Health inequalities for looked after children: a summary of the North East regional report on ‘fit for purpose’ arrangements for looked after health services

Introduction
In 2004 a regional audit attempted to assess how much progress had been made since the Department of Health issued guidance for securing the health of looked after children in November 2002. A Capacity Analysis Model was used to help districts develop their services in an equitable manner. A report summarising the audit of the arrangements for the health of looked after children in the north east of England identified a need for improvements in the following areas:

- consistent provision of dedicated designated doctors for looked after children;
- fast-tracking of health records;
- mental health, sexual health and substance misuse screening during initial health assessments;
- dedicated Child and Adolescent Mental Health (CAMHS) LAC service provision;
- care leavers’ access to health and CAMHS support;
- CAMHS training, support and consultancy for carers;
- access to substance misuse and sexual health services;
- policies for substance misuse and sexual health;
- young people’s involvement and feedback on the service;
- Independent Reviewing Officers (IROs) monitoring Individual Health Plans;
- leisure and arts provision for looked after children;
- linkage between education and health initiatives for looked after children co-ordinated within the new Multi-Agency Looked After Partnerships (MALAP) infrastructures;
- annual reporting and monitoring of the LAC health service.

In the north east MALAPs are beginning to co-ordinate improved access to multi-agency provision for looked after children with responsibility for consistent capacity-building. There is a key role for regional agencies to ensure this takes place – eg:

- Strategic Health Authority;
- Regional Public Health Group;
- Regional Substance Misuse and Teenage Pregnancy Co-ordinators;
- Regional ConneXions service;
- Commission for Social Care Inspection;
- Department for Culture Media and Sport.

The new Government Office Regional Steering Group for MALAPs will, hopefully, provide a forum for ensuring greater equality of access to health, educational, leisure and arts provision in this region. Ways of taking this forward across the region should include:

- regional monitoring of MALAP action plans;
- development of a regional multi-agency looked after strategy;
- regional benchmarking to ensure consistent capacity;
- regional co-ordination of children’s MALAP participation feedback and concerns.

It is beyond the scope of this article to elaborate on all areas where improvement is needed. However, Chris Bonnett presents a useful model of good practice that deals with the looked after population in partnership with other mainstream CAMHS in Sunderland.

Making use of scarce resources: psychological assessment of looked after children in Sunderland
In 2003, Sunderland appointed a clinical psychologist for looked after children. This was a very limited resource for approximately 450 children and young people; we

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1 The full report can be accessed online at http://www.dfes.gov.uk/choiceprotects/publications/
discussed various ways of making best use of the post. We decided that one of the psychologist’s roles would be to provide a psychological health assessment service for looked after children (described in Bonnett and Welbury, 2004).

There have been a number of benefits to the psychological assessment. First, it identifies unrecognised psychological problems in the looked after population. Second, it produces a psychological formulation (or explanation) of the problems, their likely causes and their significance within the child’s foster or residential placement. Third, it clarifies the need for extra support to the placement, therapeutic work with the child or their family/placement or for the care plan to be adapted to take account of psychological needs. The psychologist then refers the child on to other mainstream services for therapy or support or liaises with the child’s social worker as appropriate.

Finally, since the assessment is linked to the regular health assessments for looked after children (repeated every six or 12 months depending on age), the psychologist is able to have an overview of the progress of all children in the LAC system, noticing additional needs as they arise and identifying gaps in provision. Mainstream services have found this especially useful; it has provided an opportunity to improve co-ordination between CAMH services and joint planning to improve service provision.

Initially, carers are asked to complete the Strengths and Difficulties Questionnaire (Goodman, 1997) to give an indication of the child’s overall difficulties, and the child is assessed by a paediatrician. If there is any indication of psychological, emotional or behavioural problems she or he is seen for half an hour by the clinical psychologist. If psychological problems are present and the nature of these is clear enough to identify the appropriate service, the child is referred on; where problems are present but unclear the child is seen for two further assessment sessions.

Since the psychologist does not provide further therapy or support after the assessment, it can be done in only six sessions (three days) of clinical time per week. In the seven months between November 2004 (when the 30-minute initial appointment was introduced) and June 2005, 89 children were offered a half-hour appointment. Fifty-eight (65 per cent) attended – see Table 1 for outcomes.

Fifty children (86 per cent of those seen) had unrecognised psychological or mental health needs. Half could be referred on or discharged immediately. For this group, the carers most often needed extra support to help them meet the child’s complex emotional needs, which was provided by the two clinical psychologists. Less than a quarter of children needed to be referred to mainstream therapeutic services for individual or group therapy.

This model highlights a number of issues. A relatively small investment (three days of clinical time) has been sufficient to serve a population of approximately 450 children. In seven months the service identified 50 looked after children who were not receiving the mental health support they required and referred them to the appropriate services. Half of the children only needed to be seen once for this to happen. Most children did not need to be referred for individual, family or group therapy. It was more common for the carers to need extra advice and support or for the care plan to require some adaptation to take account of the child’s psychological needs.

### Table 1

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Referred on after first appointment</th>
<th>Seen for further assessment</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No problems</td>
<td>8</td>
<td>0</td>
<td>8 (14%)</td>
</tr>
<tr>
<td>Referred for therapy</td>
<td>3</td>
<td>10</td>
<td>13 (22%)</td>
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<tr>
<td>Extra support only needed</td>
<td>12</td>
<td>5</td>
<td>17 (29%)</td>
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<tr>
<td>Input to planning</td>
<td>6</td>
<td>2</td>
<td>8 (14%)</td>
</tr>
<tr>
<td>Assessment not completed</td>
<td>0</td>
<td>12</td>
<td>12 (21%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>29</td>
<td>29</td>
<td>58 (21%)</td>
</tr>
</tbody>
</table>

References

Bonnett C and Welbury J, ‘Meeting the mental health needs of looked after children: an example of routine psychological assessment’, *Adoption & Fostering* 28:3, p 81–82, 2004