... I used to just sit in the house and just say 'I'm not going out' or something, but now I'm going out a lot more and just keeping myself busy, and it definitely helps just to take your mind off things. So yeah, I would definitely say it's a good idea to keep yourself busy. (Anna)*

Although Dylan found it previously very hard to talk to people about his mental health (because of his past, and memories of being shouted at and not being listened to), he was starting to speak freely to others. He talked about the negative effects of keeping these issues to oneself:

*I haven't really been talking to [foster mother] about it really, but I'm starting to. I'd be waiting at least a week to talk to her. I really was going to talk to this person, psychiatrist you call it, they'd help you understand why you're getting upset and I go to that and then I'm starting to talk to [foster mother] a bit more, open myself up with her ... I felt I didn't want to talk ... I was afraid because of my past ... people wouldn't listen to me ... so I would just keep it in, keep it in me and just leave it. It just bottles up and makes me worse.*

Similarly, Kevin and John also spoke about the benefits of talking to somebody else when not feeling mentally well:

*I was at rock bottom at one point, and I promised myself that I'd never do it again that I'd never let myself go so far down, so if I feel like I'm coming down or if I'm not feeling well or my head is not at the way it's meant to be, I would ring one of my mates and ask them to come up to me, and if they don't, I would go down to them and see if it's alright for me to go down and sit with them. That would help me out a lot ... because they're telling you about their life and about what they done during the day, so you're thinking about what all their problems is, so you think 'what am I sitting here complaining about when there's other people out there that's worse?' You just need that wee bit of assurance that gets you up, 'yeah, happy days, I can do it' ... but you need to be with somebody to be thinking like that, but if you're on your own, it's all bad thoughts that you're thinking and you don't get nowhere with it ... If you be stubborn with somebody, you think that you're getting the better of them, but it's actually making you worse than them, because you're not going to get what you really want ... it all works the same way, I'd say, you just need to be somewhere to give you that wee lift. (Kevin)*

*... talking to people helps more than trying to work things out on your own, because you hold it all in and then one day you just pop, and you take it out on the wrong person. (John)*

Most young people sought help from those closest to them, in particular, their foster/kinship carers, family members or residential carers (52%), as well as to a lesser extent, their partners and friends (24%), and three were also very much reliant on professional help (i.e. counsellors and psychologists). They explained their reasons for seeking help from these particular people:



*I would speak to my other sister because she lives next door and she helps me when things are going wrong with me and she's been through a lot of things. (John)*

*[I would tell] foster mum ... because she is a girl ... because she understands, and plus she has probably went through the same experience and stuff. (Morgan)*

*I just feel like my girlfriend has been through most of the stuff I chat to her about, so it wouldn't be chatting to someone that's guessing about it, she's actually went through it. Then my counsellor, he gives me all the advice and all on how to keep myself calm and all that sort of stuff, and that's what I need really like because I can flip out at times. (Trevor)*

To sum up, although the majority of young people were able to seek help and talk to significant others (especially their families and carers) when they were not feeling mentally well, a considerable number did not feel able or did not think it was necessary to talk to somebody and kept their problems to themselves, often due to complex feelings of embarrassment, insecurity, or guilt.

## Supports

All the young people, except for one (Bridget), claimed that they were getting enough help and support to be healthy. The support needed came from their carers and families, as well as professional support, such as doctors, social workers or psychological services, and voluntary organisations and groups:



*Well I have [older sister – carer], I have the doctors and I have social workers if I have any problems, like the way if I have a problem of getting, like I was saying I wanted to go on a trip to [other country] and my sister says 'I have to sort it out with social workers', they would help me, and my sister helps out, planning it and all, and figure out what you would need, and help us and all. (Adam)*

*Probably staff in here, if they ever noticed I was looking unhealthy or something, they would point it out and tell me to start eating healthier, or if I was at the GP or somewhere, they would try and advise me towards going the better way, it's always if they pick up on something they point it out to me. (Trevor)*

*VOYPIC are helpful ... mentoring and other things. It is fair, some man takes you out or some girl you know you get £30 a month I think it is. You just hang out with them ... it's awesome because I actually done that, and it was brilliant ... although I don't like doing much physical stuff, we were doing like squash and badminton. I don't like badminton. It's too tiring but we do all sorts of things. Pool, we done loads of stuff. (James)*

On the other hand, Bridget felt she had been failed by social services when she needed help with her mental health. She explained the difficulties she had in accessing the right services. Thus, although she availed of CAMHS services, it took a long time to get the service needed, because of social workers' judgement that she did not need it, a long waiting list, and her inability to engage with the service, due to fear to open up, and of even entering the building:



*There was a waiting list and probably the fact of they didn't really think that I needed it, it took me a wee bit longer, and the fact that I didn't really want to go ... I felt sick every time I went into the building because I was just like 'what are they going to try and get out of me?', I put a guard initially up, and it took me a long time before I let them do the grounding therapy or anything on me, because I ended up crying and going 'you can't get it out of me', it was like somebody trying to pull it out, so it was more me pulling back from it, was in fear.*

Most young people thought children and young people in care received enough support to be healthy, with many stating that they did not really know. However, most also gave suggestions on how to make things better for children in care, and how to improve services. Many focused on the active qualities that social workers should have (i.e. friendly, informal, understanding, good listeners, not prejudiced against them, not pressuring them to avail of services when not ready), and highlighted that they needed to build positive strong relationships with young people. Some of them described negative relationships or experiences that they previously had with professionals, who did not take the time to know them or pressurised them in some way:



*... maybe they could go out of their way a wee bit more, just to make like themselves known, friendly and that kind of thing ... at the start, they talk to us, but like say if we are meeting, our parents or it's just sitting in a room like and sometimes, they talk to you, but it would be better if they actually told you what they were doing there, and why they were there, explain a wee bit more maybe, better detail ... yeah, at the start, I was going like 'why is this person in the room with me like? should it not just be family like?' So maybe if they made that a wee bit more clear, and you understand a wee bit better. (Daniel)*

*... they (social workers) should spend some time with the children that are looked after, where you get to know the children more ... just like more as a friend probably, and you would start talking to them more. (Claire)*

*... they don't take enough time and effort to actually see what's wrong, they don't get to know, they assume too much sometimes I think, maybe that's just personal experience but they assume like she or he is the same as him, so we'll keep them that way, nobody is the same ... I think they need to try and meet the individual needs of the young people, which I don't think they always do ... They're assuming, they are doing a lot more assuming than they are listening all the time. (Bridget)*

*... take for example a LAC review, it's a looked after children review, you go into a room with a lot of professionals and every one of them is talking about you and you barely get a say, because everybody is so busy making all these decisions for you ... you feel as though you're being looked down upon, you feel intimidated, and I know a lot of kids do, especially, like I feel intimidated by professionals as well, or I used to, whenever I was sort of new to the care system, so if there was a service that was available, or even if professionals understood that we felt intimidated ... maybe people who related to us or even professionals who were a wee bit more understanding or maybe if there was training there ... if we had something like that there, that there was training for people who could deal with kids in care, and especially with mental health issues, that's definitely important. So I would just say for them to come off their high horse and kind of get on the same ground as us, and just you know be a little bit more informal and relax, and maybe we'll be able to open up to them ... it helps to talk to the professionals maybe outside of the meeting before you go in or maybe even after, afterwards, so if they approached us and just had a chat or whatever, it would maybe make us feel more comfortable because it can be really intimidating ... just a wee chat maybe, or something informal would be nice so we feel more comfortable. (Anna)*



*... the social worker ended up sending me to three different counsellors and I keep explaining things, I couldn't keep doing that and it upset me more, whereas when I went to my doctor, he referred me to this woman ... I sort of got a bit annoyed with my social worker because they just pressured me ... They didn't really care about the person ... I would be panicking, not trusting people like that. I ended up in a worse state crying and stuff, because they made me change, and I just ended up refusing to go anywhere, and tried my doctor and decided to send me to the place up in [name] and help me out there just sort of with my doctors. ... I know they've tried helping me but I think sometimes things, they get in the way too much. They try to pressurise a lot of people to do things and all. (Nicole)*

When offering suggestions, others focused on the need to provide the right information to young people and parents, so they could avail of the support they required and their needs could be met. For instance, Anna claimed that young people often did not have enough information about the services available; Morgan believed that there should be more talks about health; and Bridget felt parents/carers should be given more information at an early stage so they can “notice signs quicker”:

*There's help available but a lot of us don't know that it is there ... because nobody tells us, I mean if social services can get away with not doing something for us, they'll not do it, if you know what I mean, and I know that sounds sneaky but we've clicked on now ... but you really have to ask for it, you really have to push the Trust for something that you want, instead of them actually telling you what's available, and I know that's not just me because I have spoken to people about it and I'm actually working [in some capacity for one of the Trusts] and so we get a lot of ideas, and I used to [work with a voluntary organisation], so I would get ideas from them, and I have worked with them for a long time, so I know that that's a big issue for kids, that there is a lot of support available, we just don't know about it, and we aren't told about it really, so we really just have to find out for ourselves, it takes someone quite able and capable to go out and try and look for the help, but maybe kids who are less able, they don't you know, it's not really available for them, but I mean there is help out there, we just don't know about it. (Anna)*

Anna also argued that many young people suffering from mental health issues did not talk about it, did not even know they had mental health issues, and did not know there was help available; as well as that, services available were “not made easy” for children in care. However, some young people felt that there was not enough support/help available, particularly in terms of local mental health and addictions services, as well as not enough foster families:

*Well there could be, mainly in [name of city] there could be a couple of more places towards mental health and all, and addictions and all that sort of stuff, there could be a couple of more schemes or something like that. [Do you think it's lacking around those areas?] Yeah, I think [name of organisation] was the only one I knew of for a good while, and it was for drug addiction, I was in that last year, it's the only I could really find that was mainly for support and that, I was surprised at that like for how bad the actual drug problem is in [name of city]. (Trevor)*

*... they're not trying hard enough to get more people to help the young ones, because if they really wanted to they could do it, because see now it's all about the government and money and even social workers they're fighting on our behalf, plus their own behalf, and they can't do it, there's not enough there to fight towards it, so they're going by their job and that's all they can do at the minute, and see now by the looks of things, there is going to be no change, if anything it will get worse, that bothers me, because now I'm leaving and I still know young lads who's in the care system and who needs help with their mental health ... and I know myself half of the ones I know who have all them problems isn't going to get it, they're not going to get the help because there's not that many people there, that's just the way I see it. (Kevin)*

In addition, Bridget advocated for more outreach mental health support, and highlighted the reasons for it:

*I would like to find a way that they could come into the house or do something that they can analyse maybe more and see exactly what you can do maybe without necessarily going to a place like that [i.e. CAMHS], because I think sometimes you don't need it, you just need somebody to talk to. Like somebody maybe your own age, just hanging out, just doing that but I'm ... again I'm independent, so I'm quite maybe not the same as a lot of other people ... You feel like the invalid going in, it's just like I have to go and do this, and you don't really want to tell people that's where you're going, whereas you can say 'I have a friend coming over', that's a lot easier to say than 'oh, I have to go to an appointment', because I didn't tell anybody in school. I was just like 'I have a doctor's appointment', and then they kept asking what was wrong with you, and you didn't really want to tell them 'aye, my head is not right', you don't really want to tell them that. (Bridget)*

Other suggestions were: using mentors instead of social workers; more communication between health professionals (so young people do not have to repeat their problems over and over); plenty of local sports facilities, as well as more schemes and programmes to be active and working with groups of young people; and more local drop-in-centres:



*I think there should be more schemes about, get them out playing football and connecting more and like see two people connecting like getting them to hang around, like let them go play sports or I don't know, take them to the movies or something to clear their heads. I just think it's better to work as a group than be alone because you don't want to be alone forever. (John)*

*Maybe just somebody like that comes out and checks on you from time to time, if you're OK, other than social worker because some people don't like their social workers [Like a mentor?] ... Yeah I had a mentor and it was quite good because ... you just go out with them and stuff once a week and do stuff, but if you needed to speak to them, then they would pass it on to someone, if they thought you would need help. (Claire)*

*Do you know the drop in centre just down the street from up here? ... more of them there sort of set ups, they're good like ... keeps them off the streets just, if they have it set up for say seven at night to nine or so, that would be the main time where anything could happen like, if it keeps them off the street for them main hours, they could just head back to the house then ... you can just go in and chill out, mess about on the computer, play Xbox or something, it's good like, definitely. (Trevor)*



## Summary

- ◆ When asked about their definitions of health, most young people focused on physical health, in particular referring to diet and exercise. They seemed to be knowledgeable about what a healthy lifestyle should consist of. However, some interviewees recognised the diversity of aspects that the concept of health was comprised of (including physical, mental, emotional and social health), and a few participants focused on mental health. These were young people who had suffered mental ill health at some point in their lives.
- ◆ The main sources of health advice mentioned by young people were school and their families, followed by friends. Over one third of young people also received advice from professionals, such as their GP, social worker or counsellor. Some young people claimed not to seek advice from anybody, as they believed they already knew how to be healthy. Health advice was usually given in relation to physical health (in particular regarding exercise and diet), but mental health advice was also given by carers/family members, and at school or by professionals.
- ◆ The majority of young people interviewed did not report any major problems in relation to their physical health. The only problems reported were weight issues, ADHD and other related health problems, and stomach problems. A few had had health issues in the past, but these tended to have been resolved as a result of a change in their circumstances.
- ◆ Mental health issues were more prevalent than physical health problems. Half of the young people interviewed had had some mental health difficulties in the past, and a few were still struggling. For those who felt their mental health was alright at the time of the interview, their recoveries were attributed to the support they had received from their carers/families, having grown up, or to the help provided by certain services/professionals.
- ◆ In terms of help-seeking behaviours regarding physical health, the vast majority stated that they would ask for help from their foster/kinship carers or residential staff, while a quarter would not ask for help from anybody.
- ◆ One third of the young people felt unable to talk about mental ill health with anybody due to feelings of embarrassment, insecurity, or guilt which was fuelled by previous life events. Some underplayed the relevance of feeling mentally unwell, and how it is something that eventually goes away, whilst a small minority believed they never felt mentally unwell. A few others had also found it difficult to open up to anybody in the past, but had made the effort recently, and talked about the benefits of doing so. Most young people sought help from those closest to them, in particular, their foster/kinship carers, family members or residential staff (52%), as well as to a lesser extent, their partners and friends (24%), and professional help (i.e. counsellors and psychologists) (14%).
- ◆ Although nearly all of the interviewees felt they had all the support needed for them to meet their health needs, the majority felt that there were improvements to be made, and they offered some suggestions. Some commented that they did not know what support was available, and claimed that more information about services would be welcome. Common suggestions were for social workers and other professionals to take time to get to know the young people better and to listen to them and be more understanding; more outreach mental health services; the use of mentors; more drop-in centres to combat addictions; and more local sports facilities and schemes for groups of young people.

## Chapter 6: Multidisciplinary professionals' perspectives

Multidisciplinary focus group interviews were conducted in four of the five HSC Trusts between February and March 2015. No focus group was conducted in one HSC Trust due to logistical reasons and project time constraints. In this instance, service provision was informed by the data collected during the phase 1 interview with social work staff. Table 13 provides information on the type of professionals that were interviewed, and these ranged in number from three to eleven participants per focus group across the Trusts. The interviews focused on identifying the roles of the different professionals in meeting the health needs of LACYP, as well as the resources available within each of the HSC Trusts. The focus group participants also identified the challenges they faced, and offered a range of suggestions and recommendations as to how to improve the way the health needs of LACYP are currently addressed. These have not been specified by HSC Trust or profession to protect the identity of participants when presenting quotations.



**Table 13: Composition of focus group interviews**

Professionals	N
Therapeutic LAC nurse	1
Assistant Principal/Principal Social Worker/Practitioner	2
Senior Social Worker	3
Head of Public Health nursing	1
Education Welfare Officer for LAC	1
School nurse	3
Consultant clinical psychologist	2
CAMHS Service/Team Manager	2
Residential/LAC Service manager	2
Head of Services (for LAC or 16+)	3
Participation and Life Skills Project Worker	1
Assistant Manager – Health Improvement Department	1
Manager of voluntary organisation	1
Lead nurse public health	1
Service Manager LAC	1
Specialist nurse for LAC	2
Clinical Director of Psychology	1
Substance Misuse Practitioner	1
Team Manager of therapeutic service for LAC	1
<b>Total</b>	<b>30</b>

## Description of professional roles and level of coordination

Two of the focus groups included a **Specialist Nurse for LAC**<sup>6</sup>, who discussed their role, and their role was also discussed in another group, although they were not present.

The role of the specialist nurse for LAC was first introduced in Northern Ireland in 2007 in the South Eastern HSC Trust and was subsequently introduced into the Southern, Western, and Belfast Trusts. The Northern Trust was due to appoint in the near future. This role includes:



- Working Trust-wide (one nurse for each HSC Trust);
- Working with young people with complex health needs (sexual health, child sexual exploitation, drugs, alcohol, substance misuse, self-harm, emotional/mental health, dental, teenage pregnancy, etc). This work includes programmes of individual health promotion work with the young person. These young people predominately live in residential care or in foster care;
- Training health visitors and school nurses regarding their role with looked after children and young people; and
- Advising and supporting residential care staff on health issues that may be affecting young people.

In the focus groups, professionals highlighted the following tasks for these Specialist nurses: undertaking health assessments (children in foster care with complex issues as identified via a local referral process – Western Trust; young people coming into residential care – Western, Southern and South Eastern; young people in the Frontline Assessment Scheme); attending LAC review meetings and core group meetings (all Trusts); sitting in and chairing different committees; carrying out health promotion activities; supporting teenage pregnancies (South Eastern); and health advice/guidance/signposting social work staff in relation to health queries with regard to a looked after child (Western).

In contrast with the other four HSC Trusts, in the South Eastern HSC Trust, there is also a **therapeutic LAC nurse**. This role involves: mental health screening of all young people going into residential care; support for young people admitted to Beechcroft; training with residential carers and foster carers around mental health issues; and individual work with young people who do not meet the CAMHS criteria for input or they do not want to go to CAMHS or to other services provided. The post is based in SET Connects (i.e. specialist provision of therapeutic services for LACYP), and involves working closely with CAMHS.

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<sup>6</sup> The title of LAC Nurses in Northern Ireland is Specialist Nurse for Looked After Children, but within the Western HSC Trust, the title is Specialist Nurse for Looked After Children and Young People.

**School nurses** attended three of the groups. When children go to school, including those already in the care system, health visitors transfer cases that are either looked after children, child protection, or they are concerned about, to the care of the school nurse. Their role is focused on carrying out home visits and statutory health assessments for LACYP, following these up with health promotion and sign posting. They occasionally attend LAC review meetings. In the Western Trust, the school nurse offers the core school health surveillance programme, which is an overall general health assessment, and following up on any care plans or medical needs. In terms of health assessments, when children are first placed in care, school nurses do a full health assessment on the child and the carers, and signpost on to other services (if needed).

In one of the focus groups, the **Public Health lead nurse** attended. This person manages health issues and family planning, including health visitors. The role involves a series of tasks, including: identifying/setting up support for foster carers; being part of the regional group looking at the health care needs of LAC; being involved in the workshop currently ongoing in the Trust developing services for LAC; having discussions with others regarding delegated authority, trying to be clearer about policy. Regarding family planning, they have developed clear pathways for children accessing family planning and GUM services. In terms of health visiting, **health visitors** visit all pre-school children, with foster children being a priority group. Foster children are visited monthly for the first three months of becoming looked after, and then depending on age, six months after that. Health visitors contribute to their LAC reviews and write reports. In addition, health visitors have a role in supporting foster carers in meeting children's needs. They carry out family health assessments, as well as children's assessments. They are trained in the Solihull approach, the generic 0-5. The public health lead nurse explained how they were trying to get training on Solihull specifically for fostering and adoption. Family support workers are also trained in the Solihull approach, and training is to be extended for social workers, as it is linking with the Infant Mental Health Strategy.

In another focus group, the **Head of Public Health Nursing and ASD Services** also attended the meeting. This person manages public health nursing and school nursing. They are responsible for making sure that children have their immunisations, their development is assessed, their physical and mental health needs are assessed, and parents/carers are supported in meeting their health needs.

A number of different **senior social workers, social work managers and heads of services** also attended the focus groups. They all fulfil different roles while overseeing, monitoring and supporting staff/teams (among other tasks) to ensure the health needs of LACYP are being met. Some of their duties include: attending LAC review meetings; sitting in different groups and committees; chairing professional meetings and resource panels; identifying operational and strategic issues; and signposting. These roles were described as collaborative in nature, as they have to work closely with different professionals and agencies.

An **Education Welfare Officer for LAC** attended one of the focus groups. This service was described as:

*... a bridge between school and social services, in terms of educating schools on the backgrounds of these young people, and putting support in place, and attending a number of multi-seed meetings. And I suppose it is all about maintaining that child's placement, promoting their attendance, making sure they get the most of the school, in terms of developing friendships and doing the best they can in school.*

With the Personal Education Plans, Education Welfare Officers examine social and emotional issues and behavioural problems, and identify what provisions can be put in place for that particular child to address these issues. That would be within school through the North Eastern Education and Library Board provision, and services provided could include a pathway of behavioural support (entitled to some level of one-to-one support and classroom assistance in school, and a placement outside of school to help them with their behaviours), and the school counselling service.

A **Participation and Life Skills Project Worker** also described how the post relates to LACYP within that particular HSC Trust. The post involved providing training for young people (LAC and care leavers), especially for those in residential care, who are more likely to smoke or abuse alcohol at a younger age, by targeting these specific areas. An education drop-in-centre is available in the City where the project is based, where different organisations (eg Nexus, Divert, etc.) come in to provide taster sessions for young people. The work is conducted directly with the Looked After service, receiving referrals from social workers, and visiting residential units to identify areas of need.

Focus groups also included **professionals working within particular services, agencies and organisations** (i.e. mental health services such as CAMHS and LAC Therapeutic, Youthlife, and the Health Improvement Department). These will be described in the following section.

In terms of **the coordination of roles**, professionals in all focus groups believed there was a good level of coordination and interdisciplinarity in their Trust. In the Southern Trust, it was noted that it depended on the role of the professionals, as some roles were Trust-wide and had this capacity, whereas others (e.g. psychologists in CAMHS clinics) did not. In the Southern Trust, as in the Western, the care planning and the LAC Review process were identified as the main forums for professionals coming together in order to identify and meet the child's health and wellbeing needs. Professionals in the South Eastern Trust also acknowledged the multidisciplinary character of LAC Review meetings:



*The care planning process would bring people together and there is a social worker, my understanding is it's a social worker who has got responsibility for the child's case, co-ordinates that. ... And through that, the Looked After review, the chair will chair those meetings on at least a six monthly basis. So that's your co-ordinating role.*

In one of the focus groups, professionals talked about the function of the core groups:

*... there is a time frame after a LAC review or after an initial case conference, within 10 days after, the core group of people that are involved with the young people, will meet to discuss what the support plan is going to look like and who is going to be responsible for what aspects of it.*

The core groups are attended by the core people that take forward the care plan (in terms of the actions that they take to deliver it). Their composition depends on a case-by-case basis, but the social worker would be there, and they could also include the health visitor, school nurse (if school age), CAMHS (if significant mental health issues), Scaffold, LAC nurse, residential workers (if in residential care), the young person (if old enough), the parents or carers (depending on how involved), and school (if significant emotional issues). The frequency of core group meetings depend on the complexity of the cases, and “*some of the settled LAC don't have core groups because they don't need it*”.

In another HSC Trust, a range of other forums were also described, including the care managers meeting (occurring once a month, and once a quarter, the senior social workers get invited along to that); the resource panel (for if somebody is coming into care or if they need links involved); the fostering panel; and the adoption panel.

*There are lots of different panels that various people would cross paths or sit on ... planning or make recommendations around the best interest of children in the looked after population.*

Similarly, in one of the HSC Trusts, there is an education focus group (jointly made up of staff from the Trust and the Education and Library Board), and for residential care, there are six-monthly holistic planning meetings (a big core group where therapeutic plans are reviewed; with two other types of meetings in-between, i.e. core group meetings, and consultation meetings).

In one of the groups, professionals held a very positive view on the functioning of the HSC Trust in relation to multidisciplinary working. They believed that “*relationships with professionals within the Trust are good*”. They also argued that they were starting to have a “more joined up” approach, having strong links between professionals in education, health and family support. In their view, teams are working very closely together and are very integrated, and there is a range of multidisciplinary meetings.

### Interventions/resources

In terms of **mental health service provision**, there is a therapeutic service specifically for Looked After Children in each of the HSC Trusts: SET Connects (South Eastern); LAC Scaffold service (Southern); Therapeutic Team for LAC (TT-LAC) (Northern); LAC Therapeutic Service (Western); and Children’s Therapeutic Support Service (TSS) (Belfast). Professionals in one of the HSC Trusts discussed the origins for these services being set up and their rationale. While CAMHS deals with children and young people in the whole community, these other services specifically deal with the looked after population and those adopted





from care (post-adoption), and the reason is two-fold: *“the need for a proactive service to avoid placement breakdown”* and disruption; and the *“recognition that the needs of the children in the LAC population were different to the general”*. Professionals in another HSC Trust also highlighted the first reason, i.e. maintaining and supporting placement stability:

*... our remit is looking into placement stability, and looking at how can we prevent children from moving around the care system, and help them psychologically adjust to what brought them into care in the first instance, and also settling into a new family and helping carers manage their needs.*

According to professionals in one of the groups, there appeared to be a regional effort in the Department *“to have a uniform baseline of what’s provided”*. Professionals in the focus groups identified the number of staff working in this service, and/or described the work they do:

- SET Connects in the South Eastern HSC Trust employs a clinical lead psychologist, three other psychologists, a mental health nurse, and one social worker (the Therapeutic LAC nurse is also based in this service). SET Connects works with Looked After and adopted children aged 0-18, and provides a range of consultation support for carers, residential staff, adoptive parents, and Social Services. Therapeutic support for young people and their carers, as well as therapeutic parenting support, is provided. Mental health screening and support for the residential assessment model is also available as standard. SET Connects facilitates extensive training across fostering, adoption, residential care, and Social Services. In addition, they play a key role in supporting care planning within the Trust, for example, by representation on Permanence and Pre-Linking Panels. SET Connects was set up in addition to mainstream CAMHS services, and Looked After and adopted children should be included in the mainstream CAMHS service where appropriate.
- LAC Scaffold service in the Southern HSC Trust comprises seven staff (including the specialist nurse for LAC; the rest of staff have therapeutic, psychological, and social work training). They respond to referrals from the system regarding children in foster care or post-adoption. Children in residential care automatically get an assessment with a therapeutic plan and a process to support that. They have a specialist fostering scheme and intensive support fostering scheme, and a post-adoption service. They have also conducted some pieces of research, including a needs assessment in 2006 (which found a high level of mental health difficulties among all 16+LACYP), and they are currently working on a collaborative project with CAMHS looking at pathways into mental health care for LAC and adopted children.
- The TT-LAC in the Northern HSC Trust provides a range of services. They have an involvement in adoption pre-linking, providing a therapeutic input, and provide consultation, assessment, and establish what the treatment will be for LACYP. They have a member of the team on the admission process for residential care, which influences the trajectory of who gets in and who does not. Consultative (non-referral) services are provided for residential care, the post-adoption team, and the specialist fostering team.

- The LAC Therapeutic Service in the Western HSC Trust sees itself as part of the LAC system, supporting it. Children in foster care, at home, or in residential care can be referred to the service by social workers, and they do individual work with them. They support staff in residential homes. Once a fortnight, children's homes have the opportunity to reflect with them on the work they are doing with the children in their care. The plan is to expand training to foster carers.
- The Therapeutic Support Service (TSS) in the Belfast HSC Trust is considered part of the overall LAC Service, offering support, consultation, and direct intervention to children, young people, professionals and carers.

In some focus groups, there was an attempt to differentiate between these services and CAMHS. However, it was often stated that they worked closely with CAMHS, in order not to duplicate any work, and they sometimes referred young people to CAMHS, and vice versa.

The Child and Adolescent Mental Health Service (CAMHS), which operates in all five HSC Trusts, was described in two of the focus groups. CAMHS (as its name indicates) is a mental health service for the general population aged 0 to 18 years old. The service is composed of multidisciplinary teams (social work, nursing, psychiatry and psychology). They carry out assessments, make diagnosis, provide therapeutic treatment, as well as provide consultation to social services and to LAC therapeutic services, if required. It is a tiered model. There are primary mental health services, Tier 1 and 2 (which are being developed). Tier 3 is the middle group, and Tier 4 is intensive treatment. Referrals come from a number of different sources: community paediatrics, LAC Therapeutic, GPs, social workers, A&E departments. When discussing this service, two issues were emphasised: 1) the long waiting lists; and 2) the difficulties in engaging young people with the service:

*If they are classed as an emergency, they are seen within 24 hours, urgent would be seen within ten days, or routine, which is nine weeks. Or because we are breaching, it can be up to about five months at this stage, which is a very long time, which really isn't acceptable.*

*... I think it is fair to say at the outset, one of the key things is, engagement. These are the hard to reach young people, very, very difficult to engage in what we might say, formal therapeutic type needs. So there it is back to how we work together.*

One CAMHS substance misuse practitioner also talked about engaging with young people, and also saw it as crucial for the success of the service that was provided. This person had been in post for two years, working with young people (usually aged 12-18 years old) with significant mental health problems alongside drug and alcohol problems. One-to-one psycho education work was delivered with young people, using the FACE Risk Assessment Tool, to then develop a care pathway. The role consists of helping young people understand the impact of their drug and alcohol misuse on their mental health. It also involves a lot of outreach work to engage young people, and collaborative work with other services (16+, Scaffold, residential units, youth justice, etc.). There is more involvement with 16+ and residential units, but not as much involvement with field social workers. The service is only delivered by one person, so can only manage a small number of cases. Other voluntary agencies are dedicated to these kinds of issues, but there have been many changes lately

with new funding applications. Some organisations have lost funding, whereas others have made applications that require development of new programmes, which leads to new referral criteria. This appears to have led to confusion about what services exist or what existing/new services provide. Through time, it was hoped that this would be rectified with consultation and shared communication.

In order to address young people's mental health difficulties and find a way to engage them, there is a mental health worker within the Southern HSC Trust (different from the CAMHS approach), intended to be more accessible to young people, working alongside a Consultant Clinical Psychologist, but based in the 16+ Service.

Regarding training on mental health, in the South Eastern HSC Trust, there is Mental Health Matters training, which has been delivered five times, and it is driven by CAMHS and the Family and Child Care Interface Group.

Professionals described the policies on the **statutory medicals and the LAC Review process** within their own HSC Trusts, and these expand upon the processes described by social work managers in Phase 1 of the study:

- In the Southern HSC Trust, all first admissions into care from November 2010 have a health assessment completed before the three-month LAC review. This provides a baseline, and a health plan is generated. However, a frontline assessment is completed within six weeks, and it is a very complex and detailed assessment. Health assessments (based on the UNOCINI model) are completed by health visitors and school nurses, or the specialist nurse for LAC. Because of heavy workloads, it can be challenging to complete a very thorough and robust assessment. Assessments are taken to the LAC reviews, and included into the LAC pathways and documentation. There are two different health assessment templates, one for the 0-11 age group, and one for the 12-18 age group. There are also 'About Me' questionnaires, which are used to engage young people in talking about their health. The initial health assessment includes: antenatal history; developmental assessments; immunisation history; attendances at A&E; emotional health and wellbeing (how settled in placement, attachment and bonding, how they adjust at school, behaviours at school, hobbies and social activities, etc.); if they are 12-18 years old then risk-taking behaviours (i.e. smoking, drugs and alcohol), sexual health, independence, etc.
- In the other HSC Trusts, LAC statutory medicals are also done as children enter the system. However, in the Northern HSC Trust, professionals explained how they also had a pilot for screening the emotional health needs and wellbeing needs of children coming into care.
- In the South Eastern HSC Trust, professionals discussed the LAC statutory medicals in terms of its effectiveness, which they believed depended on the children, especially in terms of their age (assessment more thorough for younger children, but young children can feel a bit 'traumatised' by it, as they might be scared of strangers), and the GP (with some being more thorough than others). They also discussed the terminology used, and argued that 'a GP check-up' might be a better term than 'statutory medical', as the

former appears to carry less stigma, while the latter could make the children and young people feel 'different'.

Professionals in the focus groups also described a range of interventions, projects, services and organisations aimed at supporting young people. For instance, in the Southern HSC Trust, professionals talked about different projects. Firstly, they described the **personal development guidance document**, which was created in 2010 initially to deal with sexual health issues for young people in care. Carers are trained to use it, in order to discuss these sensitive issues. This document has been recognised regionally, and it is being considered for development as a regional piece of work. Secondly, in terms of young people's participation in policy-making and practice, the Southern HSC Trust also has a **service user group** (running for about 6 years). This was described as a group of young people that are either still in care (mostly foster care) or have just left care, who are trained by the Trust or in conjunction with community work colleagues and the Education Board, and meet generally once a month to consider issues which impact on them, including health issues. This group helped design and develop a mobile health site for LACYP and the regional website for LACYP and young people leaving care, and were involved in setting up a sexual health clinic for young people.

Thirdly, another service identified was the **Young People's Partnership (YPP)**, which consists of three locally based teams, whose overall aim is to be involved with young people in order to try to prevent them coming into the care system. They work primarily *"with young people who are in particularly traumatic situations perhaps at the stage where they're involved with family support or child protection"*. This involves outreach work, group work, mentorship, parental support, and educational parent groups. The YPP collaborates with CAMHS practitioners and Barnado's, and young people are referred into that service by social workers or through education. Another service mentioned in this particular Trust was the **TASKE (Transition Awareness Skills Knowledge Employability)** team (part of the 16 Plus Service), which is managed by a community work trained person, and includes employability workers, but often deals with health issues. Finally, the last service mentioned in this focus group was the **Intensive Support Foster Care Service**, which is made up of a small number of carers (n=10) that get extra training in a variety of issues, including the ARC (Attachment, Regulation and self-Competency) framework used in residential care, and who get a high level of support from a special therapist that is allied to the Scaffold therapeutic service.

In the Northern and Western HSC Trust, the **Family Nurse Partnership** was mentioned. This is based on validated research about home visiting and the relationship with the nurse. The Family Nurse Partnership (FNP) is an intensive preventive programme for first time young parents. It runs from early pregnancy until the child is two. The Family Nurse Partnership team was first established within the Western HSC Trust since October 2010, and was the first pilot site within Northern Ireland. It was being rolled out in Northern Ireland. It had already also been established in the Northern and South Eastern HSC Trusts, and the other Trusts were moving it forward that year (i.e. 2015).

In one of the HSC Trusts, a voluntary organisation dealing with the mental health of young people in the area was described, as its manager attended the focus group. **Youthlife** is a voluntary organisation that works directly with children and young people who have experienced bereavement and loss from the age of five to 25. They run different projects: a

youth cafe (focusing on prevention, from 12-18 years of age – open at weekend nights from 8 until 11.30pm); residential weekends (a team of young volunteers who have been trained to help their peers - four weekends a year); and a therapeutic programme for younger children in primary schools on bereavement and loss. Referrals are received from CAMHS, the EWO's, from all social work teams, from Gateway, and from parents and foster parents directly. The organisation was funded by the Big Lottery Fund to work specifically with LACYP, and they are now three years into the funding. They created a clinic in the residential units, which is emotional health and wellbeing-orientated. Through that, they get to know the young people, who are engaged through peer volunteers. Because it is their peers who are helping them, it is found to be less intrusive. They have developed an accredited basic counselling skills course for young people who are trained to be peer counsellors. The course is delivered in secondary schools, and they also run short programmes. They are involved in the Duke of Edinburgh awards and many of their courses are OCN.

In addition, the assistant manager of the **Health Improvement Department** attended the focus group meeting in one of the HSC Trusts, and described this regional agency (there is one in each HSC Trust). The Health Improvement Department is mainly commissioned by the Public Health Agency, as well as by each HSC Trust. Its role is to optimise the health (in every sense: physical, emotional and mental) of the population during the life course. It comprises a multi-disciplinary team (staff with nursing, teaching and social work backgrounds). It was claimed that they have developed good working relationships with a range of health and social care professionals. They deliver training to foster carers (e.g. online safety) (through foster care co-ordinators) and other staff, “*skilling them up*”. It is also a strategic service, and aims to influence policy for LAC (e.g. they were involved in writing the children's emotional health and wellbeing strategy for the Trust and the infant mental health strategy). Another role fulfilled by this organisation is sign posting to specific services, as they have a wide network of contacts and work with the community and voluntary sector as well as statutory services.

### Challenges and suggestions to improve service provision

Focus group participants identified challenges to their work, and again these expanded upon the issues that were raised during Phase 1. Professionals talked about capacity issues and a lack of appropriate resources. Regarding this, they revealed that the increase in numbers of LACYP and the rise in the complexity of problems (especially emotional needs) these children and young people entered the system with, coupled with insufficient resources, meant that services were placed under significant pressure trying to address this need:



*To give you some context, we have now [specifies number in 100s] looked after children (in a particular HSC Trust). The ceiling for this [therapeutic service] is usually around [100 lower than earlier figure], so we have a significant rise in our LAC population. They are coming into care with varied needs. We have children as young as five and six with very complex emotional needs so it has its implications for our planning in meeting those needs.*

These capacity issues are summarised below:

- ◆ Only one short-term residential unit (which is often full, and it means that children are directly placed into long-term residential units), and too many young people living in one residential unit:

*... we have very young people coming in in crisis ... to stay in a children's home where there are seven other children who have just come in in crisis, and they are all bringing their difficulties and issues with them.*

- ◆ Lack of fostering placements for children coming into care aged 13 and beyond (unless they had been in care previously);
- ◆ Lack of appropriate placements for children who go in and out of secure units because of mental health issues (sometimes meeting the mental health criteria and sometimes not):

*... the difficulty for so many of our adolescents, where they are in and out and in and out ... because they meet the mental health criteria today and then they are settled tomorrow and they no longer meet the mental health criteria. And then ... we can't find a placement for them, we can't find secure accommodation, and you are left with these poor unfortunate high risk young people who are in trauma or are experiencing a very high degree of distress, and you feel so powerless ... I feel that kind of swinging door scenario is really not helpful for those, and then from the point of view of fostering, you are so kind of restricted 'cos you don't have the resource to be able to provide the service those young people need.*

- ◆ Long waiting lists for health services (e.g. young people could be waiting for 2-3 months to see a paediatrician, or 14-15 weeks to have an appointment with CAMHS) (mentioned in 3 focus groups):

*... when a young person wants to be seen, that's the time for them to talk and the sooner they get seen the better. Otherwise you have emotional things just building up and building up.*

- ◆ Limited dedicated therapeutic budget for LACYP;
- ◆ No CAMHS support for children who do not meet their criteria, but would still need to be treated:

*... not every child necessarily will meet the criteria. So, although you may feel they need that service or would benefit from that service, because it is a good service, and they don't meet the criteria and then the waiting lists are so long... and then you are sort of talking about the sticking plaster effect of it.*

- ◆ Lack of supports for adolescents aged 16 and over (especially those aged 18 and above), falling between paediatrics and adult health services:



*.. there are huge challenges ... where some of our LAC children are in hospital at age 15, 16, they are still children in the widest sense of the word, but they are falling between the two stools of paediatrics and adult health services and we have that dilemma ... I think in terms of that young person, because they were 16+, they were being treated as an adult, the consultant was talking to them or nursing staff, there wasn't the same engagement with carers or the Trust that there would have been had they have been 12, and there were assumptions made about the nature of the young person's condition.*

◆ Shortage of staff in terms of school nurses and health visiting:

*There isn't a lot of detailed one-to-one work done with looked after children at this time, but it is widely recognised that this is a huge gap in Northern Ireland and that there is a role for school nurses, if they had their capacity.*

- ◆ High turnover of social work staff, which impacts on continuity of relationships (mentioned in 2 focus groups);
- ◆ Termination of work with birth parents when the care plan is not to return home due to shortage of resources.

Other challenges faced were related to procedures within the organisations:

- ◆ 'Tricky' interface between Children Disability and Children's Services (some vulnerable children not being able to access the services provided by Children's Disability, as they would not meet their criteria, which are the care plan needs to be settled, and they have to be in a long-term placement):

*... children that we have that are in short-term placement or their care plan remains twin track or ... is not fully set, those children might be for two years unable to access the disability team because of those criteria.*

- ◆ Difficulty in bringing professionals together at LAC Review meetings (bearing in mind that professionals have extremely busy diaries and meetings may be organised at short notice). This being even more the case as the children grow older (and they do not fit in particular tight categories) (mentioned in 2 focus groups):

*As the young people get older, the number of people around the table drops significantly ... when they are over 18, I will have nobody around the table, but me and the social worker ... because the young people invariably do not fit into the categorisations that are around for mental health referrals or for a learning disability, they are maybe on the edge of learning difficulty ... and we have nobody around the table, maybe the police 'cos then there's criminal behaviours.*

- ◆ System management challenges, in that to meet some of the children's health needs, a considerable number of professionals are required 'a lot of the time'. That means that these professionals need to be well co-ordinated and not duplicate work:



*... it's certainly a bunch of stuff that's about re-parenting and providing lots of experiences, very structured experiences, to facilitate a range of developmental targets so achieving that, probably involves quite a lot of people a lot of the time. So one of the challenges of that is system management, having a situation where the young person needs are both identified and understood and formulated, kind of made sense of in some sort of developmental trauma or attachment or whatever it is framework, so that everybody knows what we are at, and it's well-coordinated and there's no duplication, or actually kind of any problems with a lack of clarity ... making sure things are working together..."*

- ◆ Too much social work time spent in administrative tasks instead of meeting/visiting children/young people and families.

Another challenge mentioned (as during other phases of the study) was the difficulty engaging young people in therapeutic/mental health services. The example given below concerns the role developed by a CAMHS substance misuse practitioner:

*I try to provide more of an outreach link in with the likes of 16+ Scaffold residential units youth justice agencies there's a lot more collaborative working in order to engage the looked after children, because they are hard to engage and they go in and out of crisis, and if you don't have that model and don't have that approach, they're gone and with one practitioner, there really needs to be huge investment in the development of it as a service.*

The participants were also asked about their views on what they would do/change in order to improve service provision within their own HSC Trust. Many of the suggestions were related to bringing in more resources or focusing more resources into a particular area:



- ◆ Lowering caseloads and increasing the number of professional staff in health and social care services – thus enabling staff to have the time to build meaningful relationships with young people and families (mentioned in all the focus groups);
- ◆ Extending LAC's services to the age of 25, as they “drop off at 18”, because the services up to then would be “more likely to be looking at them ... in a developmental framework”, whereas after 18, “the services they can access are much more medically-orientated or much more focused on diagnostic criteria”;
- ◆ Increasing the number of foster carers, and starting to offer therapeutic foster placements (something more developed than the intensive support team, carers who are therapeutically-trained) (none in NI and many children that need it);
- ◆ Developing more therapeutic work around contact (with birth parents) and more family-based work;

- ◆ Increasing the resources for therapeutic services for children/young people, as adult mental health services receive considerably more funding (e.g. in terms of eating disorders, there are seven therapists in adult services, and two in CAMHS treating eating disorders, which are more likely to occur at a young age)<sup>7</sup>;
- ◆ Investing more in preventative work for the school age population around relationships, bullying, mental health, drugs, alcohol, smoking, etc., having profiled these children in order to target this work to specific schools, children, etc.;
- ◆ Focusing more on the younger age groups (there appears to be less resources dedicated to them than to older children);
- ◆ Promoting health visiting and family support - there is stigma with being visited by social workers, but no stigma with health visitors:

*I was looking at different models and home visiting is definitely seen as one of the key principles for those hard to engage families and even doing your best in home visits and building relationships to engage them ... There's no stigma about family support people going in, or health visitor, or what not. If you have social services coming knocking on your door, and after a period of time you are known within that area ... Because people just run a mile, they don't open their door and you will find they engage really well with the health visitor. They will go, 'no, you are not coming into my house', but the health visitor can.*

- ◆ Putting more supports (additional resources) in place for children to stay at home. One such support suggested was a designated family therapy service for LAC, as it does not exist, and most children come into care because of a breakdown in family circumstances.

Other suggestions dealt with systemic issues or filling gaps in the system:

- ◆ Establishing a system to collate and record all the information collected in the health assessments by health visitors and school nurses, so this information could be owned by the HSC Trust, referrals could be sped up, and resources could be better targeted. At the minute, it is not possible to find out how many LACYP smoke, self-harm or have been diagnosed with a chronic condition;
- ◆ Change the system so social workers can spend less time writing reports and assessments, and more time working directly with young people:

*... there is something about what the system is driving us to do that is losing sight about where the young person really is.*

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<sup>7</sup> It should be noted that an RQIA review report into eating disorder services is due to be published soon.

- ◆ Working in interdisciplinary social care teams (with a therapist or/and health visitor in each social work team);
- ◆ The courts recognising the expertise of social workers and their assessments, and to cease wasting resources in expert assessments, which often regurgitate what is already in the social work report; and
- ◆ Using a different assessment approach to emotional and mental health needs for the LAC Review process, which is more exhaustive:

*... another thing that I think would be very useful would be for some sort of further developed assessment approach, certainly in terms of emotional and psychological needs, as well as the health needs K model, and feeding into the LAC thing. We kind of have a model for that in residential, but that's a very small number compared to older kids who are in care, and the sort of things that can get missed are things that are kind of below the diagnostic bar. And we also know a lot of our kids have the type of insecure attachment type of presentations that tend to get a bit too suppressed, their emotional responses and all that. Some of them have learned 'you stay out of trouble and you'll be grand', and that sort of keeps you out of trouble for a while until you hit adolescence and life gets really complicated, and by that stage you haven't developed tools for dealing with it. So a lot of our kids get in trouble at that stage, and the sort of trouble that they get into is often ... kind of mental health type of presentation where you get kids that are depressed and self-harming, and increased substance abuse and medicating themselves with substance and all that sort of stuff ... So we might be missing ... those kids. If ... you're wrecking the place, you're more likely to get picked up, if you are subdued and things are going ok ... you might not as reliably be identifying the young person's needs and that might not kick in.*

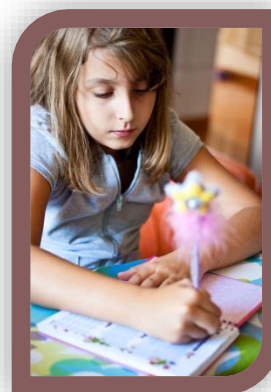


## Summary

- ◆ The different roles that the focus group participants fulfilled as part of their job appeared to be making a contribution to the overall task of addressing the health needs of the LACYP population. Some of the roles covered were:
  - specialist nurse for LACYP (attended the S & W Trusts; there is one in each HSC Trust, except for the N Trust, which is about to be appointed);
  - therapeutic LAC nurse – only one in the SE Trust;
  - school nurses (W, N & S Trust);
  - Public Health lead nurse (W Trust); and Head of Public Health Nursing and ASD Services (N Trust);
  - Senior social workers, social work managers and heads of services (all 4 Trusts);
  - Education Welfare Officer for LAC (N Trust);
  - Participation and Life Skills Project worker (W Trust); and
  - Professionals working in mental health services, and other agencies (all 4 Trusts).
- ◆ The care planning and LAC review process was identified as the main venue for professionals to come together in order to identify and address a child's health needs. LAC review meetings (and core group meetings) were viewed as multidisciplinary, although in some focus groups, professionals recognised that in some cases, they were poorly attended, and that could cause problems. In two HSC Trusts, other forums that brought professionals together were identified (e.g. care managers meetings, resource panels, education focus group, etc.), and one of the focus group specifically argued how they were having a 'more joined up' approach, and working closely together.
- ◆ Regarding mental health, as well as CAMHS (which is a service for the full population of young people up to the age of 18), there are therapeutic services specifically for Looked After Children in each of the HSC Trusts (which are differently named). These services are specially aimed at supporting placement stability and avoid breakdown. Although these services often try to differentiate themselves from CAMHS, the two services work closely together and referrals are often made between the two. Therapeutic services for LAC are provided by multidisciplinary teams, and they tend to offer: assessments, therapeutic plans and treatment, and consultation to foster carers, residential staff, and social services.
- ◆ Professionals pointed at the challenges in meeting the health of LACYP because of capacity issues (caused by an increase in the number of LACYP and in the complexity of cases, plus a lack of resources). These difficulties included: long waiting lists for health services; lack of appropriate services for 16+ young people; lack of appropriate placements for particular children/young people; shortage of staff; high social work staff turnover; etc. Other types of challenges were also highlighted, e.g. difficulties in engaging young people in mental health services; system management issues; too much social work time spent in administrative tasks.
- ◆ Focus group participants offered suggestions on how to improve service delivery. Most of these were around boosting resources, e.g. lowering caseloads and multiplying the number of staff; extending services to the age of 25; recruiting more foster carers and offering therapeutic foster placements; expanding resources for therapeutic services for children/young people; and investing more in early intervention, preventative work, health visiting and family support. Other suggestions dealt with systemic issues, e.g. courts' recognition of the expertise and suitability of social work assessments (avoiding the misuse of resources in expert assessments); establishing an information system to collect LAC health data; working in interdisciplinary social care teams; and use of more robust and exhaustive emotional and mental health assessments.

## Chapter 7: Conclusions and recommendations

This chapter attempts to answer the questions posed in the introduction, particularly in relation to: 1) profiling the health needs of LACYP in Northern Ireland; and 2) exploring how these needs are currently being met within each of the HSC Trusts and at a regional level. This is done by pulling together the main issues discussed in each of the four phases of the study. A list of recommendations is also given, based on the main findings reported here.



### Profile of the health of LACYP in Northern Ireland

Some issues emerged when examining the health needs of LACYP in Northern Ireland, and these are described below. These included the following observations:

- ◆ a large proportion of LACYP appeared to suffer from certain conditions and/or have a disability;
- ◆ an even larger proportion of LACYP displayed or had displayed (at some stage in their lives) mental health and emotional problems, behavioural difficulties, and risk-taking behaviours;
- ◆ despite the previous remarks, a high proportion of LACYP considered themselves and were viewed by their carers as “healthy”; and
- ◆ a few factors were found likely to be associated to a positive health status for children and young people, including: living in kinship care, living in the Northern HSC Trust, and being female. In addition, certain health conditions were more common in particular age groups.

### High proportion of LACYP with long-standing illnesses and disabilities

Almost one third of LACYP surveyed were believed to suffer from a long-standing illness and disability (according to their current carers). This is in contrast with recent official statistics collected by the Department of Health, Social Services and Public Safety in Northern Ireland, which state that 14 per cent (n=297) of the children looked after for more than 12 months were reported as disabled in 2012/13, the same proportion as that for 2011/12 (DHSSPS, 2014b).

There are a number of possible reasons for this discrepancy. Firstly, the data was collected in different ways. The governmental information was collected through an online survey completed by nominated HSC Trust staff, whereas the data in this study was collected directly from carers. Secondly, beyond the classification of ‘registered disabled’, classification of disability can be prone to subjective variation, i.e. what one person considers a disability another may not. However, what is clear is that when carers in this study were asked whether or not the children or young person had a registered disability, just under one in 10 stated that they had. Thus, despite the ambiguity that may surround the classification of disability, it is clear that a sizeable minority of LACYP have a formally registered disability, and that many LACYP have difficulties that their carers consider to be disabling.

### High prevalence of mental health problems, behavioural difficulties, and risk-taking behaviours

In keeping with findings from research studies in Northern Ireland (McSherry et al., 2013; McSherry et al., 2008; Whyte & Campbell, 2008; and Taggart & Menary, 2005), across the UK (Ford et al., 2007; Meltzer et al., 2003; 2004a; 2004b), and internationally (Tarren-Sweeney, 2008; Tarren-Sweeney & Vetere, 2014), high proportions of LACYP scored within the clinical abnormal range, across all the domains of the SDQ (40% for the total score), and/or presented with emotional problems (50%) and depression or anxiety (35%). That is in stark contrast with the general population, as less than four per cent of all children (0-18 years old) in Northern Ireland are considered to have learning or behavioural difficulties, and less than one per cent has mental health difficulties (NI Census, 2011). In terms of risk-taking behaviours, according to their carers, over 70 per cent of young people aged 16+ had taken alcohol, and a considerable proportion had used illegal drugs (36% of 16-17 year olds, and 25% of 18+), or solvents (20% of 16-17 year olds and 8% of 18+), and over 80 per cent had had some sexual experience. Over half of 16-17 year olds had engaged in behaviour that it was harmful to them. These figures raise particular concerns when one considers the high level of stress that foster carers can be under, the relationship between level of carer stress and child/young person behaviour, and the subsequent risk of placement breakdown (McSherry et al., 2013).



### High proportion of LACYP who are considered to be “healthy” (by themselves and their carers)

Despite the gloomy picture painted above, the majority of LACYP were considered to be “healthy” by their carers, but also according to themselves (as it was found both in the telephone interviews with carers and the semi-structured interviews with young people). This indicates that both carers and young people’s notion of health is essentially rooted in the physical aspects of health, with mental health only being considered almost as an afterthought. This is not to say that mental health issues were not deemed important and/or concerning, but that these notions were not immediately tapped into when asked to consider the health of the child or young person. Furthermore, the fact that the remit of the Specialist Nurses for LAC was often considered to be focused on physical health, would suggest that the notion that health is primarily located in the physical, a view held by many of the carers and young people, is also shared by some professionals in the system.

### Contributing factors to ‘healthy’ children and young people

This study also examined a range of factors that appeared to have an impact on the health of LACYP. It was found that the degree of mental health problems, behavioural difficulties, and risk-taking behaviour was related to some extent on the type of placement they were living in, their age, and gender.

These findings are consistent with much of the academic literature in this area (McSherry et al., 2013; Berridge, Biehal, and Henry, 2012; EveryChild, 2011; Wilson et al., 2004). For example, in McSherry et al’s (2013) study of long-term placements for young children in care in Northern Ireland, those children in kinship care were found to have the lowest level of physical and mental health problems, and scored lowest on the SDQ. This is consistent with

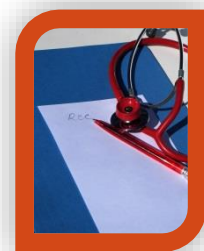


the findings from the current study. This may be reflective of the nature of kinship placements, and the fact that these tend to be less utilised for children with more challenging problems. It is also well established within the academic literature that young people in residential care tend to present a greater degree of problematic behaviour than those in foster and kinship care (e.g. Luke et al., 2014; McCrystal & McAloney, 2010). These differences can be understood in two ways. Firstly, young people in residential care tend to be older than children in foster care and kinship care, and thus are more prone to risk-taking behaviour and challenging presentations. Secondly, many of these young people will enter residential care as the result of a foster or kinship breakdown, and the inability of the Trust to be able to find an alternative family placement as a consequence of their age and placement history.

Multiple research studies have also indicated that females in care tend to display less mental health and behavioural problems than males (McSherry et al., 2013; Tarren-Sweeney & Hazell, 2006). However, as was seen from the interviews with young people, it may be the case that females are internalising their problems (self-harm etc.), rather than externalising them (disruptive behaviour etc.), as males tend to do, ironically making these problems more difficult to identify and consequently address.

### **Practical approaches, services and resources to meet the health needs of LACYP**

Once the health needs were outlined, the other key aspect of this study was to explore how these needs were being met. This generated a range of themes that are discussed in the following sub-sections.



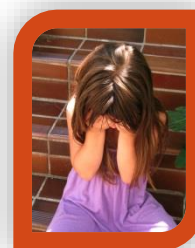
#### **Similarities and disparities among HSC Trusts in their practice**

As might be expected, considering that each HSC Trust in Northern Ireland has a different organisational structure, there were similarities and disparities regarding practice in relation to the approaches taken to meeting the health needs of the LAC population. Regarding the **LAC review process and health assessments**, all the HSC Trusts follow the regional guidance (Vol. 2 Handbook), whereby statutory medical and health assessments are completed for children on admission into care, and at least once every six months when the child is under five years old, or once a year when they are over five. The statutory medical and health assessment are then discussed at LAC Review meetings, held every six months. However, HSC Trusts differ regarding the level and type of assessment they routinely provide to children and families. For instance, in both the Southern and the South Eastern HSC Trusts, in addition to these statutory medicals, at entry to care, comprehensive health assessments and health and wellbeing questionnaires are conducted by the specialist nurse for LACYP, the child's health visitor, or the school nurse. After completing these comprehensive health assessments, health plans are drawn up, detailing the action required to address the needs identified. This information informs the LAC Review meetings. In the Western HSC Trust, health visitors visit all pre-school LAC monthly for the first three months of becoming looked after, and then depending on the age, six months after that. The school nurse offers the core school health surveillance programme (i.e. an overall general health assessment), and follows up on any care plans or medical needs.



The **specialist nurse for LAC** appears to fulfil different roles in the different HSC Trusts. Their task regionally is to attend LAC Review meetings, as well as carry out health assessments of young people coming into residential care. In the Western HSC Trust, the specialist nurse also provides health assessments for children in foster care with complex health issues, as identified through a local referral process. In the Southern Trust, the specialist nurse completes health assessments for LACYP in the Frontline Assessment Scheme, as well as having a small caseload of LACYP that are not engaging with universal health services. The specialist nurse for LAC is considered to focus mainly on physical health. In only one of the HSC Trusts, i.e. the South Eastern HSC Trust, there is also a therapeutic LAC nurse (based in SET Connects, i.e. therapeutic services for LAC), whose main task is to screen the mental health of all young people coming into residential care, as well as provide training for residential carers and foster carers around mental health issues.

As for **mental health service provision**, LACYP in Northern Ireland can access a range of therapeutic and psychological services: Child and Adolescent Mental Health Services (CAMHS); therapeutic services for LACYP (different provision in the different HSC Trusts); the Crisis Assessment and Intervention Team (C.A.I.T) (as part of CAMHS in the Belfast and South Eastern HSC Trust); Beechcroft (regional Child and Adolescent In-Patient Unit based in Belfast); specific services for drug and alcohol misuse, such as Dunlewey Addiction Services; 16 Plus Team (can also offer help); and non-Trust-run services (e.g. DAISY in the South Eastern and Western Trust; HURT in the Western Trust for drug and alcohol misuse; Surestart; Divert; Nexus; Barnado's; Extern; VOYPIC; and the Fostering Network).



The Child and Adolescent Mental Health Services (CAMHS) are available for all children and young people (0-18 years old) in Northern Ireland. CAMHS in the South Eastern area is also managed by the Belfast HSC Trust. The Belfast/South Eastern Community CAMHS include a specialist Eating Disorder Team, the Crisis Assessment and Intervention Team (CAIT), an Addictions Team, and the addiction service Drug and Alcohol Mental Health Service (DAMHS). CAIT provides rapid assessment and intervention to children and young people (5-18 years old) with acute mental ill health, self-harm or suicidal ideation, who are attended by GP, the hospital or an A&E department. There is a partnership pathway with emergency departments for same day/next day assessment. Community CAMHS in the Belfast and South Eastern area have four outpatient teams, offering a range of services, including mental health assessment and specialist therapeutic care by a multidisciplinary team. CAMHS in the Northern HSC Trust are delivered from a range of community settings, and comprise three locality-based teams providing assessment and treatment. CAMHS teams in the Southern HSC Trust operate from three locality-based clinics (at Tier 3). These three teams consist of a psychiatrist, a psychologist, a social worker, clinical nurse therapists and family therapists. There are Tier 2 services in all localities, to which the Tier 3 service provides consultation.

CAMHS provision in the Western HSC Trust includes a primary mental health service at Tier 2 (dealing with mild to moderate mental health problems); a consultation service provided by referral coordinators; assessment and planned intervention with complex mental health problems; and an intensive care management service, providing assessment and treatment for young people with severe psychiatric and psychological difficulties (at Tier 3). Within this

Trust, an Emergency Department/ CAMHS Pathway had been developed and had been operational from 2010. The Northern, Southern and Western HSC Trusts also provide a specialist eating disorder service at Tier 3. Beechcroft, the regional adolescent and children's unit, is the only Tier 4 inpatient service in Northern Ireland, and is located in Belfast. It has 18 adolescent inpatients beds, including two intensive nursing support beds, and 15 children's beds, the cut-off age between the two wards being 14/15 years. Children and young people are admitted to Beechcroft from across Northern Ireland for assessment and management of complex mental health problems, and uncontrollable risk for children and young people who cannot be assessed or safely treated in the community (RQIA, 2011).

In addition, as previously stated, each HSC Trust has specialist therapeutic services for LACYP, with additional investment in these services provided by the HSC Board. These are focused on maintaining placement stability and avoiding placement breakdown. In each HSC Trust, provision of these services is similar but different. SET Connects in the South Eastern HSC Trust consists of a multidisciplinary team, which includes a clinical lead psychologist, three other psychologists (including an art therapist), a mental health nurse, and one social worker. The range of services offered are: consultations/therapeutic support with foster carers, families, residential staff and other professionals involved in the care of a child/young person; co-work with individuals from the network around the young person; direct therapeutic work with the child/young person; and training and group work with foster carers, families and residential staff. The LAC Scaffold service in the Southern HSC Trust comprises seven staff (including the specialist nurse for LAC; as well as psychologists, therapists, and social workers). They respond to referrals from the system regarding children in foster care or post-adoption, and provide all children in residential care with an assessment, a therapeutic plan, and a process to support that.

The Therapeutic Team for LAC in the Northern HSC Trust also provides a range of services: influencing adoption pre-linking; consultation services to residential care, the post-adoption team, and the specialist fostering team; and appraising the admission process for residential care (thus influencing who gets in and who does not). The LAC Therapeutic Service in the Western HSC Trust provides individual work to LAC in foster care, at home or in residential care who have been referred by social workers; and supports staff in residential homes. Finally, the Children's Therapeutic Support Service (TSS) in the Belfast HSC Trust is a psychological service for children and young people in foster care, kinship care, residential care, and adopted from care. It provides: individual psychotherapy, consultations to staff and carers, reflective practice, and training. In the Southern HSC Trust, there is a mental health worker working alongside a Consultant Clinical Psychologist, but based in the 16 Plus team, who is arguably more accessible to young people. Also, in the South Eastern HSC Trust, Mental Health Matters training has been delivered five times to social work teams driven by CAMHS and the Family and Child Care Interface Group. It is unclear from our data if that has also happened in other HSC Trusts.

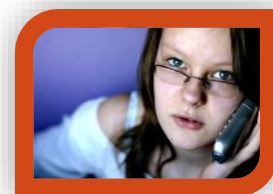
In terms of **health promotion**, HSC Trusts were employing a range of different initiatives and projects, most of which were particular to each Trust. In addition, there is a Health Improvement Department in each of the HSC Trusts. These Departments aim to improve the physical, mental and emotional health of the population during the whole life course. They aim to influence policy for LACYP, as they were involved in writing up the children's

emotional and wellbeing strategy for the Western HSC Trust, and the Infant Mental Health Strategy. Health promotion initiatives discussed in each of the HSC Trusts were:

- ◆ Training for social work staff in residential units (e.g. regarding addictions and legal highs, etc.) (Northern);
- ◆ A training package for foster carers regarding different health issues and conditions (e.g. Foetal Alcohol Syndrome; mental health; First Aid; etc.) (Western);
- ◆ Work of the Intensive Support Foster care Service (Northern and Southern) – a small number of carers that get extra training in a variety of issues, including the therapeutic framework used in residential care, and who get a high level of support from a special therapist who is allied to that;
- ◆ Participation and Life Skills Team (Northern and Western) – provision of training for LACYP and care leavers, especially in residential care;
- ◆ The Personal Development Guidance Document (Southern), provided to foster carers along with training on how to use it with their children/young people, and produced to mainly deal with sexual health (it runs alongside a puberty booklet);
- ◆ A mobile health site being developed for LACYP with health advice and information (Southern);
- ◆ The Health for Youth through Peer Education (HYPE) scheme (Belfast), which is a peer mentoring scheme dealing with sexual health and relationships;
- ◆ The Rainbow Project in Belfast (mentioned by professionals in the Northern Trust), which deals with sexual health for all children on a care order;
- ◆ A pilot for a sexual health clinic (GUM clinic), specially allocated to young people, with young people in care being given priority (Southern); and
- ◆ The Family Nurse Partnership (Western, Southern and Northern) – a long-term project aiming to fully support teenage mothers and help them parent their children. It is being established across Northern Ireland.

### Help-seeking and engagement

Services that consider children and young people as passive recipients of interventions (Bergnehr & Nelson, 2015) are destined to fail, as they are active agents and their engagement is crucial for services to work. Young people (mid-teens to early twenties) have been found to be the age group most likely to suffer from mental health difficulties, but they are also the group less likely to seek help in relation to these concerns (e.g. Burns & Birrell, 2014; Plaistow et al., 2014; Rickwood, Deane & Wilson, 2007; Rickwood et al., 2005). This appears to be especially true for LACYP. In this study, carers, and especially health professionals and senior social work managers, highlighted the challenges of young people not engaging with services; and some young people stated that they and/or their peers did not seek help regarding their health, and offered explanations as to why.



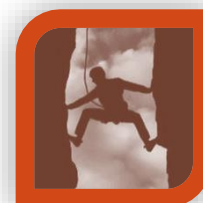
It was found that teenagers and adolescents often refused to have annual statutory medical assessments, mainly because they did not see it necessary (i.e. they go to the doctor when they feel they need to) and because this provision instilled feelings of difference from their peers. In addition, research participants (professionals, carers, and young people themselves) highlighted the difficulties in engaging young people especially in mental health

and addiction services. Some reasons for that were identified, including young people's feelings of stigma, embarrassment, insecurity, guilt, and fear (to open up and to enter the building), which prevented them from seeking help and attending appointments; as well as their inability to recognise (or their capacity to ignore and underestimate) a particular problem (e.g. depression or taking drugs); and the deterrent of knowing that they will have to wait for a long time for the service, due to long waiting lists. Similar themes (e.g. fear of the unknown, partially due to limited advance information; and lack of accessibility and children-centeredness) emerged in a qualitative study of children referred to CAMHS and their parents/carers (Bone et al., 2014). In another review of LACYP in Northern Ireland, young people also referred to the stigma of seeing a mental health professional, as well as their perceptions of not needing to do so, or not wishing to talk (Mullan et al., 2007). In addition, in our study, young people often employed different coping mechanisms to deal with their mental health (e.g. writing it down, watching funny videos, or having a busy social life). However, most young people sought help from carers and family, and in a lesser extent, friends and partners.

Mental health and addiction services were often regarded as not able to engage young people, because they were not taking the time to encourage and reassure them, making them feel comfortable, and “pull them gently into the process”. Carers were concerned for young people (especially those in residential care) who needed urgent help but had refused these services, and they felt that no effort was being made to engage them. The solution often given was more outreach work. Other suggestions were: to make services more accessible, in terms of being in the local area, and being more flexible and “less formal”; and professionals taking the time to know the young person and establish a positive relationship.

### Difficulties in accessing services

A considerable number of LACYP appear to have difficulties in accessing the services they need. This can be due to timing issues (long waiting lists, difficulties in getting a referral, etc.), locality issues (no local services available, having to travel, etc.), getting the appropriate service (not always the case), and a lack of information available of what services are available and where to ask for help.



Within all the HSC Trusts, long waiting lists for services, especially for mental health services, was a recurrent problem, identified in all the phases of the study. For instance, professionals in the Phase 4 focus groups pointed out that children/young people could be waiting for 2-3 months to see a paediatrician, or 14-15 weeks to have an appointment with CAMHS; and carers explained how sometimes they never received the service at all. The importance of receiving the right service at the right time was highlighted by social work and health professionals, carers and a young person. If the service is not provided when needed, it can then be too late for the service to work (as the level of need has multiplied), the young person might have had to look for immediate short-term help somewhere else (metaphorically referred to as sticking a plaster on it), or/and the young person might not be ready to avail of the service (at the time it is finally offered).

Another barrier to accessing services was difficulties in getting a referral in the first place. This issue was outlined by carers and a young person. Sometimes, this could be due to staff

turnover (which slowed down the time to put actions in place to meet child's needs), or the efficiency of particular social workers or the social work team that the child/young person had (in terms of their ability "to fight for" the interests of the young person, or their ability to recognise mental health, behaviour or emotional problems).

The availability of local services and travelling times to specific services were also outlined as another difficulty to accessing supports. This was a particular issue for LACYP that did not live in the Belfast HSC Trust, and especially for those living in rural areas, far from any city, as well as for those that had moved HSC Trusts or jurisdictions. These children/young people had to travel long distances to access a service, taking them out of their own communities. This has implications for the effectiveness and responsiveness of the service, as well as for the young person's engagement.

Carers, professionals and even some of the young people sometimes queried about whether LACYP were getting the appropriate service at the right time. Sometimes, it was argued that LACYP had too many appointments and were seen by a wide variety of health professionals, e.g. paediatricians, GPs, dentists, health visitors, counsellors, psychiatrists, LAC nurses, school nurses, etc. Professionals also mentioned challenges in placing the young people in the appropriate resource, often due to the difficulties in assessing their mental and emotional wellbeing (e.g. lack of appropriate indicators and training for social workers in doing so), as well as gaps in service provision (which are going to be discussed in a following section).

Finally, carers, especially kinship carers new to fostering, and some young people outlined a lack of information on the services available to them. They highlighted the need to provide the right information to young people and parents, so they can avail of the support they require and their needs can be met.

### What works well

Some positive factors were identified by professionals as currently helping in the capacity of meeting the health needs of LACYP:

- ◆ LACYP being given priority status in their referral to particular services;
- ◆ Professional cooperation, especially obvious when professional teams are sharing buildings;
- ◆ Organisational structures that aid communication and coordination between different services/departments/professionals;
- ◆ Delegated authority given to foster carers;
- ◆ Young people participating in meetings and in dealing with their own health needs;
- ◆ Good quality of foster placements;
- ◆ Health promotion initiatives;
- ◆ Targeted mental health services (LAC Therapeutic teams in each Trust); and



- ◆ Training around health issues for social work staff, foster carers<sup>8</sup>, and residential staff.

Young people also identified factors that helped, including the following:

- ◆ Talking to somebody else when not feeling mentally well;
- ◆ Being involved in sports clubs and other community activities, and “keeping busy” or having a good “social life”;
- ◆ Social workers keeping in touch with the young people regularly but letting the young people decide how/when they should contact them (without pressurising them or making them feel ‘nagged’);
- ◆ Getting advice and support from particular health professionals (including counsellors);
- ◆ Attending particular courses in youth organisations; and
- ◆ Placement stability and a positive caring environment.

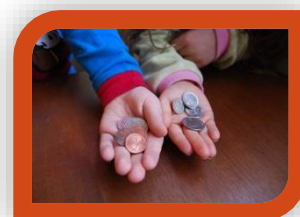
Indeed, the last item in the list has been found to be particularly relevant in the literature (it was in fact mentioned in different ways by professionals, carers, and the young people). Unsurprisingly, it is argued that “the quality of the child’s relationship with the caregiver is key to their well-being” (Luke et al., 2014, p. 112). Carers also identified other factors that helped them meet their children’s/young people’s health needs, including the following:

- ◆ Their own constant reassurance, encouragement, and affection towards the LACYP they were caring for;
- ◆ Young people having somebody whom they feel comfortable enough to talk to (particularly about sensitive issues, e.g. sexual health);
- ◆ Having delegated authority (particularly in terms of being able to take decisions regarding child’s health);
- ◆ Support services from particular community and voluntary organisations, such as Fostering Network, VOYPIC, NSPCC, Barnado’s and Extern, but also statutory services such as LAC Therapeutic or SET Connects, the 16+ Team, or CAMHS; and
- ◆ Having social worker or other professional (who knows the details of their particular case) immediately accessible, and having quick access to the services required.

### Gaps in service provision

A number of gaps were identified regarding service provision for LACYP. Many of these had to do with a lack of resources and capacity issues, but others were concerned with the organisation and coordination of services. From the interviews with carers and the focus groups with professionals, a number of challenges and gaps in service provision emerged, including:

- ◆ A lack of medical information being received when the children/young people had been placed. Some carers felt that medical information (e.g. diagnosed behavioural problems, conditions, etc.) as well as background information on the child (in terms of the past




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<sup>8</sup> The evidence on the effectiveness of training and support for carers on the health of LACYP appears to be mixed, and further research is needed (Everson-Hock et al., 2011).



traumas, etc.) would have been useful at the start, particularly as certain issues were having an impact on their families, which had been unforeseen. It would also have avoided them having to request basic information, such as the child's GPs name or whether immunisations were up-to-date or not. However, it was also recognised that some issues were not known to social workers either, and had only come to the surface sometime after they had been placed. Kinship carers were more likely to already know the child and to feel less the need of background information, and residential care workers were more likely to be satisfied with the information received.

- ◆ A lack of information in relation to delegated authority and the decisions that carers can or cannot take across the HSC Trusts. This term appeared confusing to a large number of carers, with many misunderstanding what it meant. Practice seems to be very varied within and among HSC Trusts, but in general, kinship carers were less likely to have delegated authority than foster carers, as birth parents were often still very much involved in the lives of the young people.
- ◆ A lack of information regarding the services that LACYP and carers can avail of. This was especially true for kinship carers, and more so for those who were new to fostering. This gap was outlined not only by carers but also by young people.
- ◆ High level of social work staff turnover, with some children having had a large number of social workers in the space of a couple of years. This issue was considered troubling by carers and professionals alike for a number of issues, the main one related to the building of trust and the implications of this for the social worker-young person relationship. As it can be expected, young people who had many social worker changes were less likely to invest in a relationship with any of them. In addition, health and social care professionals also outlined a shortage of staff in terms of school nurses and health visiting.
- ◆ Lack of availability of social workers. Some carers found it challenging or even nearly impossible to speak to their social worker when they needed to. This was particularly troubling in emergency situations. Young people highlighted the need for social workers to take time to know them. In this respect, professionals argued that too much social work time is spent in administrative tasks, instead of meeting/visiting children/young people and their families.
- ◆ Unreasonably lengthy waiting times for specific services, especially mental health services. This has already been touched on in the previous section regarding accessibility of services. It was a recurrent criticism heard in all the phases of the study, by carers, professionals, and young people alike.
- ◆ Lack of appropriate support from schools. In some cases, carers had had particular negative experiences with the education sector, in terms of professionals not displaying a supportive role, but an unhelpful one, towards children with especial difficulties (e.g. autism or other behavioural issues), and carers having to 'fight' with schools to get the supports needed.



- ◆ Lack of breadth in statutory medical health assessments. Some carers felt it was a ‘tick box’ exercise, with GPs not being thorough enough. Oftentimes, the quality of the assessment seemed to depend on the individual doctors.
- ◆ Not enough focus on early intervention and long-term provision of services; and a lack of out-of-hours support (particularly in issues to do with mental health, alcohol and drugs). Carers and professionals (as well as young people) believed the timing of services were crucial, particularly regarding mental health. Professionals also indicated a service gap for young people when discharged from Beechcroft, and a lack of appropriate placements for children who go in and out of secure units because of mental health issues.
- ◆ Inadequate approach of CAMHS for engaging young people. This has already been discussed in the previous section in relation to engagement. Carers felt that CAMHS needed to be a more proactive service in order to work properly. Professionals also highlighted the difficulties of engaging young people in mental health services, and argued for the need to do more outreach work.
- ◆ Lack of communication and coordination between services and professionals, and a lack of consistency in terms of having just somebody involved throughout. Professionals indicated the existence of system management challenges, in that a considerable number of professionals are often required to meet the needs of a particular child, which means that these professionals need to be well co-ordinated and not duplicate each other’s work. RQIA (2011) already recommended that *“CAMHS should be fully integrated within the wider network of children’s services across the trust to ensure better links and communication across services”* (p.135). Young people pointed at a lack of communication between health professionals, which meant that they had to describe their problematic history over and over. Carers also highlighted that professionals did not often share information among themselves in relation to children with very complex needs, and slowed the process down. Two solutions were suggested: 1) a central point of referral for professionals: *“something central where a child was referred and went into a central hub and professionals looked up at all this information and maybe decided – we’ll send him to such and such”*; and 2) LAC nurses to have a much more coordinating role, as *“link people”*, who could enable LACYP to access services quicker. In this respect, professionals also pinpointed at the lack of a centralised information system storing all the health information gathered by different professionals about each child in the care system. In addition, they indicated that there is also no regional policy and procedure for transferring/sharing health information when a child moves HSC Trust.
- ◆ Lack of a regional assessment framework (including key performance indicators) for which to assess the social and emotional wellbeing of children in care. This gap was outlined by social work practitioners. In this respect, carers talked about professionals not listening and acting on what carers told them regarding what the child needed, especially in the case of mental health issues. Carers explained that sometimes children who did not overtly show any problematic behaviours or “did not fit a box” were not seen by professionals, despite the fact that carers felt they needed help, as social workers did not listen to or took their concerns seriously. Because of that, problems became seriously worse, and the young people were not offered help until it was too

late. Similarly, health and social work professionals also talked about the lack of CAMHS support for children who do not meet their criteria, but would still need to be treated. In that sense, the RQIA review of CAMHS (2011) recommended the role of the Primary Mental Health Worker to be developed to provide relevant support and advice of Tier 1.

- ◆ Gaps in service provision for carers and their families (with carers' birth children being overlooked), including not enough respite care for carers of children with severe complex needs. This was outlined by carers. However, professionals also identified a gap in service provision for children with complex needs, requiring 24/7 care, and argued that too much is expected from the carers looking after these children. In this respect, carers also suggested support groups for foster carers, summer schemes for children, courses for carers delivered in the mornings (when children are at school), and events to bring together young people and carers.
- ◆ Lack of services for adolescents aged 16 and over. This was specifically mentioned by professionals, particularly in relation to mental health services, and carers specifically outlined a lack of support for young people with behavioural problems or disabilities aged 16 and above. Young people themselves also had a sense of a lack of mental health and addiction support services, as well as not enough local sports facilities, schemes and programmes to be active, and local drop-in centres. Research in England has also indicated that statutory mental health services in particular are not geared towards young people aged 16-19, and there is a lack of formal transfer arrangements from child to adult services (Richards & Vostanis, 2004; Vostanis, 2005).
- ◆ Lack of therapeutic services for children under the age of 11 (especially help in terms of behavioural difficulties for young children), and lack of services for young people with ASD. These gaps were outlined by social work practitioners.
- ◆ No inpatient treatment (i.e. detoxification facilities) for young people's drug abuse in Northern Ireland, as well as no regional secure mental health facility and assessment centre for children with risk-taking behaviour and severe mental health issues. These gaps were outlined by social work professionals.

## Summary

- ◆ Almost one third of LACYP surveyed were believed to suffer from a long-standing illness and disability (according to their current carers), and approximately one in 10 were registered disabled.
- ◆ Many LACYP in the study sample displayed behavioural and mental health problems. Thus, high proportions scored within the abnormal range across the different dimensions of the SDQ, which matched the percentage who had been diagnosed with behavioural problems (40%). The LACYP in the sample also included large proportions of children with diagnosed emotional problems (35%), and depression or anxiety (21%).
- ◆ Despite this, a high proportion of LACYP considered themselves and were viewed by their carers as 'healthy'. This indicated that 'health' was primarily viewed as representing physical health, even when mental health problems were apparent.
- ◆ Placement, age and gender were found to be significantly related to health profile.
- ◆ Similarities and disparities among HSC Trust practices were found. Regionally, statutory medical health assessments were being carried out for LACYP in similar procedures. In all HSC Trusts, LACYP had access to CAMHS (although services differed in the different areas) and to targeted mental health services (but they also differed in the different Trust areas). There were also a range of health promotion initiatives in each of the Trusts.
- ◆ Young people's engagement with services, particularly mental health services, was considered challenging regionally and by professionals, carers and the young people themselves. Some of the reasons for that were outlined, and respondents gave different suggestions on how to engage young people.
- ◆ Many LACYP had difficulties in accessing the services they needed, due to a range of issues, including: long waiting lists; lack of local services available; difficulties in getting the appropriate service; and a lack of information available.
- ◆ Some positive factors were identified as currently helping in the capacity of meeting the health needs of LACYP, including: priority status for LACYP in their referral to particular services; professional cooperation; delegated authority for carers; placement stability and good quality foster placements/positive caring environment; young people being able to open up to somebody; support services from particular voluntary and statutory organisations; and training around health issues for carers.
- ◆ Gaps in service provision were also identified, some having to do with a lack of resources and capacity issues, but others concerning the organisation and coordination of services. These gaps included: staff turnover, lengthy waiting times for services, lack of information, and lack of communication and coordination between services and professionals.

## Recommendations for policy and practice \*

1. Northern Ireland may benefit from the development of **bespoke and regionally-specific statutory guidance** on promoting the health of looked after children, as used in England (DCSF and DH, 2009). Such guidance would delineate the roles and responsibilities of HSC Trusts and voluntary organisations in relation to the health promotion of LACYP, and in principle assist the range of professionals involved to efficiently and effectively meet the health needs of this vulnerable group. Furthermore, the Volume 2 Handbook of Policies and Procedures (1998) is in urgent need of updating to reflect subsequent changes in legislation, policy, and procedure.
2. A **central information system** should be established, in which all health and social care professionals record the information for a particular looked after child/young person, and where services provided for him/her are coordinated. Such a system would facilitate cross-Trust information-sharing to ensure those LACYP placed outside their own Trust do not experience delays in accessing or being referred to appropriate services, as LACYP with more complex needs may be more likely to experience increased placement instability. In addition, this system would support the establishment of more targeted policies and services for the LACYP population. This is important as many carers received very little or no information when the child/young person was first placed; and professionals and carers highlighted a lack of information-sharing and coordination among professionals and services.
3. **Placement stability and good quality placements** emerged as key factors impacting the health of LACYP. Placements need to be well supported, particularly when children have complex needs. The current findings suggest that this was not always the case, thus sufficient resources need to be targeted to **supporting foster families** to avoid placement breakdown.
4. More emphasis should be placed on **prevention**, for example targeting supports at vulnerable parents on the edge of care, and **early intervention**, for example early screening of young children entering care to pick up on emotional vulnerabilities, or providing intensive supports to carer when children are in the teenage years and relationships begin to come under strain.
5. More effort should be made for **mental health services to engage young people**, making services more locally accessible, reducing waiting times, providing more outreach work, extending the upper age limit to 21 (and possibly older), and with professionals taking more time to get to know the young person and establish a relationship with them.

6. Regarding the statutory medical health assessments, **more comprehensive tools** should be used, and particular attention should be paid to mental and emotional health (especially for young people aged 15 and over). Consideration should be given to changing the terminology, so the stigma associated with them is removed, e.g. defining this as a 'health check-up'.
7. Greater emphasis should be placed on **flexible outreach services for hard-to-engage young people** and discrete groups (e.g. children with complex needs, female LACYP with internalised behaviours), and there should be ease of access for self-referral (e.g. specific helpline number, named contact person).
8. The finding that 'health' is primarily understood by many carers and young people to mean physical health, rather than also encapsulating mental health, should be factored into any **future health promotional work**, and also professional training.
9. Practice regarding **delegated authority needs to be consistent regionally**. Guidelines about delegated authority should be clarified and consistently implemented across Northern Ireland, taking into consideration the different particularities of each case.
10. Greater effort should be made to ensure that LACYP are provided with **tailored and targeted services** to meet their particular health needs. A broad brush approach to health promotion for LACYP as a whole is inappropriate. It is clear from the findings of the study that there are a number of discrete groups within the LACYP classification, for example older male teenagers in residential care or young females in kinship care, which have quite distinct and different health needs, with varying resource implications.



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## Appendix 1

### CARER TELEPHONE QUESTIONNAIRE

(To be completed prior to commencing the interview)

Date of telephone interview: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

Participant ID: \_\_\_\_\_

Date of birth of LACYP: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

Placement status:

Gender: Male / Female

Ok, so now that you've consented to take part, I'm going to begin the questionnaire. The first few questions will provide us with some background about the child or young person. Please remember to answer these questions about the child or young person I identified at the start of this phone call.

1. **What is the child's ethnicity?** (White Irish, White British, Traveller, Mixed ethnicity, Asian, Black, Chinese or other)
2. **What are his/her religious background?**
3. **Do you know the legal status of the child?** (probe: Care order [interim or full], Freed for adoption, Residence Order granted, voluntary accommodated, detained for child protection [police protection, emergency protection order, child assessment order], Residential Care Order, Secure Accommodation Order, youth justice legal status [on remand or committed for trial, detained under the Police and Criminal Evidence Act, Supervision Order])
4. **Confirmation of placement: Can I confirm that the child is (see placement status above)?**
5. **Do you know the reason the child was referred to Social Services for this care episode?**
6. **How long has the child been in care?**
7. **How long has the child been in your care?**
8. **Are you aware of the number of placements the child has had?**
9. **Are you aware of the number of times the child has been in care?**
10. **Is the child registered with a GP?**

First of all I would like to ask you questions from two questionnaires which are routinely used with children and young people to assess health. I would like you to answer these questions about the health of the child or young person that this interview is focussed on. Not all of these questions will be applicable to every child or young person but we are asking the same questions of all carers.

- 11. Listed below is a set of statements which could be used to describe this child's behaviour. For each item, please state whether it is Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of the child's behaviour over the last six months or this school year.**

	Not True	Somewhat True	Certainly True
a. Considerate of other people's feelings .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b. Restless, overactive, cannot stay still for long .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c. Often complains of headaches, stomach-aches or sickness .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d. Shares readily with other children (treats, toys, pencils etc.) .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e. Often has temper tantrums or hot tempers .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f. Rather solitary, tends to play alone .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
g. Generally obedient, usually does what adults request .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
h. Many worries, often seems worried .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
i. Helpful if someone is hurt, upset or feeling ill .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
j. Constantly fidgeting or squirming .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
k. Has at least one good friend .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
l. Often fights with other children or bullies them .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
m. Often unhappy, down-hearted or tearful .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
n. Generally liked by other children .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
o. Easily distracted, concentration wanders .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
p. Nervous or clingy in new situations, easily loses confidence .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
q. Kind to younger children .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
r. Often lies or cheats .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
s. Picked on or bullied by other children .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
t. Often volunteers to help others (parents, teachers, other children) .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
u. Thinks things out before acting .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
v. Steals from home, school or elsewhere .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
w. Gets on better with adults than with other children .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
x. Many fears, easily scared .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
y. Sees tasks through to the end, good attention span .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

- 12. Do you think the answers to these questions may have been different in the past?**

*Warwick Child Health and Morbidity Profile*

## GENERAL HEALTH STATUS

**13. Which of the following best describes the child's overall state of health?**

Very Healthy      Healthy      Not very healthy      Unhealthy

## MINOR ILLNESS STATUS

**14a. Does he/she have minor illnesses such as coughs & colds, runny nose, fever, stomach pains, vomiting & diarrhoea more often than other children of similar ages?**

Yes/No      If 'NO', go to question 15.

If 'YES'

**b. Compared to other children of similar ages would you say he/she had**

A few more      A lot more      Never free of them

**b. You have said that he/she has more minor illnesses than most, can you tell me what he/she has had during the last 12 months?****c. How many separate episodes have there been?**

## BEHAVIOURAL STATUS

**15a. Does your child have any behaviours which are a problem to you and your family?**

Yes/No      If 'NO', go to question 16.

If 'YES'

**b. Would you say this was a:**

Small      Moderate      Big Problem

**c. Can you tell me what the problems are?****d. Have you sought professional help for any of these problems?**

If 'YES'

**e. With whom?**

## ACCIDENT STATUS

**16a. Children have accidents or injuries sometimes. Has the child had an accident in the last year that required medical attention? (i.e. swallowing bleach, having a serious fall, cut or burn, being injured on the road or other type of serious injury).**

Yes/No      If 'NO', go to question 17.

If 'YES'

**b. If 'yes', can you tell me about the accident?****c. Where did the accident occur? (i.e. home, street etc.)****d. Are there any lasting side effects?**

No lasting effects      Doubtful as to lasting effects      Lasting effects

## ACUTE SIGNIFICANT ILLNESS STATUS

**17a. Has the child had any serious illnesses or health problems in the past year that have required active medical treatment?** (serious enough that it required medical treatment)

Yes/No      If 'NO', go to question 18.

If 'YES',

**b. Can you tell me what the illness was?**

**c. Are there any lasting problems?** *Please state*

Doubtful (as to full recovery or 'lasting problems')    Yes, full recovery    Yes, with persistent problems

## HOSPITAL ADMISSION STATUS

**18a. Has the child been admitted to hospital for one night or more, at any time and for any reason during the past year?**

Yes/No      If 'NO', go to question 19.

If 'YES',

**b. How many times have there been?**

One time      Two times      Three or more times

**c. What was the reason for the admission(s)?**

## IMMUNISATION STATUS

**19. Do you think he/she is up to date with immunisations?**

Yes/Unsure      No (due to illness or professional advice)      No (due to parental refusal)

## CHRONIC ILLNESS STATUS

**20a. Does the child/young person have any long-standing illness or disability that has troubled them over a period of time, or is likely to affect them in the future?**

Yes/No      If 'NO', go to question 21.

If 'YES'

**b. Does this illness or disability affect their activities in any way?**

Yes/No

**c. Can you tell me the nature of the illness/disability?**

**d. Does this illness or disability have an effect on your daily activities?**

Yes/No

**e. Does this have a big or a little effect on your daily activities?**

**f. Can you tell me which daily activities are affected? (if any)**



## PERCEIVED FUNCTIONAL HEALTH STATUS

**21a. Do you think he/she has any health problems which will prevent him/ her from leading a normal life?**

No      Doubtful      Yes

If 'YES',

**b. Do you think these health problems will be small or big problems?**

Minor problem      Major problem

**c. Can you tell me what the health problems are and how they will affect his/her life?**

## LIFE QUALITY STATUS

**22. Has his/her state of health caused any loss of quality of life during the past year?**

None      Mild      Moderate      Severe

Remember, not all of these questions will be applicable to every child or young person but we are asking the same questions of all carers.

**22. Which, if any, of the following conditions/disorders has the child/young person had? (If yes, ask if this is a current or a past issue)**

A condition present since birth such as club foot or cleft palate  
 A heart problem  
 Acne  
 Allergies/rashes  
 Any blood disorder  
 Any difficulty with co-ordination  
 Any muscle disease or weakness  
 Any stiffness or deformity of the foot, legs, fingers, arms or back  
 Asthma  
 Cancer  
 Cerebral Palsy  
 Chest infection (e.g. bronchitis)  
 Chronic Fatigue Syndrome or ME  
 Cystic fibrosis  
 Diabetes  
 Dyslexia  
 Eczema  
 Epilepsy  
 Eye/sight problems  
 Food allergy  
 Glue ear or otitis media, or having grommits  
 Hay fever  
 Hearing problems  
 Kidney or urinary tract problems  
 Migraine or severe headaches  
 Missing fingers, hands, arms, toes, feet or legs  
 Obesity  
 Some other allergy  
 Spina Bifida  
 Stomach/digestive problems or abdominal/tummy pains  
  
 Autism (ASD)  
 Bed wetting  
 Behavioural problems  
 Depression/anxiety  
 Eating disorder (e.g. anorexia, bulimia)  
 Emotional problems

Hyperactivity  
Learning difficulties  
Soiling pants  
Speech/language problems

None of the above

**23. Is the child registered disabled?** (a physical or mental impairment which has a substantial long-term adverse effect on his / her ability to carry out normal day to day activities)

Yes/No,

**24. Does the child have a statement of special educational need?** (a formal document detailing a child's learning difficulties and the help that will be given)

Yes/No

**25. Is the child on any medication?**

Yes/No

**26. Has the child/young person ever been expelled or suspended from school?**

Yes/No (Probe for reason)

**27. How many portions of fruit and vegetables (including fresh, dried, tinned, juiced and frozen) does the child/young person usually eat each day?**

0 1 2 3 4 5 More than 5

**28. How often does the child/young person usually eat breakfast on school days?**

Never eat breakfast on school days

Has breakfast on most school days

Has breakfast every school day

**29. Does the child/young person enjoy doing sport or physical activity?**

Yes, a lot Yes, a little No, not very much No, not at all

**30. Is the child/young person a member of a school club or team that involves them taking part in sport or physical activity?**

Yes/No

**31. Is the child/young person a member of any other clubs or teams not connected with their school that involves them taking part in sport or physical activity?**

Yes/No

**32. In the last week how many hours did the child/young person spend...** (Tick one box for each line)

	None	Less than 10 hours	10-20 hours	More than 20hours
Watching TV, videos, DVDs?				
Playing computer or console Games (Playstation, Gamecube, Xbox, Wii, DS, DSi, etc)?				
Doing school homework?				

**33.To the best of your knowledge, has the child/young person ever smoked tobacco?** (At least one whole cigarette, not just a puff of someone else's)

Yes, in the last week  
 Yes, in the last month  
 Yes, in the last year  
 Yes, over a year ago  
 No, never

If no, go to question **37**.

**34.To the best of your knowledge, how often does the child/young person smoke cigarettes now?**

Every day  
 At least once a week but not every day  
 Less than once a week  
 They do not smoke now

**35.To the best of your knowledge, how many cigarettes does the child/young person usually smoke in a week?**

\_\_\_\_\_ cigarettes a week

**36.To the best of your knowledge, has the child/young person ever taken an alcoholic drink** (not just a taste or a sip)? (That means beer, wine, cider, alcopops or spirits like Gin, Vodka, Whiskey)

Yes, in the last week  
 Yes, in the last month  
 Yes, in the last year  
 Yes, over a year ago  
 No, never

If no, go to question **39**.

**37.To the best of your knowledge, has the child/young person ever been in trouble with any of the following because of drinking alcohol?** (Tick one box for each of the people or groups listed)

	Never	Once	More than once
Parent(s)/carers or other family member			
Local people School			
Police			
Friends			

**38.To the best of your knowledge, has the child/young person ever used solvents?**

Yes, in the last week  
 Yes, in the last month  
 Yes, in the last year  
 Yes, over a year ago  
 No, never

If 'No', go to question **41**.

If Yes

**39.To the best of your knowledge, how often does the child/young person use solvents now?**

A few times a week  
A few times a month  
A few times a year  
Rarely  
Not any more

**40.To the best of your knowledge, has the child/young person ever used or tried illegal drugs?**

Yes, in the last week  
Yes, in the last month  
Yes, in the last year  
Yes, over a year ago  
No, never

If 'No', go to question 43.

If Yes

**41.To the best of your knowledge, how often does the child/young person use illegal drugs now?**

A few times a week  
A few times a month  
A few times a year  
Rarely  
Not any more

**42. Has the child displayed any behaviours which you or others would consider harmful to themselves?**

Yes/No If 'NO', go to question 41.

If any issues were identified from questions 34-43 ask

**43. Are any statutory or voluntary agencies aware of these issues?**

**44. To the best of your knowledge, has the child/young person ever had a boyfriend or girlfriend?**

Yes/No

**45.To the best of your knowledge, how much sexual experience, if any, do you think the child/young person has had?**

None  
Small amount (eg: only kissing)  
Some experiences but no sexual intercourse  
Experienced, including sexual intercourse  
(Probe about inappropriate sexual behaviour and sexual abuse if hinted at)

OK, we are on the final section now.

**46.I would now like to know your general impressions about the health of the child or young person this interview is focused on.**

- a) What medical information did you receive when the child or young person was placed with you? (Probe: Did you receive a full health history of the child or young person when they were placed with you? Probe about mental, physical, dental, nutrition, sexual, behavioural, immunisations)
- b) What are your perceptions of the child or young person's physical health needs?
- c) What are your perceptions of the child or young person's mental health needs?
- d) Who is responsible for ensuring that the child or young person's health needs are met? (e.g. you as carer, LAC nurse, GP, social worker, school nurse, health visitor)

- e) Can you describe how the child or young person's health needs are currently assessed and addressed?
- f) How do you think previous and on-going assessments have addressed these health needs? By assessments we mean six-monthly/ yearly medical by a GP.
- g) Have any other health services been offered to the child or young person? e.g. LAC Therapeutic Service, Speech and Language, Nutritionist, Physiotherapist, CAMHS
  - Did you avail of any of these?
- h) What are your experiences of the types of supports that are provided to looked after children and young people to meet their health needs?
  - Do you think that these types of supports actually meet the health needs of looked after children?
  - Were these supports helpful to you as the carer?
  - Do you think that they were acceptable to the child or young person?
  - What services would you want to assist you in your caring role?
- i) As a carer, do you feel you have a say in the services the child receives?
- j) Do you feel that the child has a say in the services they receive?
- k) What is your understanding of the term "delegated authority"?
- l) To what extent have you been informed of your authority to make decisions about the child's health care?
- m) Are you aware of any health needs which have gone unaddressed before the child or young person was placed with you? (Probe about diagnosis, why it wasn't treated and is it being treated now?)
- n) Have any health issues arisen since the child or young person has been living with you?
- o) Has the child been given/ offered any advice about health issues? (e.g. from yourself, birth parent, school nurse, LAC nurse, health visitor, GP) (e.g. about issues such as dental and personal hygiene, sexual health, nutrition)
- p) Do you think the child's health has been influenced by the health of their birth parents? (Probe about issues during contact. Are there any health conditions that the birth parent may have, for example, poor dental health?)
- q) Are their birth parents involved in decisions about their health?
- r) Does the child have any dental health problems compared to other children of similar ages?
- s) **(If the child is 12 years old or over ask)** Do you think that the young person would be willing to take part in a face-to-face interview?

## Appendix 2

### Young person semi-structured interview

1. In your opinion, what does it mean to be healthy?

*Probe: Can you give any examples?*

2. In your opinion, what does it mean to be unhealthy?

*Probe: Can you give any examples?*

3. Do you get any advice about how to be healthy?

*Probe: from schools, carers, birth parents, professionals, friends*

4. How is your own physical health at the moment? Has it always been like this?

5. When you feel physically unwell, do you tell anyone?

*If Yes - who, why them, does it help?*

*If No - why not? What stops you from telling anyone? Do you think you need help?*

6. How is your own mental health at the moment? Has this always been like this?

7. When you feel mentally unwell, do you tell anyone?

*If Yes - who, why them, does it help?*

*If No - why not? What stops you from telling anyone? Do you think you need help?*

8. Do you feel you are getting the help you need to be healthy?

*If Yes - from whom? Does it help? How?*

*No - why not?*

9. Do you think there is enough help available for LACYP to be healthy?

*Probe: Do you know where to get help if you need it?*

10. If you could, what would you do to make health services better for LACYP?

What type of services would be helpful?

## Appendix 3

### Phase Four Focus Group Interview Schedule

1. What are your specific roles and contribution to meeting the physical and mental health needs of LACYP?

Probe: Is there any multi-disciplinary coordination of this work?

Probe: If no, why not?

Probe: If yes, how does this work?

2. What interventions/resources are used to assess and support the physical and mental health needs of LACYP?

Probe: Do you feel that these are effective?

Probe: If no, why not?

Probe: If yes, how?

3. Do you believe service provision regarding the physical and mental health of LACYP can be improved?

Probe: If no, why not?

Probe: If yes, how?