Issues concerning the health of looked after children

There is substantial evidence that looked after children have extensive health needs and disabilities, that they have often missed out on routine health surveillance and health promotion before entry to care or accommodation, but that at present they receive little compensatory care. Harriet Ward, Helen Jones, Margaret Lynch and Tricia Skuse discuss these issues. They look at how frequent changes of placement and poor inter-agency communication exacerbate difficulties in gaining access to adequate health care, especially when children lack an advocate who takes proactive action on their behalf. The Department of Health has responded by issuing new Guidance that sets clear standards for service delivery, encourages children’s participation, and ensures that health assessments recognise inequalities and take a holistic view of healthcare needs. The implementation of the Integrated Children’s System should improve the quality and accuracy of health information concerning all children in need.

New Regulations and Standards for foster care, a National Healthy Care Standard and, on a broader policy front, the National Service Framework for Children should all ensure better access to health care for this population. However, as the authors conclude, such measures will only be successful if inter-agency working can be improved through multi-disciplinary training and better co-ordinated structures for service delivery.

Harriet Ward is Director of the Centre for Child and Family Research, Loughborough University
Helen Jones is Social Services Inspector at the Department of Health, London

Introduction
A number of reports have suggested that social services departments have difficulty in providing effective services for children in need, particularly when they are placed away from home. Not only have several enquiries revealed that children whom statutory agencies claim to protect are sometimes further abused by substitute carers, but there have also been repeated concerns about the numbers in care or accommodation who have unmet health needs, who fail to achieve educational qualifications or who form part of the prison or homeless population in later life (McCann et al, 1996; Butler and Payne, 1997; Acheson, 1998; Bamford and Wolkind, 1988; Wade et al, 1998; Jackson, 2001). In response to these concerns, under the Modernising Social Services initiative, a series of national objectives has been set for children’s services in England. The objectives focus on children’s progress or developmental outcomes. In order to demonstrate how far they are being achieved, Councils with Social Services Responsibilities (CSSRs), as local authorities are now called, are now required to provide data annually on a number of performance indicators, covering such issues as educational achievement, access to health provision and stability of placement for looked after children (Department of Health, 1999a). This paper explores what action needs to be taken at both national and local level to meet part of Objective Four: to ‘ensure that children looked after gain maximum life chance benefits from . . . health care’.

Health needs of looked after children
There is considerable evidence to suggest that many looked after children have substantial health needs, although the absence of clear definitions and the lack of available data make it impossible to ascertain the exact numbers. Findings from the Looking After Children longitudinal study of 242 children who have spent at least a year in care or accommodation in six CSSRs show that:

. . . over half (125:52 per cent) appeared to have an identified physical or health condition of sufficient gravity to require out-patient treatment; a substantial proportion (64:26 per cent) had more than one condition, 37 (15 per cent) having two, 12 (5 per cent) having three and 15 (6 per cent) children having four or more.
The authors estimated that 36 (15 per cent) were likely to have required specialist physical care (Skuse et al., 2001, p 51).

In addition to the 8,000 or so disabled children who, each year, receive an agreed series of short-term placements under section 20 of the Children Act 1989, about three per cent (750) of the rest of the care population become looked after primarily in response to a disability (Department of Health, 2002a). Many other disabled children will also come into the care system for other reasons.

Furthermore, abuse or neglect is the primary factor in the decision to place almost one in two (43 per cent) of looked after children in the care of CSSRs (Department of Health, 2002a). The continuing physical and mental health needs of children who have suffered abuse and neglect have been well documented (Gibbons et al., 1995; Iwaniec, 1995; Buchanan, 1996). We also know that poverty is a key, though often hidden, factor in precipitating children and young people into the care system (Bebbington and Miles, 1989; Ward, 2000), and the relationship between poverty and poor health has been well established (Acheson, 1998; Roberts, 2000).

Mental health needs
There is also a substantial body of evidence to suggest that a high proportion of looked after children have extensive mental health needs, although psychological assessments are not routinely undertaken for this population. Attempts to introduce some measurement of children’s emotional and behavioural difficulties through the Looking After Children Assessment and Action Records mark an initial step towards more routine assessment, but the materials have not been sufficiently well implemented to produce reliable data. Quinton and Murray’s (2002) summary of the research in this area concluded that:

. . . rates of emotional and behavioural problems are very high amongst looked after children and young people and at a level of difficulty nearer to that of children attending clinics than to the general population. (p 282)

Most studies that have tried to estimate the prevalence of such disorders have shown a rate of at least 40 per cent, with problems of conduct being particularly evident (see Lambert et al., 1977; Quinton and Rutter, 1988; McCann et al., 1996; Quinton and Murray, 2002).

Much of the work on developmental outcomes for looked after children is designed to demonstrate how difficulties in one area impact on other dimensions of development (see Parker et al., 1991; Ward, 1995). While poor physical or mental health can be major issues in themselves, they are also likely to have adverse effects on children’s education, their sense of self-esteem and their relationships with peers.

Health surveillance, health promotion and compensatory care
Not only will many looked after children have intrinsically poor health; factors within their family circumstances mean that they are at considerable risk of having missed out on routine health surveillance such as immunisations or regular dental care. Yet they come from a group who are most in need of the protection that such programmes can offer: infectious diseases such as measles or pertussis are more likely to have long-term consequences for children whose general health has been weakened by a poor diet or adverse living conditions; children who come from the poorest families are also more likely to suffer from tooth decay (Acheson, 1998). Most health education is undertaken through schools; poor attendance may mean that many looked after children will have missed out on opportunities for informed discussion on issues such as contraception, sexually transmitted diseases and the likely consequences of risk-taking behaviours such as the misuse of drugs, including nicotine and alcohol.

There is, therefore, a case for arguing that many children in this population will have extensive health needs. A number will also require compensatory health care. Provision should be put in place to ensure that, once they become looked after, immunisations that had previously been overlooked will be given, dental
caries will be treated and attention will be
given to health education.

CSSRs were first required to provide
data on health provision for looked after
children in 2000. Statistics for the 42,200
children who were looked after continu-
ously in England for the year preceding
30 September 2000 show that about two-
thirds (63.5 per cent) had their teeth
checked by a dentist during the year and a
similar proportion (68.6 per cent) were up
to date for their routine immunisations
(Department of Health, 2001). Even
allowing for the inclusion of babies too
young to see a dentist and unaccompanied
asylum seekers with no previous immuni-
sation history, these figures still demon-
strate a shortfall of compensatory care. This point is reinforced by the finding
that developmental assessments were up
to date for only 71.6 per cent of children
under the age of five in this very vulner-
able group. Lack of attention to routine
medical care can later become a cause of
substantial concern, as is demonstrated by
the following comments from an adoptive
parent interviewed as part of the Looking
After Children longitudinal study:

The point I would like to make about
when they were in foster care is regarding
medical care. I feel that they did not get
as good medical care as they do now they
have a permanent family. My son had
some pretty ropey dental work done when
he was in foster care and that tooth has
had to be removed. The dentist said there
had been a pretty bad job done on it. And
[child’s name] hadn’t had her inocula-
tions on time at all and she was in care
from five months old, so there was no
delay excuse for her to not to have had her normal
jabs. The record book was not filled in at
all. There was no real reason for that and
in my opinion there was no real excuse
for it. All medical aspects really were very
unsatisfactory, to be honest. (Skuse and
Ward, forthcoming)

Young people in care or accommodation
are also thought to be more likely to put
their health at risk, both because low self-
esteeam prevents them from caring about
the future, and because they are often ill-
formed about possible adverse

consequences of risk-taking behaviours
(Mather et al., 1997). It is difficult to find
evidence of health promotion on case
files. In the longitudinal cohort study
such data were only available from
Assessment and Action Records, but
these were only completed for about a
third of this age group. These showed that
just 18 (58 per cent) considered they had
received enough health promotion con-
cerning sex and contraception and that 24
(77 per cent) thought they had received
sufficient information concerning the
consequences of tobacco use (Ward et al.,
forthcoming).

Issues such as those identified above
should be raised as part of the child’s
statutory annual medical examination.
However, a number of studies have
demonstrated that these are often over-
looked or, when they do take place, are
frequently resented by the children and
young people concerned (see Butler and
Payne, 1997; Mather et al., 1997). Only
65 per cent of all children looked after
long term on the 30 September 2000 had
received their statutory medical examina-
tion in the preceding year (Department of
Health, 2001). Moreover, even when these
take place, case files often show little or
no easily accessible information concern-
ing the content of the examination or how
it contributes to future healthcare plans.

Why do children looked after not
receive better health care?
The above findings suggest that children
looked after have extensive physical and
mental health needs and may often have
missed out on routine health surveillance,
but that many do not receive compen-
satory care. Why are their health needs
not more effectively met?

Firstly, numerous studies have found
an absence of accurate, up-to-date data
concerning children’s health needs and
their access to health care on social
services case files (see Butler and Payne,
1997; Ward and Skuse, 1999; Skuse et al.,
2001). Programmes designed to standar-
dise the data recorded on case files, such
as Looking After Children and the Frame-
work for the Assessment of Children in
Need recording forms, may improve the
collection of some basic information, but
they are difficult to implement uniformly (Nicholson and Ward, 1999; Scott, 1999; Cleaver and Walker, 2002). Many social workers do not regard it as part of their task to gather accurate data about routine procedures such as visits to the dentist or immunisations, because they see this as a bureaucratic exercise which detracts from their more pressing responsibilities. Nor are they necessarily trained to regard it as important to ensure that children’s health needs – particularly when these are relatively mundane – are adequately met. It is possible that the written evidence from case files provides a much less encouraging picture of the quality of care which children receive than extensive interviews would show. However, given the frequency with which social workers move jobs and children change placements, the written record is likely to provide the most readily available source of information about a child’s experience. When a small child stays long in care (and 50 per cent of long-stay children are aged under five at entry), important information, including medical history, will be lost.

Secondly, there is substantial evidence that indicators of poor health, particularly poor mental health, are not adequately acknowledged. The Looking After Children longitudinal study of case file information found that the placement plan handed to carers at admission frequently gave no indication of apparent difficulties, even when children were displaying clear evidence of disturbance. The following is one of several examples where extreme behaviour patterns were not acknowledged as problematic.

**Girl aged 13**

The placement plans indicated that there were no concerns, despite the fact that this young woman had previously shaved her head and plucked out all her eyebrows and eyelashes. By 1 April 1998 she had been involved in truanting, self-harming behaviours and had attempted suicide. While she was no longer self-harming by that stage, she was still seeing a psychiatrist. (Ward and Skuse, 1999, p 23)

A previous study showed that, while parents insisted on gaining access to child mental health services, carers were often advised that very bizarre or challenging behaviour could be managed with ‘tender loving care’ (Ward, 1995).

The failure to identify emotional and behavioural problems in looked after children is often related to the very low expectations that are generally held for this population. Such poverty of expectation can have serious consequences: it is not unknown for a looked after child to be excluded from school for behavioural problems when the cause is severe and undetected hearing loss. Similarly, evidence from foster carers and community paediatricians suggests that severe developmental delay is often not picked up until a pre-adoption medical.

The Looking After Children longitudinal study also found that children whose emotional difficulties were overtly expressed were more likely to receive specialist support than those whose distress was less obvious. Children with conduct disorders, and those who demonstrated inappropriate sexual or self-harming behaviours, were all significantly more likely to be receiving support from a mental health professional than others with identified emotional and behavioural difficulties (with Fisher’s Exact of 0.004, 0.036 and 0.001 respectively). However, perhaps the most important finding was that, of the 82 children whose case files demonstrated clear evidence of behavioural difficulty, as assessed by psychologists, 51 per cent were not receiving any specialist support (Ward and Skuse, 1999).

Although the above are important factors, a major reason why looked after children often have difficulty in accessing adequate health care is likely to be related to the frequency with which they move placements (see Jackson and Thomas, 1999). The national figures now show that about 16 per cent of looked after children experience three or more placements in any one year. However, there are substantial variations between councils, with a range of between four and 40 per cent of children experiencing this level of instability (Department of Health, 2002a).
Data from the Looking After Children longitudinal study show that children tend to move most frequently in the first year that they are looked after, and that a substantial proportion (9 per cent) have five or more placements during this period (Skuse et al., 2001, pp 24–25).

It takes time for carers to get to know a child and appreciate what their health needs are, especially if only very sketchy background information is passed on to them. It can take months for health records to be sent on from one area to another. Every time a child moves, the chances of information about medical or dental appointments being passed on to new carers are lessened. Children who move from one area to another may be pushed to the back of speech therapy or child and adolescent mental health services (CAMHS) waiting lists. Indeed, many clinicians prefer only to see children once they are established in a stable placement, with the result that some of the most needy children are excluded (Arcelus et al., 1999; Richardson and Joughin, 2000). Constant changes of placement are therefore likely to make it harder for children to access adequate or compensatory healthcare services. Moreover, frequent changes exacerbate the chances of a child’s health history becoming lost, particularly when insufficient attention is given to record-keeping. This not only has a significant impact in the short term but can have long-term consequences when key information disappears. For instance, adopted children can grow up ignorant of a family history of genetic conditions such as muscular dystrophy or Huntingdon’s Chorea.

Limitations of corporate parenting

Findings such as those identified above underline other evidence which suggests that many looked after children fail to access the kind of parenting which gives them advocacy, support and all the advantages which come from carers knowing their vulnerabilities. Indeed, in 1998, a government report into the health of looked after children concluded that:

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

(House of Commons Health Select Committee, 1998, para 265)

Most children living in the community have a parent or parents who automatically, consciously or otherwise, advocate on their behalf to ensure that their needs are recognised and met. This will include accessing routine health care, for example immunisations and regular dental checks, seeking advice for acute illness and making sure that for more chronic conditions diagnosis, treatment and follow-up all take place. In effect, the parent acts as a co-ordinator of their child’s contact with health services and provides a safety net ensuring that planned interventions and follow-up action are organised. In order to meet their child’s healthcare needs parents must have sufficient motivation to find out how the system works, though the input of the health visitor is likely to be invaluable in helping them do this. If a family moves, the efficient handing on of a child’s health care will in part be dependent on the parent taking pro-active action and notifying those involved that a move is planned so that appropriate arrangements can be made to ensure that provision of treatment is not interrupted.

However, when children are looked after they become the joint responsibility of the birth parent, the carer and the council, and it is difficult to ensure that these communication and advocacy roles are adequately fulfilled. A number of studies have highlighted the problems of getting action even when health conditions and problems have been identified. A recent study found that in only 56 per cent of all health reviews were recommendations from earlier healthcare plans achieved, thus highlighting the failure of the corporate parent to advocate for health (Mather and Batty, 2000).

Many of the failures of corporate parenting can be attributed to poor inter-agency communication and understanding.
(Ward and Peel, 2002). Social workers and care staff do not always understand the health needs of children in general and the individual child in particular (DeGates et al., 1995); nor are they always sufficiently familiar with the intricacies of the National Health Service (NHS). On the other hand, doctors and healthcare staff do not always appreciate the impact of inequalities on health, and the need to promote the concept of compensatory care. There is insufficient clarity over the requirements concerning consent to medical treatment when children are not living with their birth families. Staff in all agencies are insufficiently aware of the importance of encouraging children’s participation in decision-making and ensuring that they have information on their health and available services (including health promotion and reproductive health) presented to them in a manner appropriate to their age and understanding.

Finally, the cumulative effect of the many factors which impede the successful delivery of health care to looked after children and young people is their increasing disengagement. A lack of consultation, involvement and choice for young people leads to a poor take-up of those services which are on offer (Latham, 2000). The short-term consequence may be a failure to access preventive health care and sexual health services; in the longer term, young people who have been looked after may display a reluctance to go to doctors generally, which prevents them having the advantages of early diagnosis for potentially serious illnesses.

The government’s response to the research evidence

The growing body of research evidence about the scale and nature of the physical and emotional health needs of looked after children, and the difficulties of meeting them, has informed new policy initiatives for England and Wales to improve the life chances of this population.

A consultation document, Promoting Health for Looked After Children, was issued by the Department of Health in 1999, seeking views on how the delivery of health care to looked after children might be improved and the role of the corporate parent be better fulfilled (Department of Health, 1999b). The 149 responses came from a range of health agencies, social services and other interested parties, including the voluntary sector. The responses were broadly supportive of the policy direction outlined and in agreement on key areas which needed greater emphasis – CAMHS, health promotion, consent and the health of unaccompanied asylum-seeking children. Consultations with children and young people were undertaken as a part of this exercise or conducted separately, and have produced the following broadly similar messages:

- Young people value the idea of seeing and keeping their own health records.
- Young people’s experience of medical examinations is negative: the event is often impersonal, lacking in explanations and without recognisable outcomes for them.
- Policies and procedures should be established to ensure that the requirements of the system do not intrude on the child’s increasing needs for personal privacy.
- Young people feel angry at the failure of professionals to respect the confidentiality of their health information.
- Information and advice that should be covered in health assessments include sexual health, fitness, stress, depression, contraception, drugs, skin and hair care and how to use a GP practice.
- Better information, advice and support should be available concerning mental health services.

Revised Guidance for the health of looked after children

Revised Guidance on the health of looked after children will have been published by the time this paper appears (Department of Health, 2002b). It sets out to address a number of the issues identified above:

- the participation of children and young people in developing services to meet their needs;
The assessment of the child or young person’s health needs, which recognises the inequalities which they have experienced;

- clear standards, both in the design and delivery of healthcare services, including arrangements for clinical governance;

- effective parenting for these vulnerable children.

The Guidance is set within the context of a holistic model of health which takes account of wider determinants and is therefore relevant to a range of agencies, including education and leisure services. It supports the development of an effective and flexible system which will address health inequalities and the assessment of health needs, obtain and manage the information required to produce individual healthcare plans for all looked after children and young people, and enable these to be implemented.

The Guidance therefore provides a set of underpinning principles upon which services should be based and outlines key roles and responsibilities of all relevant agencies. It emphasises both the importance of strategic planning and inter-agency partnerships, as well as the overarching responsibility to provide effective corporate parenting. The aim is to shift away from a healthcare approach based on annual ‘medicals’ towards a more holistic assessment of a child and young person’s healthcare needs. These assessed needs refer to both physical and emotional health and include health promotion.

The regulatory framework has been amended to address some of the barriers identified earlier in this paper:

- The first health assessment must be undertaken by an appropriately qualified registered medical practitioner. A medical examination is not required as part of this assessment but may be undertaken if necessary and appropriate consents are in place.

- Review health assessments may be carried out by an appropriately qualified registered nurse or midwife.

- The review health assessments for children aged 0–5 are now to be undertaken twice yearly.

- Notification of a placement is now required to both the Primary Care Trust (PCT) in the area from which the child is leaving and the PCT area to which the child is moving.

**Implications of the new framework for assessment, planning, intervention and review**

In addition to the new Guidance and to new programmes such as those discussed above, some of these issues will be addressed through the new framework for assessment, planning intervention and review being introduced through the Integrated Children’s System for all children in need who are in contact with social services (see Department of Health, 2001–02). When implemented as part of a computer-based information system, this programme is designed to facilitate single data entry, with items being read across as more intensive services, including being looked after, are required. Any information, once recorded about a child’s health, should thus be retained in the system accurately. As most children who become looked after will have undergone a core assessment, baseline information obtained about a child’s health will be available to inform the first health assessment which, in turn, will be recorded in a retrievable format. Lack of health history and information is one of the biggest barriers to overcome for looked after children and young people, and the new Guidance contains a planning flowchart for collating this. The care planning and review records within the Integrated Children’s System are designed to ensure that needs are identified, actions and interactions and those responsible are specified, and outcomes articulated in relation to needs.

The new system is designed to address all children in need in a joined-up way, as the issues facing those who are looked after may equally be faced by wider groups of those in need in the community, including those requiring protection. Most looked after children and young
people will return to their families in the same communities at the end of their care episode, or move into independence, while a few will be adopted. It is important to put arrangements in place to ensure that outstanding actions from a healthcare plan are monitored once children leave care, by whatever route.

**NHS records**
The majority of looked after children will already be known to local authorities as children in need, indeed about nine per cent will have been placed on the Child Protection Register (Department of Health, 2002c). This means there should be information in NHS systems on their health status and health needs, including any that have remained unmet. In addition, for all children there should be a record of immunisations and child health surveillance. Increasingly, the latter is available on child health computers as well as in the parent-held record. Where it has not been lost, the parent-held record should move with the child into a foster placement. If it has been lost a duplicate should be constructed. If there is no record of immunisations and real doubt about which ones may or may not have been given, for instance for an unaccompanied asylum-seeking child or a child from a family constantly on the move, then local schedules should exist that indicate a catch-up programme to be followed. This needs to be initiated immediately and should not be dependent on permanent registration with a GP. Primary care records should be made swiftly available to the new GP if the child moves, as should records held by the young person and/or carers.

However, currently the quality of health information on children in need is variable and all too often medical consideration of the child where abuse is suspected still goes little further than examining for injuries and other overt signs of abuse and neglect. Administratively within health there has been a tendency to view children on the Child Protection Register and those looked after as two distinct groups; clinicians may not always access previously collected health information even when it is available. The implementation of the Integrated Children’s System is intended to address some of these issues, and indeed one of the aims of the forthcoming pilot is to:

... consider the extent to which identical data are routinely collected by different child welfare agencies, and to explore the potential for sharing information that is commonly held. (Cleaver et al, forthcoming)

**New Regulations and Standards for the care environment**

While the new Guidance sets a foundation for the development of appropriate health services, it must be linked to a wider set of issues if health outcomes are to be improved. Particular attention should be paid to the quality of the care environment. The new Regulations and Standards for foster care, residential care, boarding schools and boarding special schools require carers to be provided with the appropriate support to access health services (Department of Health, 2000). All studies in this area have identified the need for improved training and support for foster carers and residential staff.

In addition to the new Regulations, a National Healthy Care Standard is being developed as a parallel programme to the National Healthy Schools Standard. It will set a national standard for promoting the health of children in care. The Standard will provide social services departments, health agencies and partner agencies with an opportunity to evidence the progress of their work in promoting health. Such evidence will include programmes to enable children and young people to access personal, social and health education. The Standard is being developed through a major consultation exercise with children and young people, staff and carers to ensure that it is both appropriate and deliverable (National Children’s Bureau, forthcoming).

On a broader policy front, the National Service Framework for Children will develop new national Standards across the NHS and social services for children. The new Standards will help to ensure better access and smoother progression in the provision of services for children,
from initial contact with the NHS through to social services support.

Changing attitudes
The introduction of new Guidance, Regulations and Standards can only go so far. If the health of looked after children is to be genuinely improved and the gap between their outcomes and those of their peers in the general population significantly narrowed, attitudes towards the provision of health care to these and other children in special circumstances must change. This attitudinal shift is needed in all professionals who should be playing a part in ensuring access to universal and mainstream services and, when needed, compensatory health care.

Quality Protects nurses and other dedicated individuals can do much to advocate on behalf of and with looked after children and young people. However, without those in mainstream services also taking up the challenge and seeking innovative ways of working, their efforts will be frustrated in many of the most needy cases. For example, a looked after young person who has previously refused to attend for her annual ‘medical’ may welcome the opportunity of discussing her health or emotional worries with a nurse who has been identified as ‘on our side’. However, if a need is identified that requires a referral to another part of the health system, disillusionment will still occur if the young person’s status results in delays or if those dealing with the request are insensitive to the implications of being looked after.

Implications for training
Training is one of the main vehicles for attitudinal change, provided it is delivered effectively. In professions where much is learnt by observing seniors interacting with patients or clients, the attitude and knowledge of the trainer is of particular importance. One of the greatest challenges lies in engaging those long-established practitioners and trainers who have the power to influence newcomers to a field. Professional organisations can also influence attitudes by including topics related to children in special circumstances in their training curricula, examinations, scientific meetings and publications.

Unlike child protection, the needs of looked after children are an area where there is currently little multi-disciplinary training. Yet much could be gained from training opportunities which include health, education, foster carers and even law enforcement. It is increasingly recognised that all staff dealing with children require certain common core competencies (Children’s National Service Framework, 2002). This should include an appreciation of the needs of children in special circumstances. It will be important that this aspiration reaches beyond social work and education and includes those working in primary care, specialist children’s health services and CAMHS. Those who plan, manage and administer children’s services should also be included.

Social workers require training and support in taking on the roles of advocate for and co-ordinator of a child’s health care. This will be facilitated if they and their supervisors have some knowledge of how the NHS should function in relation to looked after children. Foster carers, too, need to be empowered to speak up on behalf of the child.

Service provision
Under the recent NHS reorganisation, the newly created PCTs are potentially in a position to identify the looked after children for whom they are responsible (all those living within their geographical boundaries) and promote and monitor approaches to meeting their needs. The publication of Improvement, Expansion and Reform: The next three years’ priorities and planning framework, 2003–2006 (Department of Health, 2002d), and the associated requirements for Local Delivery plans, will increase the priority of children, including those looked after. The National Service Framework (NSF) for children will support these changes. Even without the NSF, the government response to the Kennedy Report (Department of Health, 2002e) accepts the requirement for all trusts and strategic health authorities to appoint a senior lead for children’s services. Such a person
should be in a position to see to it that
looked after children are regarded as a
priority and that systems are in place to
ensure their health needs are identified
and met. Where universal and mainstream
specialist services are unable to do this
effectively, consideration will need to be
given to the development of a specialised
service for looked after children, such as
camhs team with a specific focus on
this group.

PCTs have responsibility for the health
care of all children living within their
boundaries, as do the local social services
departments. This provides an
opportunity for the two agencies to work
together, both to produce a policy and to
develop services to meet the needs of all
children living in special circumstances.
Implementation of the new Guidance
outlined above should ensure that local
systems are in place, although there will
still be considerable challenges for
children placed out of area.

Better information, new Guidance, new Standards, new structures and
changed attitudes – all are being intro-
duced in response to extensive research
evidence that identifies the obstacles to
delivering services sufficient to meet the
extensive health needs of this vulnerable
population. The extent to which such
innovations succeed in engineering the
changes necessary to ensure that looked
after children ‘gain maximum life chance
benefits from health care’ remains to be
seen, and should be the subject of
continuing enquiry.

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