



# Health and Wellbeing Research: Looked After Children and Young People

**Blackburn with Darwen**

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## EXECUTIVE SUMMARY

### INTRODUCTION

The number of looked after children in England continues to increase. Children who enter care often have lifestyles characterised by poverty, poor parenting, abuse or neglect. Evidence shows that looked after children have poorer health outcomes and lower levels of educational attainment than their peers; therefore the health and wellbeing of looked after children is a priority issue for public health.

A looked after child is defined as someone who is under the age of 18 and:

- is provided with accommodation for a continuous period for more than 24 hours
- is subject to a care order; or
- is subject to a placement order

In Blackburn with Darwen (BwD), latest figures show that at the end of December 2014 there were 307 looked after children and young people in the care of the local authority, with half of these residing out of area. A number of statutory organisations commission services to support looked after children and young people (LACYP) within the Borough. The 2014 BwD Annual Health Report for Looked after Children identified the ongoing progress that has been made to ensure that the health needs of all LACYP are addressed, and that an up-to-date health plan is produced following assessments. In order to further inform the delivery of service provision to support LACYP in BwD, the Centre for Public Health (CPH), Liverpool John Moores University, were commissioned to undertake research to identify gaps and make recommendations for improving health and wellbeing for LACYP in BwD.

### METHODOLOGY

A comprehensive research framework was implemented to inform the development and delivery of services for LACYP in BwD. The key focus for the research aims were to: describe the epidemiology of health outcomes for LACYP in BwD, identify gaps in current service provision, and assess the quality of service experienced by LACYP. A mixed-methods approach was used to enable the triangulation of a range of qualitative and quantitative evidence. Specifically, the following methods were used:

A **rapid systematic literature review** was conducted to provide evidence on identifying, monitoring and evaluating health, emotional and social outcomes of LACYP; access and suitability of health services for LACYP; effectiveness and acceptability of interventions to improve the health and wellbeing of LACYP; and interventions with short and long term impacts on health.

**Logic modelling** was implemented to explore the frameworks and processes in place in BwD to enable the routine monitoring and identification of health, emotional and social outcomes. The logic model was developed upon completion of engagement with stakeholders, and used to identify current activities, outcomes, outputs and gaps.

**Local data and intelligence** on LACYP was reviewed and analysed. This included data taken from Protocol (the system used to record LACYP information in BwD), the Youth Justice Service (YJS) and Lifeline. Receiving data on LACYP for analysis was dependent on partner engagement with the research project and availability and accessibility of data. Additional data to enable analysis of health outcomes were unavailable. It was therefore not possible to compare outcomes with the wider population of children and young people in BwD.

Finally, **qualitative methods** were used to gather evidence regarding knowledge, perceptions, attitudes and experiences of the LACYP with a specific focus on health and wellbeing. A range of interviews and focus groups were undertaken with twelve children and young people in care, four children living in residential care homes, five care leavers and three children and young people placed outside of BwD. Interviews were also undertaken with six foster carers and nine professionals.

## FINDINGS

### HEALTH STATUS OF LACYP

LACYP in BwD appear to have a good understanding of health and the importance of a healthy lifestyle. LACYP primarily viewed health in terms of nutrition and physical activity, although happiness and stability was discussed by some as an important contributor to health. No LACYP and few carers or stakeholders discussed alcohol, drugs or sexual health. The care leavers associated health with wellbeing, recognising the influence of health on educational attainment, social support and parenting; these young people acknowledged that positive supporting influences were particularly important for health. Although evidence from quantitative data and interviews with young people suggest self-reported health behaviours are good, carers described how young people would enter their care with very poor eating habits and dental health. This finding highlights potential discrepancies in the recording of data via the health assessment, and the overall assessment of the health and wellbeing of LACYP in BwD.

The LACYP felt they had appropriate access to health services and described their GP, school nurse, foster carer or school staff as the main source of support and signposting. Care leavers described that their personal advisor would provide them with help in seeking support for health needs, if required. Carers and stakeholders described the important emotional support needs of vulnerable children and young people, as a result of the problems which have characterised their lives. Stakeholders felt that access to the child and adolescent mental health service (CAMHS) in BwD could be disjointed and that a more coordinated approach between services could be developed. Carers felt that mental health support was often not available until the young person had reached crisis, and participants from both stakeholder and carer groups acknowledged that LACYP may not recognise when they require emotional support.

### HEALTH ASSESSMENTS

All LACYP in care for more than 28 days should receive a health assessment (HA). A review of HAs found that completion of HAs in BwD was good, with the vast majority of all LACYP having a HA recorded (93.5% of those living outside of BwD and 89.1% of those living in BwD). Whilst data were not available for all LACYP (either because it was not recorded on their HA or their latest full HA was not available to researchers), analyses suggest that around a fifth of LACYP in BwD reported having worries about their health. Where data were available, analyses show that a quarter of LACYP aged 10 and over reported smoking, and just over one in ten drank alcohol and/or used drugs. More young people living in BwD reported drug use (20%, 7/35) compared to those living outside the area (8.2%, 4/49). Despite the low HA figures, data provided by Lifeline show that an average

*"If you're sad you won't exercise but if you're happy you'll be energetic".  
(Female aged 10, junior focus group)*

*You have got to be happy so that you can run around and things... because if you're not happy then you can't get loads of exercise  
(Female, aged 10, children's home)*

*The age of our [foster children] it's like "well what you touching me for? Leave me alone I don't want to be... why do we have to go?" "Oh it's just something we have to do."  
"Well why? I'm healthy, I'm fine"  
(Foster carer 1)*

of 35 LACYP had been referred to the service each year between 2012 and 2014 (total n=104). Care leavers, carers and stakeholders expressed concerns that LACYP, especially adolescents, do not like their health assessments; they find them intrusive, repetitive and feel they set them apart and make them 'different' from other children and young people.

### INTERVENTIONS TO IMPROVE HEALTH AND WELLBEING

The evidence base for interventions to improve the health and wellbeing of LACYP in both the short and longer term has expanded considerably in the last decade. BwD already have the most effective programmes in place and no appropriate effective programmes were identified that are missing in BwD. There are programmes in place that are based on recent robust evidence (such as the KEEP intervention; group based training to help manage behavioural and emotional problems, Multi-Dimensional Treatment Foster Care (MTFC)). However carers and some stakeholders felt there was a gap in the provision of services and interventions to support LACYP to learn life skills and to build psychological resilience. Resilience and life skills were thought to be important to ensure care leavers could maintain emotional, mental and physical health and were able to deal with living independent lives.

*"Mental wellbeing means...you don't wait till someone's broke and fix them, you put coping strategies in early so you're future proofing them for problems that they may eventually get" (Foster carer 3)*

### PLACEMENT STABILITY, OUTCOMES AND CONTINUITY

One third of LACYP in BwD had been in care for longer than one year and just under half (41.8%) were on their first placement. Just under a third of LACYP in BwD had three or more placements and the majority of these LACYP were placed with a foster carer (80.4%). The majority (92.2%) had no missing from care episodes recorded (times where they were reported missing by carers). The number of missing episodes ranged from zero to 37, with six LACYP (4.2%) having had five or more.

Stakeholders involved in mapping the journey of children in the care of BwD all agreed that referrals to services were most often multifactorial and very complex. Stakeholders highlighted a number of issues for consideration when understanding the journey of LACYP, particularly noting the complexity, trauma and challenges that children have faced upon entering care. Achieving permanency at an early stage was felt to be very important in terms of attaining positive outcomes for young people, including good health and wellbeing. Stakeholders agreed that there were very positive local relationships between partner agencies, and that statutory and voluntary support was provided as necessary, dependent upon need.

LACYP who took part in the qualitative engagement viewed access to support as important to ensure they achieved positive outcomes. All LACYP felt they had someone to speak to if they needed help or support, describing that they could speak to their carer and that they had good access to their social worker. The school was recognised by the LACYP as a particularly important source of support and stability.

*"If I were at school it would be my teaching assistant... if I were at home I'd go to [foster carer] or my foster sister". (Female, aged 9, foster care)*

The importance of continuity of social work support was highlighted by young people in care in BwD and all described disliking when they had to change social worker. A new social worker was viewed with distrust and young people reported it was confusing, upsetting and frustrating when their personal social worker changed. BwD have retention rates

*"Not someone [social worker] new, if it was someone new I wouldn't ask questions" (Male, aged 14, living at home)*

for social workers in line with local and national rates. LACYP reported they feel more comfortable talking about problems and worries to a social worker they trust.

*"I had a review with my book it said "what would you like to change?". And I wrote "I want to live with my family" and I got changed cos we talked about it in my review" (Female aged 9, foster care)*

*"What you say does get heard but it's an adults decision overall so has to be made by the adults" (Female aged 16, out of area)*

*"It's much harder for us when children are placed out of the borough. It's not the same health service, we have to get health provision to take people on (Stakeholder 3)*

*"No it doesn't make a difference not living in Blackburn. They still come out to see me, so no difference for me, but I suppose it's more awkward for them. I still get to see them when I need to" (Male, aged 15, out of area)*

Although young people living with foster carers felt they had a say in their care and an input into decisions about their care they did not always feel they were allowed what they requested. Some young people reported they found the annual review process distressing and were reluctant to be open about their feelings in front of carers or parents. The young people in the children's home described the importance of having frequent house meetings, and felt they could have more input into decisions that were made about their care within the home.

Compared to LACYP living in BwD, children living out of area had spent more time in care and experienced more placement changes. Stakeholders discussed their concerns regarding the stability and outcomes for LACYP living outside of BwD, particularly in terms of quality and continuity of care. Stakeholders described that some areas offer therapeutic treatment but that they need to rely on mainstream support, not specific LACYP services, which can cause delays in LACYP who live out of areas accessing support. Despite the concerns raised by stakeholders, the LACYP living outside of BwD who participated in the qualitative research felt that their area of residence did not impact on the quality of the care they received.

The care leavers who participated in the qualitative interviews reflected on their time in care, and felt that continuity of care was not always achieved in terms of their experiences of developing relationships with social workers. Carers and stakeholders described concerns that high turnover and changes of social workers could impact negatively on LACYP; this was deemed particularly important in terms of building and maintaining trusting relationships in which young people would open up and be honest about their feelings and concerns.

## **SYSTEMS AND PROCESSES IN PLACE TO MONITOR OUTCOMES FOR LACYP**

Appropriate processes are in place to collect, store and access information regarding LACYP in BwD. A number of teams within and external to the council have access to the relevant data at varying levels, and other teams and organisations receive summary statistics from the databases as required. During the stakeholder events, some partners indicated that they were not able to access data that would provide them with an overall picture of the health and wellbeing needs of LACYP.

HA data are currently collected on paper based forms which are scanned onto the shared drive; however many HA forms are not scanned or are only partially scanned so information is not available. Although some of this information is held in on Protocol, stakeholders described difficulties in accessing, using and updating this

information. HA questions are mandatory and topics covered are not within the control of BwD. However the way these forms are stored and used could be amended to allow local partners to access information on the health and wellbeing of LACYP more readily. Where possible, it is important that health services record attendees as LACYP. Although representatives from health services attend and contribute to multi-agency case tracking and management panel meetings, there is the potential to link health data with data held on the BwD databases.

## **LIMITATIONS**

Qualitative recruitment was supported by social workers, health professionals and carers. Although care was taken to ensure that LACYP (including care leavers) with a range of experiences would be invited to participate in this research, it is likely that those who agreed to participate were more confident and perhaps more in stable placements than those who may share different views.

Receiving data on LACYP for analysis was dependent on partner engagement with the research project and availability and accessibility of data, consequently data was only received from BwD Borough Council (Protocol data extract), YJS and Lifeline. Additional data to enable analysis of health outcomes were unavailable. It was therefore not possible to compare outcomes with the wider population of children and young people in BwD.

## **RECOMMENDATIONS**

See section 9 for full recommendations

## 1. INTRODUCTION

At the end of March 2014, there were 68,840 looked after children and young people (LACYP) in England. Latest figures show that the number of looked after children in England are continuing to increase, rising by 7% since March 2010 [26]. The health and wellbeing of looked after children is a priority for public health. Children who enter the care system have often had a lifestyle subject to poverty, poor parenting and abuse or neglect [27]. Data show that looked after children have poorer health outcomes and lower levels of educational attainment than non-looked after children [28].

A looked after child is defined as someone who is under the age of 18 and is:

- is provided with accommodation for a continuous period for more than 24 hours
- is subject to a care order; or
- is subject to a placement order

When a child reaches 18 years old, the child is no longer defined as looked after and is then deemed a 'young adult eligible for health and assistance from the local authority' [26].

### 1.1. GUIDANCE AND LEGISLATION

A number of key policy, legislative and regulatory frameworks have been developed to support relevant organisations to develop and deliver appropriate and holistic services for LACYP. The Children Act (1989; 2004), The Children and Young Persons Act (2008) and The Care Standards Act (2000) provide frameworks for the care, protection, welfare and health of all children and young people, detailing the roles and responsibilities of key organisations involved in providing this support. The Mental Health Act (2007) outlined the importance of ensuring that hospitals provide age-appropriate support and environments for children and young people admitted into hospital with mental health needs (as described by the Department for Children, Schools and Families [DCSF] and the Department of Health [DH] [27]).

Two of the key current policy documents, built upon previous frameworks, were produced by the DCSF and DH in 2009 [29], and the National Institute for Health and Clinical Excellence (NICE) in 2010 (updated in 2013 [30]). The DCSF and DH [29] framework provides statutory guidance to local authorities and partners to enable them to meet the health and wellbeing needs of LACYP. The guidance acknowledges that services should: be holistic and tailored to meet the individual needs of LACYP, ensure the views of LACYP (and those of their families) are central to service development, promote prevention, assess and meet health needs, and ensure that professionals work in partnership with clarity of roles and responsibilities. The guidance places importance on assessing the needs of local LACYP and exploring specific needs of sub-populations.

The DCSF and DH [29] guidance describes evidence regarding the health and wellbeing of LACYP with reference to low levels of mental and physical health. The guidance also describes the evidence that young people leaving care are a particularly vulnerable group, with lower levels of health and wellbeing than people who have not been in care. Evidence that young people's health worsens in the years after leaving care is also described within the guidance.

The DCSF/DH guidance is informed by a number of key policy frameworks which include Every Child Matters [31], Healthy Lives, Brighter Futures [27] and the 0-5 and 5-19 Healthy Child Programmes [32, 33]; a full list of policy frameworks are detailed within the report. This statutory guidance makes reference for the need to read the report in conjunction with NICE guidance on the health of LACYP, published in 2010 [34].

NICE [34] provide guidance for organisations, professionals and carers who are involved in working to deliver high quality care and stable placements for LACYP. The report provides non-statutory recommendations to inform how services and agencies can work in partnership to improve the health and wellbeing of LACYP. Key to this report is the focus placed on collaborative working, particularly across commissioning, care planning, placements and access to health and mental health services.

The DCSF/DH guidance is based upon evidence from literature and primary data collection with LACYP, key stakeholders and expert witnesses. The recommendations reiterate many of the points included within the 2009 DH and DCSF statutory guidance [29]. The report details the importance of ensuring the views of LACYP and their families are central to service development and that services acknowledge the diverse range of needs of LACYP. The recommendations highlight the importance of ensuring that LACYP have warm and caring relationships with their carers to ensure they feel safe and that they are supported to have a stable education and the opportunity to participate in wider networks of school and community activities. The recommendations also highlight the importance of ensuring LACYP are fully prepared for their transition to adulthood. This guidance was updated in 2013 to reflect the changes in commissioning arrangements; however the recommendations remain the same. The recommendations included within the guidance are not statutory, but provide support to complement the statutory guidance published by DCSF and DH in 2009.

## **1.2. LOCAL CONTEXT**

In Blackburn with Darwen (BwD), latest figures show that at the end of December 2014 there were 307 LACYP in the care of the Borough Council, with half of these residing out of area (see section 5.1.1). A number of statutory organisations commission services to support LACYP. The 2014 BwD Annual Health Report for Looked after Children identified the ongoing progress that has been made to ensure that the health needs of all LACYP are addressed, and that an up-to-date health plan is produced following assessments (see box 1.1)

The 2014 BwD report also identified a number of recommendations to ensure that services continue to improve outcomes for LACYP in BwD. Recommendations included reviewing emotional health services for LACYP and care leavers to ensure they are fit for purpose, improving statutory targets and the quality of health assessments, and improving the numbers of care leavers accessing health services via the development of an action plan. Following the publication of the 2014 report, BwD commissioned the Centre for Public Health, Liverpool John Moores University (LJMU), to undertake research in order to identify gaps and make recommendations for improving health and wellbeing for LACYP in BwD. The study was developed in order to address the recommendations from policy and guidance, in terms of ensuring the views of LACYP and their families inform service development and that services acknowledge the range of needs of LACYP, including those transitioning to adult services.

#### BOX 1.1: ACHIEVEMENTS: BWD ANNUAL HEALTH REPORT FOR LOOKED AFTER CHILDREN [1]

- 90% of review health assessments completed on time
- 100% of care leavers questioned reported they felt sexual health services in the borough were easily accessible
- 100% of children in care for longer than 12 months completed a strengths and difficulties questionnaire (SDQ) to support their emotional health and wellbeing needs and care plan
- Introduction of British Adoption and Fostering (BAAF) Health Assessments Forms in line with NICE Guidelines
- SDQ multi agency panel established-Addressing emotional health of LAC
- Annual health care questionnaire targeting care leavers delivered
- New Lancashire Care Foundation Trust (LCFT) dental referral pathway for LAC developed
- Introduction of a health information passport specifically for care leavers
- Health passport available for all children in care (foster carers responsibility)
- Health now consistently attend and contribute to multiagency Case Tracking and Management Panel meetings
- Designated LAC Nurse attends Corporate Parenting meetings
- Designated LAC Nurse quality assures all health assessments
- Twin tracking of LAC and pre-adoption medicals when feasible thereby reducing duplication of medicals and the inconvenience to the child and carer
- Introduced electronic transfer of LAC documentations including health reports which will now reduce unnecessary delays in the administrative pathways and benefits prompt delivery of health care and meeting time targets
- Transition of a major share of administrative tasks regarding organising initial LAC medicals to East Lancashire Health Trust Community and Neurodevelopmental Paediatric services for efficient and smooth management
- Monitoring timescales for completing Review Health Assessments (RHA)
- Clinical supervision for staff working with LAC and Care Leavers
- Co-location of designated LAC Nurse with Children's Social Care colleagues
- Weekly health drop in for all LAC, staff and carers
- LCFT Child and Family Health Service & Designated Nurse coordinated a health response to vulnerable children placed out of area in private residential settings.
- LAC training for LCFT Child and Family Health Service staff
- Audit of non-attendances at the looked after children assessment clinics
- Audit of the availability and adequacy of information at initial health assessments

### 1.3. RESEARCH AIMS AND OBJECTIVES

In order to provide comprehensive evidence to inform service delivery and development for LACYP in BwD, the research had a number of aims and objectives. The key focus for the research aims were to: describe the epidemiology of health outcomes for LACYP in BwD, identify gaps in current service provision, and assess the quality of service experienced by LACYP.

Objectives:

- 1) Conduct a review of current data and local intelligence to explore the health status and outcomes of LACYP in BwD
- 2) Explore current systems and processes for LACYP and care leavers, and explore whether processes are in place to identify and monitor health, emotional and social outcomes

- 3) Assess placement stability and outcomes such as continuity, length of care and interventions
- 4) Give guidance on how to routinely capture robust outcome measures and aspects of wellbeing, taking account of developmental changes across the life course
- 5) Explore LACYP access to service provision, including the number of times reported missing, attendance at accident and emergency, health status, access to primary care and identifying any areas to improve or gaps in current provision.
- 6) Explore the views of children and young people to understand their journey and to gain insight from their carers and professionals to gain their views of current practice.

In order to ensure that the research explored the range of needs of LACYP, three cohorts were identified for inclusion in the project: LACYP living in BwD, care leavers, and LACYP living out of BwD. Where possible, the research sought to explore outcomes and issues pertaining to each group.

## 2. METHODOLOGY

A mixed methods approach was implemented to ensure that each study aim could be comprehensively addressed. A combination of stakeholder engagement sessions, quantitative data analysis and qualitative interviews with LACYP, carers and health professionals were undertaken. Ethical approval for the research was granted by the Liverpool John Moores University Research Ethics Committee prior to the commencement of the research (ethical approval reference number 14/EHC/079).

### 2.1. METHODS

#### 2.1.1. RAPID SYSTEMATIC LITERATURE REVIEW

A rapid systematic review was conducted to identify both academic literature and grey literature (i.e. government or local authority reports) that: (a) evaluates the effectiveness of interventions to improve the health and wellbeing of looked after children and young people (LACYP); (b) describes or critiques approaches for identifying, monitoring and evaluating the health, emotional and social outcomes of LACYP; and (c) describes or critiques approaches for improving access to, and the sustainability of, health and other services to support LACYP. The literature review aimed to provide evidence on:

- Identifying, monitoring and evaluating the health, emotional and social outcomes of LACYP;
- Improving access to, and the suitability of, health and other support services for LACYP;
- The effectiveness and acceptability of interventions aimed at improving the health and wellbeing of LACYP, and where possible, the cost-effectiveness of promising interventions; and,
- Interventions with short term and long term impacts on health, especially interventions that build long term resilience across the life course.

A structured search strategy incorporating terms for the populations, interventions and outcomes of interest was run using four key electronic databases covering fields such as: health; mental health; behavioural sciences and psychology; social work, social policy and education; and criminal justice and criminology. Search results were limited to papers or reports produced since 1994 from the UK, USA, Canada and Australia. Searches initially identified 722 publications, which were independently reviewed by two researchers. Papers or reports that were considered relevant to one or more of the three topics above were retrieved and reviewed by the lead reviewer. The discussion in section 3 is based on consideration of 317 review articles, primary studies and reports that were identified as most relevant to the aims of this rapid review. Over 90% of reviewed publications were published since 2000, with 40% from 2010 onwards.

#### 2.1.2. STAKEHOLDER ENGAGEMENT EVENTS: LOGIC MODELLING

Logic modelling (a form of service mapping) was implemented in order to explore the frameworks and processes in place in BwD to enable the routine monitoring and identification of health, emotional and social outcomes. Logic models are useful tools for exploring the outcomes that occur as a result of a programme, service or suite of services. Over the last three decades, logic models have been predominantly used to inform evaluation planning and outcomes, and the effectiveness of their use has been widely accepted within the literature [35]. Logic models provide an illustrative tool which outline various assumptions associated between actions and outcomes. The model provides a 'theory of change' and can be used to plan, manage and evaluate key activities associated with a programme [35].

From a research perspective, the development of a logic model is as important a process as the model itself, and provides a number of benefits to key stakeholders. The development process begins with a stakeholder

event; identifying key partners with subject area expertise and inviting them to outline the key outcomes, activities and outputs involved in a programme. This engagement process also encourages stakeholders to develop agreement and identify differing perspectives. The logic model is developed upon completion of stakeholder engagement, and is then used to identify what works where and how, highlight gaps and opportunities for improvement, support the development of appropriate monitoring tools, provide a framework to support research, and help to describe a theory of change.

In order to develop the logic model for BwD, two stakeholder engagement sessions were delivered with commissioners and providers involved in the LACYP programme area. The research team recommended that representatives attend from a range of services/organisations, including service commissioners, foster carers' representatives, children's home representatives (such as senior practitioners/home managers), public health practitioners, and representatives from other services such as Child Protection, Youth Offending, Educational Welfare, Children and Adolescent Mental Health Services and Family Centres). The research commissioners invited 36 people from a variety of statutory and third sector organisations to attend the two stakeholder sessions.

Both sessions were held at Blackburn Youth Zone, 23 representatives attended session one and 15 attended session two (see appendix 1 for a list of services/organisations represented at the events; there was a crossover and some stakeholders attended both events). Session one involved working with stakeholders to outline the key activities, outputs and outcomes associated with the LACYP programme area. Session two was used to reflect upon the model that had been produced and explore 'typical' journeys of LACYP in BwD.

### **2.1.3. LOCAL DATA AND INTELLIGENCE REVIEW, COLLATION AND ANALYSES**

Working in collaboration with partners from a range of local organisations, local data and intelligence on LACYP was reviewed. The research team designed a proforma (see appendix 2) to enable the identification of data sources on LACYP including: who currently collects and owns the data; from whom the data are collected; frequency of data collection; the type of information available; data collection format (e.g. paper based survey/electronic database); data sharing agreements and processes within and between services; and data protection and confidentiality issues. Proformas were emailed to all representatives who had attended the stakeholder engagement events as well as other key stakeholders suggested by the commissioners of the research. Data were sought for the three populations: LACYP; children and young people living out of BwD; and care leavers.

#### **2.1.3.1. Data accessed for analysis**

Data were accessed from three organisations: BwD Borough Council, Youth Justice Service (YJS) and Lifeline.

##### *BwD Borough Council – Protocol database*

An information sharing agreement was set up so that researchers could access a data extract containing anonymised individual level data on LACYP in the care of BwD. The data were shared using a secure SharePoint. Two data extracts were provided from Protocol (for further information on the Protocol database see section 4.1; a full list of the data items shared is provided in Appendix 2). One data extract was provided for LACYP who were in care on 31<sup>st</sup> December 2014 (in care data extract), and the second extract was for individuals who had left care or ceased being looked after (care leaver data extract) for the three year period 01/01/2012 – 31/12/2014. Where possible, the 'in care data extract' was supplemented with data from the individual's latest Health Care Assessment (HA).

Information taken from the HAs for all LACYP included:

- If the child/young person was eating well (any form of disordered eating was classed as not eating well).
- If the child/young person was sleeping well (any disordered sleeping i.e. nightmares was categorised as not sleeping well).
- If the child/young person was utilising any of the following health services: Health visitor/school nurse, dentist/orthodontist, paediatrician, child and adolescent mental health services (CAMHS), or other services.
- If the child/young person had any worries about their own health (including worries regarding their weight)

Information taken from the HA for young people (i.e. those aged 10 plus) only<sup>1</sup> included<sup>2,3</sup>:

- If the young person was beginning to take responsibility for his/her own health needs (any level of responsibility that was indicated was included in the “‘Yes’ categorisation, including where LACYP ask for support when it is needed).
- Use or exposure to smoking/alcohol or drugs (inclusive of previous/current use)<sup>4</sup>.

#### *Youth Justice Service*

Figures for the number of LACYP engaged with the YJS within BwD were provided for the three year period 01/01/2012 - 31/12/2014. Researchers assessed the availability and accessibility of the data and designed a data analysis schedule.

#### *Lifeline*

Anonymised individual level data on referrals to Lifeline for LACYP located in BwD was provided (including: age, gender, ethnicity, disability, referral date, and if a family member uses substances) for the three year period 01/01/2012 to 31/12/2014. Demographics: age (current and when entered care), gender, ethnicity, disabilities, residency/asylum status

#### **2.1.3.2. Data analysis**

All data were entered, cleaned and analysed in SPSS v21. For several data items<sup>5</sup> received from the Protocol, response categories were grouped to provide broader categories more appropriate for analyses and to ensure data presented were not identifiable. Two fields (Immigration status and care leaver activity) had a large amount of missing or inconsistent data and were therefore excluded. Analyses presented in the report were undertaken using frequencies and cross-tabulations to examine findings by demographic and other factors.

#### **2.1.4. QUALITATIVE ENGAGEMENT WITH CHILDREN, YOUNG PEOPLE, CARERS AND PROFESSIONALS**

To understand the views of current practice, experiences of services and the journey of young people through the care system, qualitative research (interviews and focus groups) was conducted with children, young people, carers and professionals. Data gathered from the stakeholder events were used to inform the discussion guides. Further, the stakeholder engagement events provided the opportunity to collect information regarding

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<sup>1</sup> The British Association for Adoption and Fostering (BAAF) HA for looked after children define a child as from birth to nine years (Form RHA – C) and a young person as aged 10 years and older (Form RHA – YP). Additional questions about health and wellbeing are asked in the young person’s HA.

<sup>2</sup> This is dependent on the young person disclosing this information to a health practitioner during the HA.

<sup>3</sup> These fields are only completed in HAs for young people and not for children under the age of 10.

<sup>4</sup> When entering this data, information recorded as not known was classed as ‘No’.

<sup>5</sup> Ethnicity, category of need, legal status, placement type and placement provider.

potential avenues of recruitment and allow researchers to further understand existing panels, networks and groups that could be approached to take part in the qualitative element of this study.

#### **2.1.4.1. Looked After Children and Young People**

Interviews and focus groups were conducted with LACYP to explore the general health and wellbeing needs and experiences of children within the three cohorts (in care in BwD, care leavers and in care outside of BwD). Key stakeholders in BwD provided support in recruiting LACYP to the research. Interactive and engaging data collection methods were used, including LEGO, to understand the experiences of the children and young people. Topics discussed in interviews included:

- their understanding of physical, emotional and mental health and the priority they place on their health
- the accessibility of primary and secondary health care services (e.g. GP, hospitals, sexual health, mental health and emotional support etc)
- where LACYP would go for support for their emotional wellbeing and who they feel able to talk to
- their experience of inputting into decisions about their care
- experience of their input into service design and delivery
- how much they are involved with social and peer networks and how this impacts on their health and wellbeing
- the wider impacts on the health and wellbeing of LACYP and the social impact of being in care.

Children and young people were recruited to the research from the following cohorts:

##### *a) LACYP in the BwD care system*

Face to face interviews, telephone interviews and focus groups were undertaken with 16 children and young people who were within the care system at the time of the research. These participants were recruited via social workers, children's home staff and participation champions. It was originally anticipated that 9-15 LACYP would be interviewed from this cohort. Participants were recruited through a variety of methods and took place in a variety of settings (details below).

##### *a1) LACYP in care*

Interviews were undertaken with four children in foster placements and one child at home who had a care order. Children were recruited via social workers and a child participation champion within the Children in Our Care Team. Interviews were conducted in one-to-one or paired interviews; paired interviews were with two related children in a foster placement at the same residence. All interviews took place in the participants' house.

A focus group was conducted with the junior participation group, this included seven children aged 8-13. This was conducted within their regular monthly meeting and three members of council staff were present. It was originally anticipated interviews would be undertaken with between 8-12 participants; the final sample was 12.

##### *a2) Children living in children's homes*

Children and young people living in a children's home were invited to take part in interviews or focus groups. One interview (n=1) and one small focus group (n=3) were undertaken with LACYP living in one children's home. Although fewer children live in children's homes, compared to within foster care, these are local authority facilities; it is therefore important to understand the health and wellbeing needs of children who are currently living in such homes. It was originally anticipated interviews would be undertaken with 2-3 participants.

One interview was conducted with a female resident of the home; LEGO was used to facilitate this discussion. A group interview was conducted with three teenage residents of the home; one of the participants used the LEGO but two participants did not wish to take part with LEGO. A member of staff from the home was present during the group interview to support one resident. Both interviews were recorded and fully transcribed. All information was anonymised.

#### *b) Care Leavers*

Qualitative engagement with care leavers provided insight into their perspective of young people who have been through the care system process. Engaging with this cohort allowed discussion of the 'big picture' and elicited insight regarding the longer term health and wellbeing needs of LACYP.

One focus group was conducted with a group of five male and female care leavers aged 20-24. The focus group was organised through the care leavers team and took place in a private room at a young people's supported accommodation venue in BwD. The group all knew each other and met regularly. Also present at the focus group were two personal advisors and one participant's young child. The 50 minute focus group was audio recorded and fully transcribed.

#### *c) Children and young people living out of BwD*

Children and young people living out of BwD may have different experiences from the other two cohorts. Therefore qualitative engagement with young people who are placed out of the area provided evidence on experience of services out of their home local authority, how this may differ from experiences of placements in BwD and how this may affect their health and wellbeing.

Telephone interviews were undertaken with two young people living with the same foster carers in the Midlands. One face to face interview was conducted with a young person in their home in Lancashire. Recruitment was supported through a social worker who worked with the young people who lived out of area.

#### **2.1.4.2. Carers and professionals**

To understand current practice, priorities, service design, challenges and improvements interviews were conducted with a broad selection of carers and professionals who work with LACYP. This enabled exploration of carers and professionals perceptions and experiences of the current services available. To gather a broad range of perspectives it was anticipated that focus groups and interviews would be conducted with representatives from two groups:

##### *1. Social workers and other key stakeholders*

Eight in-depth telephone interviews and one face to face interview were conducted with social workers and other key stakeholders. The participants who took part in telephone were three social workers, a senior staff member at a children's home, a psychologist, a CAMHS practitioner, a senior manager in Children's Services, a LAC nurse and a member of the child sexual exploitation service. This elicited evidence about the practice of many different organisations and professionals who work with, and care for, LACYP. Engaging with social workers who help support different LACYP enabled exploration of evidence on a wide range of children and young people whom the professionals come into contact with and placed the young peoples' experience within the wider context of the whole care system. Participants were recruited through the stakeholder engagement event and through suggestions from the commissioners. Interviews were audio recorded and transcribed.

##### *2. Foster and kinship carers*

Interviews were conducted with six foster carers who foster children and young people within BwD; three face-to-face interviews (one paired interview) and two over the phone. Four of these were recruited through the Foster Carer Association (FCA). A researcher attended the FCA meeting to explain the research and invite foster carers to take part in the research. Two potential participants cancelled their interviews and it was not possible to reschedule, thus four foster carers were interviewed. Two out of area foster carers were recruited through a social worker. In-depth qualitative engagement with foster and kinship carers elicited evidence about the everyday experiences of LACYP and their emotional/physical health. These interviews also explored evidence on current practice, challenges, and improvements from the perspective of those who care for LACYP. Interviews lasted 20-80 minutes and were recorded and transcribed.

#### **2.1.4.3. Qualitative engagement analysis**

The majority of focus groups and interviews were recorded and transcribed from the recordings; one young participant declined to be recorded so detailed notes were taken during the interview. All identifiers (including names of participants, carers, family members, schools and areas) were anonymised. Framework analysis was used to analyse the data [36]. Framework analysis begins inductively with a preset group of aims and is considered particularly appropriate for policy related or applied qualitative research [37]. The analysis is presented with illustrative quotes to highlight key findings (see section 7).

## 3. RAPID SYSTEMATIC LITERATURE REVIEW

This chapter provides a summary of findings from the rapid systematic literature review, focusing firstly and primarily on a consideration of the effectiveness of interventions or programmes to protect and promote positive outcomes for LACYP (section 3.1). The subsequent two sections will then discuss the evidence for monitoring outcomes in this population (section 3.2), and potential approaches for improving services which support LACYP (section 3.3).

### 3.1. INTERVENTIONS TO IMPROVE THE HEALTH AND WELLBEING OF LOOKED AFTER CHILDREN AND YOUNG PEOPLE

Evidence identified in this rapid systematic review was broadly categorised into three sections: interventions that target or work with children on their own (i.e. without the involvement of their foster parents or caregivers); interventions that are designed to support or train foster parents; and interventions that work with both children and their foster parents collectively. In the following sections, different approaches are described and, where possible, examples of particular programmes and their component parts given, before the international evidence base is summarised. Where possible, examples and research evidence from evaluations conducted in the UK is given. However, for many approaches, it is important to recognise that the vast majority of evidence is drawn from the USA, and therefore the extent of transferability and applicability to the UK setting should be considered.

#### 3.1.1. INTERVENTIONS THAT TARGET THE LOOKED AFTER CHILD OR YOUNG PERSON DIRECTLY

The rapid systematic literature review identified a range of interventions in which services or programmes are delivered directly to the child or young person, both whilst they have looked after status, and in some cases when they are transitioning out of care (care leavers). These interventions do not involve the LACYP's birth or foster parents, although they may involve other adults (e.g. teachers), siblings, or be delivered with groups of other young people. Evidence is described for: mentoring programmes; school attainment programmes; tutoring; substance use prevention; sibling interventions; strength-based programmes and therapeutic interventions; and transition support.

##### 3.1.1.1. Mentoring programmes

Mentoring is a partnership between two people (the mentor and the mentee) that can be used to build confidence, support the development of new skills, and empower a person to make positive changes in their life. Mentors act as guides, using their own experiences to help mentees negotiate (some of) the challenges they face. The heterogeneity of LACYP and their experiences and needs suggests that person-focused one-to-one approaches such as mentoring that allow them to build trusting relationships with an adult role model (other than their foster parent or social worker) may be beneficial for a range of health and wellbeing outcomes.

Although an earlier review of mentoring suggested that there is only a modest or small benefit of programme participation on educational and psychosocial outcomes [38], more recent evidence from primary research papers suggests that some mentoring programmes may effectively support the mental health and wellbeing of LACYP.

In **Fostering Healthy Futures**, a US intervention aimed specifically at improving the mental health outcomes of maltreated children and adolescents in foster care, LACYP received bespoke mentoring (alongside cognitive-behavioural skills groups) from social work graduate students who were able to tailor their support to each

child's presenting problems, strengths and interests, as well as their family and placement characteristics. At follow-up, intervention participants had fewer mental health problems, reported fewer symptoms of dissociation and higher scores on self-reported measures of quality of life [39]. The **Near Peer Mentoring Project** in Greater London provides LACYP with a mentor who has previously been in council care and is considered to be on a positive educational or employment trajectory. Mentors concentrate on educational attendance and performance, but also try to identify and support underlying issues that may be contributing to poor educational outcomes, such as lack of confidence, issues with authority, or difficulties developing positive peer relationships. Qualitative evaluation of the project suggests that programme participation was not only associated with reported improvements in confidence, educational attainment and intentions for university among mentees, but also had positive impacts on the skills and confidence of (care leaver) mentors [40].

An evaluation of a therapeutic mentoring (TM) programme for foster care youth at risk of placement disruption does highlight a note of caution, however, as findings suggest that mentoring must be of substantial frequency and duration to benefit the most vulnerable youth [41]. In this study, youth who received limited TM actually experienced less positive outcomes than those receiving no TM at all. Positive outcomes for youth receiving a substantial amount of TM included improved family and social functioning, improved school behaviour and attainment, and reduced trauma symptoms.

Current debates around the effectiveness of mentoring relationships for improved short and longer-term outcomes of at-risk children and young people include consideration of the comparative value of natural vs programmatic mentoring. Unlike programmatic (or formal) mentors who are previously unknown to their mentees, **natural mentors** are non-parental adults that young people are already connected to through their social networks, and may include teachers, youth leaders, family friends or adult relatives. Natural mentoring relationships may have particular benefits for LACYP who have suffered loss and experience difficulties in forming trusting relationships, as some of the challenges of building a foundation of trust are removed. This approach may empower mentees by allowing them to select their own mentors, and relationships may also be more likely to continue over time. Evidence from two longitudinal cohort studies in the USA found that LACYP with natural mentors had improved mental health outcomes and were less likely to have been arrested [42] or involved in a physical fight [43].

Based on the premise that information and communication technology may present an opportunity to improve the effectiveness and reach of mentoring services or programmes, a pilot project to deliver e-mentoring services to LACYP in North Lincolnshire and Norfolk is currently underway. **Confident Futures** e-mentoring allows mentors to communicate with their mentees via the internet whilst maintaining their anonymity. The programme is yet to be thoroughly scientifically evaluated, although challenges around (intrinsic) motivation and frequency of communication have been highlighted anecdotally [44].

### **3.1.1.2. Interventions to support looked after children in school / educational attainment**

School-based interventions may support LACYP to remain in school or increase attendance, as well as aiming to improve overall educational attainment and/or access to higher or further education. A systematic review of school programmes [45], identified 11 academic studies broadly categorised into six strategies. However, support for the effectiveness of many of these approaches was very limited. The discussion below focuses on three of these strategies: strategic interventions; reading encouragement; and tutoring.

#### *Strategic interventions*

Strategic interventions are applied at the organisational level and attempt to drive innovation and service provision by strengthening partnerships between education and social care services. For example, the **Taking Care of Education** programme (England) aims to: acknowledge and encourage achievement through award ceremonies and financial rewards for attainment (e.g. GCSE grades); improve educational support in care placements through the provision of additional resources such as books or computers and through educating foster parents in providing effective support to educational attainment; and provide access to a wider range of learning opportunities (e.g. residential weekends). Young people involved in this project showed improvements in scores for well-being and self-esteem, although the intervention showed no clear impact on educational attainment. Supporting qualitative data suggested that the majority of young people perceived improvements in their own educational progress and felt that they received more support for education within their care placements. Young people reported a particular appreciation for the rewards and award ceremonies [46].

**Virtual School Heads** (VSH), who are typically senior individuals working within the local authority, have responsibility for overseeing a coordinated system of support for improving the educational outcomes of LACYP educated locally. It is the role of VSHs to improve standards of, and access to, educational provisions, by working both strategically and operationally with local partners and service leads. Generally VSH are tasked with raising the profile of LACYP in schools and the importance placed on education and social workers. From 2007/9, 11 local authorities in England piloted VSH, and an evaluation was commissioned by the DCSF. Preliminary findings suggested a relationship between the VSH model and educational outcomes for LACYP, with pilot areas performing well in terms of official educational outcome statistics (compared to the national average) and many showing improvements in GCSE results [47]. As a key part of the VSH role was to develop successful relationships with local school headteachers, VSH who had previously held school headships, or were placed at a senior level within the education section of children's services, were found to operate more effectively.

#### *Reading encouragement programmes*

Some programmes focus on developing the literacy skills of LACYP, as a mediating factor in their educational attainment. Children in the **Letterbox Club**<sup>6</sup> are sent a personalised parcel each month addressed to them at home which includes books, number games and stationery. Originally set up by the University of Leicester in partnership with the national charity Booktrust, the scheme now reaches over 7,000 children in England, Wales and Northern Ireland. An independent evaluation of the Letterbox Club in Northern Ireland found that children who participated in the programme showed improved accuracy and comprehension scores on standardised measures. Further, just over a third also improved their number skills by the equivalent of one national curriculum level [48]. However, interpretation of findings is limited on the basis that there was no comparison to a control group, and it is not possible to determine how much of a child's progress is due to the effects of other policies or initiatives. Evaluations from the rest of the UK are similarly limited.

One suggested limitation of the Letterbox Club is that it does not actively engage foster carers alongside LACYP. In contrast, the **Paired Reading** initiative is an example of a programme that was designed specifically to encourage foster parents to read with their children [49]. In this approach, foster parents begin by reading to their children, providing a model of competent reading. As the child becomes more confident, they read along with the parent, until they are then able to read alone. If the child makes a mistake that they are unable to correct themselves, their reading partner (foster parent) repeats the correct word and then reads along with

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<sup>6</sup> See [www.letterboxclub.org.uk](http://www.letterboxclub.org.uk)

the child again until they are ready to continue to read alone. Although results from a UK evaluation should only be taken as very preliminary findings due to the small sample size (n=35), initial findings showed improvements in the reading age of LACYP and feedback from foster parents was positive in terms of enjoyment, reading fluency and comprehension. The Paired Reading approach has also recently reported similar findings with a population of LACYP in Sweden [50].

### *Tutoring programmes*

Generally, personal tutoring has been empirically validated for students considered at risk of school failure or those with an identified learning disability [51], and evidence from a range of educational approaches suggests that tutoring is a popular initiative among LACYP themselves [47]. **Catch Up** is a structured tutoring programme that is delivered by trained foster carers and teaching assistants and has been piloted with two samples in the UK. The programme is designed specifically for children who find reading difficult, and addresses all aspects of the reading process from word recognition and language comprehension. Children in these pilot programmes achieved gains in reading age, in many cases equivalent to those gains reported when Catch Up is delivered to mainstream pupils [52].

However, a scoping review of evaluated interventions aiming to improve LAC's school achievements concludes that there is a paucity of intervention research in this area, with those studies that have been conducted carried out using only weak designs and small samples [53]. Tentatively the review concludes there is some evidence to suggest that tutoring programmes with university student or teacher volunteers may support improvements in reading and spelling, however authors urge that more attention be paid to developing and improving LAC's numeracy skills.

A preliminary study into group-based tutoring for children in long-term foster care suggests the potential for new approaches to improve educational attainment within small-groups. With initial findings suggesting that a 25-week direct instruction programme with groups of four children had positive effects on reading and spelling (exceeding those gains made by children in the waiting list control group who had not yet participated in the programme), authors intend to complete a larger two-year study and explore potential moderators that may impact the influence of group-based tutoring on achievement in LACYP [54].

### **3.1.1.3. Substance use prevention programmes**

Although there is some limited evidence drawn from programmes to prevent or reduce substance use among institutionalised adolescents (including those in residential foster care homes, as well as secure estate for juvenile offenders and treatment facilities for severe psychiatric problems; [55]), evidence for foster youth substance use prevention is extremely scarce. In one randomised controlled trial (RCT) from the USA, the substance use and delinquency of middle school<sup>7</sup> girls in foster care receiving the **Middle School Success (MSS)** intervention were analysed [56]. MSS aims to promote healthy adjustment in adolescent girls in foster care during their transition to middle school. The programme emphasises increasing prosocial skills and building self-efficacy, and also involves a caregiver curriculum designed to increase placement stability. During group-based skills building sessions, the girls' curriculum includes increasing the accuracy of perceptions about peer norms for abstinence from substance use, sexual activity and violence, along with strategies for meeting new people, dealing with exclusion, and talking about life in foster care. The programme also incorporates a small ceremony, in which girls publically proclaim their goals and commitments. Although the programme had no

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<sup>7</sup> Middle school (also known as junior high) is one of three compulsory education levels in the United States and covers a student age range of 11 to 14 years.

effect on girls' delinquency or alcohol use, significantly lower levels of tobacco and marijuana use were reported over 12 months follow up. Girls assigned to the intervention also had significantly fewer placement changes over the same time period. Additional analyses from the MSS intervention showed significantly lower levels of health-risking sexual behaviour among intervention girls [57].

The extent to which more traditional approaches to drug and alcohol prevention such as Brief Motivational Interviewing (MI) or Screening, Brief Intervention and Referral (SBIRT) are feasible with LACYP remains relatively unknown. However, a recent focus group study conducted with foster care staff, administrators and parents in the USA attempted to explore the feasibility of these approaches with this unique population and some clear barriers emerged [58]. Focus group participants were particularly concerned about the brevity of these interventions, believing that it may be difficult for LACYP to develop a connection with an interventionist in such a short space of time, and that the subsequent abrupt ending to this connection may be potentially damaging. Participants also felt that LACYP would be reluctant to disclose their problems, through fear that interventionists would lack any real understanding of or empathy with the foster youth's history. These qualitative findings suggest that interventions designed to address substance use in the general population are likely to be a very poor fit for foster care youth.

#### **3.1.1.4. Sibling interventions**

Evidence suggests that siblings can strongly influence the mental health, academic and social outcomes of both normative and at-risk young people [59]. Relationships with siblings may be particularly pertinent in LACYP for providing a sense of connection and emotional continuity as they are removed from their home, biological parents, school and peers. However, there is currently a clear paucity of evidence for sibling interventions with this population. Although it has previously been suggested that the addition of sibling intervention components can raise parental engagement in existing parent training programmes [59], and that sibling interventions are feasible if supported by rigorous implementation [60], particular challenges may exist in implementing this approach with LACYP. For example, siblings in foster care may be living apart from one another, and/or their living situations may change over time.

A recent feasibility study explored the potential for a sibling intervention with LACYP in Oregon. **Supporting Siblings in Foster Care (SIBS-FC)** targets youth aged 7-15 years and aims to support foster youth in developing socially skilled behaviour and reducing sibling-based conflict [61]. The intervention is delivered in community settings and includes sessions on planning activities, cooperation, social relationship repair strategies and approaching adults for support. Skills are typically introduced in one session, then followed up with practice during community activities. Initial perceptions from participants suggest they enjoyed the coaching sessions and activities, and would recommend the programme to other youth in foster care. Although this is potentially an emerging area, much more research would be needed to assess the sustainability of the intervention, and the relationship between implementation of the programme and desired outcomes for LACYP.

#### **3.1.1.5. Strengths-based programmes for building resilience**

Strengths-based programmes are designed to identify, acknowledge and work with strengths as a means to bring about positive change, offering a contrast to perspectives that focus on what is wrong (i.e. defining and addressing problems). In recent years, resilience (Box 3.1) has been a common theme in these approaches.

### BOX 3.1: RESILIENCE

The term resilience refers to the process of adapting well in the face of adversity; limiting the lasting impact of trauma, threats or sources of stress. Although there has been much debate as to whether resilience is a personality trait or a process of adaptation, it is now generally believed that resilience can be learned and developed, and is related to an individual's ability to use the resources available to them in meaningful ways. In the field of resilience, LACYP are often a point of focus, as they may lack some of the characteristics of resilient children, such as a positive self-concept, hopefulness, emotional expression in stressful situations and interpersonal problem solving skills [2].

A briefing report produced by Barnardo's [62] explores the issue of resilience in the context of children's services, and provides recommendations for designing and implementing interventions. These include: incorporating flexibility so that practitioners can work in ways suitable to each child and his/her parents; working collaboratively with other professionals such as teachers and psychologists so that skills learnt in the context of the intervention can be practised, internalised and extrapolated to other situations in the outside world; and ensuring regular and structured communication between sources of referral and those delivering the intervention, so that referrals are appropriate and realistic expectations of the intervention and what it can achieve are maintained. Details are also provided of Barnardo's own **Arch Project (Achieving Resilience, Change, Hope)** which worked with children with emerging emotional or behavioural difficulties aged 5-14 years in central Birmingham. As well as building the six domains of resilience (secure base; education; friendships; talents and interests; positive values; social competencies) the project aimed to strengthen protective factors associated with resilience and reduce challenging behaviour, developing individualised action plans for each child. Although the project is yet to be independently evaluated, findings from an early internal evaluation suggest that many children had made positive changes to their behaviour as a result of participation (as identified by parental reports).

The **Holistic Arts-based Program (HAP)** is an example of a group programme that aims to help LACYP develop resilience. HAP uses arts-based and mindfulness methods that teach children how to: pay attention and listen; use their imagination; identify and explore their feelings, thoughts and behaviours; and recognise and develop their strengths [63]. Arts-based approaches have previously been used to address specific problems faced by young people in the USA, for example dealing with bereavement. Such approaches are designed to be enjoyable for young people and emphasise the importance of fun. Although programmes like HAP are only in the very early stages of development, and are yet to be suitably evaluated, initial qualitative feedback from young people involved with HAP suggest that they viewed the programme positively and could provide specific examples of how it had supported the development of their self-awareness and self-esteem [2].

#### 3.1.1.6. Therapeutic approaches

##### *Mental health and treatment for abuse and neglect*

Children and young people in foster care have disproportionately high rates of trauma exposure and mental health problems. **Trauma-focused cognitive behavioural therapy (TF-CBT)** is a structured programme that is designed to address both behaviour problems, and trauma-related symptoms using individual sessions with children, and joint child-caregiver sessions. During these sessions, children are taught relaxation skills, coping strategies and how to manage their emotions. Initially developed to address the psychological trauma associated with child sexual abuse, TF-CBT has been adapted for a wide range of traumatic experiences and is supported by evidence from over 14 RCTs. It is the only treatment considered well-supported and efficacious by the US Office for Victims of Crime in their examination of mental health interventions for children who were

victims of intrafamilial physical or sexual abuse [64]. In a recent trial in Illinois (USA), LACYP who received 11 or more sessions of TF-CBT had significant reductions in symptoms of post-traumatic stress [65]. Positive emotional and behavioural outcomes of TF-CBT for LACYP in Washington (USA) aged 5-16 years experiencing one or more symptom(s) of post-traumatic stress disorder were reported [66].

This rapid review identified a single preliminary study considering the therapeutic treatment of LACYP presenting with self-harm [67]. This intervention incorporated outreach techniques and residential activities (i.e. strategies that have demonstrated effectiveness in engaging challenging young people) with a pilot **Dialectic Behaviour Therapy (DBT)** treatment package and bespoke telephone support. DBT is a type of talking therapy that not only aims to change unhelpful ways of thinking and behaving (similar to CBT), but also focuses on acceptance techniques to help people understand why they do what they do. DBT was found to be successful in reducing standardised depression scores, hopelessness scores and self-harm among LACYP, although no significant impact on negative automatic thoughts or quality of life scores was found. Rate of non-completion of therapy was also considered high, with over a third of adolescents failing to engage, and some suggestion that the group format and high intensity programme was considered too overwhelming for some participants.

#### *Therapeutic placements and treatment for behaviour problems*

**Treatment Foster Care (TFC)**<sup>8</sup> is an intensive and individually tailored intervention that provides treatment and substitutive care for young people with chronic behaviour problems or other clinical problems that place them at risk of multiple or more restrictive placements (e.g. secure residential settings). Through placements with specialist foster carers who are selected and trained to provide therapeutic care (typically lasting nine to twelve months), young people are provided with support in all areas of life, from developing better relationships to solving problems and coping with adversity. As well as promoting the young person's strengths and addressing their difficulties, foster carers provide close supervision and set clear limits on behaviour, reinforcing prosocial behaviours and monitoring negative peer relationships. TFC can also, where appropriate, support the young person's birth family through interventions such as counselling, family therapy and parenting training. In many cases the intervention aims to enable young people to return home or enter a stable long-term placement.

A Cochrane review in 2008 summarised findings that suggest that TFC may be a useful and effective intervention for addressing the delinquency and antisocial behaviour of both boys and girls with complex emotional, psychological and behavioural needs, although no effects of the intervention were found for other outcomes such as education, training and employment [68]. The authors also raised some concerns as to the generalisability of the research, considering that all studies included in the review were from the USA and were conducted by those involved in developing the TFC programme. Although positive effects on behaviour have also been reported in Sweden [69], such findings are yet to be replicated in the UK, with an evaluation of the Multi-Dimensional Treatment Foster Care - Adolescents programme finding no effect of TFC on offending behaviour [70].

#### **3.1.1.7. Transition support for care leavers**

Leaving care is an important transition for LACYP. Compared to the general population, care leavers are more likely to experience a range of detrimental health and social outcomes, compounded by the fact that they will

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<sup>8</sup> May also be referred to as multi-dimensional treatment foster care (MTFC), specialised foster care or wrap around foster care.

often transition to independence earlier than non-LACYP and retain far less, and often no, financial, emotional or social support from their families. Often it may be the case that educational, social and behavioural gains made whilst looked after are not maintained upon leaving care. Some support services or interventions therefore aim to aid the transition into adulthood (and consequently independence) for young people ageing out of care.

### *Transition support services*

In a review of evidence for the effectiveness of such transition support services (TSS), Everson-Hock et al [71] identified seven cohort studies that reported longer-term adult outcomes for LACYP, although authors were careful to note that there was considerable inconsistency in the methodological quality of included studies, as well as the quality of reporting. Consequently, only moderate evidence was found for the majority of outcomes. For example, a US study by Georgiades et al [72] reporting on a subsidised independent living programme for 18-21 year olds that involved general life skills training classes (e.g. employment, money management, decision making and problem solving) combined with case-worker support reported positive outcomes for education and employment, but found no intervention effect on likelihood of being arrested, homelessness or depression. A similar intervention specifically targeting LACYP in higher education in California with a curriculum that also included housekeeping and nutrition, found significant positive effects only for hopefulness for the future [73], with no effect of the intervention on reported happiness with life. The review suggests that TSS may have the potential to achieve positive outcomes in adult care leavers for education, employment, parenthood and housing, although studies are almost exclusively from the USA and many are more than 10 years old. As few formal evaluations have been conducted, authors highlight the need for future studies to evaluate the effectiveness of TSS using more rigorously designed studies. These conclusions are also echoed in a review by Montgomery et al [74] who highlight that although outcomes for participants of independent living programmes compared favourably with outcomes among other care leavers, these young people still report poorer outcomes compared with the general population.

Since these reviews, a small-scale evaluation of a transitional living programme for pregnant and parenting foster care youth with mental health problems in Chicago has shown some preliminary positive changes in participants' family relationships, parenting behaviour and parental competency [75]. However, the intervention had no effect on mental health outcomes, and the evaluation was unable to consider outcomes for these young mothers at and following discharge from the programme.

A recent paper from Batsche & Reader [76] highlights the potential utility of Geographic Information Systems (GIS) for assisting in the identification and evaluation of housing for youths transitioning out of foster care. Using GIS to combine multiple datasets and provide a spatial perspective, the **LEASE** (Locate and Evaluate Affordable, Safe and Effective Housing) model identifies housing that is affordable, has accessible public transport links, and is proximal to a supermarket or similar outlet, whilst avoiding areas of high crime. Authors argue that GIS could be useful when planning services for LACYP transitioning to independent living.

### *Campus support programmes*

There is an emerging trend in the USA for campus support programmes for foster care leavers, who may otherwise face a number of barriers to post-secondary educational success. These programmes often offer some kind of direct financial assistance, or help students to identify other financial supports, alongside other general support services, mentoring, career programmes, and/or peer activities. The **FACES** (Foster Care Alumni Creating Educational Success) programme is one such example [77] and is based on a strengths perspective that helps students to identify their strengths and build their sense of self-efficacy and self-worth.

An exploratory case study of FACES suggests that the programme may improve freshman (i.e. first year) retention rates for foster care leavers [77]. Campus support programmes can also raise awareness among student services personnel as to the unique needs of those transitioning out of foster care.

Similarly, campus-based experiential learning residential programmes that aim to prepare foster care youth for the transition from high school to college may show some promising practices (e.g. Michigan Educational Opportunities for Youth in Care; [78]), although there is as yet no evidence to determine the impact of these approaches on longer-term educational or other outcomes.

### **3.1.2. INTERVENTIONS THAT TARGET FOSTER PARENTS ONLY**

The following section summarises evidence for the effectiveness and acceptability of approaches that work with foster parents to enable them to better support and respond to the needs of LACYP placed within their care.

#### **3.1.2.1. Foster parent training**

Parent training programmes typically support parents in the acquisition of parenting skills. For foster parents, skills-based training programmes may provide information on child development and attachment, as a means to developing techniques for behaviour management. Training with this unique population of parents may also aim to raise awareness of the role of foster families, providing information and support in dealing with issues relating specifically to being a foster carer.

Although there is a considerable evidence base in support of the lasting positive effects of parent training programmes that have been developed for birth parents of children displaying a range of problematic behaviours, there is very little evidence of the generalisability of these programmes to foster carers and children in care. In a general review of training programmes specifically for foster parents, Dorsey et al [79] note that approaches to training, and the content of training curricula in the USA (from where much of the evidence base is drawn) vary widely, with many evaluations looking at the impact of training on foster parents' subjective self-reported knowledge and attitudes immediately after the training, with very little consideration of the transference and application of training over the longer-term. Foster parent education curricula such as MAPP® and PRIDE® are widely used in the USA but with very little supporting evidence [80]. Whilst it is likely that numerous training programmes have been developed in the UK by individual and private agencies, very few have been evaluated and/or published. A review by Kinsey and Schlosser [80] suggests that few foster carer training programmes are well supported in the academic literature, with the exception of the KEEP intervention. A review of evaluations from the USA and UK also found no evidence of an impact of foster-parent training on placement stability [71].

#### *Keeping Foster Parents Trained and Supported (KEEP)*

Based on Multi-Dimensional Treatment Foster Care (MTFC; see section 3.1.1.6) but taking a more universal approach, **KEEP** aims to help foster carers develop effective strategies for managing unwanted child behaviour and emotional problems, through non-harsh discipline and positive reinforcement. The programme is delivered in groups and in a wide range of settings, covering topics such as effective methods for setting limits, strategies for avoiding power struggles, and managing the stress of being a foster carer. Much of foster parents' learning in the programme is based around the visual demonstration of behaviour management strategies, and skills practice through role-play and home assignments.

Results from a randomised controlled trial in San Diego (California) involving 700 foster and kinship carers of children aged 5-12 years showed significant improvements in parenting skills, child behaviour problems,

placement stability and family reunification [81]. Evidence also supports the effectiveness of the KEEP programme among children displaying varying levels of initial behaviour problems [82]. More recent findings suggest that the programme is effective in reducing parent stress and the behavioural problems of more than one child in the same household [83].

The evaluation evidence for KEEP has been awarded a 3-star Parenting Programme Evaluation Tool (PPET) rating by the Department for Education, indicating it has promising evidence of effectiveness [84]. The programme has been running in England since 2009. After the initial set up costs, which are estimated at around £13,000, the KEEP programme is estimated to cost in the region on £2,500-£3,000 per foster carer (four month course plus follow up support group). The financial burden of placement disruption is thought to cost between £800 and £1,700, with the recruitment and approval of each new foster carer an additional £2,200 [85].

#### *Cognitive behavioural approaches to behaviour management*

Parent training programmes with birth parents have shown some success in improving children's behaviour by enhancing parents' knowledge and skills in behaviour management. Cognitive behavioural (CB) approaches are skills-based approaches that emphasise the role of cognition as a determinant of both behaviour and mood/feelings. CB approaches therefore focus on beliefs, attitudes, expectations and attributions in accounting for behaviours, and view problem behaviour as a product of maladaptive thinking. However, in 2007, a Cochrane review of interventions that trained foster carers in cognitive behavioural methods concluded that there is no evidence of a significant impact of these approaches on the psychological functioning, behaviour or interpersonal skills of LAC [86]. Although authors suggest that studies are limited by small sample sizes and consequent lack of power (for the detection of small effect sizes), the baseline characteristics of samples of LAC who experience increased incidence of abuse and neglect, as well as other emotional, psychological and behavioural traumas, may make it more difficult for interventions to significantly impact on problem behaviours. Recommendations from the review are therefore focused on the development of longer-term and more intensive programmes with specialised content. Although evidence for the effectiveness of foster parent training is limited, there is some suggestion that this approach may appeal to foster parents themselves (Box 3.2).

#### **BOX 3.2: ACCEPTABILITY OF FOSTER PARENT TRAINING**

Although there is limited evidence of the effectiveness of foster parent training for improving behavioural problems or the emotional health and wellbeing of LACYP, a number of studies from the UK report that foster carers perceived some personal benefit from the training they received [8, 9]. An evaluation of a training programme with foster carers in England that aimed to develop skills in behaviour assessment, analysis and intervention, for example, found that training was viewed very positively by participants, with as many as 93% suggesting that they found the training useful and had applied the techniques learned [13]. A qualitative study of a parent training programme and psycho-educational group in Worcestershire also reported that foster carers felt that groups had not only helped improve their skills and improved their understanding of their child's difficulties, but also increased their confidence and made them feel more supported [9].

#### **3.1.2.2. Future research for foster parent training**

In their review, Dorsey et al [79] highlight that more research attention for foster parent training is needed in three key areas: (1) the content of curricular; (2) the timing of training (i.e. pre-placement, after placement or

across both); and (3) the delivery methods for training (e.g. group or one-to-one, practice-based or classroom taught, interactive, online or web-based approaches etc). For example, a pilot study of web-based training for foster, adoptive and kinship parents (Foster Parent College) highlights the opportunity presented by this modality for combining text and graphic elements in complex ways to enhance instruction, as well as incorporating user interactions and making content adaptable based on individual characteristics or choices [87]. In this small study, foster parents made significant improvements in knowledge and perceptions of competence, but also reported high levels of satisfaction with the training (e.g. 90% reported that they found the website easy to use).

### **3.1.3. INTERVENTIONS THAT TARGET BOTH THE CHILD AND THEIR FOSTER PARENT(S)**

In addition to approaches that work independently with LACYP, and also those that work with foster parents, there are a range of interventions that involve working with both the child and parent together to help both populations to learn new skills that can support healthier, more nurturing and more stable relationships through all stages of childhood. Whilst relational interventions born in social learning theory or attachment theory can support the developing relationship of a foster parent and a younger child, school readiness programmes can assist in parent-teen relationships.

#### **3.1.3.1. Relational interventions – social learning**

Parent-child programmes, particularly with school-aged children, are often based on behavioural principles as applied in social learning theory (Box 3.3). Examples of interventions that are based on social learning theory and have been adapted for use with LACYP include Parent-Child Interaction Therapy (PCIT) and Incredible Years (IY).

#### **BOX 3.3: SOCIAL LEARNING THEORY**

Social learning theory proposes that children’s real-life exposures directly or indirectly shape their behaviour through processes such as imitation and reinforcement. From experience, children learn strategies to manage emotions, resolve disputes and engage with others, with the early family environment providing a primary source for these experiences. Interventions therefore focus on altering the quality of parenting as a means to improving child behaviour. Important parenting behaviours in this model include positive attention and praise, criticism, and clear directions and instructions.

#### *Parent-Child Interaction Therapy (PCIT)*

Originally developed as a treatment programme for children with disruptive or externalising behaviour problems (such as conduct disorders) and founded on social learning principles, PCIT is a family-centred approach that is now recognised as a way to support foster parents in caring for abused or at-risk children aged 2-8 years. In PCIT, therapists coach parents while they interact with their children. Two different phases of the programme focus on child-directed interaction (relationship enhancement) and parent-directed interaction (discipline and compliance) respectively. PCIT is generally considered one of the more intensive parenting interventions and focuses on changing the behaviours of both the parent and the child together.

The effectiveness of PCIT for birth families is supported by a considerable body of research from over 30 trials, much of which is considered to be of high quality by inventories such as SAMHSA’s National Registry of Evidence-based Programs and Practices (<http://www.nrepp.samhsa.gov>). In two studies that look specifically at outcomes for LACYP, children who took part in a modified workshop version of PCIT showed a decrease in both the number and frequency of problematic or difficult behaviours [88], although the persistence of these

effects over time has not been determined. Foster parents report less parental stress following PCIT and high levels of satisfaction with the programme [88]. To date, PCIT has only been evaluated in the UK for use with language delayed or impaired children within a speech and language therapy context [89].

#### *Incredible Years (IY) parent training programme*

The IY programme is underpinned by social learning theory and consists of four modules focusing on: (child-directed) play; praise and reward; effective limit setting and dealing with non-compliance; and handling misbehaviour, time out and problem solving. The programme also emphasises the importance of developmentally appropriate expectations for children (depending on their age, temperament and developmental abilities) when establishing family rules and routines. Since its conception more than 30 years ago, IY has been supported by considerable evidence from across the globe, improving outcomes such as child anti-social and hyperactive behaviours, use of positive discipline, and parental stress. It is now one of two programme recommended by NICE specifically for the treatment of conduct disorder [90].

Initially adapted in the UK for use with adoptive families [91], IY was trialled with 46 foster carers in Wales in 2009, with findings demonstrating both the effectiveness and acceptability of the programme with Welsh foster carers. Intervention families showed a significant reduction in child problem behaviour and improvement in foster carers' depression levels, relative to controls [92]. Findings also suggest that foster parents enjoyed the programme and welcomed the opportunity to attend a group that was specifically for them, as this meant they felt more able to share their own experiences (in light of concerns around confidentiality issues; [93]). A pilot study of IY in the USA by Nilsen [94] found that the intervention had a significant impact on child conduct problems, hyperactivity and aggression, although no quantifiable impact on parenting knowledge and attitudes. Kinsey & Schlosser [80] urge caution in interpreting these results, however, based on the sampling used to identify a control/comparison group. Authors from both Wales and the USA call for examination of IY for foster carers within larger randomised controlled trials.

IY has also been modified and implemented in a middle childhood foster sample, incorporating a co-parenting component working with foster parents and biological parents to increase their knowledge of each other and their child, support open communication and negotiate conflicts around family visitation, routines and discipline [95]. However, although intervention families showed improvements in positive discipline and co-parenting skills, the programme had no significant effect on externalising problems among the LACYP. In their review of interventions to promote resilience in LACYP, Leve et al [5] highlight the lack of long-term follow up for this modified IY, noting that effects dissipated quickly (3 months after the intervention).

#### **3.1.3.2. Attachment interventions**

With an ever-increasing focus on the importance of early life experiences, and recent developments in scientists' and practitioners' understanding of the neurological mechanisms that link these experiences with impacts on a developing child, interventions that support secure attachment between parents and their children have gained momentum. Programmes that are based on attachment theory (Box 3.4) aim to improve parental sensitivity by increasing parents' knowledge of the needs of children, and their attachment-related behaviours.

A recent systematic review considering the impact of attachment interventions on fostered and adopted children's emotional, behavioural and relational functioning identified ten studies based on a range of different approaches within this framework [96]. Whilst some were focused on children who were already experiencing attachment difficulties and/or other behavioural problems, other interventions were delivered

with the foster parents of infants who were considered at-risk for future difficulties. Although there is some evidence that attachment theory-based interventions may have a positive impact on child behavioural functioning, and to a lesser extent emotional and relational functioning, review authors urge caution over the interpretation of results on the basis that studies are generally considered to be of poor methodological quality.

#### BOX 3.4: ATTACHMENT THEORY

Attachment theory is commonly used as a framework for understanding the needs and difficulties of LACYP, particularly those who have experienced abuse or neglect within their birth families. Pioneered by Bowlby (1988), this theory proposes that infants use their experiences with their earliest attachment figures to construct internal working models that contain core beliefs about the self, other people, and relationships. These models shape how the developing child perceives the intentions and motives of others, and therefore how they manage all their subsequent relationships. Parental sensitive responding behaviour is therefore a core component of attachment theory.

**Fostering Attachments Groups** use a three-module curricular with groups of up to 15 foster parents to develop both theoretical and practical understanding that focuses on how carers can help children to experience their home as a secure base and maintain secure relationships whilst effectively managing any problem behaviours. Group discussion is one of the main learning methods used for this approach, with foster carers providing examples from their own direct experiences with foster children. Three studies from the UK evaluating Fostering Attachment Groups show mixed findings. For example, whilst one small scale study with 13 foster parents and children aged 4-14 years reported a significant decrease in child hyperactivity at three month follow up [97], similar improvements were not found for conduct problems, emotional difficulties or peer problems, nor was this positive effect for hyperactivity replicated in other studies [98, 99]. Some qualitative feedback from foster carers did suggest that they felt they had developed a better working knowledge of how children may struggle to understand and manage their emotions, and were finding being empathetic an increasingly natural response. Although they found the group setting to be very supportive, some participants did express concerns that some of the material was difficult to grasp, particularly the content on attachment theory [98].

The **Attachment and Bio-behavioural Catch-up (ABC)** programme works on a one-to-one basis with foster parents and their young children (up to age three) within their homes. Here techniques such as child-led play and nurturing touch are used alongside adult recognition and labelling of emotions to increase the emotional regulation capacities of the child. Crucially, the programme provides the opportunity for foster parents to practice skills and receive coaching and feedback specific to their unique relationship with their foster child. Parents are also supported in reducing behaviours that could be overwhelming or frightening to a child. A randomised trial of ABC in 2006 found reduced behavioural problems in toddlers exposed to the intervention [100]. Later work has also shown direct beneficial effects on attachment - with intervention children showing less avoidant behaviour (i.e. seeking support from caregivers when distressed; [101]); decreased cortisol levels (equivalent to those children that have never had looked after status) and significant improvements in both internalising and externalising behaviours, relative to controls [102]. Individual approaches such as ABC may allow a more bespoke approach that attends to foster carer's own attachment styles and can be adapted to their unique needs. A small-scale follow up study of ABC with children aged 4-6 years provides preliminary support for the longer-term efficacy of the programme in supporting the normative development of executive function and theory of mind capabilities – outcomes considered important for school adjustment and social competence [103].

### 3.1.3.3. School readiness programmes

Being suitably prepared to meet the academic and socio-emotional demands of school is linked to longer-term positive impacts on both educational and psychosocial adjustment into adulthood. Core components of school readiness typically include early literacy skills and socio-emotional skills.

The **Kids in Transition to School (KITS)** programme is a short-term intervention that focuses on the school readiness (and subsequent school functioning) of LACYP. This programme was developed with a short duration (running 2 months prior to the start of kindergarten) to limit against the impact of placement changes, which may often prevent LACYP from receiving the full dosage of a long-term intervention. KITS focuses on preparing both children and their foster carers for school, with a curriculum for groups of 12-15 children that covers early literacy skills (e.g. letter of the day) and prosocial and self-regulatory skills (e.g. instructions on sharing, followed by role play by teachers, and an activity based intervention that requires children to share materials). Caregiver group meetings run alongside the children groups and focus on things like developing routines around school activities, or using behaviour management skills that parallel those used in the school readiness (children) group. Home practice activities are also provided. A randomised controlled trial of 192 children in foster care in the Pacific Northwest (USA) found a significant positive effect of KITS on early literacy and self-regulatory skills, although effect sizes were small and no statistically significant effects on prosocial skills were found [104]. An earlier efficacy trial also identified positive effects of the intervention on LACYP's oppositional and aggressive behaviour up to 8 months after the programme [105]. Authors consistently acknowledge the challenges of recruiting participants from this population.

### 3.1.3.4. Reunification interventions

Targeting birth parents who are considered high risk for parental criminality, poor parenting, substance use problems and consequently reunification failure, the **Pathways Home Foster Care Reunification Intervention** aims to support parents in managing their households, managing stress, staying healthy and creating safe and nurturing environments for their returning children. The programme teaches parent management strategies and emphasises positive reinforcement for prosocial behaviours and was evaluated in a randomised controlled trial (RCT) with children aged 5 -12 years returning home from their first foster placements [106]. Although families in the intervention group exhibited a significantly greater use of encouragement than control/comparison families, no differences on measures of child problem behaviours were found and the difference in likelihood of re-entry into foster care (greater in the comparison group) was not statistically significant.

**On the Way Home** is an example of a community-level programme that aims to provide support to LACYP during reintegration back into their homes, families and communities following a stay in care. In this approach, established interventions are used to: improve family communication and teach parents strategies for promoting self-control skills and decision making skills; enhance child-family-school relationships and prevent school drop-out; and develop appropriate homework environments and strategies for promoting educational growth (e.g. personal tutoring, using positive and negative consequences systems, etc). Preliminary findings from the USA suggest that the intervention can improve both residential and school stability, thus promoting short- and long-term educational success [107]. Authors highlight the need for a large scale RCT to further explore programme efficacy and understand its effects across settings and different youth populations.

Thus it is apparent that research into the effectiveness of specific interventions to support reunification is very much in its infancy. A research briefing by Social Care Institute for Excellence identified the following approaches (from a review of the literature) likely to lead to successful outcomes for LACYP returning home:

intensive outreach work; family-centred group work focused on the special needs of parents of children in care; and advocacy services to help overcome barriers between parents and community agencies (e.g. housing, financial advice, health; [108]). The briefing highlights key limitations of the current evidence (e.g. the high proportion of cases that are lost at follow up) and urges programme developers, practitioners, policy makers and researchers to refocus attention onto reunification.

### **3.1.4. INTERVENTIONS FOR SPECIAL POPULATIONS**

The following section provides a brief summary of evidence for effective interventions or approaches to support the unique needs of particular sub-populations of LACYP. These may be children who face different difficulties due to their traumatic experiences in childhood so far (e.g. unaccompanied asylum seeking children), or those whose current needs may require additional support. In many cases, it is apparent that research specific to these special populations of LACYP is scarce.

#### **3.1.4.1. Unaccompanied asylum seeking children and young people**

Although unaccompanied asylum seeking children and young people are similar to LACYP in the sense that they have been separated from their family of origin (this could be for a number of reasons, including armed conflict, economic hardship, trafficking etc), they have also experienced separation from their communities and countries of origin, and may have unique needs related to adapting to a new culture (acculturative stress) and/or dealing with the psychological impacts of trauma witnessed or experienced prior to arriving in the UK. The possibility of refusal and return to their country of origin may also be anxiety-provoking for these young people.

Guidance provided by NICE [30] acknowledges the importance of the following when supporting the emotional wellbeing and mental health of unaccompanied asylum seeking youth: high quality placements; establishing friendship networks; culturally relevant networks including those that meet religious, dietary, dress beliefs and needs; and contact with or information about family and friends in their country of origin. The guidance does, however, acknowledge the importance of any of the above being predicated on consultation with the young person themselves.

Any assessment or support given to unaccompanied asylum seeking children and young people would need to reflect the likelihood that English is not their first language (and that even if they appear to speak good English, their expression and comprehension may be much more limited). Cultural differences such as attitudes towards authority figures, understanding of mental health, or beliefs about bodily exposure (for example, for physical health assessments) may also be important considerations.

The **Scottish Guardianship Service** aims to improve separated children's experiences and understanding of immigration and welfare processes, as well as their access to services, by providing them with an independent adult (i.e. not their social worker) to act as an advocate, mentor and protector. Preliminary findings from an independent evaluation of the first two years of a three year pilot (based on data from 81 young people who were allocated a guardian) suggests that young people's views of their Guardians were almost exclusively positive, with clear suggestions that Guardians helped them to access the welfare, health and education services they needed, but also made sure that these services were good quality and timely. Authors identified evidence of 'added value' of Guardianship across asylum, well-being and social (networks) outcomes [109].

No other evidence of interventions with unaccompanied asylum seeking children was found in this rapid review.

#### **3.1.4.2. LACYP with disabilities**

Disabled children constitute a significant group in the looked after system, yet there is a clear lack of evidence around interventions targeted specifically for this population, with this rapid review finding no relevant research conducted in the UK or elsewhere.

A scoping review by the Centre for Excellence for Looked after Children in Scotland (CELCIS) concluded that LACYP with disabilities are less likely to reunify with their birth families, wait longer than non-disabled LACYP for adoption, stay in foster care longer than their peers, and are more likely to be placed out of their local authority or in inappropriate placements [110], all of which suggest a need for specialist programmes and support. The review identified a clear lack of evidence exploring disabled children's views and experiences in foster care, suggesting these children are widely excluded from both decision making and research.

Young disabled people may have particular problems during the transition to leaving care as they may experience inadequate planning, and may be more restricted by housing and employment options. Therefore the opportunity for programmes to provide transitional support should be explored.

#### **3.1.4.3. Black and minority ethnic (BME) LACYP**

Although it is reported that the number of BME children who are looked after by local authorities in England is increasing year on year, again no research was found evaluating interventions to improve the health and wellbeing of this group of LACYP specifically. Perhaps most importantly, although guidance produced by the Department for Education requires that attention is paid to a child's faith, ethnic origin and cultural and linguistic background, there is a notable absence of interventions to support these specific needs. Furthermore, studies that do examine the effectiveness of different interventions for LACYP have often highlighted limitations concerning the ethnic and cultural diversity of samples, with many studies examining outcomes with white Caucasian children only.

The British Association of Adoption and Fostering is currently running a Black, Asian and Mixed Ethnicities Perspectives Project which aims to promote a wider understanding of the particular needs of these children in the public care system in the UK (<http://www.baaf.org.uk/ourwork/bmeproject>).

## **3.2. APPROACHES FOR IDENTIFYING, MONITORING AND EVALUATING THE HEALTH, EMOTIONAL AND SOCIAL OUTCOMES OF LOOKED AFTER CHILDREN AND YOUNG PEOPLE**

As systems, processes, services and interventions are developed to better support the complex needs of LACYP, attention turns to how to measure the range of health, behavioural, social and emotional outcomes that are most pertinent to this population. Keeping track of experiences and monitoring outcomes for LACYP is important for commissioners and practitioners developing and delivering services, as well as for researchers in this field who seek to further our understanding of trajectories for LACYP and the risk and protective factors that may impact on their longer-term health and wellbeing. This section of the rapid review sought to consider different approaches to monitoring relevant outcomes for LACYP. Although very little evidence was identified that offered a formal evaluation of different approaches, some critique of current systems was offered, and some examples of data collection tools and methods were found and are discussed below. This section summarises evidence from the rapid review based on the journey of LACYP through the care system; from initial assessments upon entering care, through to monitoring important outcomes during looked after placements, and longer-term follow up for care leavers.

### **3.2.1. ASSESSMENT AS CHILDREN ENTER CARE**

Children entering looked after care may present with high levels of physical, developmental, emotional and behavioural difficulties. It is therefore important to ensure that action is taken on any early signs of health concerns, and that LACYP receive appropriate care and services based on these needs. Initial assessments may also provide a baseline upon which improvements in outcomes can be evaluated. Box 3.5 below summarises current statutory guidance on health assessments for LACYP in England.

Statutory guidance on promoting the health and wellbeing of LACYP provided by the DCSF and DH in 2009 reflected research of unknown origin (i.e. that is not referenced within the guidance document) that was proposed to indicate that although statutory health assessments were able to identify health needs that may otherwise go unrecognised, there is considerable variability in the extent to which recommended assessments are implemented, with many failing to capitalise on the opportunity to promote children's health. Research has raised particular concerns about the suitability and accuracy of statutory health assessments (which tend to focus on physical health and developmental disorders) for mental health screening, based on difficulties obtaining coherent medical and developmental histories and gaining input from caregivers [111].

A paper by Eichler [112] describes a nine month change project that aimed to improve the service provision of statutory health assessments to better address the health needs of LACYP. The project involved an initial literature search, audit and stakeholder interviews (including named nurses, administrative support (both health and social services), child protection, leaving care teams etc) to understand current service provision. A force field analysis was then undertaken to identify factors affecting the current provisions, and potential barriers to change. Implemented changes included a streamlined referral system, improved team working, regular service review meetings and ongoing evaluation.

### BOX 3.5: STATUTORY HEALTH ASSESSMENTS

The Care Planning, Placement and Case Review (England) Regulations, 2010 require that initial health assessments are carried out for every child entering care. These assessments must be carried out by a registered medical practitioner and should be holistic and include physical and mental health, as well as health promotion. Local authorities must ensure that every child has an up-to-date individual healthcare plan, which is based on this initial assessment and subsequent review health assessments. Review assessments must take place at least twice a year for children under five years of age, and once a year for those over five years.

Local authorities are also required to use the **Strengths and Difficulties Questionnaire (SDQ)** to assess the emotional well-being of LACYP. Whilst the Department of Education requires that local authorities provide SDQ data as part of their annual statistical return (SSDA903) with the intention that trends can be monitored and comparisons made between different local authority areas, guidance urges local authorities not just to use the SDQ as a data collection exercise for central government, but to use aggregate SDQ scores to help quantify the needs of LACYP and feed into Joint Health and Wellbeing Strategies. Using a nationally representative British sample of LACYP, Goodman & Goodman [10] demonstrated that the scores on the SDQ reflect real differences in mental health in LACYP, even though they have a much higher prevalence of disorders compared with the general population. This supports the use of the SDQ for monitoring mental health. However, local authorities are free to use other tools to supplement the SDQ if they so wish. Data from SDQs conducted with LACYP are included in section 5.1 of this report

Further information and guidance as to the principles of a good health assessment, and the role of different health and other professionals, can be found here:

[www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/413368/Promoting\\_the\\_health\\_and\\_well-being\\_of\\_looked-after\\_children.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf).

### 3.2.2. EXPERIENCES AND OUTCOMES WHILST LOOKED AFTER/IN CARE

Following their entry in to care, LACYP's experiences within their placements are likely to shape their continued development. Whilst it is hoped that their looked after status may provide children with supportive family relationships that are a platform for improved health and wellbeing, educational attainment and other positive outcomes, it is important to monitor the progress of LACYP to ensure that they are supported appropriately and do not experience any additional negative outcomes as a result of their time in care.

#### 3.2.2.1. Health information sharing

Accurate and up-to-date personal health information may have significant implications for the wellbeing of LACYP during and following their time in care. Recommendations produced by NICE and Social Care Institute for Excellence (SCIE) [30] highlight the importance of sharing health information, including ensuring that social workers obtain permission to access the neonatal and early health information of LACYP, as well as information on parental health (including obstetric health). It is also suggested that early health information may enhance life story work with LACYP, which is intended to help them to make sense of their situation by answering questions such as who am I and how did I get here. Life story work (and the production of a life story book) relies on gathering full and accurate information from birth parents, siblings or other relatives, friends, school and health records. NICE and SCIE further recommend maintaining up-to-date personal health records (known

as 'red books') for LACYP and ensuring there is a clear process for reissuing the personal health record to all new carers.

#### **3.2.2.2. Comparing cross-agency data**

A case study of children's services in Ontario, Canada provides an example of how a regular review of outcome data for LACYP can be used to monitor key variables, as well as measure service quality and inform practice [113]. Data review days are organised to bring together LACYP, staff within children's services, foster parents and community partners (e.g. community mental health services; schools) to review local-level data and discuss the results. These days are used to raise awareness of the needs of LACYP, as well as celebrate successes and make informed planning decisions. Key partners are encouraged to assess their own capacity to gather relevant measures and data that may be used in forums like this to inform practice, policy and research.

#### **3.2.2.3. Monitoring risk for abuse and neglect**

A recent report by the NSPCC draws focus to the issue of abuse and neglect in foster care. In a survey of social work agencies in the UK, the NSPCC found that there are an estimated 450-550 confirmed cases of abuse and neglect in foster care in the UK each year [114]. The report suggests that aggregated statistical data are needed at both a local authority and national level to provide an accurate picture of substantiated abuse or neglect in foster care, with particular focus on clear communication strategies that support the monitoring of children placed out of the local authority area. As authors found evidence that warning signs may have been missed, they highlight the importance of making practitioners aware of signs of stress accumulation in foster carers. Other recommendations include high quality supervision of frontline staff and good cooperation and coordination between the agencies involved in the lives of children.

However, it appears there is very limited literature exploring how to monitor and ensure the safety and wellbeing of children placed in looked after care. One single study from the USA describes a critical incident reporting system that has been implemented by a child welfare agency in Connecticut [115]. In an agency-wide initiative, a system was designed, incident categories defined (e.g. abuse or neglect reports; fire play or fire setting; hospitalisation; self-injurious behaviour; etc), automated forms and notification procedures created, and the requirements of follow-up actions stipulated. The system is based on a hierarchy that ensures that senior managers are notified of certain incidents. Although a survey of users supported the programme's acceptability, no further evidence of the impact of this system on abuse and neglect is evidenced.

#### **3.2.2.4. Assessing attachment**

Children who have experienced maltreatment or other adverse childhood experiences may struggle to develop secure attachments, with potential lifelong consequences for their physical, emotional and social development. Although there is emerging evidence as to the effectiveness of interventions to support attachment in LACYP and their caregivers (see section 3.1.3.2), this rapid review found very little evidence for approaches for assessing attachment relationships in this population.

In one paper, researchers in Australia describe an approach used for assessing the relationships between LACYP and their foster carers using a semi-structured observational procedure, and argue for its clinical utility as part of a comprehensive assessment for LACYP [116]. Observations would typically include a period of play, an activity or task (that requires attention and perseverance, as well as reliance on the caregiver for support) followed by brief separation and reunion. Authors suggest that this approach could help to identify strengths and vulnerabilities in current foster or care placements, and could be used to inform suitable interventions for

that child or child-foster parent dyad. However, no evidence of the effectiveness of this approach in identify attachment problems was found, and authors themselves recognise that the relevance (e.g. age range), cultural appropriateness, reliability and validity of this observational procedure should be considered in detail before implementation, along with practical considerations such as time and resources available.

In a report for the Institute for Research Innovation in Social Services, Furnivall [117] suggests that for young children placed away from home, it may actually be more important and/or appropriate to assess the functioning of the family in which they are placed, rather than attachment security per se. Measures such as the Family Assessment Measure (FAM III; [118]) have been shown to have good psychometric properties when assessing family functioning, although no evidence of the use of these tools or scales with LACYP was identified in this rapid review.

### **3.2.2.5. National surveys and participatory research**

In national surveys that use a cohort of young people, it may be possible to identify individuals that are or have been looked after, and subsequently conduct analyses to look at particular outcomes in this subpopulation.

For example, the **National Survey of Child and Adolescent Wellbeing** in the USA is a nationally representative, longitudinal survey of children and families who have been the subjects of investigation by Child Protection Services ([www.acf.hhs.gov/programs/opre/research/project/national-survey-of-child-and-adolescent-well-being-nscaw](http://www.acf.hhs.gov/programs/opre/research/project/national-survey-of-child-and-adolescent-well-being-nscaw)). The survey draws on self-report from children, their parents and other caregivers, as well as reports from caseworkers, teachers, and data from administrative records, and attempts to relate well-being outcomes to experiences within the child welfare system. Studies have considered issues such as the assessment of mental health functioning [17], behavioural needs and service use [119], and cognitive problems, academic achievement and maltreatment [120]. Tools or scales used in the national survey include the Child Behaviour Checklist, which is summarised in Box 3.6 along with other scales that were identified in the rapid review for use with LACYP.

### BOX 3.6: SCALES OR TOOLS USED TO ASSESS OUTCOMES FOR LACYP

Although a full critique of the different tools or scales for assessing the health, social and emotional problems of LACYP is beyond the scope of this rapid review, considered academic papers and reports have identified a range of measures that have been used with LACYP that are briefly summarised below. Selection and use of these (and other) tools should be based on a careful consideration of their reliability and validity, with particular attention paid to whether or not their use has been validated with LACYP.

The **Ages and Stages Questionnaire** (ASQ; [4]) is a screening tool for mental health disorders that can be used with infants and children aged 0-5 years and is designed to take account of the rapid socio-emotional development that occurs during these early years. Designed to be completed by parents and caregivers, a US study found that the ASQ was feasible for use with LACYP and increased detection of developmental disorders [7].

Developed specifically for use with children in care (aged 4-11 years) and completed by caregivers, the **Assessment Checklist for Children (ACC)** covers a wide range of behavioural domains, including: sexual behaviour; insecure interpersonal behaviour; abnormal pain response; food maintenance behaviour; self-injury and suicide discourse; and negative self-image. Developers of the ACC have demonstrated content, construct and criterion-related validity with LACYP [12].

A number of studies report use of the **Child Behaviour Checklist** (CBCL; [14]) to describe the clinical status of children that are looked-after. Aimed at slightly older children and young adults (6-18 years) the CBCL can be self, caregiver or clinician administered and combines domains such as anxiety, depression, attention problems and rule-breaking or aggressive behaviour into externalising and internalising subscales and a total problem score. There is extensive support for the CBCL's psychometric properties; it is considered more culturally sensitive (and descriptive) than clinical diagnosis alone, and norms are provided for looked after populations. The CBCL has been used to measure outcomes for LACYP in the National Survey of Child and Adolescent Well-being [16, 17](also see section 3.2.2.5).

The **Child Health and Illness Profile-Adolescent Edition** (CHIP-AE) was developed as a tool for involving young people (aged 11-18 years) in assessing their own health and wellbeing and has been used with LACYP in foster care, as well as youth living in group homes or institutions [18, 19]. Domains covered by the CHIP-AE include: perceptions of overall health and self-concept; emotional health and disorders; resilience and vulnerability; risk; physical health and disorders; and achievement of social expectations in education or employment. The CHIP-AE has shown acceptable levels of reliability and validity in the USA [20].

The **Pediatric Quality of Life Survey** (PedsQL) is considered one of the most widely used measures for assessing child and adolescent health-related quality of life, with parent-proxy report for young children and self-report for older children and teenagers. Initially covering core domains of physical, emotional, social and school functioning, an "in-care" module was subsequently developed and has demonstrated reliability and validity [21].

Perhaps the most widely used scale for LACYP, the **Strengths and Difficulties Questionnaire** (SDQ; [22]) was mandated for use with LACYP in England in 2008. This extensively validated tool covers five domains: conduct disorders; emotional problems; hyperactivity/inattention; peer relationship problems; and prosocial behaviour. Studies support the use of SDQ with LACYP in Britain [10], Norway [23] and the USA [24]. A focus group study of frontline workers, senior practitioners and senior social workers in Northern Ireland considered views as to the usefulness of SDQ as a screening tool to inform services and support for LACYP. All participants viewed the SDQ positively, noting its particular utility in identifying strengths (that would otherwise not be evident) that could then be promoted and developed [25].

The **Growing Up in Care Project** is a longitudinal study of children in a long-term fostering programme of Barnardo's Australia. This study, which incorporates both quantitative and qualitative methods, assesses strengths and needs of LACYP four months after entry to their care placement, and at 18-24 month intervals thereafter. Data are provided by LACYP themselves, caseworkers and foster carers, and explores outcomes such as attachment, self-esteem, behavioural problems, anxiety and family cohesion [121]. The need for careful consideration of consent, privacy, child-friendly data collection strategies and sensitive communication is highlighted, as well as working closely with caseworkers to address issues related to the emotional impact on children participating in research interviews.

### **3.2.3. APPROACHES TO LONGER-TERM FOLLOW UP**

Whilst data collected from youth leaving care may provide some useful indication of initial outcomes (e.g. school attainment) and be in many ways predictive of future adult functioning (e.g. educational level), follow-up into later life may be required to identify how effective the care system has been in preparing LACYP for adulthood. Important aspects of adult functioning may include self-sufficiency, employment and/or income, and social capital. However, outcome studies that rely on locating and interviewing or surveying adults who were looked after as children may often have modest response rates, and this raises concerns of biases if non-responders may be those who experience more negative outcomes.

#### **3.2.3.1. Foster care alumni studies**

Foster care alumni studies typically use case record reviews and interviews with alumni to explore how LACYP are faring as adults, and whether they differ from other (non-looked after) adults with regards to functioning status. Large-scale studies such as the **Casey National Alumni Study** in the USA may also consider which key factors or programme components (e.g. placement stability, group therapy, employment training etc) are linked with better adult functioning [122].

Williams et al [123] provide a detailed overview of strategies that have been used across multiple US states for tracking foster care alumni and engaging them in research. After initially searching case files for contact information (including for possible family members and friends of the foster care alum) and contacting schools and past employers for clues as to what occupation the person was pursuing or other interests they may have, researchers used both professional search firms and internet-based services (including fee-based databases and free online directories) to identify potential participants. Numerous follow-up telephone calls were used, along with postal mailings of study information and attempted face-to-face contacts, to appeal to differences in communication norms. Incentives were offered to both respondents and informants (e.g. people who provided information to researchers about the possible whereabouts of foster care alum). Although these strategies were shown to be effective for tracking care leavers, not only are they costly and hugely resource-intensive, but it is important to note that many of the approaches identified may not meet the ethical standards required to conduct such research in the UK.

### **3.2.4. CHALLENGES TO MONITORING OUTCOMES FOR LACYP**

Successfully monitoring outcomes for LACYP requires the careful negotiation of numerous barriers and challenges, many of which have been drawn out of the literature identified in this rapid review.

Firstly, there is the challenge of identifying and then defining appropriate constructs. Child wellbeing, for example, is difficult to define and measure as it is a multi-dimensional concept that may include a wide range of sub dimensions such as resilience, overall functioning, school functioning, physical and/or mental health. The relevance of alternative outcomes may also need to be carefully considered. For example, much of the

current literature relies on measures of placement stability, but questions as to whether or not this should be the focus over and above placement satisfaction or other constructs related to the quality or features of a placement remain. Crucially, any measures of these constructs should be validated for use with LACYP.

Secondly, establishing who should provide input to measures of outcomes for LACYP is also a key concern. In some cases there may be a lack of correspondence between the views of youth, their caregivers and their teachers, raising questions as to whether the best approach uses only one of these informants, or finds some way of combining input from all, even when responses may be disparate. If LACYP themselves are to provide input via self-report, it may be important to consider the implications of engaging them in research. In particular, whilst being asked to reflect on how they feel may be empowering for some LACYP, it may also be quite overwhelming if individuals feel that they are rarely listened to or that their views are not usually considered. Focusing on negative experiences could also be potentially distressing for LACYP, particularly if they fear that highlighting negative outcomes may impact on their current placement. If questionnaires or other such approaches are to be used, attention should be paid to the timing, delivery and approach methods used. For example, it should be considered who might be best placed to engage the young person (e.g. an independent person such as a researcher, or a gatekeeper with whom they already have an established relationship).

When looking at changes over time for LACYP, it is also important to consider against what baseline or control comparisons are to be made and whether or not/how to account for natural recovery processes when measuring outcomes. For example, are outcomes for LACYP to be considered against outcomes for other at-risk children, or non-LACYP within the general population.

Once again, placement stability is also identified as an inherent challenge when considering work with LACYP. In the case of monitoring outcomes, lack of placement stability may pose a particular challenge in identifying and tracking LACYP over time [124]. This is compounded by the fact that data collection/record keeping in many organisations is considered quite lax. In some cases, this has been attributed to institutions (particularly educational institutions) paying most attention to their mainstream purposes and client groups, as opposed to marginal or at-risk populations [124].

### **3.2.5. SUMMARY**

Although this rapid review provides some limited and tentative suggestions of approaches for monitoring the outcomes of LACYP, much more research evidence is needed to define, develop and evaluate these methods. Perhaps most importantly, it appears that there are many outcomes that are neglected entirely, including sexual health, bullying and peer relationships, and successful transition from primary to secondary school. This is in spite of research that has actually been able to highlight outcomes that are considered most important to LACYP and their foster carers, which include: love; sense of belonging; having someone to talk to; and preparation and support for leaving care [125]. The Children and Young People's Forum, an independent group of experts from local government, NHS and third sector organisations, recommend the use of new health outcome indicators such as time from first NHS presentation to diagnosis or start of treatment, and age appropriate services or transition from children and adult services. They also highlight the possible utility of NHS numbers as unique identifiers to bring together health, education and social care data for all children and young people.

### 3.3. APPROACHES TO IMPROVING ACCESS TO, AND SUITABILITY OF, HEALTH AND OTHER SERVICES THAT SUPPORT LOOKED AFTER CHILDREN AND YOUNG PEOPLE

The needs of LACYP vary, but are often complex, relating to experiences gained before entering care and/or during the care process. Supporting these needs and achieving positive outcomes for LACYP may therefore require input from a range of different services across a range of different settings. The challenge comes in providing services that are accessible, effective and cost-effective, whilst able to respond to a diverse range of needs by maintaining focus on the child or young person. In the following section, evidence for approaches, methods or techniques that improve LACYP's access to services will first be considered, before evidence as to how to improve the content and delivery of these services once a child or young person is engaged is explored. The following discussion should be considered in light of the considerable limitations of the evidence identified in this review.

#### 3.3.1. IMPROVING ACCESS TO SERVICES

There is an apparent predominance of literature outlining and exploring the key barriers and challenges to service access and appropriate service provision for LACYP, a summary of which is provided in Box 3.7. However, currently it seems less is known about how to overcome these barriers, highlighting the need for the future development and evaluation of targeted methods for improving access to services. Some evidence describes how changes to the way services are structured (in terms of personnel and joined-up working) may impact on access for LACYP. Research is also beginning to explore the voice of LACYP, and how to appropriately and sensitively engage this vulnerable population in research, evaluation, and service user feedback.

##### 3.3.1.1. Designated teams and multi-disciplinary assessment

In a UK-based focus group study exploring the views of local authority professionals and foster carers, the difficulty faced in accessing CAMHS for LACYP, particularly when children were not in a stable placement, was highlighted [126]. Respondents suggested that long CAMHS waiting lists fundamentally failed to respond to the life circumstances of LACYP (e.g. instability, mobility and rapid change), outlining a need for CAMHS involvement from as early as possible in a child or young person's experience of care. For example, being able to access CAMHS for consultancy as part of the initial care planning process. Respondents also suggested that significant efforts should be made to dispel the myths surrounding all services for LACYP.

Input from the above focus groups was subsequently used to inform the development of a model for a **designated mental health service for vulnerable children** (including LACYP, as well as homeless families, young offenders, asylum seeking and refugee children). The tiered team provided telephone or face-to-face consultation with primary mental health workers, joint assessment or intervention with the referrer, and brief intervention or referral to the team psychologist or psychiatrist. To improve access to the service, the team accepted referrals regardless of placement stability, and there was no waiting list for the service. By operating under a multi-agency steering group, the team encouraged the maintenance of strong links and positive working relationships between CAMHS and social services. Although evidence as to the effectiveness of this approach for improving access to mental health services is not available, this case study provides a good example of a service that responds to the needs and concerns highlighted by professionals and experts that work most closely with LACYP. In a subsequent evaluation, significant improvements in behaviour problems, emotional symptoms, family life and relationships were reported over a short-term follow up (5 months; [127]).

### BOX 3.7. CHALLENGES TO ENGAGING LACYP IN MENTAL HEALTH, HEALTH AND OTHER SERVICES

For young people in general, a variety of barriers may impede access to services, including poor service design; transportation and physical access difficulties (e.g. location or timing of services); poor transitions between child and adult services; and lack of developmentally appropriate services [3]. However, additional barriers may be faced by LACYP, including:

- Narrow and/or (nationally) inconsistent referral criteria, meaning that many LACYP may miss out on opportunities for support and referrals and support commencing in one geographical area may not continue if the child is transferred to another (new) area.
- Non-detection of mental health problems in children and young people who may have learned to be self-reliant and hide their feelings or difficulties.
- Fear of admitting a problem, particularly considering the stigma associated with mental health and the potential for this to be compounded for LACYP who have experienced parental mental illness [6]
- Reluctance by referrers to pathologise a child's behaviour; foster parents may also be reluctant to seek support for their child if they believe health professionals may not recognise the parenting challenge that the child presents, and fear they may be blamed for the child's problems [11].
- Reluctance of LACYP to draw attention to current problems, perhaps through fear that they will be removed from their current placement if it is considered ineffective, or if it may affect their chances of being reunified with their birth family.
- Engagement difficulties due to negative experiences with/perceptions of statutory or support services (a LACYP is likely to have experience of multiple health and social care agencies) resulting in widespread mistrust.
- High levels of mobility/placement instability.
- Lack of parental advocacy (birth parents or stable foster parents) to request assessment and treatment when necessary.
- Logistical difficulties for LACYP in residential care settings, for example if there is not a member of staff available to transport or accompany them to sessions [15].

In the only systematic review identified in this entire section, Jones et al [128] explored the effectiveness of interventions to improve access to specialist or universal services for LACYP, identifying only five relevant studies. In the one included study from the UK, social services were provided with a detailed immunisation history for every looked after child and access was measured in the number/percentage of children with up-to-date immunisations [129]. However, no significant difference in immunisation uptake rates was found after 12 months. Although review authors concluded that there is some evidence as to the effectiveness of **comprehensive multi-disciplinary assessments** for improving access to mental health and medical services generally, and services specifically for LACYP in the USA, they acknowledge that findings have limited applicability to the UK context and also raise concerns about the timeliness of this research (with studies published more than five years ago), the poor methodological quality and small sample sizes.

#### 3.3.1.2. Advocacy

Being able to communicate their thoughts, wishes and feelings can help to empower children and young people, build their self-esteem and encourage positive relationships with adults and services. Existing statutory legislation and guidance recognises the role of LACYP in determining their own care journey (e.g. The Children Act, 1989). However, many young people may find formal decision making settings intimidating and

may need the support of a trusted adult to help them make sense of their feelings and express them to other adults.

Social workers may play a role in accessing services for LACYP. In a UK postal survey of Lambeth social service users that was carried out to assess attitudes towards mental health services, a small proportion of young people indicated that their social worker had supported them by referring them to organisations such as mental health services. Similarly, foster carers identified contacting other agencies and/or services as a helpful function performed by social workers. However a number of carers also listed failure to help complete referrals as a criticism of social workers [130]. For professionals who work with LACYP in the social care setting, their representation of the 'best interests' of the child or young person may not actually be the same as the views and preferences of that individual themselves.

Independent advocates therefore have an important role to play in representing the views and opinions of LACYP and ensuring that they are granted an active role in decision making about key aspects of their lives. They may also support positive outcomes by helping to secure access to services that are appropriate, timely, and of the desired quality. Although some LACYP in the UK receive the support of an advocate, a report by the Children's Society suggests that access to quality independent advocacy is itself inconsistent, varying by geographical location and a child's additional needs [131]. For example, research has shown that advocacy services have struggled to respond to referrals for support for disabled LACYP in particular [132]. The Children's Society runs nine advocacy programmes for children living in care and children leaving care across England, working with young people between the age of two and 21 years. Figures suggest that advocacy support costs an average of £31 per hour.

Currently, evidence on advocacy provision for LACYP is extremely limited, with no relevant primary academic research identified in this rapid review. Telephone surveys with 48 LACYP in 2006 found that young people's access to advocacy was influenced by geography primarily, but also age and the extent to which young people were aware of the advocacy services available to them [133]. Surveys with advocacy services themselves revealed half of all services relied exclusively upon social workers distributing publicity material to LACYP. Respondents from these services did, however, identify foster carers as an important means of raising awareness of advocacy among the children in their care. The majority of LACYP surveyed reported high levels of satisfaction with advocacy services, suggesting that advocates had helped them obtain access to housing and counselling in particular.

A report by the Office of the Children's Commissioner highlights that lack of standardised monitoring and evaluation of advocacy services, and the difficulties this creates for identifying how the support of an advocate may impact on children and their outcomes [134]. Authors call for evidence as to the long-term effectiveness ('added value') and cost-effectiveness of advocacy. An audit of a representative sample of 142 cases conducted in 2010-12 by the Children's Society revealed that although advocates most frequently supported LACYP with placement issues, a key outcome for LACYP who received advocacy support was the improvement of relationships between the child or young person and professionals such as social workers [131].

### **3.3.1.3. Guidance on promoting quality of life for LACYP relevant to improving access to services**

Formal guidance provided by NICE and SCIE on improving the physical and emotional health and wellbeing of LACYP in 2010 [34] called for the commission of services dedicated to LACYP that link in with universal services and are friendly, accessible and non-stigmatising. In particular, dedicated services to promote the mental health and wellbeing of children and young people in care were recommended, ensuring that services receive

specific training to prevent placement breakdown and include a specialist practitioner to support young people moving to independent living (at age 18 or older), who may otherwise not meet the threshold for onward referral to adult mental health services. Guidance also highlights the importance of supporting professional collaboration on complex case work.

Multiple recommendations from this guidance relate to improving access to services. For example, recommendations refer specifically to ensuring access to mental health services for BME LACYP and unaccompanied asylum seeking children. It is suggested that these services should provide appropriate interventions for emotional and mental health problems associated with racism and cultural identity, and post-traumatic stress or stress-related to the immigration process for these special groups of LACYP respectively. Recommendations also refer to ensuring access to specialist services for babies and young children, with a need for comprehensive and sensitive assessments as early as possible, and training for frontline practitioners to provide a good understanding of the emotional, physical and developmental needs of this age group.

The provision of care-leaving services is also a focus, with recommendations to ensure that services available to care leavers are clearly outlined in local plans and are readily available in suitable formats. Guidance suggests that a 'one-stop shop' approach should be considered, providing services that are more easily accessible and in a familiar environment. No evidence of the implementation or evaluation of such an approach was found in this rapid review.

### **3.3.2. IMPROVING THE SUITABILITY OF SERVICES**

To effectively support LACYP in achieving positive outcomes, services must be appropriate, adequate and acceptable to both consumers and providers. For some services, frameworks or guidance for standards of service may exist and provide a benchmark against which to measure suitability. In other cases, acceptability or adequacy of a service may be based on local opinion. As with any population, factors like cultural beliefs and practices, age, gender, communication skills and education level may all affect how LACYP experience a service. LACYP may also have unique needs when it comes to their engagement with services.

#### **3.3.2.1. NICE guidance**

NICE quality standard for the health and wellbeing of looked-after children and young people (April 2013) describes best practice and high priority areas for quality improvement, cross referenced against improvements outlined in both the NHS Outcomes Framework (2013-14) and the Public Health Outcomes Framework for England (2013-2016). The standards apply to all LACYP aged 0-18 years and those who have transitioned out of care (care leavers), placing importance on child- and young person-centred and integrated approaches to providing care and services.

Whilst some of these quality standards focus on the relationship between the caregiver (i.e. foster parent) and the child, for example, highlighting the need for high-quality specialist training and support to help caregivers understand and develop positive attachments, others focus on the direct role of services and professionals. These standards include:

- Collaborative working between services and professionals (including carers) to manage a multi-disciplinary care plan with the aim of promoting high-quality and consistent care and a stable experience of placements.
- Effective local information sharing protocols between health, social care and educational services.
- Support from specialist and dedicated services on a continuing basis and within agreed timescales, with particular focus on young people moving from child to adult mental health services.

Quality standards also focus on ensuring continuity of services for LACYP who are placed outside of the local authority or health boundary, with the need for good transition planning to enable the appropriate transfer of relevant information. Continuity of services, ideally allowing continued contact with the same key professionals, even when LACYP move areas is also a focus.

### 3.3.2.2. Staff training

Training health and other professional staff to raise awareness of the needs of LACYP, including the implication of challenges such as placement stability on referral and engagement, may help to improve the suitability of services for this population.

NICE recommend the development of a national core training module, appropriate for delivery with a wide range of health and other professionals, and aimed at increasing their understanding of LACYP as a diverse group of children, thus supporting the provision of suitable high-quality care [34]. Guidance suggests that this core module should include material to develop understanding and awareness of: the reasons why children and young people enter care; the impact of care on babies, children and young people; the impact of trauma and distress on the behaviours and development of LACYP; the roles of professionals who work with LACYP and accountabilities within and among different agencies; how to work effectively within multi-agency settings; and good practice in recording information on LACYP to support better care planning.

In addition, guidance from the Royal College of Paediatrics and Child Health (RCPCH) that was developed in partnership with the Royal College of Nursing and the Royal College of General Practitioners outlines the required knowledge, skills and competencies of health care staff for meeting the needs of LACYP [135]. Recommendations reinforce the need for enabling staff to access education and training, as well as flexible learning opportunities, to acquire and maintain the necessary skills to improve outcomes for LACYP. Although the role of specialist health professionals for LACYP is emphasised (e.g. Specialist nurses; Named professionals; Medical advisors for fostering and adoption), the framework of competences also describes levels of competence for all staff in a healthcare setting. For example, knowledge of the legal definition of LACYP and care leavers; an awareness of the impact of neglect and abuse on LACYP; and an understanding of appropriate referral mechanisms and information sharing.

### 3.3.2.3. Multi-agency approaches

Absence of interagency communication has been suggested as a key barrier to effective service provision for LACYP [136, 137]. For example, there is some evidence to suggest that children that are involved with two agencies (e.g. child welfare and juvenile justice) are less likely to receive a service referral than those children who are involved with just one agency [136]. Interagency structures are therefore central to the provision of coordinated assistance to LACYP with multiple and complex needs. However, Golding [138] highlights some of the key challenges of multi-agency working, which include: lack of commitment to integrated practice at a strategic level; difficulties caused by divergence in organisational policies, structures and processes; the need to bring together different organisational cultures, often in the face of historical difficulties between those agencies; and time and effort needed to build a new collective team identity, shared vision and ethos.

Multi-agency working may be crucial from the moment a child enters care, with some experts calling for holistic assessments which: (a) do not view health issues in isolation but in the context of development, relationships and emotional wellbeing; and (b) allow observation of the child in multiple settings, including home, school and the community [12]. From Australia, the **Stargate Early Intervention Programme** is an example of a multi-disciplinary team assessment process, which is based on the premise that being placed in

out-of-home care is distressing and disruptive, and therefore all infants may benefit from early intervention. The programme provides a comprehensive multi-disciplinary therapeutic assessment for all LACYP within 10 days of entering care. In a pilot study, the programme was linked with earlier access to mental health services and improved placement stability for LACYP [139].

Following initial and subsequent assessments, multi-agency teams drawing on the strengths and expertise of multiple services may be best placed to deliver effective interventions to LACYP with complex needs. Golding [138] advises that teams must not only be adequately resourced to allow effective partnership working and time for liaison and communication, but must also be able to establish creative and innovative solutions to placement instability, ideally working with as wide a network (for the child) as appropriate and practicable.

**Integrated Service for Looked After Children and Adopted Children (ISL)** in Worcestershire is a multi-agency, holistic service jointly provided by health and children's services that works in partnership with all relevant agencies in an attempt to ensure that LACYP receive educational opportunities, benefit from positive health and wellbeing, community and leisure opportunities, and experience stable social care environments. Alongside mental health- and education-focused interventions, a multi-disciplinary team provides support to carers/parents (particularly in meeting attachment needs), with training and support networks, and the opportunity for the delivery of home-based interventions.

An independent evaluation of service user views of ISL (based on interviews with 10 foster carers) suggested that foster carers valued the personal and professional nature of the team and their flexible approach to solving problems. Positive changes in foster carer emotions and feelings were predominantly reported, although possible improvements in access and service provision were also suggested [140].

The **Integrated Care Pathway (ICP)** was developed to improve the coordination and communication of multiple agencies in relation to the health assessments of LACYP in Birmingham [141]. The ICP aims to: clarify roles and responsibilities for different agencies; ensure services are delivered consistently; ensure documentation is streamlined and standardised; and certify that services are monitored for quality. To achieve these aims, a working group of experts (including former looked after children, health, education and social-care professionals, and a care pathway facilitator) developed a process map and protocol, highlighting the key minimum standards that should be met for a child in care. These included: primary health assessments completed four weeks after initial placement; up-to-date checks for immunizations, dental and visual appointments; on-going assessments every 6 (age 5+) and 12 months (age 5-); and the child being provided with a summary of their health information. This approach has since been replicated in numerous other local authorities across the UK.

#### **3.3.2.4. Service user feedback and consulting with LACYP**

Although service providers may be reluctant to engage LACYP in feedback about services, a number of studies have shown that with appropriate support, vulnerable children can provide valuable reflection on the services they have received [142, 143], shaping the future development of these services in line with users' needs.

In a review of qualitative literature exploring LACYP's views of mental health services, Davies & Wright [144] conclude that children were able to provide balanced views of services received (i.e. including both positive and negative comments), with primary importance attached to the positive personal attributes of individual contacts during interactions with staff. LACYP also appeared to value non-verbal interactions (e.g. drawing and playing) as a helpful tool within therapeutic processes, and considered both physical surroundings and practical arrangements to be particularly important features of suitable services. Although studies included in

this review did not sample LACYP who had poor outcomes from therapy, those with specific learning difficulties or disabilities, or younger (primary school age) cohorts (all of whom may present their own unique challenges for consultation) findings do provide some suggestion of the potential for service improvement founded in feedback from LACYP.

An example of a methodology developed specifically for achieving service-user feedback from LACYP with disrupted attachments who had received mental health services (psychodynamic therapy, dyadic therapy (also involving the child's caregivers) and abuse-recovery-focused psychotherapy) is provided by Davies et al [145]. Authors emphasise the need for use of more than one method when eliciting the views of children, and therefore conducted separate child and carer semi-structured interviews simultaneously. Child interviews used four different approaches: (1) the 'bag of feelings' technique in which children are asked to write or draw about all the different feelings they have; (2) the cartoon strip method which uses a cartoon of a child visiting a therapist with empty thought bubbles in the first and last images (i.e. the child first arriving and leaving the clinic) for the child to complete to show their own story; (3) attending therapy scenarios, where children are shown a picture of a child their age leaving therapy and are asked questions such as 'what do you think he is feeling now?' or 'what do you think she will do next?'; and (4) direct questioning in the form of a pretend television interview, in which children were provided with props (e.g. a microphone) and asked for their top tips for improving therapy. Although no formal evaluation of this methodology is provided, authors report that the children involved viewed the approaches positively (although preferred the other approaches over the direct questioning), and views from carers were useful in shedding additional light on the feelings and experiences that their foster children reported.

### **3.3.3. Summary**

Clearly the evidence base for the effectiveness of approaches to improving access to and the suitability of health and other services is only in its infancy, with very little relevant evidence identified in this rapid review. In particular, the needs of specific populations such as BME LACYP, unaccompanied asylum seeking children or LACYP with disabilities have not been considered, and literature is focused primarily on mental health services, with very little consideration for physical or sexual health, or other services that address social or educational needs. As with other sections of the review, much of the available evidence appears to be drawn from research conducted in the USA. Although some lessons can arguably be learned from discussions and evaluations of stand-alone interventions (section 3.1) that have been implemented in other countries, the positioning of relevant health and other services within wider national structures considerably limits the applicability of evidence from the USA to the current UK context. Therefore focus was given to guidance and frameworks developed within the UK, rather than drawing on evidence of health passport or caseworker training programmes from the USA.

LACYP (like all children) should be considered experts in their own experiences, with valuable contributions to make to service developments. Research from the UK is beginning to explore the role of advocates in empowering LACYP and ensuring that their voices are heard. It will be important to ensure that the effectiveness of these approaches is considered moving forward, including the impact of advocates on longer-term outcomes for LACYP. In consulting with LACYP in any form (including via an advocate), it is important to consider how to resolve potentially competing principles of evidence-based practice or research evidence (for example, NICE guidelines) with the preferences expressed by children.

## 4. ASSESSMENT OF DATA COLLECTED AND SHARED IN BwD

In order to review local data and intelligence on LACYP in BwD, partners from a range of organisations working with LACYP who had attended the stakeholder engagement meeting (see section 6), or expressed an interest in the project, were asked to complete a questionnaire/proforma (see appendix 2). The questionnaire aimed to explore: the type of data collected on LACYP; data sharing processes across partner agencies; data protection and confidentiality issues; and partner views on current LACYP data collection and sharing processes. Eleven complete questionnaires were received, encompassing partners from a range of services including: BwD Borough Council (i.e. public health; children's services; safeguarding unit); the designated nurse for looked after children; CAMHS; children's homes; Brook (sexual health service); Lifeline; YJS; Short Breaks Providers, Lytham Road and Apple Trees Units; and Project BME. Within this report only data collection and sharing processes identified through completed questionnaires were examined. Other data collection and sharing processes may exist between services within BwD that are not reported here.

### 4.1. WHAT INFORMATION IS HELD IN BwD ON LOOKED AFTER CHILDREN AND YOUNG PEOPLE?

BwD Borough council hold a range of information on all LACYP in their care in the two databases Protocol and Tribal. Protocol is the main database used by partner agencies engaged with LACYP for storing and accessing information on LACYP. Box 4.1 provides a summary of the key features of these two databases. A number of teams within and external to the council have access to the two databases at varying levels. Other teams/organisations receive summary statistics from the databases as required. In addition to data held on Protocol/Tribal, some teams/organisations hold further information on LACYP, as do other organisations that do not have direct access to Protocol/Tribal, details of which are provided below.

#### **BwD Borough Council Public health**

BwD Borough Council Public Health do not have access to individual level data on LACYP in BwD. They do however hold information on the number of LACYP who have completed a Health Assessment (HA), and broader population level data collected at a local and national level (e.g. Integrated Strategic Needs Assessment [ISNA<sup>9</sup>]).

#### **BwD Borough Council Children's Services**

BwD Borough Council Children's Services<sup>10</sup> have access to information on LACYP via Protocol and by the use of a shared drive which holds electronic records on LACYP. Letters from social workers, home records and foster carer records are scanned and uploaded to this drive; these records include evidence as to how the individual care needs of LACYP are being met by the relevant agencies who are responsible for their care. Other records held include foster carer and adopter assessments which detail the health of foster carer's, thus identifying if they are able to meet the needs of the children in their care. The assessments and records of children on the MTFC (Multi-Dimensional Treatment Foster Care, a specialist fostering programme led by clinical psychologists, see section 3.1.1.6) are also available. These assessments include SDQ scores that are completed by the MTFC team and are a separate SDQ score to the SDQ assessment stored on Protocol (completed by teachers/carers). Some information is also held on paper based case files. Data held (Protocol

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<sup>9</sup> For further information see [www.blackburn.gov.uk/Pages/Integrated-strategic-needs-assessment.aspx](http://www.blackburn.gov.uk/Pages/Integrated-strategic-needs-assessment.aspx)

<sup>10</sup> Including: fostering, adoption, residential services, looked after children nurses and the East Lancashire Community Adolescent Services [ELCAS] Practitioners.

and within the shared drive) is accessible to everyone within BwD Children's Social Services, and all social workers, but not all individuals are able to add data to the shared drive.

### **BwD Borough Council Safeguarding Unit**

The safeguarding unit holds looked after child review records, which are stored on Protocol. The unit has access to HAs, education reports, and legal reports and records. This data are either paper based (scanned and saved onto a shared drive) or electronically input onto Protocol. Data are only shared with appropriate individuals, including: LACYP, parents/carers, or appropriate professionals, via secure email or letter when necessary. The different data sources are linked using the Protocol unique reference number (see box 4.1). The data are primarily used in the safeguarding process to measure outcomes for LACYP and the performance of staff.

### **Lancashire Care NHS Foundation Trust (LCFT) - designated nurse for looked after children**

The designated nurse for looked after children (also known as the LAC nurse) is a member of LCFT's safeguarding team, and an independent member of the BwD Foster Panel. This role has close relationships with other services for LACYP including Lifeline and East Lancashire Child and Adolescent Services, dental services and sexual health teams. The designated nurse for LAC holds information on the number of LACYP located within BwD and the number of review HAs requested/completed (see box 4.1) for LACYP located within BwD. There is a statutory target for completion of LACYP health assessments (HA)<sup>11</sup>; consequently the number of completed HAs is collected monthly from the Child and Family Health Service (LCFT) to inform the service needs/requirements in relation to LACYP.

### **Child and Adolescent Mental Health Services**

Data are held for all referrals to CAMHS (e.g. for further support) including data collected from social workers and the carers. CAMHS also hold SDQ scores for all children in the care of BwD (see box 4.1)

### **Brook sexual health service**

Brook is a charity that provides sexual health services, support and advice to young people under the age of 25 years. In BwD, Brook holds data within clinical and counselling records, from which LACYP can be identified, however there is no unique reference number used that would link this to other data sources anonymously. Consequently this data cannot be linked to information held on Protocol.

The data held by Brook is collected from all service users (including LACYP) by Sexual Health Nurses, Clinic Support Workers and other Brook personnel. At the clinic a full social and sexual history is taken through a face to face discussion, which is revisited at each further contact and reviewed fully on an annual basis. Clinic data (including personal identifiable data) is stored electronically, on secure servers; however counselling records are paper based.

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<sup>11</sup> In BwD a key performance indicator has been set specifying that 90% of HAs should be completed within this time period (see [http://blackburndarwenchildcare.proceduresonline.com/chapters/p\\_healthcare\\_assmt.htm](http://blackburndarwenchildcare.proceduresonline.com/chapters/p_healthcare_assmt.htm) for further information on HAs).

#### BOX 4.1: PROTOCOL AND TRIBAL DATABASES

**Protocol:** Protocol is a database held by BwD Borough Council which stores information on LACYP, for all children that the council has social care responsibility for (including: LACYP located both in and outside of BwD, and care leavers). The information held on Protocol is used both locally and nationally (data are submitted to the Government on an annual basis as part of the SSDA903\* return). Protocol also holds details taken from HAs\*\* (e.g. date of medicals) and SDQ scores\*\*\*. The data held is collected at different points throughout the child's care (including: on entry to care, through periodic reviews and statutory visits). Most data are inputted onto this system by social workers. However information from the HAs are inputted by the BwD children's services central administration team within the council. All cases within Protocol are assigned a unique number so that the data can be linked to other data sources, including Tribal (see below). The NHS number is also recorded within Protocol so that data from health departments can be linked, however excluding the HAs, at present no health data are collected and stored on Protocol.

Protocol is held on a secure server and access to the database varies. Individuals with sufficient permissions can access the system, however sometimes access is arranged through a social worker. Data stored on Protocol is shared at LAC reviews on a six monthly basis and with the senior leadership team within BwD children's services.

**Tribal:** Tribal is an education database that was purchased for use in BwD. It contains generic data for all children that attend school within the LA (including: name, date of birth, address, school attendance, and parent contact details). When the BwD children's services central administration team receive notifications from social care that an individual is in the care of BwD, these are added to a child's record on Tribal as a reference note for all users to see.

\*The SSDA903 is the children looked after return for the Department for Education (DfE). Completed on an annual basis (on 31st March), this collects information on LACYP who are looked after by LAs to ensure LACYP are getting the right access to education/services. To complete this return, a report is run from data stored on Protocol for all LACYP in the care of BwD, the results of which are uploaded to the DfE website.

\*\* HAs are statutory assessments initially conducted by a consultant paediatrician, with subsequent assessments by a registered nurse, registered midwife or health visitor under the supervision of a registered medical practitioner. HAs take place within 28 days of a child becoming looked after, then for the duration of care, with subsequent assessments on an annual basis for children of school age (children aged five and over) and six monthly for those below school age (children under five).

\*\*\* The SDQ is an internationally validated short behavioural screening questionnaire that covers: emotional difficulties, conduct problems, hyperactivity or inattention, friendships and peer groups and positive behaviour. SDQ scores are used to capture the emotional and mental health and wellbeing of LACYP and to help formulate an individual's care plan. Within BwD SDQ data are collected by carers and teachers on an annual basis and then scored by the principle CAMHS practitioner and clinical psychologist. SDQ scores are entered on Protocol and also shared with: the SDQ panel (principal CAMHS practitioner, designated nurse for LAC, education manager for LAC, clinical psychologist and social workers); social workers; the LAC education manager; and the senior leadership team for children's services in BwD (including the heads of services for all children's service in BwD) via the annual board report (a written report detailing information on all LAC).

A Brook practitioner is based within the Engage Child Sexual Exploitation (CSE) team<sup>12</sup>. Data collected by Brook in the Engage team is owned by Engage. Brook is currently in the process of developing a data sharing

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<sup>12</sup> Engage is a co-located multi-agency specialist team which was created in BwD as a response to child sexual exploitation. For more information see [www.blackburn.gov.uk/Pages/Child-sexual-exploitation.aspx#contact-tab](http://www.blackburn.gov.uk/Pages/Child-sexual-exploitation.aspx#contact-tab)

agreement with Engage for the use of this data within the overall Brook service. Currently data collected is available to the client on request, partner agencies with client consent, or for safeguarding.

### **Children's homes**

Most data held on LACYP by children's homes is specific to the individual and their care (e.g. education plans [inputted onto Protocol], management and behaviour plans, placement information plans and pathway plans). Most of the data that the children's homes collect is stored on hard copy and not entered onto Protocol. If necessary, social workers can provide some data from Protocol to the children's home whilst they are in their care, including the history of the child and past experiences. The information that is held by the children's homes is shared with social workers, agencies involved in the care package of the LACYP and parents on a need to know basis.

### **Lifeline**

Lifeline is a registered charity that provides a range of services to prevent and reduce harm from drug and alcohol misuse and to promote recovery<sup>13</sup>. Lifeline offers a free confidential and voluntary drug and alcohol support service for young people aged under 25 in BwD Lifeline holds data in relation to substance use for LACYP. Some of the data collected is shared on a quarterly basis with the Government anonymously through the National Drug Treatment Monitoring System (NDTMS), (see section 5.4 for details on LACYP involvement with Lifeline). The service has access to YJS data via the Child View case management system (see below) and to limited information on Protocol.

### **Youth Justice Service**

BwD YJS hold data on engagement with LACYP on their Child View case management system, which is collected via the completion of the comprehensive Youth Justice Board assessment tool, ASSET. The YJS also have access to education and social care records via Protocol. Information is only held or shared as per data sharing requirement of Section 115 of Crime and Disorder Act. A note is made on Protocol of all cases known to YJS. Information is reported to the YJS Board, so that they have a local indicator for offending of LACYP; however young people are not identifiable within this information.

When LACYP contact with the YJS ends the information which has been generated by the service is attached to the LACYP social care paper file held by the social worker, and then deleted from the YJS system. The only exception to this is, if a young person is still open to YJS at the age of 18, when, as part of the transition plan, relevant information on this individual is shared with the National Probation Service and Community Rehabilitation Company (see section 5.3 for details on LACYP involvement with YJS).

### **Short Breaks Providers, Lytham Road and Apple Trees Units**

Most data held on LACYP by short break providers is specific to the individual and their care (including: placement information and care plans for the individual, short break plans, young person's plans, child protection plans, accident forms and risk assessments). However access is available to the Statement of Special Education Needs and Protocol (by managers within the providers). All data on LACYP use the same unique ID as Protocol and therefore information held by the services can be linked to data on Protocol or uploaded to the shared drive held by BwD Borough Council Children's Services.

Some information is shared on a need to know basis with parents, social workers and other agencies (including: referrals, allocations, service level changes, closures, bed capacity, serious incidents, accidents or issues with

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<sup>13</sup> For more information see [www.lifeline.org.uk/](http://www.lifeline.org.uk/)

the young persons and missing from homes including unauthorised absences). A form has been devised for parents to sign, detailing their consent for information to be shared. All access to any data on the young person ends on discharge and is passed back to the referring agency.

### **Project BME**

Project BME is a voluntary sector organisation, offering a range of services to support marginalised communities. Project BME has access to data on LACYP; however this is only information which is provided to the service by clients when they request assistance from the organisation (i.e. if an individual requests signposting to services, or assistance with child proceedings from Project BME). This information belongs to the client and is only shared by Project BME with the clients consent and held under their data protection policy. Project BME have no access to Protocol, and highlighted that improved communications could be developed between agencies working with LACYP.

### **Other partners**

A number of other partners in BwD identified that they have access to data on LACYP. For example school nurses have access to the health records of LACYP and Children's Centres record any involvement/contact with the child's family. However data are not shared between these other services in a systematic way. The Troubled Families Programme indicated that a new data system is in the process of being set up so that they will be able to identify which families engaged with the programme have LACYP.

## **4.2. DATA SHARING AGREEMENTS AND PROCESSES WITHIN AND BETWEEN SERVICES**

LACYP are a highly vulnerable population, so it is important that the confidentiality of those in care is maintained. Protocol holds the most information on LACYP in the care of BwD Borough Council. Partners indicated that appropriate measures are taken to ensure data stored on Protocol and shared drives are protected. Data are stored on password protected databases, only accessible by select individuals involved in the care of LACYP (e.g. social workers) who are also trained in data protection. If partners (including parents) require information from Protocol that they do not have full access to, if appropriate, such information may be accessed via the social worker. Whilst no specific data sharing agreements were highlighted for the sharing of data on LACYP, it was noted that some wider data sharing protocols are established between partner agencies.

Outside of the council, some partners noted that they have systems in place to share data across agencies, or are in the process of developing systems and relevant agreements. Thus, Lifeline obtains consent from all individuals in contact with their service to share anonymised data with Public Health England as part of the NDTMS. At Brook, data are collected from clients confidentially, and only shared with other organisations if there are safeguarding issues. However, they are working with Engage to develop data sharing protocols to allow the sharing of information where services overlap (e.g. information collected by the Brook practitioner based in Engage CSE team).

## **4.3. SHARING FURTHER DATA ON LOOKED AFTER CHILDREN AND YOUNG PEOPLE**

Whilst no specific comments were made regarding access to further data on LACYP by the partners who completed a questionnaire, during the stakeholder event (see section 6) some partners noted that there was a lack of data available to them that would provide them with an overall picture of the health and wellbeing needs of LACYP. Whilst LACYP receive a HA at relevant points in their care (see box 4.1), data are collected on a paper based form (which is then scanned onto the Children's Services shared drive, with some information

inputted onto Protocol) and thus difficulties occur in accessing and using this information, particularly at a LACYP population level. Whilst it was acknowledged that it would be difficult to access data on LACYP's presentation at local health services such as accident and emergency departments (as LACYP are not identifiable in their data), it is evident that some services do collect data on LACYP that may be useful for developing an understanding of their health and wellbeing needs (e.g. data held within Brook and Lifeline)

#### **4.4. LINKING DATASETS ON LOOKED AFTER CHILDREN AND YOUNG PEOPLE ACROSS SERVICES**

A number of issues were identified regarding linking data on LACYP across agencies. For example, LACYP are not always identifiable in data when it is collected. Not all data sets use a unique reference number for LACYP, thus preventing anonymous linkage of data sources. For example within Protocol, a unique pupil number<sup>14</sup> is used that links to Tribal. Some datasets use the NHS number (which is stored on Protocol) so certain health system data could be potentially linked to this information. However in Brook and Lifeline, unique internal reference numbers [i.e. clinic numbers] are used that cannot be linked to NHS or pupil numbers at other organisations. In some instances, LACYP initials, date of birth or the first part of the postcode are used instead of a unique reference number. Most data are stored electronically within Protocol (uploaded to this system), or is stored in hard copies. However hard copies tend to only collect information around an individual care package and storing data in a paper format makes data sharing between organisations more difficult.

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<sup>14</sup> The unique pupil number (UPN) is a 13-character code that identifies each pupil in the education system.

## 5. ANALYSES OF LOCAL PARTNER DATA ON LOOKED AFTER CHILDREN AND YOUNG PEOPLE

To provide an overview of LACYP in BwD Borough Council, including details of their health and wellbeing where possible, data were accessed and analysed from: BwD Borough Council; YJS; and Lifeline (see section 2.1.3). This section presents findings from these data sources. Section 5.1 provides an overview of all LACYP in the care of BwD Borough Council (on 31<sup>st</sup> December 2014), with analyses then split by those located in the borough and those located outside the borough. Further, it provides an overview of care leavers for the three year period 01/01/2012 to 31/12/2014. Section 5.3 provides details of the number of LACYP engaged with the YJS for the three year period 01/01/2012 to 31/12/2014. Finally, Section 5.4 provides information on LACYP referrals to Lifeline for the same period.

### 5.1. BLACKBURN WITH DARWEN BOROUGH COUNCIL, PROTOCOL DATABASE

This section presents the findings from data extracted from Protocol. Analyses are presented for all LACYP that BwD Borough Council had responsibility for (on 31/12/14), and then split by those living in BwD and those living outside of the borough<sup>15</sup>. Information on the health of LACYP is presented for these two groups. The final section presents information on those leaving care (care leavers) from 01/01/2012 to 31/12/2014.

#### 5.1.1. ALL BWD LOOKED AFTER CHILDREN AND YOUNG PEOPLE

##### SAMPLE CHARACTERISTICS

- As of 31<sup>st</sup> December 2014, BwD Borough Council were responsible for the care of 307 LACYP.
- Nearly two thirds (61.6%) were male (Table 5.1) and 52.1% were aged 0-9 years (classed as a child).
- The majority (83.4%) were of a White background (British, Irish, other).
- No LACYP were recorded as unaccompanied asylum seeking children.
- One in ten (10.7%) were recorded as having a disability.

##### CATEGORY OF NEED AND LEGAL STATUS

- Half (51.1%) of all LACYP were provided with care because of abuse or neglect. There were some variations in category of need by gender and age group (Table 5.2).
- Nearly three quarters (73.6%) were looked after under a care order (full, 59.9%; interim, 13.7%)<sup>16</sup>. There were some variations in legal status by gender and age group (Table 5.3).

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<sup>15</sup> One individual did not have information on location of care recorded.

<sup>16</sup> A care order gives the LA parental responsibility for a child, requiring them to provide accommodation for their care. An 'interim care order' is a temporary court order where a child is taken into care on a temporary basis, initially for up to eight weeks, but this can be renewed every 28 days. See Section 38 of the Children's Act 1989 [www.legislation.gov.uk/ukpga/1989/41/section/38](http://www.legislation.gov.uk/ukpga/1989/41/section/38)

TABLE 5.1: SAMPLE DEMOGRAPHICS, ALL LACYP (AS OF 31<sup>ST</sup> DECEMBER 2014)

	(n)	%
<b>Gender</b>		
Female	(118)	38.4
Male	(189)	61.6
<b>Age group</b>		
0-9 (child)	(160)	52.1
10 and over (young person)	(147)	47.9
<b>Ethnicity</b>		
White (British, Irish, Other)	(256)	83.4
Other ethnicity	(51)	16.6
<b>Does the child have a disability</b>		
Yes	(33)	10.7
No	(274)	89.3

TABLE 5.2: CATEGORY OF NEED BY GENDER AND AGE GROUP, ALL LACYP (AS OF 31<sup>ST</sup> DECEMBER 2014)

	All %	Male %	Female %	Child (aged 0-9) %	Young person (aged 10+) %
<b>Category of need</b>					
Abuse or neglect	51.1	49.2	54.2	58.1	43.5
Family in acute stress	16.0	13.8	19.5	13.8	18.4
Family dysfunction	26.1	28.0	22.9	23.8	28.6
Other *	6.8	9.0	3.4	4.4	9.5

\*Includes: socially unacceptable behaviour, disability, parental illness and disability, and absent parenting.

TABLE 5.3: LEGAL STATUS BY GENDER AND AGE GROUP, ALL LACYP (AS OF 31<sup>ST</sup> DECEMBER 2014)

	All %	Male %	Female %	Child (aged 0-9) %	Young person (aged 10+) %
<b>Legal status</b>					
Full Care Order	59.9	60.8	58.5	45.0	76.2
Interim Care Order	13.7	12.7	15.3	23.1	3.4
Placement Order <sup>17</sup> Granted	14.3	15.3	12.7	26.3	1.4
Other (Section 20 <sup>18</sup> and Emergency Protection Order <sup>19</sup> )	12.1	11.1	13.6	5.6	19.0

## PLACEMENT STABILITY, TYPE AND PROVIDER

<sup>17</sup> A placement order is a court order which authorises the LA to place a child for adoption with prospective adopters chosen by the LA. See Section 21 of the Adoption and Children Act 2002 <http://www.legislation.gov.uk/ukpga/2002/38/section/21>

<sup>18</sup> For more information see [www.legislation.gov.uk/ukpga/1989/41/section/20](http://www.legislation.gov.uk/ukpga/1989/41/section/20)

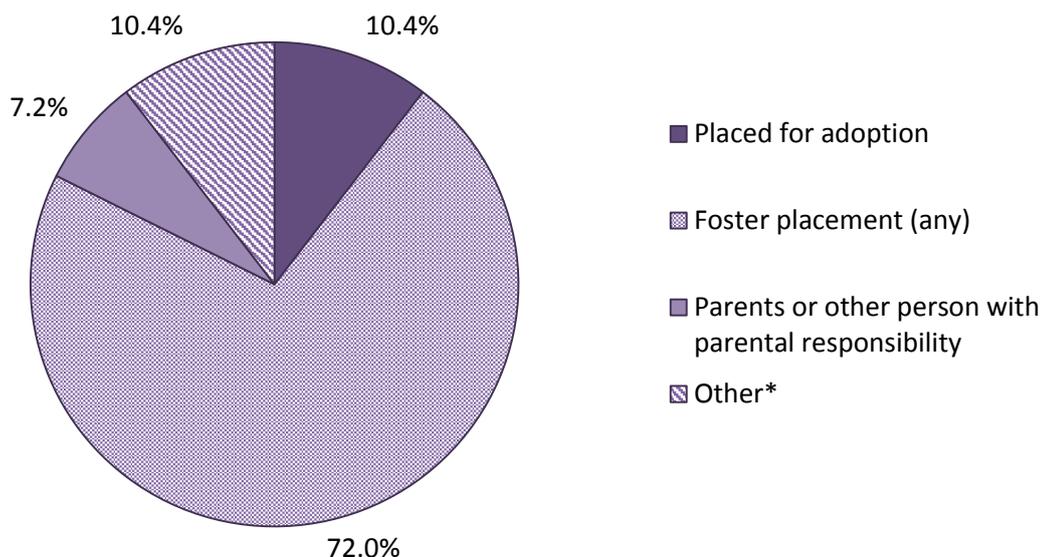
<sup>19</sup> An Emergency Protection Order is a court order giving limited parental responsibility to the applicant for the child's welfare including the right to remove the child (or prevent their removal) from their current location. See Section 44 of the Children Act 1989 [www.legislation.gov.uk/ukpga/1989/41/section/44](http://www.legislation.gov.uk/ukpga/1989/41/section/44)

- Two in five (40.4%) LACYP had been in care for longer than one year.
- Three in ten (30.9%) were on their first placement, 28.7% on their second placement and 40.4% had three or more placements recorded (Table 5.4).
- The majority (90.9%) had no missing from care episodes recorded. The number of missing episodes recorded ranged from zero to 37, with 12 LACYP (3.8%) having had five or more.
- The majority (72%) were on a foster placement (including: on a foster placement with an LA carer, other agency carer, relative or friend, or not with family or friend) (Figure 5.1).
- Six in ten (60.8%) were on a placement provided by the LA (Table 5.5).

TABLE 5.4: NUMBER OF PLACEMENTS, ALL LACYP (AS OF 31<sup>ST</sup> DECEMBER 2014)

	(n)	%
<b>Number of placements</b>		
One	(95)	30.9
Two	(88)	28.7
Three or more	(124)	40.4

FIGURE 5.1: PLACEMENT TYPE, ALL BWD LACYP (AS OF 31<sup>ST</sup> DECEMBER 2014)



\*Includes: homes and hostels, Independent living, NHS/Health Trust/Medical or Nursing Care, HM Young Offender Institution or Prison, Residential Schools

TABLE 5.5: PLACEMENT PROVIDER BY GENDER, ALL LACYP (AS OF 31<sup>ST</sup> DECEMBER 2014)

	All %	Male %	Female %
<b>Placement provider</b>			
Parents or other person with parental responsibility	7.2	6.9	7.6
Own provision by LA	60.8	60.6	61.0
Other LA/public provision	11.4	11.2	11.9
Other provision*	20.6	21.3	19.5

\*Includes: private provision and voluntary/third sector provision.

## HEALTH AND WELLBEING

### Health care assessment (HA)

- Amongst LACYP who had been in care for longer than 28 days, 8.6% did not have a HA recorded (on Protocol as of 31/12/14)<sup>20,21</sup>.
- 92.7% of those aged five and over who had been in care longer than one year had a HA recorded in the last year<sup>22</sup>.
- Three quarters (74.9%) of those aged under five who had been in care for longer than six months had a HA recorded in the previous six months.

Where available, information on LACYPs health and wellbeing from their latest available HA was analysed. Please note that the sample size for these questions was low as information on each of these themes was not recorded for all LACYP. Findings should therefore be viewed with caution as they may not be representative. Key findings are presented below along with the sample sizes for each question.

### *Health concerns*

- One fifth (19.7%, n=37/188) of all LACYP had identified that they had worries about their health.
- The majority reported that they were eating (95.2%, n=179/188) and sleeping (89.5%, n=162/181) well.
- Three quarters (73.3%, n=44/60) of young (aged 10 plus) LACYP reported that they were able to take responsibility for their own needs<sup>23</sup>.

### *Smoking, alcohol and drug use (young person's only)*

- One quarter (25.3%, n=22/87) of young people reported that they smoked.
- One in ten (11.9%, n=10/84) reported that they drank alcohol.
- One in ten (13.1%, n=11/84) reported that they had used drugs.

### *Involvement with health services*

- The majority (96%; n=215) of all LACYP had involvement with health services recorded on their HA.
- Of those involved with health services, on average they were involved with 2.4 services. The majority were engaged with a health visitor/school nurse (82.4%) and a dentist (86.4%).
- One third (35.8%) were engaged with a paediatrician; 15.3% with CAMHS; and 39.8% with another service.

### *Dental health*

- The majority (96.8%) of LACYP who had been in care longer than one year had a dental check in the last year (recorded on Protocol)<sup>24</sup>.

### *Strengths and Difficulties Questionnaire (SDQ)*

SDQ scores are used to capture the emotional and mental health and wellbeing of LACYP and are used to help formulate an individual's care plan. SDQs are completed for all LACYP of school age (4-17 years) who have been in care for longer than 12 months (see section 4.1).

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<sup>20</sup> 10.4% of all LACYP did not have a HA recorded; this figure includes six LACYP who had not been in care for 28 days.

<sup>21</sup> In BwD the key performance indicator is that 90% of LACYP have a HA completed (see section 4.1).

<sup>22</sup> Using date of most recent HA.

<sup>23</sup> Included in the HAs of those aged 10 plus only.

<sup>24</sup> Routine dental checks should be made for all LACYP and the date of the most recent dental check is recorded in the HA.

- Three quarters (77%; n=87) of those applicable for an SDQ assessment<sup>25</sup> (n=113) had an SDQ score recorded on Protocol. An additional 68 LACYP who had not been in care for one year also had an SDQ score recorded<sup>26</sup>.
- Using the most recent<sup>27</sup> SDQ score, the mean SDQ score was 15.2 (range zero to 34). Over one third (43.2%) had an SDQ score of 17 or above<sup>28</sup>.

### 5.1.2. LOOKED AFTER CHILDREN AND YOUNG PEOPLE LOCATED IN BWD ONLY

#### SAMPLE CHARACTERISTICS

- As of 31<sup>st</sup> December 2014, there were 153 LACYP who were located within BwD (i.e. 50% of the population that the LA were responsible for).
- Six in ten (60.8%) were male and 61.4% were aged 0-9 years (Table 5.6).
- The majority (79.1%) were of a White background (British, Irish, other).
- Just under one in ten (8.5%) had a disability.

TABLE 5.6: SAMPLE DEMOGRAPHICS, LACYP LOCATED IN BWD (AS OF 31<sup>ST</sup> DECEMBER 2014)

	(n)	%
<b>Gender</b>		
Female	(60)	39.2
Male	(93)	60.8
<b>Age group</b>		
0-9 (child)	(94)	61.4
10 and over (young person)	(59)	38.6
<b>Ethnicity</b>		
White (British, Irish, Other)	(121)	79.1
Other ethnicity	(32)	20.9
<b>Does the child have a disability</b>		
Yes	(13)	8.5
No	(140)	91.5

#### CATEGORY OF NEED AND LEGAL STATUS

- Over half (56.9%) of LACYP located in BwD were provided with care due to abuse or neglect 15.7% due to family in acute stress, 20.9% because of family dysfunction and 6.5% for other reasons (Table 5.7).
- There were some variations in category of need by gender and age (Table 5.7). Compared to males (12.9%) a higher proportion of females (20.0%) in care (20.0%) were looked after because of family in acute stress. Six in ten children (60.6%) were looked after because of abuse or neglect, compared to five in ten young people (50.8%).
- The majority (81.1%) were looked after under a care order (full, 59.5%; interim, 21.6% [Table 5.8]).
- Legal status varied by gender and age group (Table 5.8).

<sup>25</sup> LACYP in care for over one year and school age (4-17).

<sup>26</sup> It is likely that this SDQ was conducted in line with other medicals.

<sup>27</sup> 106 LACYP had more than one SDQ score reported.

<sup>28</sup> SDQ scores of 17 or above indicate that action is needed by the child's social worker and that the child needs to be brought to the attention of the principle CAMHS practitioner.

TABLE 5.7: CATEGORY OF NEED BY GENDER AND AGE GROUP, LACYP LOCATED IN BWD (AS OF 31<sup>ST</sup> DECEMBER 2014)

	All %	Male %	Female %	Child (aged 0-9) %	Young person (aged 10+) %
<b>Category of need</b>					
Abuse or neglect	56.9	58.1	55.0	60.6	50.8
Family in acute stress	15.7	12.9	20.0	17.0	13.6
Family dysfunction	20.9	20.4	21.7	18.1	25.4
Other *	6.5	8.6	3.3	4.3	10.2

\*Includes: socially unacceptable behaviour, disability, parental illness and disability, and absent parenting.

TABLE 5.8: LEGAL STATUS BY GENDER AND AGE GROUP, LACYP LOCATED IN BWD (AS OF 31<sup>ST</sup> DECEMBER 2014)

	All %	Male %	Female %	Child (aged 0-9) %	Young person (aged 10+) %
<b>Legal status</b>					
Full Care Order	59.5	57.0	63.3	46.8	79.7
Interim Care Order	21.6	20.4	23.3	34.0	1.7
Placement Order Granted	6.5	9.7	1.7	10.6	0.0
Other (Section 20 and Emergency Protection Order)	12.4	12.9	11.7	8.5	18.6

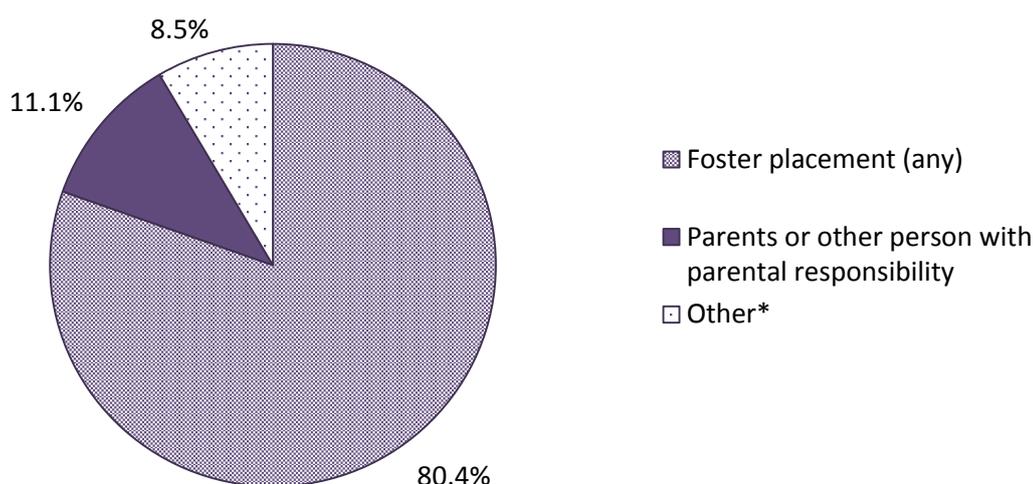
#### PLACEMENT STABILITY, TYPE AND PROVIDER

- One in three (30.7%) LACYP located within BwD had been in care for longer than one year.
- Two fifths (41.8%) were on their first placement, 26.1% on their second and 32.0% had three or more placements recorded (Table 5.9).
- The majority (92.2%) had no missing from care episodes recorded. The number of missing episodes ranged from zero to 37, with six LACYP (4.2%) having had five or more.
- The majority (80.4%) were on a foster placement (Figure 5.2).
- No LACYP in BwD had the placement type of placed for adoption.
- The majority (79.6%) were on a placement provided by the LA (Table 5.10).

TABLE 5.9: NUMBER OF PLACEMENTS, LACYP LOCATED IN BWD (AS OF 31<sup>ST</sup> DECEMBER 2014)

	(n)	%
<b>Number of placements</b>		
One	(64)	41.8
Two	(40)	26.1
Three or more	(49)	32.0

FIGURE 5.2: PLACEMENT TYPE, LACYP LOCATED IN BwD (AS OF 31<sup>ST</sup> DECEMBER 2014)



\*Includes: homes and hostels, independent living, NHS/Health Trust/medical or nursing care, HM Young Offender Institution or prison, residential schools

TABLE 5.10: PLACEMENT PROVIDER, LACYP LOCATED IN BwD (AS OF 31<sup>ST</sup> DECEMBER 2014)

Placement provider	All	Male	Female
	%	%	%
Parents or other person with parental responsibility	11.2	9.8	13.3
Own provision by LA	79.6	80.4	78.3
Other LA/Public provision	4.6	6.5	1.7
Other provision*	4.6	3.3	6.7

\*Includes: private provision and voluntary/third sector provision.

## HEALTH AND WELLBEING

### Health care assessment (HA)

- Amongst LACYP located in BwD who had been in care for longer than 28 days, 10.9% did not have a HA recorded (on Protocol as of 31/12/14)<sup>29,30</sup>.
- All those aged five and over who had been in care longer than one year had a HA recorded in the last year<sup>22</sup> above.
- Four fifths (80.7%) of those aged under five who had been in care for longer than six months had a HA recorded in the previous six months.

### Health concerns

- One fifth (20.7%, n=18/87) of all LACYP located in BwD had identified that they had worries about their health.
- The majority reported that they were eating (94.2%, n=81/86) and sleeping (92.7%, n=76/82) well.

<sup>29</sup> 14.4% of all LACYP in BwD did not have a HA recorded; this figure includes six LACYP who had not been in care for 28 days.

<sup>30</sup> In BwD the KPI is that 90% of LACYP have a HA completed (see section 4.1).

- Three quarters (74.1%, n=20/27) of young (aged 10 plus) LACYP located in BwD reported that they were able to take responsibility for their own needs<sup>23 above</sup>.

#### *Smoking, alcohol and drug use (young LACYP only)*

- One quarter (25.6%; n=10/35) of young LACYP located in BwD reported that they smoked.
- One in ten (12.8%; n=5/35) reported that they drank alcohol.
- Nearly a fifth (20%; n=7/35) reported that they had used drugs.

#### *Involvement with health services*

- Seven in ten (69.9%; n=107) LACYP located within BwD had involvement with health services recorded on their HA.
- Of those involved with health services, on average they were involved with 2.5 services. The majority were engaged with a health visitor/school nurse (89.2%) and a dentist (88%).
- Two fifths (41.8%) were engaged with a paediatrician; 12.5% with CAMHS; and 47.9% with another service.

#### *Dental health*

- Over two thirds (68.1%) of LACYP located in BwD who had been in care longer than one year had a dental check in the last year (recorded on Protocol).

#### *Strengths and Difficulties Questionnaire (SDQ)*

- Three quarters (76.7%, n=33) of those applicable for an SDQ assessment (n=43) had an SDQ score recorded on Protocol. An additional 34 LACYP who had not been in care for one year also had an SDQ score recorded<sup>26 above</sup>.
- Using the most recent<sup>31</sup> SDQ score, the mean SDQ score was 14.0 (range zero to 29). Over one third (37.5%) had an SDQ score of 17 or above<sup>28 above</sup>.

### **5.1.3. LOOKED AFTER CHILDREN AND YOUNG PEOPLE LIVING OUTSIDE BWD**

#### **SAMPLE CHARACTERISTICS**

- As of 31<sup>st</sup> December 2014, there were 153 LACYP living out of BwD (i.e. 50% of the population that the LA were responsible for).
- Six in ten (62.1%) were male and 42.5% were aged 0-9 years.
- The majority (87.6%) were of a White background (British, Irish, other).
- Over one in ten (13.1%) had a disability (Table 5.11).

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<sup>31</sup> 25 LACYP had more than one SDQ score reported.

TABLE 5.11: SAMPLE DEMOGRAPHICS, LACYP LOCATED OUT OF BWD (AS OF 31<sup>ST</sup> DECEMBER 2014)

	(n)	%
<b>Gender</b>		
Female	(58)	37.9
Male	(95)	62.1
<b>Age group</b>		
0-9 (child)	(65)	42.5
10 and over (young person)	(88)	57.5
<b>Ethnicity</b>		
White (British, Irish, Other)	(134)	87.6
Other ethnicity	(19)	12.4
<b>Does the child have a disability</b>		
Yes	(20)	13.1
No	(133)	86.9

#### CATEGORY OF NEED AND LEGAL STATUS

- Under half (45.1%) of LACYP located outside of BwD were provided with care because of abuse or neglect, 31.4% because of family dysfunction, 16.3% because of family in acute stress and 7.2% for other reasons (Table 5.12).
- There were some variations in category of need by gender and age group (Table 5.12).
- The majority (66.7%) were looked after under a care order (full, 60.8%; interim 5.9%; table 5.13).
- Legal status varied by gender and age group (Table 5.13).

TABLE 5.12: CATEGORY OF NEED BY GENDER AND AGE GROUP, LACYP LOCATED OUT OF BWD (AS OF 31<sup>ST</sup> DECEMBER 2014)

Category of need	All %	Male %	Female %	Child (aged 0-9) %	Young person (aged 10+) %
Abuse or neglect	45.1	40.0	53.4	53.8	38.6
Family in acute stress	16.3	14.7	19.0	9.2	21.6
Family dysfunction	31.4	35.8	24.1	32.3	30.7
Other *	7.2	9.5	3.4	4.6	9.1

\*Includes: disability, other cases, parental illness and disability, and absent parenting.

TABLE 5.13: LEGAL STATUS BY GENDER AND AGE GROUP, LACYP LOCATED OUT OF BWD (AS OF 31ST DECEMBER 2014)

	All %	Male %	Female %	Child (aged 0-9) %	Young person (aged 10+) %
<b>Legal status</b>					
Full Care Order	60.8	65.3	53.4	43.1	73.9
Interim Care Order	5.9	5.3	6.9	7.7	4.5
Placement Order Granted	21.6	20.0	24.1	47.7	2.3
Other (Section 20 and Emergency Protection Order)	11.8	9.5	15.5	1.5	19.3

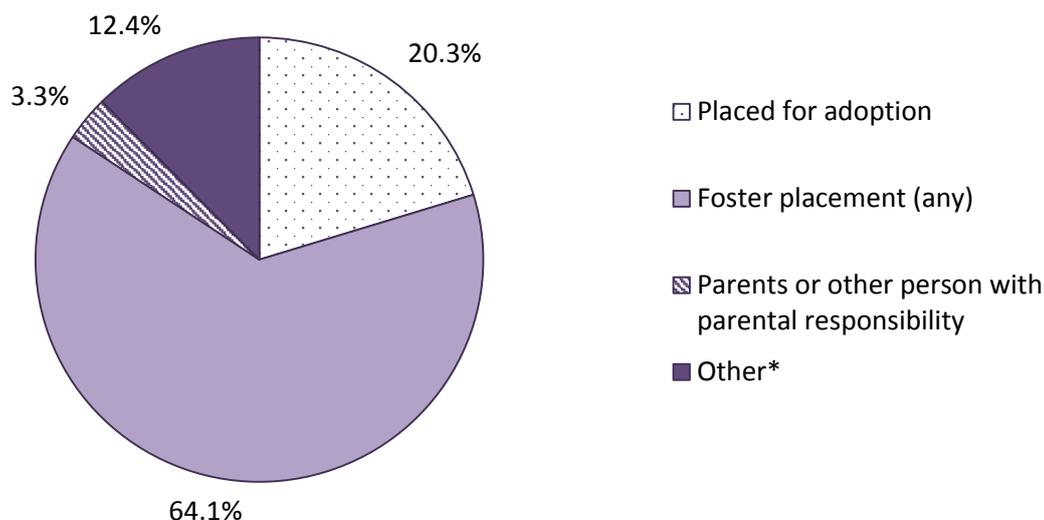
#### PLACEMENT STABILITY, TYPE AND PROVIDER

- Half (50.3%) of LACYP located outside of BwD had been in care for longer than one year.
- One fifth (20.3%) were on their first placement, 30.7% on their second and 49.0% had three or more placements recorded (Table 5.14).
- The majority (89.5%) had no missing from care episodes recorded. The number of missing episodes ranged from zero to 33, with six (4.1%) LACYP having five or more.
- The majority (64.1%) were on a foster placement (Figure 5.3).
- Two in five (42.5%) LACYP were on a placement provided by the LA; 35.9% had a provision of other (Table 5.15).

TABLE 5.14: NUMBER OF PLACEMENTS, LACYP LOCATED OUT OF BWD (AS OF 31<sup>ST</sup> DECEMBER 2014)

	(n)	%
<b>Number of placements</b>		
One	(31)	20.3
Two	(47)	30.7
Three or more	(75)	49.0

FIGURE 5.3: PLACEMENT TYPE, LACYP LOCATED OUT OF BWD (AS OF 31<sup>ST</sup> DECEMBER 2014)



\*Includes: homes and hostels, independent living, NHS/health trust/medical or nursing care, HM Young Offender Institution or prison, residential schools

TABLE 5.15: PLACEMENT PROVIDER BY GENDER, LACYP LOCATED OUT OF BWD (AS OF 31<sup>ST</sup> DECEMBER 2014)

Placement provider	All	Male	Female
	%	%	%
Parents or other person with parental responsibility	3.3	4.2	1.7
Own provision by LA	42.5	42.1	43.1
Other LA/Public provision	18.3	15.8	22.4
Other provision*	35.9	37.9	32.8

\*Includes: private provision and voluntary/third sector provision.

## HEALTH AND WELLBEING

### Health care assessment (HA)

- Amongst LACYP located outside BwD who had been in care for longer than 28 days, 6.5% did not have a HA recorded (on Protocol as of 31/12/14).
- One in ten (12.1%) LACYP aged five and over who had been in care longer than one year, did not have a HA recorded in the last year<sup>22 above</sup>.
- Two thirds (67.9%) of those aged under five who had been in care for longer than six months had a HA recorded in the previous six months.

### Health concerns

- Nearly one fifth (18%, n=18/100) of all LACYP located outside of BwD had identified that they had worries about their health.
- The majority reported that they were eating (96%, n=97/101) and sleeping (86.7%, n=85/98) well.
- Three quarters (72.7%, n=24/33) of young LACYP located outside of BwD reported that they were able to take responsibility for their own needs<sup>23 above</sup>.

### Smoking, alcohol and drug use (young people only)

- Nearly one quarter (23.1%; n=12/52) of young LACYP located outside of BwD reported that they smoked.
- One in ten (10.2%; n=5/49) reported that they drank alcohol.
- Less than one in ten (8.2%; n=4/49) reported that they had used drugs.

#### *Involvement with health services*

- The majority (74.5%) of all LACYP located outside of BwD had involvement with health services recorded on their HA.
- Of those involved with health services, on average they were involved with 2.3 services. The majority were involved with a health visitor/school nurse (75.8%) and a dentist (84.8%).
- Nearly a third (29.7%) were involved with a paediatrician, 18% with CAMHS and 32.7% another service.

#### *Dental health*

- Over two thirds (68.8%) of LACYP located outside of BwD who had been in care for longer than one year had a dental check in the last year.

#### *Strengths and Difficulties Questionnaire (SDQ)*

- Three quarters (77.1%, n=54) of those applicable for an SDQ assessment (n=70) had an SDQ score recorded on Protocol. An additional 34 LACYP who had not been in care for one year also had an SDQ score recorded<sup>26 above</sup>.
- Using the most recent SDQ score<sup>32</sup>, the mean SDQ score was 16.2 (range three to 34). Almost half (47.6%) had an SDQ score of 17 or above, indicating that action is required by the child's social worker<sup>28 above</sup>.

### **5.1.4. DIFFERENCES BETWEEN LOOKED AFTER CHILDREN AND YOUNG PEOPLE LIVING IN BwD AND THOSE LIVING OUT OF BwD**

#### **DEMOGRAPHICS**

- A higher proportion of LACYP outside of BwD (57.5%), than within BwD (38.6%) were classed as a young person.
- A slightly higher percentage of LACYP living outside of BwD were disabled (13.1%) compared to those living within BwD (8.5%).
- More LACYP living outside of BwD were of a White (British, Irish, Other) ethnic background (outside of BwD, 87.6%; in BwD, 79.1%).

#### **CATEGORY OF NEED AND LEGAL STATUS**

- The proportion of LACYP in care because of abuse or neglect was higher for LACYP located inside BwD (56.9%) than those located outside of BwD (45.1%).
- More LACYP located outside of BwD (31.4%) were in care because of family dysfunction than those located within BwD (20.9%).

#### **PLACEMENT STABILITY, TYPE AND PROVIDER**

- Only 3.3% of LACYP located outside of BwD were on a placement provided by parents or other person with parental responsibility (LACYP in BwD, 11.2%).
- A higher proportion of LACYP located in BwD were on their first placement (41.8%) than LACYP outside of BwD (20.3%).

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<sup>32</sup> 62 LACYP had more than one SDQ recorded.

- Placement stability was poorer for LACYP living outside of BwD in comparison to LACYP who were located within BwD. Thus, a higher proportion of LACYP living outside BwD had more than one placement in the last year than those inside BwD (38.6% versus 19%). In addition, LACYP based outside BwD had been in care longer - 30.1% had been in care for longer than five years, compared to 21.6% for those who lived inside BwD.
- The mean number of years in care to date was also higher for LACYP living outside of BwD (3.6 years) than for LACYP living in BwD (2.7 years).
- Although the proportion of LACYP with missing episodes was relatively low across the whole sample, more LACYP living outside of BwD had a missing episode recorded (10.8%) than those who were currently located within BwD (8.1%).

#### LOOKED AFTER CHILDREN AND YOUNG PEOPLE'S HEALTH

- A higher proportion of LACYP who had been in care for longer than 28 days did not have a HA recorded within BwD (10.9%) than LACYP located outside of BwD (6.5%).
- The mean SDQ score was slightly higher for LACYP living outside of BwD (16.2 versus 14.0 for LACYP within the LA). A higher proportion of LACYP living out of area (47.6%) compared to those living in BwD (37.5%) scored over the threshold for action<sup>27</sup> above.

#### 5.1.5. CARE LEAVERS

##### SAMPLE CHARACTERISTICS

- Over the three year period of 1<sup>st</sup> January 2012 to 31<sup>st</sup> December 2014, BwD Borough Council had 134 care leavers recorded. During this three year period, six LACYP were recorded as leaving care twice.
- Over half (56%) of care leavers were male and 72.4% were aged ten plus (Table 5.16).
- Nearly eight in ten (76.9%) were of a White background (British, Irish, other).
- One in ten (11.9%) had a disability.

TABLE 5.16: SAMPLE DEMOGRAPHICS, CARE LEAVERS, 01/01/2012 TO 31/12/2014

	(n)	%
<b>Gender</b>		
Female	(75)	44.0
Male	(59)	56.0
<b>Age group</b>		
0-9 (child)	(37)	27.6
10 and over (young person)	(97)	72.4
<b>Ethnicity</b>		
White (British, Irish, Other)	(103)	76.9
Other ethnicity	(31)	23.1
<b>Does the child have a disability</b>		
Yes	(16)	11.9
No	(118)	88.1

## CATEGORY OF NEED AND LEGAL STATUS

- Six in ten (61.1%) care leavers were provided with care due to abuse or neglect and 18.7% due to family dysfunction. There were variations in category of need by gender and age group (Table 5.17).
- The last legal status reported for care leavers indicated that over half (56%) were looked after under a care order (full, 37.3%; interim, 18.7%).
- Two fifths (39.6%) had a legal status of single period of accommodation under Section 20, and 4.5% had a legal status of other (Table 5.18).

TABLE 5.17: CATEGORY OF NEED BY GENDER AND AGE GROUP, CARE LEAVERS, 01/01/2012 TO 31/12/2014

	All %	Male %	Female %	Child (aged 0- 9) %	Young person (aged 10+) %
<b>n</b>	134	75	59	37	97
<b>Category of need</b>					
Abuse or neglect	61.1	54.7	69.5	75.7	55.7
Family in acute stress	11.2	10.7	11.9	13.5	10.3
Family dysfunction	18.7	20.0	16.9	5.4	23.7
Other *	9.0	14.7	1.7	5.4	10.3

\*Includes: disability, parental illness or disability, socially unacceptable behaviour, absent parenting and other cases.

TABLE 5.18: LAST LEGAL STATUS RECORDED BY GENDER AND AGE GROUP, CARE LEAVERS, 01/01/2012 - 31/12/2014

	All %	Male %	Femal e %	Child (aged 0-9) %	Young person (aged 10+) %
<b>n</b>	134	75	59	37	97
<b>Legal status</b>					
Full Care Order	37.3	37.3	37.3	5.4	49.5
Interim Care Order	18.7	18.7	18.6	62.2	2.1
Single Period Of Accommodation Under Section 20	39.6	38.7	40.7	18.9	47.4
Other*	4.5	5.3	3.4	13.5	1.0

\*Includes: on remand, or committed for trial or sentence and accommodated by LA, placement order granted, under police protection and in LA accommodation.

## PLACEMENT LENGTH, LOCATION AND PROVIDER

- Over the three year period the number of care leavers per year was fairly consistent (2012, n= 49; 2013, n=37; 2014, n=48).
- The majority (64.9%) had been in care for over one year, whilst 10.4% had been in care for between one to two years and 37.3% four or more years (Table 5.19).
- The majority (63.6%) were located within BwD on their last placement (2012, 68.1%; 2013, 64.9%; 2014, 58.3%).
- The last placement for the majority (60.9%) of care leavers was provided by the LA (Table 5.20).
- For over half (55.2%) of care leavers, the length of their last placement was less than one year (Table 5.21).

TABLE 5.19: TOTAL LENGTH OF CARE BY GENDER, CARE LEAVERS, 01/01/2012 TO 31/12/2014

	All %	Male %	Female %
<b>n</b>	134	75	59
<b>Length of care</b>			
Less than 1 year	35.1	37.3	32.2
Over 1 year but less than 2 years	10.4	9.3	11.9
Over 2 years but less than 3 years	9.0	9.3	8.5
Over 3 years but less than 4 years	8.2	5.3	11.9
4 years and above	37.3	38.7	35.6

TABLE 5.20: LAST PLACEMENT PROVIDER RECORDED, CARE LEAVERS, 01/01/2012 TO 31/12/2014

	(n)	%
<b>Last placement provider</b>		
Parents or other person with parental responsibility	(13)	9.8
Own provision by LA	(81)	60.9
Private provision	(31)	23.3
Other provision*	(8)	6.0

\*Includes: other LA provision, other public provision, voluntary/third sector provision.

TABLE 5.21: LENGTH OF LAST PLACEMENT, CARE LEAVERS, 01/01/2012 TO 31/12/2014

	(n)	%
<b>Length of last placement</b>		
Less than 1 year	(74)	55.2
Over 1 year but less than 2 years	(25)	18.7
Over 2 years but less than 3 years	(8)	6.0
Over 3 years but less than 4 years	(5)	3.7
4 years and above	(22)	16.4

#### REASON FOR END OF CARE

- Two fifths (41%) of care leavers left care because they reached the age of 18. One third (32.1%) left care because they returned home to parents or relatives (Table 5.22).
- A higher proportion of care leavers whose last placement had been within BwD left care to return home to parents/relatives, compared to children who were located in other LAs (35.7% compared to 27.1%).
- A smaller proportion of care leavers whose last placement had been within BwD left care because they had reached 18 years of age, in comparison to LACYP whose last placement had been outside of the LA (38.1% and 47.9% respectively).

TABLE 5.22: REASON FOR END OF CARE BY PLACEMENT LOCATION, CARE LEAVERS, 01/01/2012 - 31/12/2014

	All	BwD	Other LA
	%	%	%
n	132	84	48
<b>Reason for end of care</b>			
Child reached 18 years	41.0	38.1	47.9
Independent living	9.0	7.1	1.4
Special guardianship order	9.0	11.9	4.2
Returned home to parents/relatives	32.1	35.7	27.1
Other *	9.0	7.1	10.4

\*Includes: adopted - application unopposed, adopted - consent dispensed with, period of being looked after ceased for other reason, residence order granted, special guardianship order made to carers other than former foster carers and special guardianship order made to former foster carers.

## 5.2. LOOKED AFTER CHILDREN AND YOUNG PEOPLE'S ENGAGEMENT WITH THE YOUTH JUSTICE SERVICE (YJS)

- Over the three year period (January 2012 to December 2014) 32 LACYP were in contact with the YJS in BwD. Due to the small numbers and the format in which the data were provided we are unable to break this figure down any further.

## 5.3. LOOKED AFTER CHILDREN AND YOUNG PEOPLE'S ENGAGEMENT WITH LIFELINE

- Over the three year period (January 2012 to December 2014) 104 LACYP in BwD had been referred to Lifeline.
- Just over half (58.7%, n= 61) were male.
- The majority were of White ethnicity (89.4%, n=93).
- The mean age at referral for both sexes was 18 years (males, 18; females, 19). Ages ranged from 13 to 23 years.
- Less than 3% had a disability.
- Over a third (36.5%, n=38) had a family member who was a substance user.

## 5.4. DISCUSSION

Information on the number of children in care is essential for service planning. The analysis highlighted the number of LACYP in care, both within and outside of BwD. The overview of the profile of LACYP in BwD is presented in section 5.1.1. Receiving data on LACYP for analysis was dependent on partner engagement with the research project. In some instances information on LACYP was available, but data quality was low, consequently it had to be removed from analysis. It is apparent that additional information is collected which would enable an additional examination of LACYP. Further discussion is included in section 8.3.

## 6. STAKEHOLDER ENGAGEMENT FINDINGS

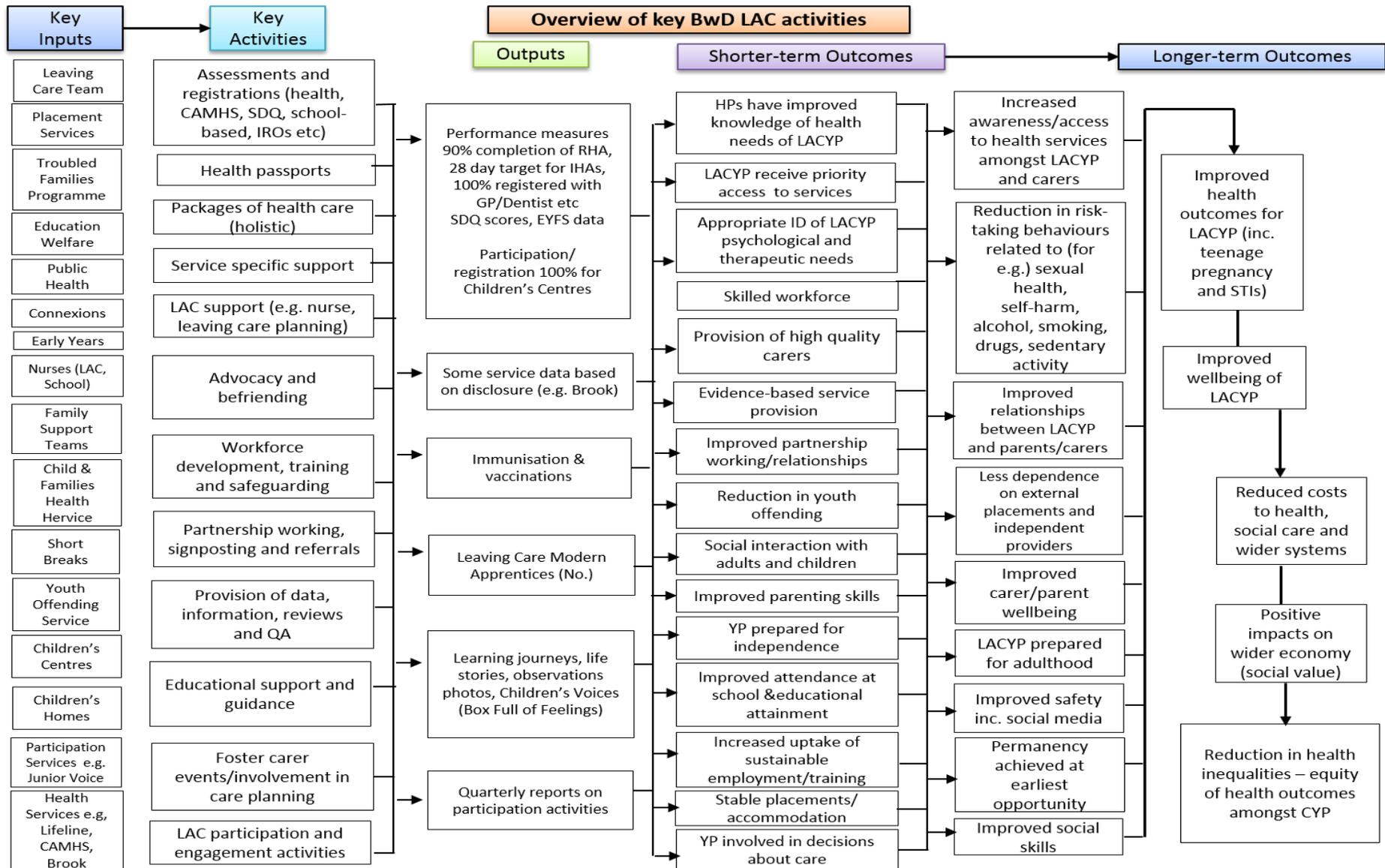
### 6.1. SESSION 1: DEVELOPING THE LOGIC MODEL

Two stakeholder engagement events were held during the initial phase of the research. The first stakeholder session was held on 6<sup>th</sup> November 2014 and involved attendees mapping out the activities involved in the delivery of services supporting LACYP in BwD. Stakeholders were invited to identify the key activities, outputs and outcomes involved in their work. This process focused on programme outputs and the changes and impact this has for the young people, their carers and families, and wider relationships. The research team worked with the stakeholders to explore how the outcomes linked to the outputs, and gathered information regarding how these outcomes are currently evidenced. The activity identified gaps in evidence and provided stakeholders with the opportunity to consider elements of the service that require change.

Following the first stakeholder session, the research team collated the data and used the information collected to develop the logic model (outlining the activities, outputs and outcomes of each programme; figure 6.1).

The logic model outlines the wide range of stakeholders involved in supporting LACYP in BwD, from carers, family support teams and placement services, to education, youth offending and health services. The logic model presents an overview of the range of activities implemented to support LACYP, their carers and wider stakeholders, along with the key outputs generated through these activities. A range of performance measures are captured, along with data regarding health, quality of life, and participation. The model describes the short and long term outcomes associated with the services available to support LACYP and their families living with BwD.

FIGURE 6.1: LOGIC MODEL



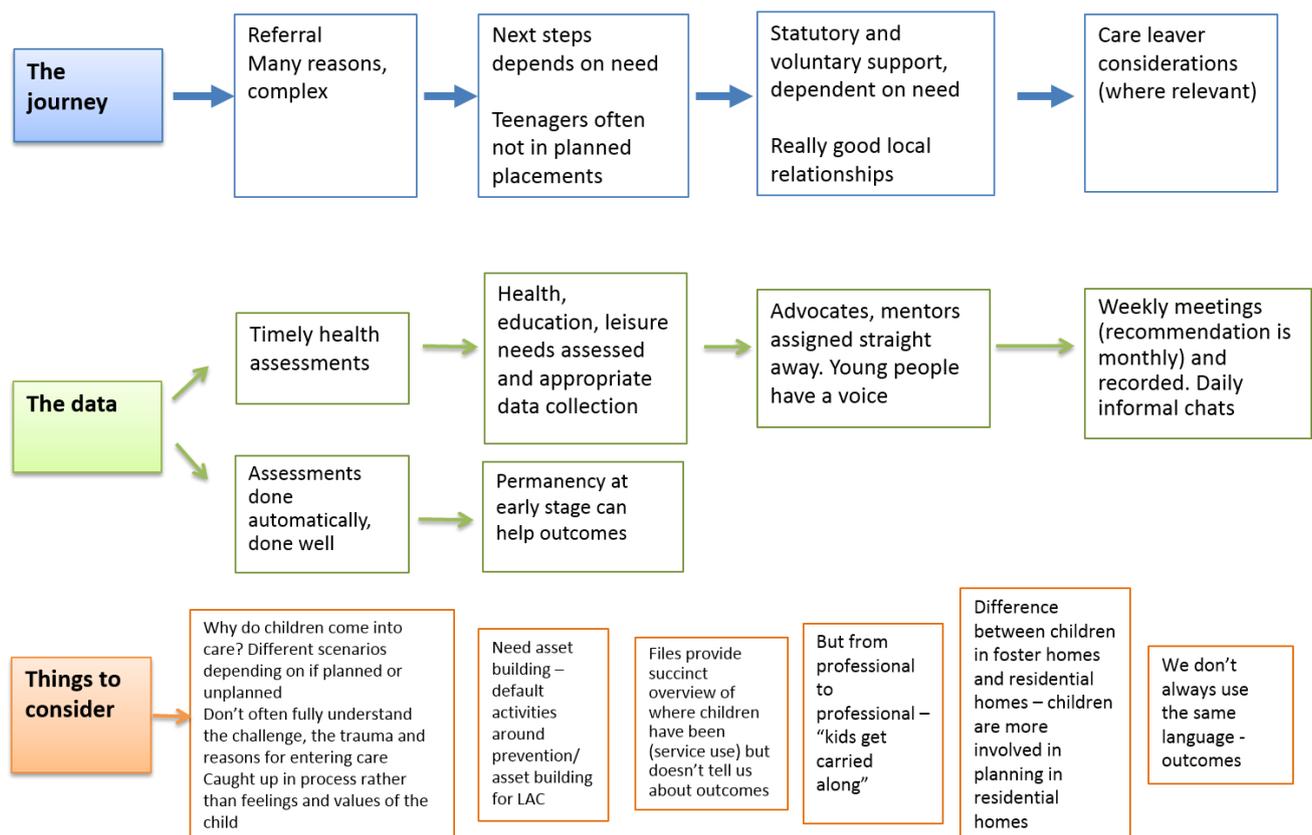
## 6.2. SESSION 2: MAPPING THE JOURNEY OF THE LOOKED AFTER CHILDREN IN BLACKBURN WITH DARWEN

Stakeholders were invited to attend a second stakeholder session, held two weeks after the first session. The research team presented the logic model that had been developed following session one, and used this as the basis for session two discussions. Stakeholders were asked to work together to build a story surrounding the typical journey of a looked after child, a care leaver, and a child living outside the area, and map the potential different methods of support provided by the programme, including referral sources and missed opportunities. This activity also aimed to capture views regarding this “ideal journey” (figures 6.2 – 6.4).

This activity brought the logic model to life, allowing stakeholders to use the model to identify what changes could be made, and where. This provided stakeholders with the opportunity to consider any elements of the service that may require change. Recommendations for enhancing outcome identification and monitoring, in line with evidence from reviews and research, will also be discussed at the second session, to determine appropriateness, feasibility and design. Findings from this session were made immediately available to commissioners to inform service development in a timely manner.

FIGURE 6.2 MAPPING THE JOURNEY OF A CHILD IN THE CARE OF BLACKBURN WITH DARWEN

### Understanding the Journey – Child in the Care of Blackburn with Darwen

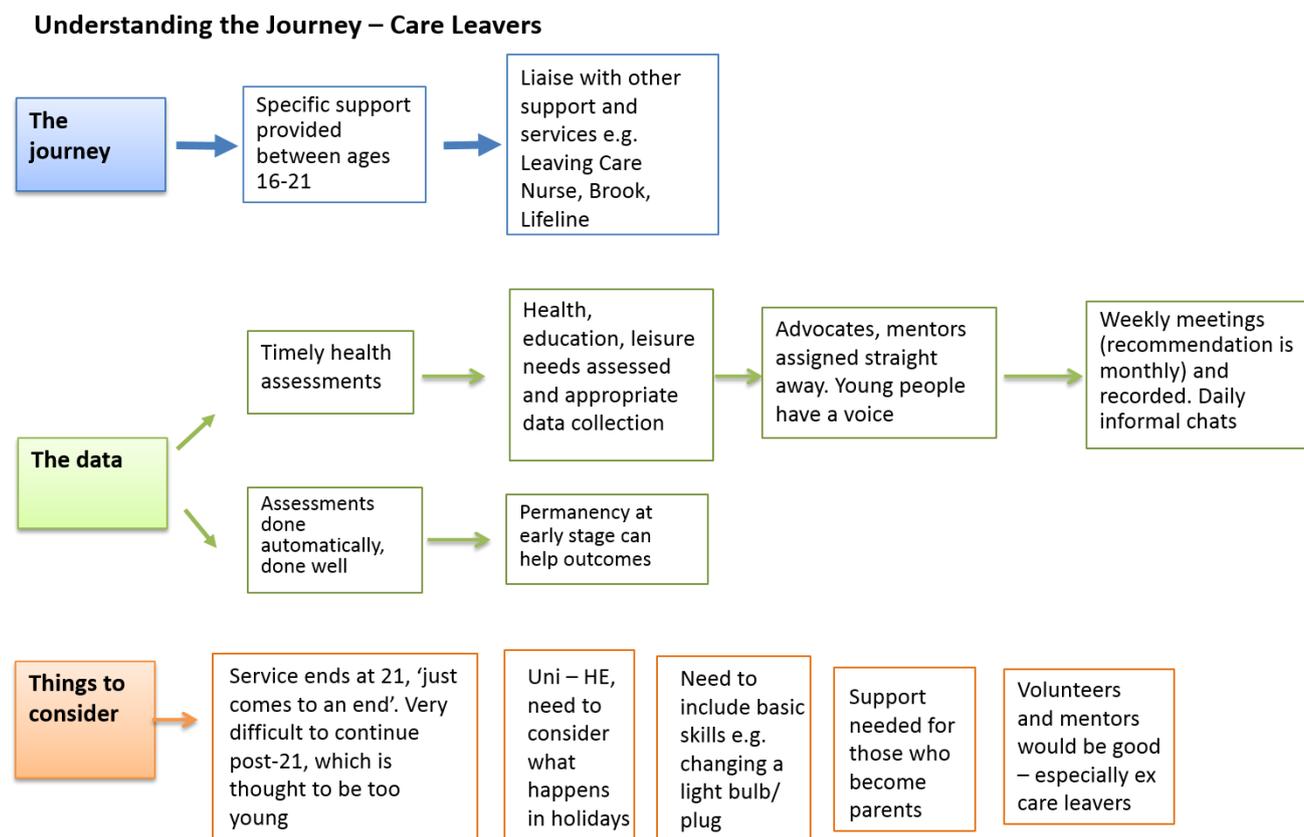


For children in the care of BwD (figure 6.2), stakeholders described the complexity of the cases and the range of reasons for referrals. Often, teenagers were not placed in planned placements, which could present issues in terms of accessing health and other relevant information. LACYP were described as being given the support they required from the range of statutory and voluntary support agencies available, and that very good local

relationships facilitated this. The stakeholders recognised that care leavers may have specific needs that would require consideration. Stakeholders were asked to describe the data that are produced and/or accessed. Here, assessments were described as being undertaken in a timely and acceptable way, and that information regarding health, education and leisure needs. Stakeholders described that they felt that each element had appropriate data collection in place in order to monitor activity and progress. In terms of ongoing support, stakeholders described the role of the advocates who are assigned to support young people and the weekly meetings and informal discussions which take place.

Stakeholders highlighted a number of issues that required consideration, these included the acknowledgement that stakeholders can never fully understand the reasons and trauma that children have experienced upon entering care. Some stakeholders felt they could get 'caught up in the processes rather than ensuring they recognise the feelings and values of the child. In terms of assessing impact, stakeholders recognised that the data collected and shared provide a good overview of the services that the child has accessed, but that these data do not evidence outcomes. This was felt to be important in terms of understanding the impact of previous service use.

FIGURE 6.3 MAPPING THE JOURNEY OF CARE LEAVERS

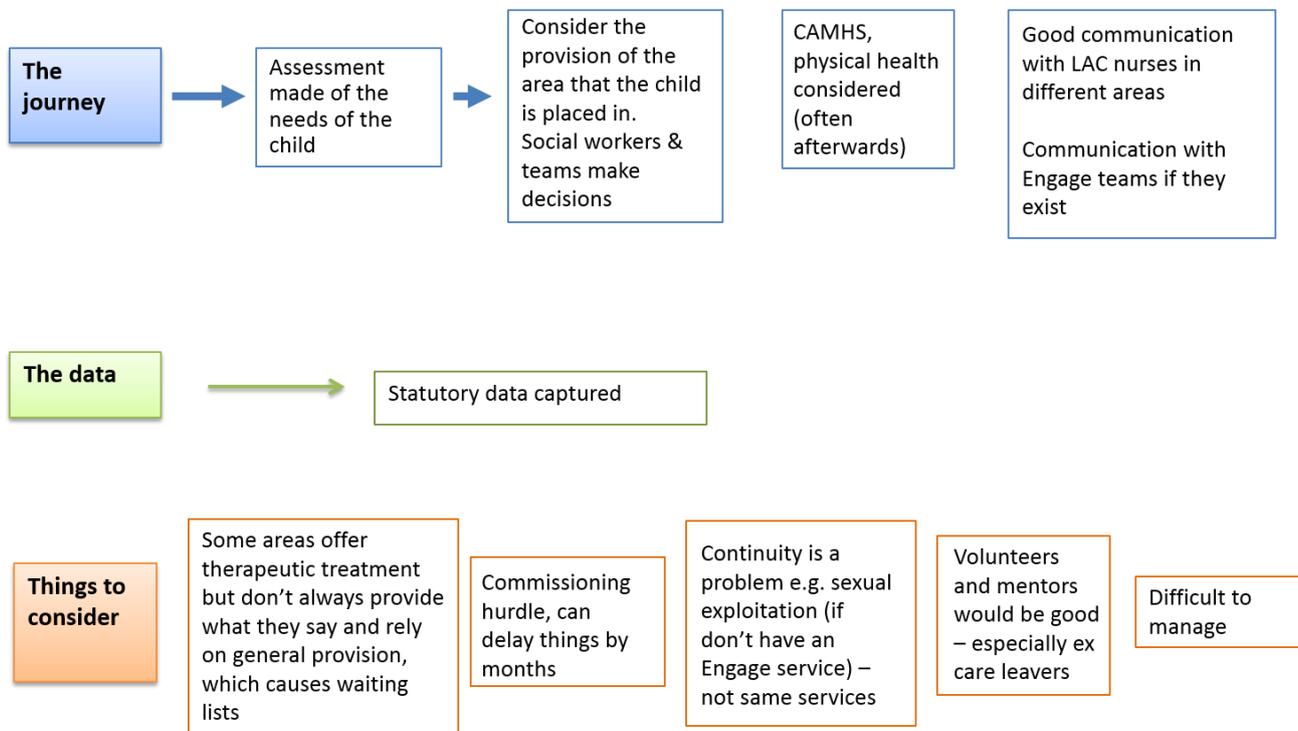


Stakeholders described that care leavers receive specific support between the ages of 16-21 depending on their needs, and that this is determined in liaison with other support services (figure 6.3). Again, all agreed that care leavers received timely health assessments and that these were done well. However, stakeholders identified a number of key issues surrounding support for care leavers which could be addressed. It was felt that the support ended abruptly when the care leaver reached the age of 21, and that more training regarding basic life skills would be useful. Stakeholders felt strongly that specific consideration needed to be given to care leavers who were at university and may not have appropriate caring accommodation to stay in during the

holiday period, and that specific support would be useful for those who had become parents. Stakeholders felt that it would be good for care leavers to receive mentoring support from ex-care leavers.

FIGURE 6.4: MAPPING THE JOURNEY OF CHILDREN PLACED OUT OF AREA

**Understanding the Journey – Children Placed Out of Area**



Children placed outside of BwD receive statutory assessments, and are then considered by social workers and their teams in terms of the provision they require (figure 6.4). Stakeholders described that input to support emotional and physical health needs is often required, and felt that there was good communication with LAC nurses in the different areas. Child sexual exploitation teams were described as good sources of communication, if they were available in areas where LACYP had been placed. Stakeholders felt confident that all statutory data were captured for these LACYP. A number of issues were highlighted which could impact the quality of the journey experienced by the LACYP placed outside of BwD; it was highlighted that not all areas provide therapeutic treatment, and that some rely on general provision, which can cause delays in LACYP accessing treatment. Commissioning was viewed to be a barrier which could delay processes, and continuity was described as an issue where areas do not have the same or similar services in place. Sexual exploitation was raised as an example of this. Stakeholders agreed that the differences in service provision made it often difficult to manage the experiences and outcomes for LACYP living outside of the area. Again, stakeholders raised the issue of training and support for LACYP, although this was focused on less here. Some suggested that volunteers or mentors with experience of living out of area may be useful for these LACYP.

## 7. QUALITATIVE DATA FINDINGS

### 7.1. CHILDREN AND YOUNG PEOPLE IN CARE

Interviews and focus groups were conducted with 19 children and young people in care. All interviews were conducted in their place of residence. Two interviews were conducted over the telephone.

Group	Participants
<b>Children in foster care/care placements</b>	<ul style="list-style-type: none"> <li>• Face-to-face interview with a male, aged 14 living at home with his mother and placed on a care order. Previous experience of foster care.</li> <li>• Face to face paired interview with female, aged 9 and male, aged 7. Placed with same foster family. LEGO used to prompt discussion</li> <li>• Face to face paired interview with male, aged 10 and female, aged 9. Placed with same foster family. LEGO used to prompt discussion</li> <li>• Focus group with seven children aged 8-13, five male and two female. Part of an existing participation group in BwD. LEGO used to prompt discussion</li> </ul>
<b>Children's home in Blackburn with Darwen</b>	<ul style="list-style-type: none"> <li>• Face to face Interview with female, aged 10. LEGO used to prompt discussion</li> <li>• Focus group with male aged 17, female aged 14 and female aged 16.</li> </ul>
<b>Children living out of area</b>	<ul style="list-style-type: none"> <li>• Telephone interview with male, aged 15, living in Midlands</li> <li>• Telephone Interview with female, aged 16 living in Midlands</li> <li>• Face to face interview with male, aged 13, Living in Lancashire</li> </ul>

#### Access to healthcare

The young people believed that they had good access to healthcare. Most children and young people discussed having been their doctor (GP) previously and some had been to hospital for minor accidents. The children in foster care all said they could talk to their carer or parent if they felt unwell. Some participants talked about seeing their school nurse though knowledge of other health services was limited.

The children living out of area were registered with a GP in the area they were living in and had good knowledge of how to access support for their health from their GP. Their knowledge of other health services was limited, due to the fact that they stated that they would always seek support from their GP or foster carer in the first instance. One young person discussed that a nurse will visit his house to undertake the annual medical assessment and he also has contact with the school nurse. This young person was happy to undertake the medical assessment as it didn't occur often.

The young people living in the children's home felt they would feel confident to ask for medical help if they needed it and indicated they would ask staff at the children's home if they

*"I would speak to my doctor if I needed anything" (male aged 15, out of area)*

*Researcher: So if you need help with your health what would you do if you weren't feeling well?*

*Participant: I'd go "I don't feel well" I'd just shout it. [children's home staff would] make me an appointment*

*Researcher: And do you feel quite happy like chatting with the doctor about like not feeling well and stuff?*

*Participant: yeah (female aged 10, children's home)*

thought they needed a GP appointment. However they all reported they do not need to go to the GP regularly and are generally very healthy.

### **Annual health assessments**

The younger children in foster care and in the children's home (aged 8-10) were not as aware of the formal annual health assessments, though through prompting most remembered having health check-ups with a nurse; either at school or home. Few of the children recognised this as a formal regular assessment and none mentioned that it was required or formal. Some of the younger children said it was boring and said they had forgotten it and another thought it was a bit repetitive though enjoyed being weighed and measured. Two other younger children (aged 9 and 10) did not really remember having a health check though they thought a nurse might have come to their home and asked some questions. The focus group felt the worst thing about having a health assessment was when they were taken out of their favourite lessons.

The older participants in the children's home were asked about their experience of the annual health check. Despite researchers working to elicit further detail and information responses on this topic were vague and non-committal, though none expressed a particular dislike or reluctance to attend medical reviews.

The young person living at home with a care order had recently had a health assessment that was conducted by the school nurse. He thought it was acceptable but boring and was happy to answer the questions.

The focus group of younger children suggested the assessment was better when conducted at home rather than school as it was more private and they didn't have to miss the lessons they enjoyed.

### **Dental health**

All children and young people reported attending the dentist regularly, one participant preferred the dentist to the GP because they didn't give injections. One participant (aged 7) reported having a lot of teeth out in the past and blamed this on him having been unhealthy.

*Researcher: Do you have [check-ups] is it like every year or something?*

*Participant: Erm not every year nearly though*

*Researcher: And what kind of like questions do they ask?*

*Participant: They just ask me if I am feeling well or not (Female aged 10, children's home)*

*"[The annual health assessment is] getting slightly repetitive but alright" (Male, aged 10 in foster care)*

*Researcher: How would you describe the health assessment to someone who didn't know what it was?*

*Participant: A way to see if you're alright and healthy" (Male, aged 14, living at home)*

*"They [annual health assessments] are boring" (Male aged 11, junior focus group)*

## Importance of health

The young people had a good understanding of what it means to be healthy and about the impact of lifestyle on health.

When asked what 'being healthy' meant to them, all children and young people discussed the importance of a healthy diet high in fruit and vegetables as their first idea. All children and young people felt they themselves had a healthy diet and gave examples of eating lots of fruit and using the salad bar at primary school. The junior focus group discussed how McDonalds and junk food was unhealthy but allowed as an occasional treat.

All young people also talked about physical activity and sport as promoting health. The majority of young people in all groups were involved with physical activity outside of school including football, dancing, cricket, gymnastics, cycling, swimming and martial arts. All of these were general sports groups not activities specifically for LACYP. One young male mocked his sister for being a bit lazy and spending too much time watching television.

Being healthy was considered very important for everyday life with some participants explaining physical activity made them feel energised and being healthy made them happy.

Emotional health and happiness was only discussed by participants with prompting; few thought of health as anything other than physical. It was agreed that it was important to look after your emotional health and some participants considered school important for good mental health as it provides a stable environment. 'Happiness' was discussed by some of the participants who felt being happy and being surrounded by friends was good for your health. Friends and social support was important to participants and thought to be linked to mental wellbeing. Being praised by teachers, parents and carers was also discussed by some participants as making them feel good.

Some participants talked about other young people they knew who had unhealthy lifestyles, who ate diets high in sugar and fat or who did not do any physical activity.

*"Healthy is having a balanced diet, having varied meals and having fitness above the average level" (Male aged 15, out of area)*

*"If you're healthy you have got to be happy so that you can run around and things and you can get exercise because if you're not happy then you can't get loads of exercise" (Female, aged 10 Children's home)*

*"Things that affect my health are eating fast food. Not doing enough fitness and highering my resting heart rate" (Male aged 15, out of area)*

*"if you're sad you won't exercise but if you're happy you'll be energetic" (Female aged 10, junior focus group)*

*"[Bread] isn't healthy to eat...Because it can have loads of fat things in it like pepperonis, ham, meat" (Female aged 10, children's home)*

*"School is good for mental health because it keeps your mind focused, it helps because it educates you and it's a stable environment" (Female aged 16, out of area)*

*"Being healthy is very important to me because it's important and helps everyday life and exercise" (Male aged 15, out of area)*

*"Being fat – watching tele all the time" [participant coughed and pointed at his sister] (Male, aged 10 in foster care)*

*Participant: Something might have happened, something really bad might have happened.*

*Researcher: do you think happiness is an important part of healthiness?*

*Participant: Yeah (Female aged 10, children's home)*

## Access to support

Young people living in the children's home discussed who they would speak to if they felt sad or wanted support for emotional issues – they all said they felt confident to speak to staff in the children's home. One child living at the children's home discussed learning to cook with the staff. She was enjoying this and felt it would help with her independence. The majority of the children who lived with foster carers said they would speak to their carers or social worker if they felt sad or were worried about anything. Many participants felt they could speak to specific teachers or teaching assistants at school. The young person living at home on a care order said he would speak to his mum if he wanted support or he could speak to his social worker. Opinion was divided on whether children and young people would speak to their social worker if they needed support or were worried about something. Two participants in the junior focus group discussed Childline as it has been promoted in their school and one discussed talking to the BwD staff who support their participation group.

Three of the young people who took part in the research resided in areas outside of BwD but are supported as looked after children and young people under BwD Council. Two of the young people lived in the Midlands and one lived in Lancashire with their foster carers. One had been in their current placement four weeks and this was the third place they had resided at. One had been in their current placement for seven months; this was their fourth home and the other young person had been in his current placement for six years. They described having good access to support through their social worker from BwD despite living out of area. The young people discussed receiving support from their social worker, foster carers, other family members and through pastoral support at school. The young people residing on the Midlands discussed seeing their social worker on a regular basis; every 4-6 weeks. It was noted that it was usual to see a social worker every six months, however, if LACYP had recently moved or needed more regular contact they would see them more often. The ability to have more regular contact was described as beneficial.

The young person based in Lancashire reported seeing his social worker for statutory 'check-up' visits every 'few' months. It was noted that the social worker would visit immediately if the young person or foster carers contacted them with an issue. The young person would prefer to see them only in these circumstances rather than regular visits because they felt that they did not need the additional support.

*"I have a social worker that I can talk to and we have reviews" (Male aged 15, out of area)*

*"There is pastoral support in school for the certain people who know, only certain people know, a very few" (Male, aged 15, out of area)*

*"There is enough support, there is support there if you want it, I don't really need it, but it's there if and when you need it" (Male aged 15, out of area)*

*"I get support from my carers. I also have close family members, not biological, but close, that I can talk to" (Female, aged 16, out of area)*

*"if I were at school it would be my TA [teaching assistant]...if I were at home I'd go to [foster carer] or my foster sister". (Female, aged 9, foster care)*

*"I've just moved so I see them quite often, every six weeks. It's usual to see them every six months but I see them more often after what happened" (Male aged 15, out of area)*

A young person living out of area discussed receiving a booklet asking about health, feeling and aspirations. It was reported that he had received this a few times with the same questions but does not have any awareness of what happens with this information and how it is acted on. This young person has been offered other support but does not require it; however the support is based in Blackburn.

### **Social workers**

Most young people in foster care had a positive opinion and experience of their social worker. They felt they could talk to their social workers if they had a problem. One male participant (aged 14) who lived with his mother spoke very positively of his social worker – he has had the same social worker for a long time and discussed how he felt he could trust her and was comfortable with her. He discussed how he would not like a new social worker as he would not trust them.

The majority of children reported they disliked it when they changed social workers; it confused them and some said it had upset them. Children discussed how it took time for them to trust the new social worker and they felt frustrated as they had to repeat themselves every time they got a new social worker. Some children discussed having had 3-4 different social workers they could remember.

The young people in the children's home did not discuss their social workers, though due to time restraints they were not asked directly about this.

*"I think it is important to have one social worker – cos that other social worker might not know what you have talked about and you'll get mixed up... I think when they change social worker it mixes me up...they go over what we've talked about with the other social worker and it gets a bit boring" (Female, aged 9, foster care)*

*"I had mine [social worker] for a couple of years then I changed, then I changed again" (Female aged 10, junior focus group)*

*"Not someone [social worker] new, if it was someone new I wouldn't ask questions" (Male, aged 14, living at home)*

*"[changing social workers] is a bit annoying...they come more regularly than the other [previous] social workers cos you got used to them. And you have to see more of them and it just repeats itself" (Male, aged 11, junior focus group)*

*"The other social worker I got used to" (Male aged 11, junior focus group)*

*Researcher: "If you have to explain something to a new social worker how does that make you feel?"*

*Female participant: "Like I repeat myself"*

*Male participant: "you get annoyed"*

*Female participant: "you feel like you're going over yourself again and again and again" (Male, aged 10 and female, aged 9, foster care)*

## Feeling listened to

Opinions and experiences of having a voice and feeling listened to varied.

The young people living out of area did feel that they 'had a voice' and were listened to by the carers and social worker. They acknowledged that they had an input into the decision making, but ultimately the decision around their care was made by the adults. However, it was noted that foster carers are present at reviews, making it difficult to discuss any issues concerning the placement. It was agreed that it would be preferable if parts of the review were kept separate so the young person could speak more freely and feel that they can give an honest opinion. The third young person living out of area felt that social workers often said no to his requests and this had given him a negative perception of communicating with social workers. Often decision around seeing biological families would be made, but only after carers had pursued the request to ensure it happened. This young person was happy to attend reviews to see his mother and to make more of a case for his requests. The independent reviewer at the review had visited before the review took place and this was perceived as helpful as his request could be discussed.

The young people living in the children's home felt they had less a say in their care. Regular house meetings were important for these young people, although these were not always felt to be frequent within the particular home in which they were living. Young people felt they could have more input into decisions made about how things were run within their home.

The youngest children's home resident discussed how she would not feel confident to tell the staff if there was something she was not happy with, she feared it would seem 'cheeky'. The focus group in the children's home did not discuss the review process or having a say in their reviews.

The young person living at home with his mother felt he was listened to and had a voice. When he lived with foster carers he felt he got a say in his care and could ask to ring his social worker. However he felt he was sometimes reluctant to ask to ring his social workers as he didn't want to be viewed as 'cheeky'. He had not liked one of his foster placements and explained how when he asked to move he was listened to.

The four children living with foster carers all felt they were mainly listened to and had a say in their care. One child described how she behaved badly in a previous foster placement because she was unhappy and when she asked to live somewhere else The social worker helped, however it took a long time. Two of the children (siblings) discussed that they found it frustrating that they said the same thing at all

*"Yes I have the main input in decisions. I discuss it with them" (Male aged 15, out of area)*

*"To an extent yes. What you say does get heard but it's an adults decision overall so has to be made by the adults" (Female aged 16, out of area)*

*"I do feel like I'm listened to but it could be improved, like at the review. They ask you what you think about the carers while they are there. I'm ok with saying, but some would not want to say it in front of the carers. It's hard in the same room, I would be good to have the reviews in private" (Female aged 16, out of area)*

*Researcher: What about being able to have your say in decisions, do you get chance to give your opinions?*

*Participant: No (Male, aged 17 children's home)*

*Well they have not done children's meeting for a while and we don't get to say what we want anymore... I only had one children's meeting here but we use to do that but they have decided not to do them. [I feel] sad cos they keep wanting to do children's meeting and they end up not doing it (Female, aged 10, children's home)*

*"Sometimes it does but it takes a long time" (Male, aged 13, out of area)*

*"When I was asking to see my mum they were saying no a bit too fast" (Male, aged 13, out of area)*

*"She (independent reviewer) did what I said; she didn't say no, she tried" (Male, aged 13, out of area)*

*"[I said] I don't want to be here anymore [and I moved] a few weeks later" (Male, aged 14 living at home)*

*"I was a little bit naughty cos I didn't like where I was...when we were split up I was*

reviews and they were just repeating themselves or it took a long time for things to change.

The children in the junior focus group felt like they were asked their opinion regularly but they did not feel like their comments and thoughts were always actioned. They gave examples of some things they had asked for that had not happened and some that had. They did not appear to know why some requests were possible and some were not. They discussed the review process in detail and were generally dissatisfied with the experience. Many reported they did not attend, this was mainly because they did not like sitting in the room with adults talking about them, they were shy and they got frustrated when they weren't listened to. These participants reported the review was boring and frustrating as they sometimes sit quietly whilst the adults in the room discuss them.

All engaged with the process of completing their pre-review booklets and used this to express their wishes; though they were not always listened to. One female member of the junior focus group felt it was important to go to her reviews as although they were repetitive she didn't want to seem rude.

*getting upset a lot because I wasn't with any of my family...And then I went to another person's house and I still didn't know who I was with. So I said to my social worker 'please can I go and be with part of my family like [brothers name]?' And she said 'yeah we'll try and move you'. It took like ages but I got to move with [brother]."* (Female aged 9, foster care)

*"I find it boring cos you keep repeating yourself...you say the same thing again and again and again and again".* (Male, aged 10, foster care)

*"I had a review with my book it said what would you like to change. And I wrote I want to live with my family and I got changed cos we talked about it in my review"* (Female aged 9, foster care)

*Researcher: do they listen to you at reviews?*

*Participant: not all the time sometimes they're just bothered about what they are talking about"* (Male aged 11, junior focus group)

*"They could do better [at listening to us] – cos every time our IRO comes same thing said. Next time same thing. Next time same thing."* (Male, aged 10, foster care)

*"You go in [to your review] and they treat you different, they don't even talk to you...boring it makes me angry...I just want to go back and do what I was doing."* (Male ages 13, junior focus group)

*"[Reviews] are ok but they ask you the same questions every single time I always go every time to talk to them. But I don't want to not go cos it is a bit rude."*(Female aged 11, junior focus group)

*"They hear me but don't listen. Not all the time, partly true partly not true...they do listen to it though sometimes they don't do things about it"* (Male aged 11, junior focus group)

## Improvements for LACYP

All of the young people were asked whether there were any improvements they would suggest making to the support they receive as a LACYP.

Generally the young people felt happy with the way they were supported and looked after.

Children living out of area felt that it might be more efficient and effective to work with a social worker from the area that they lived in. One suggestion for improving young people access to support included improving access to internet based support. Another young person living out of area felt information could be explained more clearly to children, especially when they first move into care.

Young people in foster care referred to specific changes in their placements where they would have liked to move or had been moved when they did not want to.

The junior focus group felt the main change they wanted to see was to be listened to more often (see above). They talked about the participation group they attend and felt they have a voice and are listened to in this group – they wanted this level of say in their general care.

*“No there is nothing missing. I have my carers and social worker and have no concerns” (Male aged 15, out of area)*

*“I would like to have different social workers here. The carers are from here so they have a social worker here. It would be good if I can see one here because it’s easier if they are closer. Its fine working the way it does but would be handy if they were closer” (Female aged 16, out of area)*

*“Listen and explain their answers and explain everything so they (children) are not clueless” (Male aged 13, out of area)*

*“They listen to you [at the participation group]; a lot more than they do at reviews” (Male aged 11, junior focus group)*

*“Listen to you a lot more...when you go to reviews” (Male aged 11, junior focus group)*

## Knowledge of and access to networks and groups

The children living with foster carers all enjoyed the Christmas and Easter parties for children in foster care. Two of the children talked in detail about how much they enjoyed spending time with other young people in care. They thought the common background and experiences made them easy to talk to.

The junior focus group were part of an existing participation group that meets once a month. They discussed how much they enjoyed attending the group as it was fun, friendly and adults/the council listen to you. Some of the participants in this group knew other children who were in care but some did not know any. Most of the group felt they liked the participation group because spending time with other young people who were in care as they have things in common.

The young person who lived at home with his mother did not like attending specific events or activities for children in care. He had attended such groups when he was younger but now he thought they were awkward and he didn’t know what to say to people. He much preferred spending time socialising with his friends from school.

*“[We] talk about what it is like to be in care” (Male, aged 10, foster care)*

*Female participant: It is good playing with people from your background. Somehow, I don’t know how to explain it.*

*Male participant: people with same background it is good to talk to them cos they’ve been through it, is that what you mean [sisters name]? (Female aged 9, male aged 10, foster care)*

*“You get to know what it is like with other people who have had difficult times as well” (male aged 11, junior focus group)*

*“No I don’t go to any groups. I wouldn’t want to go to specific groups for people in care because it’s singling you out. I go to other clubs and groups but not for care. I am aware of groups through school but it would be singling me out” (male aged 15, out of area)*

Young people living out of area had mixed knowledge on support groups and networks for looked after young people. One young person was not aware of any groups whilst the other two were. Two of the young people stated that they would not want to attend a group specifically for LACYP as they felt this was highlighting the fact that they are looked after and singling them out. It was agreed that it was preferable to attend generic groups including sports teams that were open to all young people. One young person did however agree that networks could be useful for some young people. The third young person living out of area was aware of the 'Voice' group but was not keen to attend discussion based groups to 'talk about his life' or activity groups as this was not something he would be interested in, regardless if it was organised specifically for LACYP or not. However it was discussed that he did enjoy mixing with other LACYP when he first moved into care as it helped him understand the situation and make friends.

*"I would rather just go to groups, the same as people not in care" (Female aged 16, out of area)*

*"Sitting around chairs talking about stuff, your life" (Male aged 13, out of area)*

*"Like Youth Zone and the Voice?" (Male aged 13, out of area)*

The young people living in the children's home were not involved in any support groups or networks for LACYP, however they did not explain if this is something they would be interested in. The youngest girl was hoping to get involved in a youth group based at a church and another young person was already a member of a youth activity group. However neither of these were specific to looked after children.

### **Living out of area**

Two of the young people discussed living out of area and that it did not have an impact on the care that they received and the support that they currently received was not any different to support they had received living in other areas. It was noted that social workers still come out to visit regularly. However, it was discussed that living out of area can cause communication barriers initially and that after being placed somewhere long term it maybe be more convenient to work with social workers based in that area. One young person noted that it could be difficult to arrange visits to see their parents, as they would need to travel to Blackburn as the social workers would arrange visits and activities local to the area and had little knowledge of the area they currently resided in.

*"No it doesn't make a difference not living in Blackburn. They still come out to see me, so no difference for me, but I suppose it's more awkward for them. I still get to see them when I need to" (Male, aged 15, out of area)*

*"It's good but could do with more communication between everyone. There can be confusion between social workers and carers. Mainly a problem with being out of area. Well it was to begin with, but not much of an issue now. Personally I don't mind because I don't need the support at the moment" (Male, aged 15, out of area)*

*"I was seven when I moved over, it would have been better if I had moved over to that area for those to look after us. I think that would have worked better rather than still being with Blackburn (female, aged 15, out of area)*

## 7.2. CARE LEAVERS

A focus group was conducted with a five care leavers aged 20-24 male n=3, female n=2) A care leaver personal advisor from BwD Council was present for some of the focus group.

### *Importance of health*

The young people could define what being healthy meant to them. Important factors of being healthy included eating healthily, regular exercise, personal care, having good physical and mental health and having the 'right supporting influences'.

Being healthy was considered as important to all of the young people and considered to have an impact on their lives. Being healthy was important for doing well in school, having friends, family life and being a parent. One young person discussed how their health was not important to them before they had children and now it is of great importance for both parents and children.

*"Physically and mentally able to do stuff" (Male aged 21)*

*"Keeping yourself well fed and well exercised" (Female aged 20)*

*"Making yourself clean and stuff because that's, that's healthy because if your unhygienic that can make you ill" (Female aged 20)*

*"Like being on the right medication and in the right surroundings influences in your life" (Male aged 21)*

*"Like your grades and how people see you so like whether they want to be your friend or not" (Male aged 21)*

*"Definitely your family life with like mental health can affect everything" (Male aged 21)*

*"Mines very important because I have got a child and I have got one on the way as well so I have to make sure that I am doing what I am supposed to be doing to look after my kids make sure my kids are eating properly" (Female aged 20)*

### *Access to health services*

The young people had good knowledge of where to access advice and support at local health services. They accessed services themselves rather than through referral and discussed accessing services regularly. However they also discussed that their leaving care personal advisor could help them to seek support.

The young people discussed accessing services for physical, mental and sexual health. Others noted not needing to access services but were aware that they were there should they need them. The young people discussed the 'Everybody Centre' which provided somewhere where they could go to speak to a nurse or health advisor about their health concerns. Other services included the Brook, the local health centre and Share Advice for adult fostering day care support. Having access to

*"Someone extra that you can kind of talk to as well about things that can bother you like other things as well that other people can't help you with" (Male aged 24)*

*"Say people have a problem with family for instance you can speak to them about it instead of like your support worker or anyone else" (Male aged 24)*

*"I think we would at this age most of the time you access it yourself" (Male aged 21)*

*"If you are engaging with your PA then they can help you do loads of things like, they will take you to the doctors and book you appointments if you are not that confident in doing stuff" (Male aged 21)*

such services was deemed important as it gave the young people additional support; someone else they could talk to in confidence. Confidentiality was highlighted as important for such services.

### **Support for care leavers**

The young people explained what it meant to be a care leaver. They explained that they are still considered as in care and supported by a social worker until they reach 18 years of age and they are then supported by a leaving care personal advisor until they are 21. They noted that you are provided with more support if you remain in full time education and are supported until 22 and young people with a disability are supported until 25 years.

Some of the young people lived in children's care or supported or independent living. None of the care leavers have remained with foster carers. It was discussed that there was more support available if you engaged with the leaving care personal advisors. The young people believed some people do not engage because of negative experiences; because they do not believe they can be helped, feel too ashamed or too proud to ask for help or they do not want or require the support. The young people did not believe there was anything that the personal advisors could do if the young person did not want to engage.

The young people felt that there was enough support available because if there was something that their personal advisor could not help with, they would help them find support through a referral to another service that could help. They discussed receiving support to access college, write CVs and develop interviewing skills to gain employment.

*"If you doing something then they will support you but if you're not they will support you but not as much" (Male aged 21)*

*"Personally I don't like to ask for help because I'm a proud independent person you know and I don't like going and saying 'right I need help with this' because I feel like I have failed then. A lot of young people feel like that" (Female aged 20)*

*"Nothing there than if they don't want the help you can't force them" (Male aged 21)*

*"I don't live with my foster carer now I did live with me fosterer but I'm more independent now I don't need fostering anymore"" (Male aged 24)*

### **Input in to where they live**

The young people discussed that they had not had an input into the decision on their foster care placements, however they did acknowledge that if it was often an emergency placement. The young people felt they had much more of an input into their care as care leavers and were given more options on where they could live and control over their lives; whether they wanted to continue to live supported or live independently.

*"I didn't like choose I just got place there because I was an emergency placement so I just got placed wherever I was getting placed and I was there for four nearly five years" (Female aged 20)*

*"I think it can depend on circumstances, nearly three years ago there was an option to stay where I am now or live on my own completely, now there are more other options" (Male aged 24)*

The young people believed that some foster carers could be 'in it for the money'. Based on their own experiences during foster placements, they felt that were treated differently and unfairly to the carers biological children. This feeling was reinforced when the young people reached adult age and moved on and did not sustain a relationship with their carers.

*"I have had different foster parents and I have moved around a lot. There are some foster parents who cherish kids you know and then there are some well they treat you differently to their own" (Female aged 20)*

*"I think it is a case when you leave as well you know that you are not theirs, you know what I mean because they don't stay in contact with you and like once the money stops it stops then like you're on your own then" (Male aged 20)*

### **Contact with support**

The young people noted that it was easy to contact and see their personal advisor. They would see their advisor at least every six months to complete a pathway plan. Depending on need, they would meet with the advisor on a regular basis through a set appointment; however, they could see them more often if needed. The young people discussed appreciating that they were able to pick up the phone and call the advisor to 'have a chat' if they needed to.

*"If you need more support you tell them" (Male aged 21)*

*"Sometimes if you just feel like talking to someone you can ring them up and they will come round for a brew" (Female aged 20)*

*"If I need to get in touch I can ring her or text her, the social workers you can't do that you have to go to their office and if your social workers not in I don't know how long you have to wait for" (Male aged 24)*

The young people described a smooth transition from being in care and working with a social worker to becoming a care leaver and moving over to a personal advisor. They described meeting with both the social worker and personal advisor. The young people described working with personal advisors as preferable to working social workers because they felt they had been provided with more opportunities. The young people highlighted that the regular contact that they currently have was a vast improvement on how often they had contact with social workers while they were in care. They associated seeing their social worker whilst in care as a negative; seeing them when they were in trouble rather when things were going well. Overall, the young people agreed they had more structure and stability as care leavers.

*"They talk to you like your part of the family and they are easy to get in contact with" (Male aged 24)*

*"If you are doing something bad and you have got to move foster home or you've ran away that's when you will see them it's never under good circumstances that you see them" (Male aged 21)*

*"It's like a switch over you get to meet them both and your social worker will bring your leaving care worker and they tell you this is you leaving care worker" (Male aged 21)*

### Continuity of care and support

The young people had one personal advisor as a care leaver but discussed having had multiple social workers during their time in care. They discussed working with the same personal advisor for a number of years and building a relationship with them. The young people discussed getting to know the other personal advisors when they would all go out for meals. They noted that the care leaver advisors were a small team so they got to know them all well.

Having multiple social workers was described as a barrier to receiving support, the young people felt that it was a setback and communication was poor, they described often feeling like they were going 'back and forth'. Continuity of care was not sustained for young people requiring specialist support, for example young people with disabilities who required specific housing facilities.

*"I think so when you start getting to my age a care worker and they don't change very often like it's not very often they change" (Male aged 21)*

*"Since from the age of 5 I have had over twenty five social workers in and out of care they don't stick around they don't listen to you when you build a trust with that social worker and you get a new one and you have to trust them again. It's just like you have to repeat yourself you feel like a broken record in a way" (Female aged 20)*

*"When they keep changing me to someone else nothing got sorted, so it affects the wrong person" (Male aged 24)*

### Feeling listened to

The young people felt that they were not listened to or included in decisions when they were in care. Similarly, they associated seeing a social worker when they were in trouble; they also felt this was the only time they were listened to. They felt that children and young people who caused trouble and had antisocial behaviour received the most attention and that encouraged young people to get into trouble to receive some attention. They also felt this was portrayed negatively in the media.

The young people also noted that it was difficult to have a voice in the review meetings; they had found it difficult to say how they really felt. The young people believed there was stigma attached to being 'a child in care'. The young people often felt that when they did 'speak up' their words were often 'twisted'; they had little trust in the care system.

The young people felt more listened to as care leavers, they had more independence, were kept informed and were included in decisions around their lives. The young people hope that having a voice as care leavers and being involved in formal groups would have a positive impact on the

*"The only time when you are a kid they listen to you is when you are doing something you're not supposed to do if you are doing well they don't notice you, they don't ask you what you want. But if you are doing something bad and they say listen be good for a week we will sort you out, that is just promoting bad behaviour" (Male aged 21)*

*"It's on the news and stuff, all these teen kids in care getting into trouble that's the only way we get noticed" (Female aged 20)*

*"You see the problem is when you're in the meetings, that's when they ask you if there is anything wrong, 'is there anything that you want to talk to us about and tell us' you don't feel like you can because you don't know them. I think that is why a lot of people run away and stuff because you just take it into your own hands" (Male aged 21)*

*"I think again sometimes when you're a kid in care, people they don't look at you right, they don't listen to what you are saying, such as they would an adult so it is hard" (Male aged 21)*

*"They look at you differently and they think they know better for you" (Female aged 20)*

systems in place to support the younger children currently in care.

*"You have got more of a voice because they will listen, they don't judge as well" (Female aged 20)*

*"I think because they understand you you're not a kid anymore, because we are independent as well they know what support we need" (Male aged 21)*

*"They talk to you they don't talk at you" (Male aged 21)*

*"Well it changes all the time doesn't it and if we get our say and that it might be a bit better for people who are going through it later on" (Male aged 21)*

### **Groups/networks**

The young people are members of a leaving care group for young peoples aged 16 to 25 that meet monthly. The young people discussed participating in a number of different groups and networks designed for young people/young adults who are in care or have left care. Some young people within the group were also part of the care leavers group, Scrutiny group, Our Care Council, Corporate Parenting meetings and were involved interviewing for social workers through the Participation Officer. They also attend different events including seminars and the 'who cares trust' event.

*"Sport that is just as important as it all I think for mental health and physical health" (Male aged 21)*

*"They are like exclusively for leaving care as well so you get to meet a lot of new people as well. It is good to talk to people about their experiences. It's like what experience have you had and they will tell us things about their experiences. It's hard to tell people that you are in foster care because they ask so many questions" (Male aged 21)*

*"I have met a few care leavers and some of them have become my best friend's (Female aged 29).*

The young people were part of sports clubs organised through the care leaving personal advisor including football, boxing, weight lifting, self-defence and netball. Sport was considered important for physical and mental health.

*"I think it's important to get activities with people in leaving care to get out the house. Because you know when you get to a certain age there is nothing to do. It makes them have a better life they can get out of their house or sit in all day" (Male aged 24)*

The young people noted that some people do not want to engage in groups because of low confidence. The clubs and teams were described as important because it gave the young people an opportunity to 'get out of the house', meet new people, make new friends and have fun. The groups provided a support network through spending time with other looked after young people and care leavers. The young people appreciated that the groups were specifically for looked after children and young people as they could meet people with similar experiences, they noted that it can be difficult to talk to other people about being in care. Being part of a young person's group also provided the young people with more of a say on the care system.

*"Because then it can be improved can't it so if someone is listening to what we are saying and they are actually going to take it on board to try and improve it then it's always going to help people in the future" (Male aged 21)*

*"Because they need to know that it's not good enough for what's happened in the past and they need to change it" (Male aged 24)*

*"It's the same like if you are talking about your experience of being in care and there is a child sat in the same room thinking I've been through that , so you can talk to them about how you have got the help you have accomplished that" (Female aged 20)*

The care leavers also discussed groups that you can participate in while you are in care, including Junior Voice for children aged eight to 11 and the

Voice for young people aged 11 to 16. They believed the groups for younger children provide an opportunity to build their confidence to have a say over their care. The groups will come together for awards events, giving the children and young people the opportunity to meet and discuss their experiences. The care leavers also discussed being able to provide advice to the younger children and help improve the services for children and young people currently in care.

### Recommendations

The young people were keen to ensure that they received a copy of this report. They discussed that it has been frustrating in the past when they have not heard back or seen how their contributions have been put to use. They wanted to make sure that their feedback does have an impact on support for looked after children and young people in the future, and were keen to understand the next steps for the report. It was suggested that an easier to read summary report would be most interesting to them.

Recommendations for future practice included ensuring young people have access to more information on what support they are entitled to and better training for social workers to ensure young people and children are matched to the most appropriate carers. For example, specific training around disabilities were discussed, to ensure the carers have a full understanding of what specific needs and support a child with a physical or learning disability might have/need. Another young person suggested antenatal and 'mums and babies' groups for young mothers.

*"Is there a way we can get better information for young people to get to know what they are entitled to it's alright having it in a corner of a website , but they need to know exactly what they are entitled to because it is really confusing and stressing (Male aged 24).*

*"What I want is something for training for like social workers; foster carers whatever were they can get the right person for the right child making them matched up" (Male aged 24)*

*"I think you know like maternity classes for like mums and stuff, I think me personally I would feel more comfortable if there where classes just for teens. Because I will go to play groups with my son and there are a lot of mums there who are older than me and I don't like it because I feel really uncomfortable. There are a lot of kids who are in care and young mums and stuff who are in care and it's difficult when you have got a child because you can't get out and meet people, so I think it would be the best way for young mums to get to know each other. Because a lot of young mums suffer with depression and stuff" (Female aged 20)*

### 7.3. FOSTER CARERS

Interviews were conducted with six foster carers; three interviews were conducted in person (one a paired interview) and two over the telephone. Carers had been fostering for between five and thirty years. The participants had between one and four LACYP living with them and one carer also had some of their birth children living at home. The carers had a wide variety of experiences of fostering including short-term placements, long-term placements, respite care, emergency placements, pre adoption care of babies and multi-dimensional treatment foster care (MTFC). As well as looking after their general health and wellbeing needs, carers reported experience of caring for young people with mental health and emotional health issues, physical disabilities, attention deficit hyperactive disorder, eating disorders, violent behaviour, foetal alcohol syndrome, severe neglect, self-harm, experience of abuse and forced marriage.

#### Available Support

When asked about the services available, participants discussed the services they had accessed and their experience of these services. The mostly commonly discussed issue amongst participants was the annual health review.

##### Annual statutory health review

Most carers reported that children and young people dislike the annual medical review. Reasons for disliking this included:

- Young people feel that health reviews reinforce that they, as looked after children, are 'different' to other children who are not in care.
- They dislike having to talk to health professionals about personal health issues
- They dislike being physically examined by health professionals – this was especially important for teenagers who found it embarrassing
- It seems unnecessary and distressing to young people to visiting formal hospital settings when they feel healthy

The statutory medical review was described by foster carers as causing stress and upset to young people. Carers talked about the careful negotiations to encourage young people to attend the appointments as many will refuse to participate. When medical reviews are done at home, rather than in school or in a hospital this was less distressing.

The statutory medical check was thought to be quite basic and there are many other systems in place (within school etc) that report any minor health issues for looked after children.

Some foster carers suggested less frequent medical reviews would reduce the stress and negative impacts on the children and young people. One participant suggested an improvement to medicals would be to

*"Major one [review] done by a health professional... check like their head circumference and their fingernails and their toenails and all that and like the ages ours are now it's like "well what you touching me for, leave me alone I don't want to be... why do we have to go?" "Oh it's just something we have to do." "Well why I'm healthy, I'm fine?" (FC1)*

*"They go for a medical I suppose it can be a bit intrusive for teenagers" (FC2)*

*"Yeah, definitely, [many young people dislike medicals] oh yes, the amount of people who I've spoken to, definitely....They're getting upset about being made to feel different" (FC4)*

*"He asks the question 'if he still lived at home with his birth mum and dad would he still have to have medicals so often?' obviously I'm not gonna lie but no, so he said that he's being made to feel left out and not included in everything like everybody else" (FC4)*

*"But they use to be in schools and that but that's not appropriate now so they are usually at home...At school well everybody knows don't they, you know why are you going out your lesson why are your parents coming or such a body coming? And it's not that's not good" (FC2)*

*"I've got an older boy whose 14 who does not want medicals at all... upsetting him. He says that he doesn't want any more medicals because he feels*

enable the foster carer to go through a health questionnaire with the young person.

Two foster carers discussed that most health professionals were very good and considerate with looked after children, however foster carer 1 did have some concerns about the way some health professionals and reception staff talk to and about looked after children. They described experiences where doctors had asked in front of the child if their parents were alcoholic or talked about the child in a negative way in front of them. They suggested the health professionals need to do part of the consultation with the young person out of the room, so that the foster carer can speak openly and honestly without distressing their foster child.

One foster carer felt the health assessment was not a major concern for LACYP, the annual review was more of a priority and something they worried about more

#### **Use and experience of services**

Foster carers reported experience of a variety of health services within BwD and Lancashire.

#### *East Lancashire Community Adolescent Services (ELCAS)*

One reported a young person they looked after had used ELCAS services for support with mental health and emotional needs. They had had a positive experience of the service. However another carer discussed the waiting list for ELCAS was too long and it could take up to a year to get a referral. This carer was concerned that by this point the young person has got worse or will no longer engage with any therapy that is offered. This delay was due to the long waiting list but also young people not meeting the criteria for ELCAS. Foster carer 4 reported a positive experience of ELCAS supporting a young person they care for, they suggested that LCAS was the main reason the placement had succeeded. Foster carer 4 also reported a quick referral time to LCAS. Foster carers 5 and 6 reported they had extreme difficulty accessing CAMHS support for the young person they cared for.

#### *Supporting Children and Young People Together (SCAYT)*

Two carers reported using SCAYT services to support them and the young person they looked after. One carer had had a very positive experience of SCAYT and the service had enabled them to put strategies in place to reduce extreme and violent behaviour. This had benefited the young person and the foster family.

*that my own children or 'normal children' as he says it, 'normal children' at school don't keep having medicals, and he has to keep having medicals and talking to a nurse and telling her things that's not wrong with him, and the last one he actually refused it" (FC4)*

*"But the actually statutory medical is a very basic thing, it's nothing different really to what goes on every time but because it's statutory and it's part of the regulations it has to be done. I personally would like them to alter it to do it once every three years or something because any problem that happened with a looked after child would be flagged up straight away so if they went to school looking a bit ill or you know" (FC1)*

*"I think probably that's the least of their worries because it only happens once a year, whereas there are things that happen more regularly than that like visits from social worker and LAC reviews are every 6 months, but that takes a longer period of time and is more intrusive in their day" (FC6)*

*"He's come a long way, so he's opening up more now, which before he was quite withdrawn and angry and now he's opening up a lot more. That's due to LCAS, definitely, they've kept the placement going have LCAS" (FC4)*

*"I joke that the CAMHS office is just a room with three people sending out rejection letters. They can never see anyone" (FC5)*

*"I'll be quite honest with you, I think the support and the, well obviously I deal with anybody LCAS, psychology, everybody, paediatricians, I think it's absolutely fantastic, to be honest with you, compared with your normal birth children" (FC4).*

*"A long time to access a very long time to access six months can of gone before you even hear, I have had to try and do it about three or four times, and even my doctors wrote and that's been extremely hard as well. Yeah I find that's the hardest part when it's a lot of it on mental health issues and things like that it's very hard and by the time you have accessed it the young person doesn't really want to do it then, they are either too old or they have left the placement" (FC2)*

The other carer had used SCAYT services for family therapy but had not found it very useful, they think it was provided too late.

#### *Psychologists*

One carer reported a mixed experience of psychologists, one psychologist had done play therapy with a young person she cared for, however, she felt the child had not engaged with the service and manipulated the system as he is bright and knew what the psychologist was looking for. Foster carer 2 had also used the psychology service and reported the psychologist was very supportive.

One foster carer reported attending intensive additional training (the KEEP course) to learn how to support her foster child with their attachment issues and dislike of change. They reported they had found the training very constructive and they had a much better understanding of what kind of boundaries to put in place. Foster carer 5 discussed how the KEEP course was a very effective way of empowering carers and believed a lot of the support for young people needed to come from the carers not the from external agencies.

#### *Services to support physical health*

Two foster carers discussed using services to support physical health needs. Foster carer 4 discussed how quick the referral can be for the health needs of looked after children, especially when compared to services for their birth children. This carer had experienced a much shorter waiting time for their looked after child who needed physiotherapy. Foster carer 4 also discussed the services being linked up and supporting their young child who had experienced neglect and abuse.

Foster carer 2 cared for a young child with complex needs and physical disabilities. The care for him had been very good as he needed to see a lot of different health professionals and specialists. The foster carer has experienced very joined up holistic care with good communication between all health providers, social services and the school.

#### **Multi-dimensional treatment foster care**

One carer reported a mixed opinion of MTFC. They had looked after two adolescent girls who had been on the MTFC programme. For one of these young people the programme had been very successful and they were now very settled in their placement, this was thought to be because she went on the programme when she was young. For the other young

*“The young person didn’t get as involved as really I mean we were more involved, you know eventually they did come round a lot, but I think sometimes it’s too late should have been done earlier... Probably because maybe the social worker didn’t access it soon enough” (FC2)*

*“We have [the psychologist] that helps us for support we have just got a booklet actually off him about some training that we can do at home on wellbeing you know for children and that. We’ve accessed [the psychologist] and [he has] been out to us and we have also had meetings where you know we could ask him things are we doing this right and certain things he’s very, I think I find him very informative and very very supportive. He’s very positive to carers as well” (FC2)*

*“[Services link and communicate] very very well. With this little boy, definitely, yes, I found a very, the communication with each other was absolutely it was spot on” (FC4)*

*“Yeah I find that because he goes to [special] school we can access most consultants through the school. I see dietician, I see physio, his consultant goes there as well...School wise everything’s organised you know we can have all these appointments at school which I find fantastic and then also some of the professionals that he sees the consultants we see at a children’s centre which is not far from here, so that’s good as well so that means he is not having time off school to go and get these appointments” (FC2)*

*“They didn’t expect her [teenage girl they currently foster] to be in a long term placement like she is you know so that [MTFC] has definitely worked. I have seen were it hadn’t worked as well. I had another young girl with me that was violent she was on the program and they had to actually remove her from here because of the violence. So you know I have*

person the programme has not been successful and she only stayed with the foster carer for a brief period because she had been very violent.

Foster carer 3 had been an MTFC carer and also been a mainstream foster carer. They had a generally positive experience of MTFC and felt it was an effective programme that worked very well for many children. They expressed some concerns about the rigidity of the programme, especially in relation to some of the 'Americanisms'. They were also pleased the programme was now only offered to younger children as they felt it did not work with teenagers, this was because behaviour is too ingrained by the time they are teenagers. They were concerned about the term 'forever family' that is used to describe where a young person will live if they complete MTFC. This term led to a false sense of hope, children felt they had been lied to and it also implied the young person has failed if they do not find a permanent placement. They also reported they had experienced some MTFC carers not being honest about the challenges they were facing with some young people because carers worried it may make them look like they were doing a bad job.

*seen both sides to it so they had to give up on that that programs not right in fact I think she will possibly end up in secure this is the young girl" (FC2)*

*"Yeh, so, that that was the problem with the scheme, that some kids were left on too long and the family finding was tough and I didn't particularly agree with calling it 'forever family' because you're tempting fate. It is and it hasn't always worked, so they're basically, the children are very blunt and say 'you've lied to me', because who knows if it's gonna be their forever family" (FC3)*

### **Health & Wellbeing Priorities**

All foster carers were asked to identify health and wellbeing priorities for children and young people in care in Blackburn with Darwen.

#### **Feeling 'different' to other young people**

The stigma that many young people in care feel was discussed by all participants. Foster children wanted to feel like all other children and many of the processes, paperwork and rules in their lives made it impossible for them to feel the same as other children their age. This was reported as a very important issue for all children and young people in care.

Examples of this included the consent and prior permission that was needed for activities such as having their photograph taken and sleepovers with friends. This makes them feel like they have a lot of bureaucracy to overcome to be able to do normal things that all children and teenagers are able to do.

Carers reported that some children and young people will try to hide that they are looked after and will amend their language and behaviour in public so no one knows.

*"Because they don't want to fill in paper work and they are not willing, they want to be normal like everyone else" (FC1)*

*"One thing looked after children are saying at the minute, and the ones that I've spoken to, they don't want to be treated different, they don't wanna be the one you can't have their picture taken, they wanna be included, they wanna talk with other foster kids" (FC3)*

*"They have to come in care, they still don't understand and they still love their parents...Going to live with a strange family in a strange house then they're going to have to have medicals, therapy and psychologists, it's a lot, it's a lot of professionals in a child's life that they wouldn't normally have...So they're already made to feel different by walking in to somebody else's house to live...some have to change schools and it's an awful lot for a child to comprehend" (FC4)*

### **Health problems as they enter care**

Two carers discussed the immediate health needs of the children they foster as they enter care. When children arrive on emergency placements there may be health concerns due to neglect and lack of medical attention. For example foster carer 1 discussed how one young child they fostered arrived with very bad painful eczema and another had no glasses. Carer 2 described how most children they have fostered arrived with gum disease. The immediate need to resolve these health concerns took priority.

There are also health problems that only reveal themselves over the first few weeks – for example one carer discussed a week after a child came on an emergency placement they discovered he had food allergies. Emergency placements were particularly challenging as this information was not available to social workers yet.

Once children are within the care system they receive a care list and healthcare passport which includes this information. This was thought to make transitions between placements a lot easier. This also includes information about what food they like and their emotional health. One carer thought it was very important that this list was easily available, especially information about the long term medication.

### **Emotional health**

All carers reported emotional and mental health needs of the young people they cared for. These were thought to be due to neglect and abuse, unstable living situations and mental health conditions. Some carers reported how some young people in care have difficulty coping with change, this can translate into angry, violent or disruptive behaviour. This can be due to attachment issues, post-traumatic stress disorder, distrust and self-esteem issues. Foster carer 3 discussed in detail the need to promote more mental wellbeing in young people in care. They felt that currently young people were only supported when in crisis and they needed more support to build up resilience and mental wellbeing – they suggested an upstream prevention approach was needed.

### **Attachment issues**

Attachment issues were mentioned by three carers. Some young people were thought to have difficulty forming relationships, especially with their foster carers. Carer 1 mentioned support from SCAYT that had been very helpful in enabling them to support the young person they looked after.

*“They were originally here on an emergency placement so ... showed up at our front door with nothing, just what they were wearing. So no toothbrush, no pyjamas, the older boy has eczema and he was bleeding from everywhere you know, every point of eczema problem so his wrists, his ankles, his feet and no creams or anything came with him so we didn’t know he had eczema, we didn’t know they wore glasses because they didn’t have any glasses, so that was sort of the beginning of them and with social services working with us to find out what’s actually wrong with them you know, do they need actually anything for eczema or was it just a case of neglect.” (FC1)*

*“I think that nearly everyone that has come has had gum disease when they come so obviously you know we have had to cut the sugar right down” (FC2)*

*“Yeah when they first came, obviously the social workers that brought them had no idea what they needed because they didn’t want to be questioning them, they had just been taken away from their parents, it’s not going to be twenty questions you know, do you wear glasses, are you allergic to anything...” (FC1)*

*“It’s mental wellbeing and mental wellbeing means to me you don’t wait till someone’s broke and fix them, you put coping strategies in early so you’re future proofing them for problems that they may eventually get” (FC3)*

*“We do have very strong boundaries and we need to because he doesn’t cope with change of any type, when he first came he wouldn’t, he would only sit in one place. He had to have the same cup, the same plate.” (FC1)*

*“They do love you, it’s not that they don’t care or anything like that, it’s the fact that they have been literally pulled from parents, they are being taught a life that is completely different to the life they’ve lived you know and I think that in itself takes a long time.” (FC1)*

Attachment to parents and guilt about caring for the foster family was mentioned by foster carer 1 as an issue for some young people.

### Healthy eating

All foster carers discussed, unprompted, concerns about healthy eating. All reported that they had looked after children who arrived in their care with very unhealthy diets. Unhealthy diets and a dislike or refusal to eat healthy food was an ongoing problem for many carers. One carer discussed the good availability of training around healthy eating which was important and useful. Foster carer 3 discussed that the child he currently cares for arrived only ever having eaten takeaways and expecting food instantly. This child also drank a lot of sugar sweetened beverages, never water, and had had all their baby teeth taken out. This carer was teaching the child to bake so that they understand how food is produced and can develop a healthy relationship with food. This carer was also concerned about the number of takeaways in BwD and how much junk food all children ate.

One carer reported that social workers or reviewing officers take the young people to Macdonald's when they want to talk to them alone. Foster carer 3 expressed concerns about this as this is not a healthy restaurant to attend and they thought it was inappropriate for social workers to encourage junk food consumption.

### Dental problems

One carer discussed dental problems and how a large number of young people they look after arrive into placement with gum disease or dental problems. This was thought to be due to lack of dental hygiene and too much sugar in the diet.

*"When you look at a looked after child they have such attachment to the carers but a massive loyalty to the parents, no matter what those parents have done, so they live in guilt a lot of the time because well should they love carers because carers aren't their mum and dad." (FC1)*

*"When she [8 year old] first came to me we went shopping and I got some salad, she thought it was grass, she said 'why are you eating grass?'" (FC3)*

*"Yeah we get lots of training on healthy eating and we have got a book down there about healthy eating and the dos and don'ts around food with young people" (FC2)*

*"I think McDonalds should sponsor foster care...Yeh cos it's a meeting place for mum and dad. It's a meeting place for social workers, they'd make a fortune out of us..." (FC3)*

*"You know obviously the dental side to it I know...Yes right away then we have had to stop the sweets situation" (FC2)*

## Improvements needed in services

All carers were asked what improvements were needed or what gaps there were in the services and support for young people in care.

### Short breaks

Three carers felt there was a need for more short breaks (also referred to as 'respite care') for young people in care. This was thought to be important for the wellbeing of the children in care and also for the foster carers themselves. Unlike their birth children they could not just ask a friend to look after their foster children. Due to the statutory rules in place around children in care it is often only other foster

*"When the carers have gone out for a meal that they may have desperately needed... [social worker and birth parents might ask] Why were they out? Why would they go out and leave my child with someone else and a lot of carers feel it's just not worth that risk unless they can leave them with another carer." (FC1)*

carers who can confidentially take responsibility for foster children. Some foster families have arrangements where they take it in turns minding each other's foster children however this is not easy. A more formal system of good quality, easily accessible short breaks is thought to be missing.

Foster carer 1 also suggested access to more residential trips for children in care would be beneficial. The children really enjoy the experience and it gives the carers some space and a break. On residential breaks with other looked after children the young people are able to feel 'normal' and like other children. One of the children she cares for had been on a residential trip with other looked after children and had a very enjoyable experience

Foster carer 3 discussed the importance of short breaks in care for those caring for children with challenging behaviour, however this support was more readily available to MTFC carers.

However, one foster carer believed that this short break care was improving and this was not as big an issue as it was.

#### **Leaving care services**

Four foster carers had some concerns about the systems in place to support care leavers.

Foster carer 2 reported some current issues with a young person they look after who will be leaving care in the next year. They were concerned that the leaving care team are overestimating the young person's ability to look after themselves. This carer felt that there needed to be more support for care leavers to learn how to care for themselves, for example with cooking and ironing. It was suggested it would be beneficial if the leaving care team started to work with them earlier to prepare them for leaving care.

Foster carer 3 talked in detail about improvements they felt were needed to increase young people's life skills and equip them for life after care. They expressed many concerns about young people leaving care without the practical skills to live independently, this was thought to have a big impact on mental wellbeing. Foster carer 3 suggested resilience training around how to live independently and cope with setbacks was missing from the service provided to young people in care. They were concerned that the majority of training is aimed at carers and it is the young people themselves who need help building resilience. This carer suggested a designated post

*"The only thing that they don't have that I feel and that's not down to them that's down to not being able to recruit is respite for some carers who do need it. I think there is some but not enough if you're a long term carer you are expected to not have respite because you took that child on long term, but there might be an event sometime where you have got to ask for respite." (FC2)*

*"I have heard that at [FCA] meeting where people have wanted respite and they haven't been able to have ...I think that was being looked at because they used to have a couple of homes ... they did take if you'd had if you were experiencing a really challenging behaviour they did do an overnight were they would keep the young person over night to let you have that break, I think that is few and far between... I don't feel it's available on the scale that really people some people need it" (FC2)*

*"The kids absolutely loved [the residential trip]. It was fantastic for them because there was no animosity as they are all the same so there wasn't any need or any problem so that was good because it helps them as well and then they keep those friends..." (FC1)*

*"I do think that leaving care need to know I think they do realise now but I think you know they need to maybe come in sooner and maybe read a bit more before they do...I mean I wouldn't hold anybody back I wouldn't say she can't do it if she could but you can force too much upon them , especially if they have got difficulties"(FC2)*

*"It's okay throwing money at them, and having centres and facilities, it's the actual getting in there and talking to them, giving them coping strategies, telling them where they can go, signposting them, build scaffolding around them so when you come away they're not just gonna fall apart, like when the social workers leave, they leave care and all of a sudden they've had everything done for them, especially residential kids, they've had their meals cooked for them, they've had everything, they can't even shop, they don't know where to shop, they don't know how to cook, it's very basic" (FC3)*

*"It's getting in before the damage is done. I mean if you were playing cricket, you wouldn't go out playing in a pair of shorts would you? You'd have*

within the council who worked regularly with young people in care to teach skills around shopping, cooking, budgeting and travelling. They felt this role would stop emergencies happening and enable young people to cope better with change and challenges in life. This carer also suggested it could be something done through peer mentoring, with carer leavers showing those in care what challenges they might face when they leave care.

Foster carer 5 discussed the need for peer mentoring for young people about to leave care. This carer thought the leaving care team needed to start supporting young people from the age of 14 and a peer mentoring scheme would be a good way to offer advice and support in a more appropriate way.

### **Multi-agency working**

Foster carer 3 felt that multi-agency working needed to improve in Blackburn, he compared the communication in mainstream fostering to that in MTFC and suggested that mainstream could learn from the multi-agency teams and communication in MTFC. However foster carer 4 felt that the agencies worked well together and were very successful at multi-agency working. Foster carer 2 thought agencies worked together especially well with children with complex physical needs.

*everything, pads, gloves, everything, helmets, the lot, to protect yourself. So to me, why would you place somebody in care unless you've built all that protective stuff round them" (FC3)*

*"Why can't you have a virtual mentor, or advocate, who's very hands on, and sees them quite a lot and gradually skills them up, doing different projects, let's plan a train journey, because that is such a difficult thing if you don't know how, if I said to a MTFC child 'right, here's £20 go to Manchester, don't get in a taxi, Manchester please' but go to Blackburn, get off, change the trains and then get to that station and then get to, you've got the train timetable...Simple skills, bus timetables, they're really small things but I think you're just building up your coping strategies, so if they're ever stuck somewhere at night and they haven't got any money, or they've only got a bit of money, they can figure out how to get their way home, rather than be vulnerable on the streets." (FC3)*

*"On the surface, there's a hell of a lot, there's a lot of facilities, there's a lot of things to do, they're trying very hard with the older kids, especially with the 'staying put' thing coming in, the leaving care, we've got good leaving care teams, although there still not altogether, the multi-agency thing isn't is not particularly working very well, communications terrible.. The MTFC team you had skills liaison officer, you had my supervisor social worker, the programme manager, you had a paediatric psychologist, you had a skills coach, um all working" (FC3)*

## **Children and young people sharing their thoughts**

All participants were asked their opinion and experience of the structures and systems in place for young people to have a say in their care and express opinions about their lives. Most of the conversations about children having a say in their care related to the process of reviews.

Three carers thought that children and young people have a lot of say in their care and are usually able to voice their opinions and wishes. The council has groups and systems in place to capture these views and ensure children and young people in care have a say. However it can be challenging for children in care to balance loyalty to their parents with an understanding of what is best for them.

The children and young people in care have a say in their care, especially during their six monthly reviews.

*"Absolutely, when they get to a certain age they have a very very big say in their lives...[except] not wanting to attend their medical" (FC4)*

*"[Looked after children] always get leaflets through there is always meetings the council put things on where you can encourage different groups age groups. There is food there they can talk and chat and draw about what they want from foster care what they are not happy with they are always asked at the reviews there are lots of opportunities.... they*

However three of the participants felt the systems of reviews needed to be improved.

All foster carers reported that the reviews caused a lot of distress to young people, and many choose not to attend. The processes in place before the review to gather their thoughts and opinions on where they want to live were thought to be effective, however foster carer 3 suggested questionnaires and surveys were an impersonal and ineffective way to gather information from a child.

Foster carer 3 discussed that they felt it was not appropriate for many children to attend the review as it is a very formal environment and with their mum and dad in attendance it can be very distressing. They suggested all the views and wishes of the child should be captured before the review meetings.

*can also do it through independent visitors and mentors or yeah they have been I find them quite good for that yeah” (FC2)*

*[The council are] trying to get the children to go to the reviews because a lot of children don’t want to go and it’s an emotional issue anyway because they need to be there just for their bit because if they are there for the whole bit they hear far too much and it’s not particularly useful. FC1*

*The 11 year old doesn’t like being sat there in a review and people talking about him in front of him...he really doesn’t like it FC4*

*“Things that are organised in Blackburn are more for younger children than older teenagers, but perhaps from their experience they don’t want it”(FC5)*

### Support for carers

All participants were asked about their opinion and experience of the services within BwD to support foster carers.

#### Support from Foster Carer Association (FCA) and other foster carers

The Foster Carer Association and training were described as the main ways carers got to know other carers. All participants reported the peer support from other carers was vitally important to them. They appreciated that other carers understand the challenges they face and most reported relying on other carers for practical and emotional support.

The FCA meetings were spoken of very highly by all participants who appreciated the opportunity to talk informally with other carers and have questions answered. The friendly and supportive nature of the group was thought to be very important, especially for those carers who might lack confidence to talk in big groups.

Participants also reported the FCA does a lot of signposting and providing information which was much appreciated. One benefit of the FCA discussed by three of the foster carers was that the carers can take questions to the FCA and they will ask the council anonymously. This gives carers the confidence to ask questions and to make complaints that they might not have the confidence to do without anonymity. The FCA also has the authority and power to make changes happen and a collective voice is more likely to be listened to. The communication between senior

*“All of us are part of this big fostering family, so yes you might have had problems, it’s like the attachment and nurturing course we’re doing now. The amount of carers that have stood up and said “do you know this is helping me to come because I’ve realised it is not just my kids that are hard work. I’m hearing stories from you lot, I’m going home and thinking my kids aren’t that bad” (FC1)*

*“We always go [to FCA] because I think that you need to talk to other carers you need that support...because you might have a bad day or a bad day the day before and you go to it and you listen to somebody and you think “well gosh that weren’t like mine you know that’s worse than mine my day” (FC1)*

*“Yeah I think that’s where we are lucky isn’t it and then the association now you can take things to them and they will voice it we have a lot of things that we can do anonymously as well were we can voice things but they don’t need to know who it’s come off” (FC2)*

*“I think we find out a lot more and a lot more support by coming to the [foster carer] association, definitely” (FC4)*

managers in Children's Services and FCA was thought to be very effective and the council was thought to be very good at delivering the commitments they made to FCA.

Two foster carers discussed that foster carers who are not involved with FCA and do not attend meetings may have difficulty accessing all the information and support available as they may not be aware of it.

### **Training for foster carers**

Training for foster carers was generally talked about very positively. All foster carers we interviewed had attended a variety of training and found the majority very useful. One carer discussed they felt foster carers could be well equipped with most issues LACYP face, however increasing the uptake of foster carer training would be needed.

Foster carer 3 discussed the comprehensive training available but was concerned it was not impacting on the health of behaviour of young people. He suggested the foster carers are very well trained and resilient, however there is little training aimed at children and young people. He also identified a gap in training to young people around mental wellbeing and life skills (as discussed above).

Foster carer 3 also suggested that training needed to be more individualised. Currently all carers must attend certain mandatory training, for example of substance use however this is not appropriate for carers with very young children.

### **Supervising social workers**

Most carers spoke positively about the role of the supervising social worker and appreciated that there was a social worker who was supporting the family. The supervising social worker was thought to be able to balance the needs of the child and the foster carers.

Foster carer 3 discussed how support for carers was more intense and more easily available for carers in the MTFC programme than in mainstream fostering. They felt lessons could be learned from MTFC and applied to mainstream fostering

*"Not the mandatory, the specialist stuff, so Blackburn and Darwen do it pretty well, they've got substance abuse, sexual harm, erm grooming, all that kind of stuff,...but no matter how much training we get, it doesn't impact on our looked after children's behaviours because they're not getting it. We're getting it and we're skilling ourselves up, and I think we become more resilient, cos we can understand why they're doing it. We've identified mental wellbeing is a big problem with foster children, but nobody's doing any training with them" (FC3)*

*"It should be more individual cos of the blanket train everybody on substance abuse, yeh you might have a 3 month old baby, so what the hell do you need to know about substance abuse" (FC3)*

*"We all have a supervising social worker and they come out and ask how the placement is going. Obviously the child has a social worker as well but the child's social worker their main aim is whatever is best for the child and sometimes that can be a little bit more than what the carer can provide because they are just looking solely at that child. The supervising social worker is there to look at the carer and support the carer for the needs of that child." (FC1)*

## Social workers

Although not asked directly about social workers the majority of carers discussed the relationship between young people and their social workers. Social workers were seen as the main professional a young person has contact with and a good relationship between young person and social worker was thought to be vitally important.

Foster carers reported a mixed experience of social workers.

The main concern was the high turnover and the number of changes in social workers experienced by the young people. It was acknowledged that social workers do need to move jobs but that for children and young people this could have a big impact on their wellbeing. The main issue related to distrust and challenges in the young people trusting a new social worker. Young people told carers that they didn't want to talk to their social worker or be open and honest if they were likely to leave. Foster carers reported that young people often express frustration at just getting to know one social worker, opening up and trusting them with their thoughts and feelings and then they leave. Children and young people can feel rejected and think it is their fault when their social worker leaves. Many foster carer reported having multiple social workers over a short period of time.

Foster carer 3 suggested the high turnover of social workers in the borough may be because many newly qualified social workers will use BwD to start their career. It is a highly deprived area and this foster carer felt social workers want something easier as they move up in their career. They also talked with concern about the ability of some newly qualified social workers to cope with the challenges and stress they can face.

Carers with special guardianship orders (SGO) were thought to have better relationships with social workers and other agencies. This was mainly because they had the freedom to take responsibility for more decisions, for example haircuts. Foster carers with an SGO also felt the social workers trusted them more and were able to respect their decisions, sometimes over the wishes of the parent.

Inconsistencies on the advice and rules given by social workers was reported by two foster carers who found this challenging. This could make it very difficult for foster carers to be confident they were making the right decisions

*"Yeah so that's why you need to get on well with your social worker because some will say "no actually it's what the parents wants so you need to do it" but you know by doing that you're going to do something that's going to cause yourselves and the child a lot of hassle and then you're going to be falling out..." (FC1)*

*"Yeah I think it is how you are with them [social workers] isn't it but you know we have had some really good positive feedback from social workers.... I think it is when your placement fails that it becomes that bit harder" (FC2)*

*"Oh young people they stop investing in the social workers, they're not gonna tell their life story to the social worker if within 3 months' time they've gone and there's another one there so tell me about your life, eventually they go 'oh well, sod off, you won't be here'". (FC3)*

*"This is the 3rd [social worker] in 4 and a half years, which isn't bad, but the reviewing officer is the same one. I mean really they should just have one and they should not change, but you can't do anything if people change jobs. That does really, it sends their confidence and self-esteem way down ...Oh, very very big impact" (FC4)*

*"So in 12 months [child in their care] had three social workers...She just feels rejected, "why do they not wanna see me anymore? What have I done?" Well moving jobs is nothing to an 8 year old, especially who's operating on a bit lower cognitive wire, so she's just saying "she doesn't wanna see me anymore, another rejection" (FC3)*

*"Cos it's a very deprived area, there's a lot of demand for social workers, so usually they can find a job pretty soon, they get fast tracked into some horrible placements, so as soon as they've got a little more time under their belt they're looking out of area for a quieter life....Newly qualified, it's horrible for them cos they're just out of uni, they've not idea" (FC3)*

## 7.4. STAKEHOLDER INTERVIEWS

Telephone interviews were conducted with 8 stakeholders. All data has been anonymised and where direct quotes have been used these have been given a participant label (as below).

### STAKEHOLDER INTERVIEW PARTICIPANTS

Participant Label	Team/role
S1	<ul style="list-style-type: none"> <li>CAMHS Practitioner, BwD</li> </ul>
S2	<ul style="list-style-type: none"> <li>Psychologist, Lancashire Care Foundation NHS Trust</li> </ul>
S3	<ul style="list-style-type: none"> <li>Senior Manager in Children's Services, BwD</li> </ul>
S4	<ul style="list-style-type: none"> <li>Engage (Child Sexual Exploitation) Service, BwD</li> </ul>
S5	<ul style="list-style-type: none"> <li>Social Worker, Safeguarding Team, BwD</li> </ul>
S6	<ul style="list-style-type: none"> <li>Social Worker, Children in our Care Team, BwD</li> </ul>
S7	<ul style="list-style-type: none"> <li>Social Worker, Children in our Care Team, BwD</li> </ul>
S8	<ul style="list-style-type: none"> <li>Care Home Manager, BwD</li> </ul>
S9	<ul style="list-style-type: none"> <li>Looked after children's nurse, Lancashire Care Foundation NHS Trust</li> </ul>

### Service provision

All participants were asked their opinions of the current services available in Blackburn with Darwen and whether these services were meeting the needs of young people and how they may be improved.

#### Effectiveness of current service provision

##### Service provision

On the whole it was felt that the support provided to LACYP in BwD was very good.

*"Having worked in a number of different areas I am very impressed with what BwD provide... overall the level of support is very very good." (S2)*

In many instances, it was said that looked after children and young people have multiple, complex needs and that this requires different professionals to be able to work together collaboratively.

*"..If I get young people that might have some emotional and health and wellbeing [issues], but also might have lots of other complex needs...they might have learning disabilities or very severe other health diagnosis...so then, you've gotta work collaboratively...you've gotta work with the whole team around that child" (S1)*

There were thought to be a good variety of services available, the number of services based in the young person friendly community was highlighted.

*"[I am]...based in the social care offices there are a lot of informal kind of advice that's given, people come and find me and talk to me about cases... Cases about safeguarding right the way through to the whole of the care continuum to the post-adoption" (S2)*

It was also felt that the new Youth Zone had been a positive new service provided for children and young people.

When looking at specific services, one stakeholder felt that the physical and sexual health service provision in BwD was particularly good and that young people were

*"I think we [psychology service] provide a good service...I think we are very accessible to social workers to come and get that advice just by being in the office and having time to talk to them about cases. I think we are able to respond*

aware of the services. One nurse (S9) was concerned about the consistency of the services and felt it was important for new services to remain in place for at least 12 months. Some services (for example young people's sexual health) are underutilised so they needed to be promoted. They felt it was important that young people did not attend clinics to find they had been cancelled.

A number of stakeholders described the positive impact of being located in the same building as colleagues from other areas; this was felt to support collaborative working and informal sharing of advice and information.

#### *Building relationships*

Stakeholders suggested that good relationships were in place between different service providers/agencies and also importantly good relationships had been established with children and young people and their families

It was highlighted that provision worked well when different professionals were based under one roof together so that they could share expertise and also that it helped them to respond in a more timely manner.

The benefits of having an established and experienced team upon being able to build successful relationships with the children and families and developing trust were highlighted. This also included the importance of continuity of care for the looked after children and young people in developing these relationships and

*in a very timely way to kind of need for urgent assessments.”(S2)*

*“We have got a LifeLine in Blackburn as well which is for the addiction drug and alcohol service... We have like a local centre I'm not sure who funds it, it's next to our health centre in Blackburn it's called The Everybody Centre and children can access that and at that centre the Brook tend to be there for drop ins.” (S1)*

*“...we've got the youth zone now, which I think has been really good in terms of giving children and young people a sort of base now and everything to occupy them and things like that.” (S5)*

*“I think physical health we've got all the services. We've got Brook, our local contraceptive and sexual health service. We've got a new service that has opened up which is right opposite our office which is called the Everybody Centre, which is a health centre for people can go there as well, similar to Brook, and they can just drop in and they can go whenever they want...so [I] think physical health and sexual health services are amazing in Blackburn and Darwen.” (S6)*

*“Because services were underutilised services were pulling out...If I send young people down there saying CAMHS, GUM, Brook are there and kids ring me back saying 'they have pulled the clinic'. That is frustrating. If services are going to these centres they must commit to staying there at least 12 months. Pushing the service.” (S9)*

*“I think it's easier because we've got long term relationships with the young people. I think they respect our decisions more, and when we sit there and explain why they can't perhaps go home to mum or dad they seem to accept that a lot easier... when I do get a young person allocated, most of the time I see them right through until they are 18, so that helps with that continuity.” (S6)*

*“One of the strengths is allowing that individual care and that individual child to be creative in their placement... Because I think it's different for each child. It needs to be bespoke to each given child.” (S4)*

*“Well I think our team, we're an experienced team and we've stayed in the team for quite a long time, so the children have had that consistent worker, that's always really positive, so we know the families really well and we know our cases really well.” (S7)*

ensuring that the children felt that they were being listened to and being involved in the decision making process.

Relationships between children and young people and their placements was seen to be very individual and based upon each child's specific needs.

It was, however, felt that the current organisation of placements is not as flexible as it could be in terms of being adapted to meet the needs of the children and young people.

It was felt that good relationships had been established with other professionals and agencies; and that the small size of the local authority enabled these relationships and made decision making processes easier and quicker. It was, however, highlighted, that constraints on resources (time, money etc) make it difficult to be able to effectively meet the needs of service users; and the expectation is still there to meet demand and the same performance levels with less resources.

#### *Child sexual exploitation services*

Child sexual exploitation (CSE) was particularly highlighted by one of the stakeholders (S4). The Engage team were seen to work with all looked after children and identify those most vulnerable. It was highlighted that this was difficult, however, as most LACYP would score highly when looking at a vulnerability matrix that took into account educational attendance/attainment, accommodation and substance misuse. It was felt that established relationships with relevant professionals and the young people themselves meant that they could provide targeted support; and follow a prevention intervention model, so that children and young people are given awareness of what a 'healthy relationship' may be.

Discussion arose around 'return interviews' and the benefits of these as a medium through which children and young people could talk to a member of the Engage team about any issues that they had and this was independent of their care plan. This was felt to be beneficial in being able to identify and manage any specific risks and engage with any specific services.

*"We have strong links with those leaving care service...and because we are a small authority, we see a lot of the kids around anyway, or they'll come back to say, "can you sign my passport form' or you know 'I need a reference for a housing, can you do me a reference' or whatever else." (S6)*

*"In terms of a unitary authority, we're small so, it's easier to get decisions made, it's quicker to get decisions made when you want decisions from heads of service or from the director... and team managers, pretty much know about all the cases that we have as well because we are only a small authority, so I think that helps..., and we have good links with all the other agencies as well within Blackburn and Darwen, so that also helps you know with health or sexual exploitation team...which is domestic violence, you know, lifeline, drugs, all those sorts of services, so we have quite good links with them all." (S6)*

*"So for us it is really about trying to identify with the relevant professionals.... So what we try to do then is try and build a lot of support around so we have done a lot of work again particularly with residential providers and some we have targeted certain specific foster carers were we know they work with those vulnerable kids in the first place...we have done a lot of work with young people either be individually, or group work or with the staff to really kind of unpick what's the bit about risk taking behaviour that's within their remit to look after and manage and what is a bit of above and beyond that might require the support of Engage." (S4)*

*"We would conduct that [return] interview independent of the care plan so...on behalf of the child we can challenge if the child tells us they are unhappy with placement reasons why we would put that forward. If a child told us that some harm had happened we'll address that, raise that, deal with that depending what the risk is specific to that and then we can open up a service to engage which we think is relevant for part of that. So by the virtue of doing that we are at a good place to ascertain where risk is and what it's about and kind of match services." (S4)*

Within the Engage team, it was felt that relationships with other service providers (e.g., social workers and the police) were considered to be strong. It was also felt that this helped increase knowledge of the local area and potential associated risks from which calculated judgements about these risks could be made. It was suggested that making placements outside of the area meant that the local knowledge and established relationships were not as developed/available and that this may pose additional risk.

The LAC nurse (S9) was concerned about a minority of young people (as young as 13) who used legal highs and engaged in sexual activity and who were very vulnerable to exploitation.

### **Barriers to access/gaps in service provision**

#### *Resources*

It was highlighted that the most was made of the available service provision, and that whilst there was always room for improvement, this was often prevented by limited/reduced resources (i.e. people/staffing, time and finances). Where resources were limited, it was suggested by one stakeholder that services need to be more creative.

One stakeholder discussed how a pilot project had enabled a number of social workers to reduce their caseloads to concentrate on a smaller number of 'more challenging' older people. However, once this pilot was finished, those young people who had been included in the pilot went from seeing their case worker from possibly once or twice a week to once every six weeks. This was a source of frustration to one social worker.

#### *Transitioning between living at home and becoming a looked after child*

It was felt that more consideration needed to be given to the transition between home and care and vice versa in terms of providing continuity of certain aspects of lifestyle, for example, the use of targeted youth services and contact with peers. This also involved partner agencies developing an increased understanding and awareness.

#### *Relationships between young people and social workers*

*"At least by having the relationships locally you develop that trust and that expertise and you can you know manage that." (S4)*

*"...if I said to you [young person in care] is going missing in [Main] Road at 7o'clock at night does that mean anything to you? It would do to me because I know the area that time of night, what it means, what activities go on in that area for most. It is based on the facts because police are part of the Engage team so partners we have got health, a number of voluntary organisations, the council and the police is that we have intel around given areas." (S4 )*

*"[We have problems with] 13 year olds using legal highs and getting involved in gang activity. Sexual exploitation has been a big issue but I think we are winning, not there yet but getting there." (S9)*

*"for me a lot of it is about cut backs... you can wrap it up any way you like but that's what I believe, that the public sector is really struggling and expected to do the same as... performance, the same as we did before with massive, massive cuts."(S1)*

*"It's just about having those resources to do that so if you have six children in a residential placement and they want to do six different things , you cannot do it you know and we talk about care plans but it is difficult to do practically or too costly to achieve some of that." (S4)*

*"Obviously the time constraint is a big change, it limits the amount of time we can spend with children and young people." (S5)*

*"...We had our social worker pilot a few years ago in Blackburn and Darwen, and we worked on the pilot and we had a reduced caseload but we had some more challenging older people....that was brilliant because we were able to respond to all the crisis's and keep them in the placements longer...now you just feel like a really rubbish social worker cos you don't have the time to spend with all the young people that you used to be able to spend." (S6)*

*"Some services understand in particular when children become looked after and the change of role. We see a lot of almost parent friendly working at times with you know just because the child has gone into foster care that doesn't mean they need to stop having the input." (S5)*

*"[Previously]....you know if you were supervising their contact before or they saw you going along to the*

It was considered by one stakeholder, that with changes in service provision, where support was previously provided by the social worker but is now provided by additional agencies, impacted upon the relationships that social workers were able to develop with children and young people; particularly in terms of developing trust.

#### *Out of area care*

It was highlighted by a number of stakeholders that looking after children and young people who are placed (for example, with family and friends) outside of BwD is an area for further consideration. It was felt that this can create challenges in terms of working with agencies in a different health services and being able to access services in these areas in a timely manner.

It was felt by one stakeholder that having an awareness of different working processes in different areas may help to improve this; but also that a more uniformed approach across areas would be beneficial.

The LAC nurse (S9) talked in detail about the financial and bureaucratic problems with providing care to LACYP placed out of area. This was particularly challenging in relation to annual health assessments. She felt they spend a lot of time negotiation with other local authorities and clinical commissioning groups (CCGs) trying to set up service level agreements and have health assessments conducted. This caused much delay and she was worried about the care these young people were receiving. She was optimistic the changes in health and wellbeing guidance since March 2015, which now clearly sets out the responsibility and statutory duty for LAs to provide care for LACYP would improve this situation. The new payment by results system was also thought to have made this more complicated and added extra layers of bureaucracy and therefore delays.

#### *Care leavers and peer mentoring*

It was felt that more support needed to be put in place for care leavers in terms of identifying their needs and preparing them for living independently. Life skills such as going shopping, planning meals, self-administering of medication, making doctors appointments,

*parenting sessions with their parents it was like well, they could almost see you not just sitting in some office you know, criticising the family but actually do it whereas it's more difficult, it's not possible now, if they only see you every four to six weeks and usually that is to tell them something they are not going to be happy with then it changes that dramatically really." (S5)*

*"I've not have that many issues with different areas, again just trying to work out how processes work there.... But again that's just more different areas work differently, what would be helpful is that if each area had the same way of this is how we deal with this.." (S5)*

*"It's much harder for us when children are placed out of the borough. It's not the same health service, we have to get health provision to take people on, if they need therapeutic work... if a child's in Blackburn we have a variety of psychologists here, we have people with a variety of therapeutic training here, DDP, play therapy, we can get that support in quickly, whereas if a child's placed in, you know, the north of Cumbria, you know or Devon you just can't do it in the same way.." (S3)*

*"The thing that we potentially, not fall down, but is vulnerable, is around children placed out of area." (S4)*

*"What this payment by results has done, if we request a health assessment for a child placed out of borough, we then have to wait for them to say yes we will do the,. Here is a service level agreement, read it, sign it and then we will do it. And we are not hitting targets, simply because of bureaucracy. [LACYP placed in in BwD from out of borough] have the same service as our children. We don't say put them on the back burner because we are short of staff. I expect the same quality of care and timing. I find it very frustrating....months, it can be passed from one department to another. Especially down in London cos there are that many boroughs and CCGs...we have to find which CCG covers that address" (S9)*

*"I do believe leaving care needs to come on board a little bit sooner, because now there not coming on until they're sixteen. [a young person in care] has just had hers allocated she's sixteen in [a few months] so I do believe they need to come on board a little bit sooner." (S8)*

washing clothes etc, were thought to be important. It was felt that the use of a peer mentor scheme may help with some aspects of preparing young people for what they may expect.

The LAC nurse (S9) discussed how care leavers still need guidance and support to access health services

Peer mentoring was also seen to be beneficial in helping children and young people to engage in activities and develop relationships outside of the care system.

#### *Care home structure*

One of the stakeholders considered that looked after children placed in care homes could not experience the same as those children who lived outside of the care system. It was acknowledged that this was due to the constraints/structure of the care system, but the stakeholder felt that finding a middle ground would be beneficial.

*"A lot of them think when they turn round at sixteen well I'm going I'm sixteen I can do what I want, but we were all fuddy duddies we didn't know anything so...X set up this scheme and X has now got a peer mentor working with her... she has told her about her experience and actually what it's like living here and what it's like living independently." (S8)*

*"Recently we have had feedback from care leavers saying they still need that support from somebody, whether it be a personal advisor or a nurse, to take them to the GP appointment. They don't feel confident enough even to make a telephone call to make an appointment....they will avoid it (S9)*

*"...Some of the stuff we are trying to do now is around peer mentors...children I've worked with I see now in their early twenties say 'god I wish I listened to you then...sometimes they won't hear that from us and they have to go and test it out.... that can be really valuable." (S4)*

*"...Certainly in residential which is more my kind of experience than it was in terms of the same as in care is that maybe we don't always have the same opportunities we have. ...it's that normalization kind of thing you know everything seemed to be kind of potentially over structured or not structured enough. And it's that middle ground really in terms of what you know having friends round and all that kind of stuff. Don't get me wrong the best placements are the ones that find a way of dealing with all of that, who are on top of that early on" (S4)*

### **Health and wellbeing needs**

A number of key health and wellbeing needs of looked after children and young people were identified across the stakeholders which included: the importance of having a stable placement, sexual health, substance use (alcohol and drugs) and mental health.

#### **Physical health and wellbeing needs**

It was highlighted that high levels of deprivation in BwD affected the type and level of health and wellbeing needs.

Whilst acknowledging that every child and young person's health and wellbeing needs are unique, there were a number of key areas of focus that arose when looking at wellbeing. For example, symptoms of malnutrition such as rickets, poor dental health, sexual health and alcohol and drug misuse.

*"It's an area of high deprivation; we're in the top 15 in the country for levels of deprivation.....It would be the predominant reason why children would there would be concerns about children...lots of our children would have, you know, never been to the dentist, they've got health issues, you know of all sorts and all kinds really." (S3)*

*"We've had all sorts really, some of them have had unprotected sex and want to get checked out and want supporting with appointments at the local clinic. I've had a couple of young people who have had unexpected pregnancies and haven't wanted to carry on with the*

The LAC nurse (S9) felt that their health was not a priority for LACYP, they were more concerned about stability and a family.

### **Annual health assessments**

Five of the stakeholders discussed the annual HAs and stated they had made some of the children and young people feel 'different'. It was suggested that for young people a more informal process may be looked at in place of annual HAs and could potentially be adapted to local/individual circumstances. Examples were given around a need for less formal health assessments for older children or those child who are in a settled placement.

The LAC nurse (S9) discussed how they now tried to do assessments in a more informal manner and make it more of a relaxed conversation. The nurses will conduct the assessment in a less medical setting, a more informal manner and complete the paperwork later.

### **emotional health and wellbeing**

It was felt by two stakeholders that the principal health and wellbeing need for looked after children and young people should be a stable placement in a loving and nurturing environment.

It was also acknowledged that in order for this to take place, foster carers and children's home carers need to be given the correct training and support to support children coming into care with emotional problems that have arisen from, for example, separation from their parents.

The LAC nurse (S9) felt the LACYP in BwD know a lot about the service available but need support around emotional strength and confidence to access them.

School nurses were seen to play an invaluable role in looking after the emotional wellbeing of looked after children and young people.

It was considered that effective practices were in place regarding for example, mental health panels, which inform care packages. As an additional measure, the carers of children and young people who have been in local authority care for 12 months receive the SDQ to look if additional support needs to be provided. This

*pregnancy. We've got a lot of people with drug and alcohol issues, but that is just casual, recreational use, but some of it goes further than that, but we can tie into our LifeLine service erm, which is brilliant." (S6)*

*"Health tends not to be high on their agenda – they want stability, They want a forever family. I want a mum and dad...they are more bothered about the nurse or their health. They want a family" (S9)*

*"I think some get frustrated like 'why am I going again'... for young people as it makes them feel different having another medical. Particularly for children who are settled in a placement, you know their health needs are being met....Nobody else has to go and see the school nurse once a year to have their height and weight done. Yes it's an opportunity for any questions to be asked but actually if you've got a settled young person and they just see a school nurse once a year, they are not going to confide in them or tell anybody else really." (S5)*

*"Now a lot of our young people don't like [to have statutory assessments]...because their friends don't have to have it." (S6)*

*"I think a lot of our young people are getting to the age where they recognise that actually 'I'm a looked after child' and actually does another person in a normal home environment have these health assessments every year. Likely they don't." (S8)*

*"We say 'look we'll chat to you in a café, chat to you in a car, I'll chat to you anywhere' we have to do that really. It is going away from the traditional way that we have nursed but it is the way forward" (S9)*

*"They need a stable placement they need a stable relationship with a carer who is able to love them and care for them, and able to respond to their behaviour in a way that is nurturing, caring and loving...but in terms of their emotional health their needs are they absolutely have carers who understand them and can provide consistent nurturing care for them." (S2)*

*"....That separation from parents at an emotional level as well, so that emotional health need is significant for many of young people and again there are a number of ways that we measure that. So young people who have been in care a year or more we would do the strength and difficulties questionnaire, that's a requirement, but here we have a process set up that allows us to, we analyse those results,*

questionnaire is also sent to schools, thus providing two comparative assessments. The SDQ was also seen as an additional route into CAMHS services.

As a new aspect to this assessment, one stakeholder highlighted that where a score of 11 or above is achieved an additional questionnaire will be sent out to the child themselves. This was currently in a pilot stage with children and young people being very much involved in, for example, designing the letter to go out with the questionnaire as well as provide more information to them about what the questionnaire aims to do. It was felt that this was an innovative approach that was not being adopted anywhere else.

#### *Socialisation*

One stakeholder highlighted that it was important for children and young people to socialise with others outside of the care system.

Within the school setting, it was also highlighted that many looked after children and young people struggle in mainstream school, especially around forming and maintaining friendships, and that this was a common theme for those attending CAMHS services.

#### **Drugs, alcohol and sexual health**

Very few participants discussed lifestyle health issues such as drugs, alcohol and sexual health. The LAC nurse (S9) discussed these issues in the most detail. She felt novel psychoactive substances (NPS; also known as 'legal highs') were a concern in BwD. The change in tendering of drug and alcohol services was thought to have caused confusion around this. She felt social workers, nurses and foster carers did not have the skills or understanding to support young people. She gave an example of young people who could obtain NPS through a used a shop that paid for second hand clothes by weight, instead of paying with cash they pay with a packet of NPS. Therefore even when young people did not have money they could still obtain NPS. She felt that NPS was a far bigger concern than alcohol, and they rarely have issues with LACYP and alcohol now.

*so if young people do have high scores we can then bring in additional services when required really. I guess the other thing we sort of recognise you know our foster carers or residential carers need to be sort of really well trained and prepared to support young people with those emotional issues that they arrive with." (S3)*

*"...We've got some good school nurses who... actually we've got some really good school nurses who will do drop in's, who will pick up all looked after children giving them that extra addition of support." (S5)*

*"For all children that are in authorities care for 12 months, up to 12 months, get sent out this questionnaire, okay. It's sent out initially to carers, and there's a borderline score of 17 and if it's 17 or above I look at it and decide whether there's an appropriate intervention or adequate plan already in place, or if I don't think there is then I'll invite the social worker to come to the panel." (S1)*

*"What we tend to find is that they socialise with other young people who are also looked after so they haven't got the experience of having friends outside you know of children's home. And sometimes this can affect sort of the aspirations particularly you know because they have no aspirations." (S8)*

*"I think we see a lot of young people who are struggling in mainstream school...anxiety, that might be around their inability to kind of make friendships and sustain friendships, so that's very very common." (S1)*

*"A lot of my cases I deal would be around sexual health, around alcohol and drugs, and mental health, they are the main areas that we work around." (S7)*

*"We have a real problem with legal highs [novel psychoactive substances; NPS] in Blackburn. Lifeline have just lost the tender for drug and alcohol services and I haven't got my head round new services. What can we do about these [NPS]? It is new on the scene it is new to us" (S9)*

*"Very very rarely do I get a social worker or a health assessment with a problem with alcohol. It is legal highs" (S9)*

*"if they get chlamydia, again, they know they can get it treated" (S9)*

The LAC nurse (s9) was also concerned about the use of electronic cigarettes and the confusing guidance around these. The use of e-cigarettes was not also discouraged in foster carers and the policy and research was confusing.

The LAC nurse (S9) also discussed her concerns about young people and sexual risk taking. In her experience young women are using the contraceptive pill or long acting reversible contraception but are not using condoms. She was very concerned that LACYP are not worried about STIs and were aware they could be easily treated if needed. She was also concerned that NPS use contributed to sexual risk taking and potential sexual exploitation.

### **Gaps and problems with health and wellbeing service provision**

#### *Emotional health support*

A common theme across stakeholders related to gaps in the current provision of emotional health support. This included where access to CAMHS may be disjointed and require a more coordinated approach between services. Also that increased staffing may enable them to offer increased support to the social worker team.

Four stakeholders gave an example where young people were not able to access emotional support through East Lancashire Child and Adolescent Services (ELCAS)/CAMHS because they were deemed to be in an unstable placement. It was suggested that this was the time when the young people are most vulnerable and in need of support. It was also suggested by one stakeholder that even where an expert such as a court psychologist has made a recommendation of referral in these instances this decision can still be over-ruled and that this can cause frustration.

In contrast to this, however, the CAMHS practitioner felt that there was enough CAMHS provision and that it was is lack of awareness about what that service does and the processes it follows that caused confusion about when it was appropriate for the service to be accessed.

It was also suggested that a pupil wellbeing coordinator (as an addition to those already

*“We struggle with kind of maintaining them in a placement for long enough...sometimes maybe they don’t get the support they should need. The CAMHS service for example...we often hear ‘we can’t do that work that therapeutic intervention until the child has settled in placement’ and guess what, some of these children never settle.” (S4)*

*“I think there are also frustrations around accessing CAMHS at times and I think we need to think more carefully about how we join aspects different aspects of the service up.” (S2)*

*“I don’t think there is enough available through ELCAS [CAMHS], one of the big issues we battle with is that they won’t see children until they are in an established placement. Well often they are not going to put themselves in an established placement as they have the ongoing emotional needs and it’s this kind of battle really on different opinions.” (S5)*

*“...maybe a court psychologist may recommend therapy. Then you make the referral, you can send the report in from the court psychologist and say ‘I’ve done a formal assessment, I recommend these children have this therapy now’ and then that gets back to ELCAS, ‘we’ve done our screening and don’t think it’s necessary’ and so you’re sort of saying well ‘that undermines somebody else’s assessment’ but also we’re saying ‘they do need something and you know if it’s not you then what is it?’...” (S5)*

placed in schools) who was specifically in place for looked after children as an independent person who can advocate on their behalf may be beneficial

#### *Engaging with/accessing support*

Young people actually acknowledging that they need emotional support was also considered to be a barrier to engaging with/accessing services. This stakeholder felt that a specialist member of staff to deliver regular up-to-date training may be beneficial.

Engaging young people to access emotional support was also seen as a barrier. It was felt that this may be due to young people not being able to cope/deal with their emotions and also acknowledge that they need support.

One of the stakeholders felt that it was about being able to engage children and young people at the 'right time'. It was discussed that this may be at the initial assessment, but that factors including age may impact upon the success of engagement and that age appropriate engagement activities could help here.

Within this, it was also highlighted that time constraints may create problems when trying to get young people to talk about their emotions.

#### *Young people aged 16-18 years*

One stakeholder felt that emotional wellbeing support needed to be reviewed for those aged 16-18 years old as it currently did not meet their needs and had the potential to leave vulnerable young people with inadequate support.

Whilst acknowledging that resources were the main issue, one stakeholder suggested that a specific worker for those aged 16-18 years may be beneficial; and that for those care leavers there was a designated mental health nurse who the young people were able to talk to and that this member of staff was able to signpost on to further services.

The LAC nurse (S9) felt that personal advisors needed to be skilled up to support those leaving and about to leave care. She felt these young people needed more support with

*"We've got stuff around emotional difficulties, anger, a lot of the abuse or whatever has happened to them as a child has starts really really emerging as they get older, and that's when they need that support and that's when we can't find it." (S6)*

*"I think there's enough provision for it. I think sometimes there's lack of understanding about what CAMHS can do and what they can't do."(S1)*

*"Some of the children shy away from emotional support as soon as you mention that they're like 'ohh there's nothing wrong with me', because they probably don't feel like there is anything wrong because they are young they don't know how to cope with emotions. They haven't got the ability to understand emotions and to actually unpick the past and what's happened and thinking actually this is what happened, it's about the right person being involved you know in that support, but some of them do shy away from acknowledging it so I don't know how we would overcome that barrier." (S8).*

*"I think it's about if it's the right time and you're able to engage with them on that initial assessment then you know they will access emotional support...A lot of the ones where I see they're not opting in it's because there is too much chaos." (S1)*

*"Sometimes they are on like a time limit as well you have got me for an hour, and sometimes when you haven't seen that person for maybe a week or two week actually by the time you have got your niceties over with they probably feel like there is a lot of pressure on them to off load it, you know so they might get to the last five minutes they might start saying." (S8)*

*"For me, the biggest worry is around emotional wellbeing of people aged 16 to 18. There's a massive hole. So they can work with CAMHS or ELCAS... until they are 16, but then it's kinda like they fall through a hole. Unless they're involved in youth offending services, where there is an ELCAS worker on the team... Also, they kind of have a two strikes and you're out. If the young people don't turn up to two appointments, then they [get] struck off that service. But a lot of our young people need perseverance, especially the more damaged ones." (S6)*

*"..we...used to have a CAMHS worker for 16 to 18 that we could refer in to and it's just looking at that gap. I know now in the Leaving Care team, they've got a designated LAC nurse within that team so it's confidential and it's a*

practical life skills and confidence building not just help to get a job. She was also concerned there is a gap in services and support for young people aged 16-18 who are not in employment, education or training as they fall between the gaps.

#### *Supporting young people and children together service (SCAYT)*

Specifically relating to the SCAYT service, it was felt that there may be some issues with its provision linked to, for example, the geographical area that the service has to cover and accessibility and availability of the service. One stakeholder suggested that additional resource was needed in order to meet the demand for the service. Also that this may be placing pressure upon other services.

#### *Issues accessing specific health services*

One stakeholder highlighted that looked after children and young people may not be able to access key health services in a timely enough manner due to processes that are currently in place with some health service providers (because they are looked after children). Specific examples were provided around self-harm and dentists. It was also discussed that these experiences may project negatively upon the looked after child as, for example, they may never have been to visit a dentist before or may be trying to access emergency treatment due to toothache.

It was felt that this could in some way be addressed by increasing the awareness and understanding of particular health professionals about the processes involved in looked after children accessing services and also the importance around being sensitive to the needs of that child, for example, not asking potentially upsetting questions. A particular example was provided relating to a new form that was provided to paediatricians.

The LAC nurse (S9) felt that some services, specifically within The Everybody Centre were underutilised and not promoted enough. She had concerns that new services were not staying in place long enough for the young people to become aware of them. She felt the leaving care nurse was effectively promoting

*drop in so young people can go and see her or she can go and see them and talk through issues and she can potentially signpost on, so that's brilliant, and she's just for care leavers." (S6)*

*"Personal advisors need to be skilled up, this isn't just about getting young people into work, this is about empowering those young people to move on, take ownership of their own health. This is you GP this is your dentist. I will go with you on your first visit. This is how you speak to people. Telephone skills, interview skills, life skills." (S9)*

*"...it (SCAYT) is the emotional health service for looked after children and crosses Lancashire as well as BwD and I think that's another reason why it doesn't quite work for us to be fair, it was set up across the whole of Lancashire." (S3)*

*"I think more resources would be better particularly in the SCAYT aspect of it, I think that the provision on that side is at the moment is doesn't feel like it's enough to meet the demand...at the moment SCAYT is just one consultant on a day and a half and the other psychology post, which I think is part time, is currently vacant and has been vacant for six months, so I think that would be an area where we could look to improve the service." (S2)*

*"[If] you are concerned about self-harm, what you would do if that was your own child is you'd go to the GP and ask for a referral and it could be done there and then...but for us we've got to go to a panel because they're a looked after child that's the process...we've got to request a panel, which is great to monitor how many looked after children go through, but a panel is not for another week or so then they might miss out because they've got to go through a different route." (S5)*

*"Dentists is one that is really frustrating. Lots of our dentists really don't understand about designated authority and consent given to foster carers. So we have quite a lot of children that would go to the dentist with the foster carer who will show the appropriate paperwork but the dentist says I'm not happy to accept that, I want a different form. It's a couple of weeks for the foster carer to send the personal consent form to them, get that signed by the foster carer of the local authority and get that to the dentist." (S5)*

The Everybody Centre and increased uptake in the carer leaver group. She also suggested the services needed to ensure they were young people friendly, for example young people had told her that banning food and drink in the services meant they would not access them on their lunch break from college.

#### *The importance of children and young people knowing their 'life story'*

One stakeholder considered that there was sometimes a big gap in children and young people's understandings of why they were in care. They felt that sometimes there was a lack of memory or understanding about why they are looked after and why they have moved (from home, from placements etc.). These memories can become distorted over time and this can impact upon their overall wellbeing.

It was felt that there were inconsistencies in how well this information was updated and kept and that it was important for each stage of the young person's journey through care to be properly documented.

#### *Awareness/support for fosters carers and children in settling children*

It was highlighted by one stakeholder that more training and support could be given to foster carers to help them understand the potential difficulties that may be encountered or arise when a child moves from home into foster care. An example was given around hygiene and cleanliness (e.g., a child may have head lice, may not be used to or know how to brush their teeth, not be used to washing their hands, having baths etc) and that if issues such as this are not approached in a sensitive manner, it has the potential to impact upon the young person's self-esteem when they are already vulnerable. The same stakeholder also suggested that it was important to prepare children and keep them informed about what

*"Because services were underutilised services were pulling out...If I send young people down there saying CAMHS, GUM, Brook are there and kids ring me back saying 'they have pulled the clinic'. That is frustrating. If services are going to these centres they must commit to staying there at least 12 months. Pushing the service." (S9)*

*"Young people's centres have to be young people friendly. You have to listen to their voice. If they want to go into there from Blackburn college, which is literally a stone's throw away, and they are in their lunch hour and they want a sexual health service. They are going to have a sandwich, a can of coke – to be saying you can't come in [with food]...Public Health did say they would look at it... If you have to Hoover up after they have been there so be it - a couple of crumbs." (S9)*

*"We have done a lot of work with paediatricians to talk about that about some of the questions they ask young people because we are finding out the initial looked after medicals were saying to foster carers "why is the child living with you?" with the child in the room... We've devised a new form now that workers can complete prior to that so that information goes to the paediatrician, but the young person doesn't need to be asked. Foster carers may not know the information, they may give incorrect information but also that child is not sat there hearing you know the ins and outs about what happened in their family discussed in front of them." (S5)*

*"...For some, it could be a booklet shoved together. Often if it's four or five social workers down the line they don't know what went on. A combined approach between foster carers, social workers, schools as well really if children have moved schools, capturing that you know. Do you have a spare copy of the class photo? Can you give us something that has teacher's names on? If you can't ask your parents because you don't live with them, you have nobody that remembers..." (S5)*

*"I think there's scope for some more support or training for foster carers and understanding health needs when they come into care and really getting a grasp on what impact it is going from some of the environments, these neglectful environments, into what can be very middle class homes so actually children probably will have head lice and how you respond to that in a sensitive way. You know children don't necessarily know how to brush their teeth, they don't know to wash their hands, they might bring items that are dirty and smelly" (S5)*

may happen to them while they are in foster care.

*"We do welcome books, we do lots to prepare children and help them to get used to the physical environment but actually again it's a lot of things that happen to children, to kind of step back and go 'I know you want to wash these children clean and you want to cut all their nails and you want to do all of that but that might feel very different to them and they might not have the voice to say I don't want you to cut my nails right now, I don't like the smell of that', just kind of get the balance really and to think like from that child's perspective rather than just ticking all the boxes because you got them free from lice and they've got nice clean nails, their hair has been brushed..." (S5)*

### ***Involvement in service development and decision making processes***

All stakeholders were asked about the processes and opportunities in place for looked after children and young people to be involved in service development and in the decisions about their care.

Stakeholders felt that processes are in place which enable looked after children and young people to be integral in the decision making process around their care, as well as being able to voice their opinions about local services and moulding how these services work:

*"There's a whole system set up around participation, and each team that we have has a champion. So the fostering team would have a participation champion and the adoption team would, the looked after children team would...and their job is to sort of champion ensuring that we do design and mould services having consulted with children and young people." (S3)*

#### **Overall communication**

It was suggested that more 'modern' ways of communicating with the children and young people could be looked at, for example, texting and email, to make the service more responsive to changing needs. For example, when looking at the complaints system, comments could be sent to share information but that are not through formal complaints structures. In turn it was felt that this would be beneficial as the information could be collected and common emerging themes/issues noted and responded to.

*"I think we could do a revision of the information that goes to looked after children when they first become looked after, a lot of the complaints stuff is aimed at adults. Young people like to text and email, that's what they do so to have a number that they can text or an email address they can send comments to that aren't treated as formal complaints that must go through the investigations process...a way of them being able to share their thoughts, not a formal 'I don't want to make a formal complaint but I just want to share a positive or negative and contribute'...give them a text number to get in touch with that could all be recorded then..." (S5)*

#### **Sharing views and thoughts about local services**

It was considered that looked after children and young people were provided with ways in which they could express their views and thoughts about their experiences (e.g., placements, schools, contacts etc) and that this could be empowering. A number of stakeholders mentioned 'The Voice' Group, which was in two sections – junior and senior voice. Some of the processes were independently reviewed and fed into service

*"We do a lot of work here around the Voice ... So I know there is clearly a system process and obviously we have got a participation officer who helps pull all that together yeah which is really helpful." (S4)*

*"I know from our perspective routinely do we capture the voice of every child that we work with? No I'm not sure. We capture the voice of children who want to talk to us." (S4)*  
*"Yeh, well we have we have a Junior Voice group within the...area, and we have a Senior Voice group, and actually a lot of things that the children and young people have discussed in those groups have actioned change, and they've been able to meet with councils and talk about local services that they want and they can address*

reviews with changes being actioned where appropriate. Youth Parliament was also mentioned.

Two stakeholders had concerns about whether they effectively managed to capture the views and voice of shyer and less confident young people. It was highlighted, however, by one of these stakeholders that current systems do not necessarily capture the views and thoughts of everyone. They discussed the difficulty of identifying a means by which it would be possible to capture the thoughts and views of those who are not involved yet would still have a contribution to make.

One participant (the LAC nurse S9) felt that BwD were very good at asking the opinions of young people but they needed to be clear about what actions were taken as a result of these. She felt that young people are questioned and assessed regularly but it was important to ensure they felt they were being listened to as well as asked. Effective information sharing between professionals was thought to be the key to this.

An additional stakeholder suggested that the children and young people from a particular children's home did not get involved in groups such as The Voice due to confidence or being too busy.

It was suggested that a young person's council may work well as a forum for children and young people to express their views about services.

### **Decision making**

One stakeholder also felt that the children and young people were able to help shape and develop their own care pathway. It was also considered important to manage expectation where it was not possible to meet a young person's request.

Within this, however, it was also acknowledged that meeting the needs of the carer can sometimes mean that the child/young person's needs are not necessarily accounted for/responded to.

It was also highlighted that improvements had been made in young people being more involved in their placement plan and also

*issue....they've actually actioned a lot of change from those groups.”(S6)*

*“Yeh, we have a group set up called ‘The Voice’, which is where children can share their views. But also it's quite a big drive in Blackburn and Darwen about hearing the wishes and feelings of children” (S7)*

*“I think...we see this as difficult to capture the voice. The risk of that always seems to be the same children...Do I think we listen to children? Yes absolutely. Can we do things differently and better? Yes probably.” (S4)*

*“...other authorities I have worked in have had young person's council I have been involved in and it has been very effective in giving young people a say. Not just young people involved in the council but actually spreading it out wider through the entire population of young people in the area, so yeah I think it would work well something that is good and useful.” (S2)*

*“We need to do the ‘you said, we did, so what?’ [Participation] is a lovely buzzword but it is very very difficult to do it with some children. They don't want to do it. They tell me they are asked questions at their review, at their health assessment, they are asked questions by their GP, questions about sexual health. They are assessed to death. We need that information to make sure they are safe. But it is how we share that information, stop repeating the same old thing” (S9)*

*“When they come to us...they haven't got their own voice and they might not even know how to express what they want and that means we need to help them to express it in a way that people will understand...if I can't meet the request or find other support from anywhere else, I will absolutely explain it to them if it's something I just can't meet. It's not an ideal world. There are things that come up you know but I would go into a great explanation to manage disappointment without them feeling like they haven't been heard and they haven't been considered.” (S1)*

*“There is a large part of our work that is focused on supporting carers and so the carer becomes our main kind of client, we are supporting the carer to respond to the child in a positive way, and often we are trying to get the carer into a better place emotionally so they are better able to respond to the child needs. I think when we do that I think sometimes the young person's views can be left out of the process, erm not that they are ignored but the focus*

making information about what happens on a daily basis a bit more child friendly and giving them an opportunity to comment on these details. It may also be seen as a way of increasing confidence and self-esteem.

It was also suggested that children were empowered to make their own decisions around aspects of their health care. A specific example given was about a child's right to consent.

One stakeholder interestingly noted, however, that those children under MTFC whilst being able to contribute actually like someone else making decisions for them.

*becomes much more what the carer needs than the young person's needs." (S2)*

*"We are getting better at that now because once upon a time a person used to come with Care plan 1 and Care plan 2 and a Placement plan. Now we are doing a placement plan for the young people so they are involved in that placement plan...they get to say the food they like, how they like to be woken up, what likes and interests they have got etc and that's really working quite well." (S8)*

*"We also raised, and again it's good that it's been addressed, around children's rights to consent to various parts of that, we had an eight year old little girl who didn't want to get undressed at her medical and the foster carer quite rightly said 'if she doesn't want to do it, she's not giving permission, we are not doing it'." (S5)*

## 7.5. TRIANGULATION OF QUALITATIVE FINDINGS

### 7.5.1. IMPORTANCE OF HEALTH

All of the LACYP who took part in this research recognised the importance of health, particularly in terms of nutrition and physical activity. Sport was described as an important factor by the LACYP living within children's care homes and foster care with all reporting taking part in a physical activities including dancing, cricket, football, gymnastics, cycling and martial arts. Happiness was also viewed as being important for health, with LACYP describing friends and social support as important here. Some of the younger participants described the association between physical activity, happiness and health.

Health was also described as important to those care leavers who participated in the research; having the right supporting influences was described a particularly significant for these participants. Being healthy was viewed as important for doing well in school, having friends, family life and for being a parent.

Although all of the LACYP interviewed felt they were aware of the importance of health and being healthy they associated this predominantly with balanced nutrition and physical activity. The foster carers discussed their particular concerns regarding healthy eating. The majority of the foster carers interviewed reported that they had looked after children who arrived in their care with very unhealthy diets or a dislike or refusal to eat healthy food. Takeaways and sugary drinks were mentioned frequently by carers. This challenge to support LACYP to eat healthily was often described as an ongoing problem, and aligned to concerns regarding poor dental health. Few foster carers or young people discussed public health issues such as alcohol, drugs or sexual risk taking. A minority of stakeholders discussed these issues and for those that took NPS was the biggest concern.

### 7.5.2. ACCESS TO HEALTHCARE

The LACYP who took part in this research were asked about their experiences of accessing healthcare within the area they live. The Everybody Centre was discussed by a minority of participants, mainly older, as a place where LACYP felt they could speak to a nurse or health advisor if they required support. Access to such services was deemed to be important, as was the importance of confidentiality. The younger participants associated health with GPs and school nurses and only one was aware of other health services (they had previously seen a psychologist).

Those LACYP living out of area described how they were registered with a GP, and that this would be their main way of seeking any support and information required regarding other health services. Similarly, the LACYP living within BwD described that they felt confident about where they would obtain healthcare support if needed, describing that they would ask their carer if they needed to make a GP appointment.

Care leavers also described having good knowledge of where they could access health advice and support, and felt they would access this directly rather than through referral. The care leavers described that their personal advisor would be someone who could help them to seek support, if required.

Stakeholders reiterated these views that BwD have a very good range of services to support the multiple and complex needs of their LACYP, with a number of community based services providing outreach support. The Everybody Centre was thought to be underutilised but this was improving.

Foster carers described specific experiences of LACYP using services, such as ELCAS (the local CAMHS). Experience of ELCAS was generally positive, though some issues were reported around long waiting list/referral time and eligibility criteria. Experience of SCAYT was very positive when provided in a timely

manner and support from a psychologist was reported as generally constructive and supporting. Some carers felt that access to health services was quicker for LACYP when compared to their peers (as assessed when compared to their experiences with their biological children). Where relevant, foster carers described multi-dimensional treatment foster care as largely positive. Some of the stakeholders felt that SCAYT was a useful service but that it did not provide enough resource to meet demands, particularly in terms of staffing and cross Lancashire uptake.

Two of the foster carers who participated in this research described the immediate health needs of LACYP they foster when they enter care. Issues were described such as painful eczema, gum disease, and missing glasses; all described to be as result of neglect and lack of medical attention. Other carers described that in some cases, health conditions such as food allergies were not immediately known to them. The health passport, received once children enter the care system, was deemed to be very important for foster carers in terms of transitions between placements. This finding was echoed by stakeholders, who described that more training could be beneficial to carers to help them to understand the issues related to health, hygiene and cleanliness. Stakeholders also raised the importance of ensuring that foster carers were well trained to support the immediate needs of children entering care (such as washing clothes and cutting fingernails), particularly in terms of their emotional health needs that may be exacerbated by the transition and separation from their parents.

Stakeholders felt that access to ELCAS/CAMHS could be disjointed and could require a more coordinated approach between services. A number of stakeholders described occasions where ELCAS/CAMHS support had been unavailable to those not in a stable placement, despite this being a time when children may be most in need of support. The stakeholder from the CAMHS service described that a lack of awareness regarding when the service could be accessed was causing confusion amongst other staff and carers.

The carers echoed these thoughts, often describing the emotional and mental health needs of the young people they cared for, as a result of neglect, abuse, unstable living conditions and mental health problems. Carers felt that LACYP do not often currently receive mental health support until they reach crisis and the CAMHS team were often unable to take a referral.

Participants from both the carer and stakeholder groups agreed that LACYP may not recognise and/or acknowledge when they require emotional support. This was reflected in the interviews with young people, in terms of them stating they would speak to their GP if they needed to access support, and that they would not always necessarily raise issues for fear of feeling too proud, or not wanting to seem as though they have failed. Carers and stakeholders felt that it is important to promote mental wellbeing in LACYP, and recommended that a preventative approach would be useful to build confidence, resilience and mental wellbeing, and ensure support is accessed in a timely manner.

#### Health Assessments

HAs were raised by carers and stakeholders, but rarely by LACYP themselves. The foster carers described that the assessment was disliked by LACYP for a range of reasons, including reinforcing the feeling that they are different to their peers. They reported LACYP do not like talking about personal health with health professionals or being examined physically and dislike visiting formal health settings when they do not feel unwell. Foster carers were concerned that this causes stress and upset to young people and described having to carefully encourage young people to attend to ensure they participated. Some foster carers felt less frequent assessments would alleviate the stress caused to LACYP with one suggesting that perhaps the foster carer could be involved in undertaking this review. Some of these thoughts were echoed by stakeholders,

who felt the assessments sometimes made children feel as though they were different to their peers. The formality of the process was described and some stakeholders felt a more informal process may be more suitable for young people. The LAC nurse described changes in the ways they conduct health assessments to make them more informal and less medical; this had led to a higher uptake and more engagement with the process. Some stakeholders felt that health assessments could potentially be adapted to meet local or individual circumstances, and questioned the importance of having annual health assessments if a child is in a settled placement.

Although the carers and stakeholders expressed specific concerns about health assessment, these were not reflected in the interviews with LACYP. The older LACYP in the children's home were asked about their experiences and views regarding the annual health check. Although none expressed a dislike or reluctance to attend these assessment, the answers from the young people were vague, even though researchers worked to elicit clarification regarding responses provided. One young person who lived with a parent (aged 14) did not mind the health assessment and he thought the questions were appropriate. The younger participants appear to be less aware of the health assessment process, though when prompted some remembered a nurse had come to their house to ask about their health. Some of the younger participants thought the health check was boring or repetitive but one participant thought it was fun to be weighed. The junior focus group were mainly concerned that their health assessment sometimes meant they missed their favourite lessons. They also preferred when appointments were done at home as it was more private. All young people described that they would speak to a doctor if they required any medical support.

### **7.5.3. ACCESS TO SUPPORT**

#### **Support for LACYP**

Access to support was described as good by the LACYP who participated in this research. The LACYP living outside of the area recognised that school was particularly important for supporting their wellbeing. Here, the school was viewed as providing a stable environment and an important source of pastoral support. This was echoed in the interviews with LACYP residing in BwD who recognised the importance of the school in providing support and stability, which was viewed as important for 'happiness'. Many of the younger participants (aged 8-10) felt they could talk to their teachers, carers or child support officers if they needed support.

Children and young people in foster care discussed how they had multiple social workers in the past but only one participant had had more than three social workers. Young people in foster care discussed how changing social workers could be upsetting and confusing for them. They found it particularly frustrating as they had to repeat themselves to all new social workers. The majority of participants liked their current social worker and reported they would struggle to trust a new social worker. Foster carers echoed these concerns and felt that the high turnover and changes of social workers could potentially have a negative impact on the wellbeing of LACYP. Many of the foster carers described how they had experienced multiple social workers over a short time period. Foster carers reported that young people had explained to them that they had found it difficult to be open and honest with a social worker if this person was then likely to leave. Foster carers were concerned that young people could feel rejected and perceive it as their fault if a social worker leaves. Interviews with stakeholders echoed these views, where one described how changes in service provision have meant that support previously provided by the social worker is now provided by other agencies. It was felt this may impact on the relationships and trust that social workers are able to develop with children and young people.

The stakeholders expressed particular concerns that more could be done to support children and young people living outside BwD, describing how this created challenges for working with different agencies and health

support services, which could result in difficulties accessing support services in a timely manner. The bureaucracy around payment by results and service level agreements could cause months of delays and were a barrier to timely and high quality health assessments. It was suggested that having awareness of the different working processes in each area would be beneficial and that having a uniformed approach across areas could improve this. However, the LACYP who lived out of area felt living outside of BwD did not have any impact on the quality of care that they received and was not felt to be any different to the support provided when they lived elsewhere. Two young people described how they see their social worker on a regular basis; approximately every 4-6 weeks. Another young person who lives in Lancashire described how it was usual to see a social worker every six months, but that they would see them more regularly when they needed increased support; this was described as being beneficial. However, it was noted that living out of area had caused communication barriers when they initially moved to a different area, describing 'confusion between social workers and carers'. One young person felt that it may have been more beneficial for them to see a social worker from the area they had moved to. This same person described how their carer has a supervising social worker from the area they were living in, and that it would be easier for them to see a social worker if they lived closer; they described that it was working well but it would be more convenient if the social worker was closer. The young person in a placement in Lancashire disliked that he had to travel to BwD for planned activities as their social worker did not know his local area.

#### Support for Care Leavers

The care leavers reflected on their experiences whilst they were in care and described how they often saw multiple social workers. The young people described how this made it difficult to build a relationship, particularly when compared to the relationship they had built with their allocated leaving care personal advisor. The care leavers felt that the continuity of their care as a looked after child was not always sustained and they felt that they often were passed 'back and forth' between social workers.

Three of the foster carers who were interviewed described their concerns about the support in place for care leavers, describing how the leaving care team should work with them earlier to prepare them for leaving care, however, this was not raised during the care leaver interviews. Three foster carers felt young people leaving care lacked the skills they needed to live independently. One carer suggested that resilience and life skills training for young people could be key to supporting them to cope with challenges they may face as they transition into adulthood. Two foster carers felt a peer mentoring programme with care leavers providing support to LACYP aged 14 and over would help them prepare for leaving care.

The stakeholders echoed the views of foster carers, in terms of feeling it was important to ensure more support is provided to ensure they are fully prepared for life outside of care. Life skills such as shopping, meal planning and budgeting were described as potentially useful. Stakeholders also felt peer mentors could play a key role here, but again this was not mentioned in the interviews with care leavers.

The role of the leaving care personal advisor was deemed central to the support that care leavers received; many care leavers felt this person was invaluable at providing advice or signposting them to a range of other services. This support included support regarding CVs, interviewing skills, housing and access to college. The care leavers felt it was easy for them to see their personal advisor, and could do this via a pre-arranged appointment or on a more ad hoc basis if required. The care leavers stated they preferred meeting with their personal advisor than they had with their social worker, as this was more relevant to their current needs and the personal advisor was viewed as more supportive. Some described how the regular contact they had with their personal advisor was an improvement upon the regularity in which they engaged with their social worker

during care. Some described the negative associations of social worker, describing how they would see their social worker if they were in trouble rather than when things were going well.

The role of the personal advisor was thought by the LAC nurse to be more than just to help young people get a job and housing, they wanted personal assistants to be skilled up to provide emotional support, build confidence and resilience in relation to care leaver's health. The leaving care nurse was talked about positively by stakeholders who felt that role was building trust and relationships between care leavers and health services and increasing use of support and health services.

The care leavers described how not all care leavers engage with their personal advisor, for reasons including feeling too proud or ashamed to ask for help, or because of negative experiences with previous staff from social services. The majority of care leavers who participated in this research described that they did receive support from their personal advisor, however one young female described how she felt she is a proud and independent person who does not like to ask for help as this would make her feel like she has failed. The care leavers acknowledged that they would only receive limited support if they did not engage with their personal advisor, but they felt there was little that could be done if the young person did not want to engage with their personal advisor. Despite this, the care leavers who took part in this research felt that they had more structure and stability as care leavers, compared to when they were in care.

#### Support for Carers and Multi-agency Working

Foster carers described the support they received from the FCA and the BwD training, and described the importance of peer support. Foster carers relied on other carers for their practical and emotional support and felt that the FCA meetings provided excellent opportunity to meet and share experiences in a friendly and supportive environment. The FCA provides a lot of signposting and information and it was acknowledged that any foster carers not attending the meeting may miss out on a lot of provision. The FCA was also welcomed as an anonymous opportunity to voice concerns to Children's Services and it was felt that senior managers in Children's Services listened to and actioned issues raised by the FCA.

Stakeholders described how they had made good relationships with other key professionals and across agencies. It was felt that the size of the local authority enhanced this and made decision making processes easier and quicker. Some highlighted that constraints on capacity and funding made it difficult to sometimes fully meet the needs of their LACYP and carers.

The majority of foster carers felt that agencies worked very well together, particularly when supporting young people with complex physical needs. Stakeholders felt professionals worked particularly well when based in one location; this enabled them to share expertise and provide a quick response to queries. In terms of access to support, stakeholders felt that the Youth Zone was a particularly positive new service available for children and young people. It was particularly noted that the Engage team felt that relationships with other service providers were strong; this was felt to increase knowledge of the local area and associated risks.

Stakeholders acknowledged the importance of ensuring that strong relationships were formed with LACYP and their families. This was felt to be of particular importance in terms of ensuring they were trusted, and that people felt able to share their views with them. Stakeholders felt the system could benefit from further support for the transition young people face between home and care and vice versa, to ensure continuity of certain aspects of support.

#### **7.5.4. SUPPORT GROUPS AND NETWORKS**

Of the LACYP involved in this project, generally younger children (aged under 11) were more interested in groups aimed specifically at LACYP and adolescents were less interested. The junior focus group was conducted with young people aged 8-13 who are involved with a participation group. Only two of the other LACYP who were currently in care, living either within or outside of BwD, attended any support groups or networks specifically for LACYP. These two participants were part of this same participation group but happened to be absent on the day the junior focus group was conducted).

Many of the participants were part of other groups; including sports and drama groups and community groups. One stakeholder highlighted that children and young people from children's homes may not necessarily get involved in user groups as they may lack the confidence to do so. In terms of the LACYP living outside the area, one was unaware of any such groups, whilst another had heard of some. It was agreed that LACYP would use generic groups, rather than ones specifically for LACYP, as they would not want to feel 'singled out'. Younger children in foster care reported enjoying spending time with other children who are in care as the similar background makes it easier to talk. The older participants (over 14) were not interested in being part of such groups with one remarking it was awkward and they had nothing in common, and another young person not wanting to be singled out as different. Most children and young people felt they had many friends through school and their local area.

Conversely, care leavers enjoyed being part of a leaving care group and that there were a number of groups and networks available to support young people/adults who are in care or have left care. A wide range of activities were described and the care leavers who participated in this research were actively involved in these. Many felt these groups provided opportunity to meet new friends and gain support from people who had similar experiences; some described it was often difficult to talk to others about being in care. Some care leavers felt it was important they were involved in activities which provided advice to LACYP currently in care and to help improve current services.

The issue of not wanting to feel 'singled out' was raised by a small number of participants in this research. The foster carers felt there was a stigma attached to being in care, and that the processes, paperwork and rules made it difficult for LACYP to feel the same as other children their age. Carers reported that some LACYP would hide the fact they are in care. This was echoed in the interviews with older children in care with one person (aged 15) describing that not many people at school know that he is in care and another young person (aged 14) saying he would rather spend time with friends from school as he had more in common with them. One young person had enjoyed mixing with other LACYP when he first moved into care as it helped him understand the situation and make friends. However none of the younger LACYP discussed feeling 'singled out' or 'different' to their peers.

#### **7.5.5. INPUT INTO CARE AND DECISIONS MADE**

All stakeholders agreed it was important to ensure that all LACYP feel they are involved in the decision making process. Stakeholders generally felt that there were adequate mechanisms for LACYP to share their views and highlighted that this could be empowering. Importantly, stakeholders described that some of these feedback processes were independently reviewed and were used to inform service development. However, stakeholders acknowledged that not all views of LACYP will be captured via the existing processes. Although it was recognised that it would not be possible to capture the thoughts and views of everyone, there may be other methods that could be introduced to support this. Some felt that using text messaging and email as methods of communication for LACYP may be effective in gathering wider views. It was also suggested that a

young person's council may work well as a forum for children and young people to express their views about services.

Findings from the interviews undertaken with LACYP living with foster carers echoed the stakeholder views, in that they felt they had a voice and had some input into the decisions that were made around their care. They all felt they were regularly asked what they wanted and had chance to input into the decisions about their care, especially leading up to their reviews. However all of the junior focus group and some of the other interview participants reported that although they were asked their wishes and thoughts, they were not always taken into account or acted upon. Participants expressed frustration when they were not listened to, however, some participants did report that changes has been made when they had requested them; for example moving foster placements.

Formal review procedures were brought up by the majority of LACYP who had mixed opinions about their say and how much they were listened to. Some younger participants disliked attending the reviews as they felt they were boring and frustrating and they felt like adults were talking about them and they were not listened to. Some participants no longer attended reviews however some still chose to attend. All LACYP completed the booklet about what they wanted prior to the review however many felt it was repetitive and although they asked for the same thing every time, nothing changed. One of the young people described how foster carers are present at their regular reviews, which could potentially make it difficult for them to raise any problems or concerns. This young person felt it would be beneficial to have time to discuss their experiences privately with the social worker. The foster carers agreed that there were processes in place for LACYP to share their views, but also acknowledged the difficulty of using the six-monthly reviews as a forum in which to do this. Foster carers acknowledged that LACYP may find it difficult to share their thoughts in a formal setting in front of their carers and parents, and suggested views should be captured in advance of the review meetings.

Two LACYP (one who lives in the children's home aged 10 and one aged 14 who lived with his mum but had previously lived with foster carers) described how they were reluctant to raise issues that they were unhappy about, as they were worried this may seem 'cheeky'. Another participant (aged 10 from the junior focus group) felt it was 'rude' not to attend their review meetings.

This feeling was also echoed by the young people who had left care, who described that when they were in care, they felt it was sometimes difficult to talk about their feelings in review meetings. Some young people felt they were worried that when they did share their feelings, their words may be twisted. These young people felt that they were more listened to as care leavers, had more independence and had an input in decisions about their lives.

The young people who lived within the children's home felt they had less input into decisions made about their care and into how things ran within their care home. These young people felt it was important to have regular house meetings within their home, and described they felt these were not always frequent enough.

The care leavers were asked to reflect on their experiences as a LACYP, and whether they felt their views were considered in terms of the support they received. The young people described that they did not have an input into decisions regarding their care and where they lived, and felt they had more options about this as care leavers. Some care leavers described their own experiences during foster placements, and how they felt that were treated differently and unfairly compared to the carer's biological children. This feeling was reinforced when the young people reached adult age and moved on and did not sustain a relationship with their carers.

Some of the care leavers who took part in our research described how they associated seeing a social worker with when they were in trouble, and that this was the only time they were listened to. These young people described how they felt that children who 'caused trouble' or had antisocial behaviour got the most attention and that this encouraged young people to get into trouble in order to receive attention.

It is important to acknowledge that the care leavers interviewed were aged between 20-24, therefore some services may operate differently now compared to when they were in care. Some of the care leavers acknowledged this, recognising that there are now more options available to LACYP than there was when they experienced the journey three years ago.

#### **7.5.6. AREAS FOR IMPROVEMENT**

All participants were invited to detail any areas of the LACYP services that they felt could be improved. Young people who were currently in care struggled to describe the improvements they wanted to see – the majority focused on specific placement issues rather than general improvements. The junior focus group felt the main improvement they wanted to see related to being listened to and having more of a say in their care.

The care leavers were able to reflect on their experiences, both as looked after children and as care leavers. They felt it was important that young people had access to more information about the types of support they are entitled to. They also felt there was a need for more training for social workers to ensure young people and children are matched to the most appropriate carers. For example, specific training around disabilities were discussed, to ensure the carer has a full understanding of what specific needs and support a child with a physical or learning disability might have/need. An antenatal and 'mums and babies' group was also suggested as something which would be useful here.

Foster carers highlighted the importance of short breaks in care and described how, unlike their birth children, they could not ask a friend to look after their foster child. The carers described how they found it difficult to go out for a meal or an event. Some described that residential trips provide some breaks and some foster families have arrangements where they take it in turns minding each other's foster children however this is not easy. However, a more formal system of good quality, easily accessible short breaks was thought to be missing.

Stakeholders felt that, although they made the most of available provision, there was always room for improvement. Issues such as staff capacity, limited time and funding were perceived as current barriers to service provision. Some stakeholders described an expectation that they would be able to meet demands with less resources. Although stakeholders felt that relationships between LACYP and their placements were determined upon individual needs, they felt that the current organisation of placements for LACYP could be more flexible to more appropriately meet the needs of children and young people. Stakeholders felt the system would benefit from further support to the transition young people face between home and care and vice versa, to ensure continuity of certain aspects of support. Stakeholders also suggested further support was needed to support emotional and behavioural issues for young people who were not in stable placements before they reached crisis point.

#### **Dissemination of research findings**

The care leavers highlighted their interest in learning how findings from this research will be used to inform future service development. Many described the importance of ensuring their feedback has a positive impact for future users of LACYP services. A number of foster carers also requested to be provided with a copy of the

findings. The junior focus group also requested a simple young person friendly version of the findings with infographics.

## 8. DISCUSSION

The purpose of this research was to support partners in BwD in enhancing and maintaining the health and wellbeing of LACYP in BwD, including those living inside and outside the borough and care leavers.

The study had a range of core objectives (see section 1.3) and utilised a number of methods to meet these objectives (see section 2). For each research objective, this section provides a summary of key research findings and discusses their implications. Where relevant, the research describes outcomes and issues relating to each of the key cohorts: children living in the care of BwD, children living outside of BwD, care leavers, and carers and stakeholders (the term stakeholders has been used throughout this report to describe the range of health and social care professionals who participated in this research).

### 8.1. THE HEALTH STATUS OF LOOKED AFTER CHILDREN AND YOUNG PEOPLE

The health and wellbeing of LACYP was explored through interviews and focus groups with LACYP, care leavers and stakeholders, along with analyses of existing and available routine data (i.e. Protocol database, health assessments, YJS and Lifeline). Few routine data sources were available on the health and wellbeing of LACYP, and even within available data sources, information was limited both in detail and reliability (see section 8.4.2). Further, no national comparisons could be made; the small sample size and differing methods of data collection mean that any comparisons drawn would not be accurate. However the available evidence provides an insight into the health and wellbeing of LACYP living in and outside the borough, as well as care leavers.

#### 8.1.1. HEALTH AND WELLBEING NEEDS

Evidence from the qualitative interviews showed that LACYP in BwD appear to have a good understanding of health and the importance of a healthy lifestyle. LACYP primarily viewed health in terms of nutrition and physical activity, although happiness was discussed by some as an important contributor to health. No LACYP discussed alcohol, drugs or sexual health. The care leavers associated health with wellbeing, recognising the influence of health on educational attainment, social support and parenting and acknowledged that positive supporting influences were particularly important for health. Although evidence from quantitative data and interviews with young people suggest self-reported health behaviours are good, carers described how young people would enter their care with very poor eating habits and dental health. This finding highlights potential discrepancies in the recording of data via the HA, and the overall assessment of the health and wellbeing of LACYP in BwD.

Foster carers described their challenges of looking after children who had very unhealthy diets or disliked or refused to eat healthy food; LACYP preferring takeaways and sugary drinks was mentioned frequently by carers. Although data show that the majority of LACYP who had been in care for longer than one year had a dental check in the last year, details of issues identified in the dental checks were not readily available. Other health issues identified as requiring immediate attention by carers included painful eczema and food allergies; routine and accessible data regarding these issues were not available for this study. Stakeholders felt more could be done to support carers to understand some of the key issues requiring urgent action in relation to health and hygiene; especially in relation to balancing these with the challenge of LACYP settling into placements. In order to further aid understandings of health needs, work should be done to capture wider health issues of LACYP (see section 8.3 for further details).

The LACYP felt they had appropriate access to health services and described their GP or school nurse as the main source of support and signposting; the Everybody Centre was mentioned as a place where older LACYP

in BwD could access a nurse or health professional if required. Care leavers described that their personal advisor would provide them with help in seeking support for health needs, if required, and the role of the leaving care nurse was discussed positively by stakeholders. A review of the latest available health assessments for LACYP found that the majority had involvement with health services recorded on their HA. Of those involved in services, on average they were involved with two or three services, primarily a health visitor, school nurse or dentist. A slightly higher proportion of those living in BwD were engaged with a health visitor, school nurse or dentist, compared to those living outside of the borough. Further, more LACYP living in BwD were engaged with a paediatrician when compared to those living outside the area (41.8% compared to 29.7%). Fewer LACYP living in BwD were engaged with CAMHS (12% compared to 18% outside BwD), which may reflect the nature of the needs of this group, rather than access to provision.

Carers and stakeholders both described the important emotional support needs of vulnerable young people, as a result of the problems which have characterised their lives. This was reflected in the quantitative data, which show that over half of LACYP in BwD come into care as a result of abuse or neglect. Stakeholders felt that access to CAMHS in BwD could be disjointed and that a more coordinated approach between services could be developed. Carers felt that mental health support was often not available until the young person had reached crisis point, and participants from both stakeholder and carer groups acknowledged that LACYP may not recognise when they require emotional support. This finding was echoed when mapping the journey of a LACYP in the care of BwD, where stakeholders highlighted the importance of providing asset building activities that were preventative in terms of health and wellbeing support.

Discussion of the wider determinants of health was limited to healthy eating, physical activity and emotional and mental health. Sexual health and drugs and alcohol were only identified as an issue by a very small minority of stakeholders and carers. One stakeholder (a nurse) spoke in detail about their concerns regarding NPS (legal highs) and how easy it was for young people to access these in BwD.

### **8.1.2. HEALTH ASSESSMENTS (HA)**

All LACYP in care for more than 28 days should receive an annual HA<sup>11</sup>. It is important to note that the nature of the collection of the HA data may limit the accuracy of the figures provided within this report, and collection of anonymous responses may yield more accurate results. Issues of confidentiality and social desirability may affect the current findings.

A review of HAs found that completion of HAs in BwD was good, with the vast majority of all LACYP having a HA recorded (93.5% of those living outside of BwD and 89.1% of those living in BwD; see section 5.1). The HAs include a range of questions asking LACYP if they have concerns about their health, and for those aged 10 and above, questions about smoking, alcohol and drug use. Whilst data were not available for all LACYP (either because it was not recorded on their HA or their latest full HA was not available to researchers), analyses suggest that around a fifth of LACYP in BwD reported having worries about their health. These data are collected in free text format and are of varying detail on the HAs; whilst some provide details of the issues raised, others simply state that there were worries with no further detail provided. Thus, exploring the types of health concerns raised by LACYP in their HAs was not possible. Although researchers did not ask LACYP directly about their personal health conditions or concerns, all agreed they had someone to talk to if they felt worried or unhappy.

Where data were available, analyses show that a quarter of LACYP aged 10 and over reported smoking, and just over one in ten drank alcohol and/or used drugs. More young people living in BwD reported drug use (20%,

n=7/35) compared to those living outside the area (8.2%, n=4/49). Despite the low HA figures, data provided by Lifeline show that an average of 35 LACYP had been referred to the service each year between 2012 and 2014 (total n=104); however it must be acknowledged that Lifeline provided data on those up to age 23.

All participants, apart from some of the youngest interviewed (aged 10 and under), were aware of the HAs and were ambivalent regarding their experiences of these. Carers and stakeholders felt the process may be too formal, which may result in stress and upset for young people. Care leavers, carers and stakeholders expressed concerns that LACYP may not raise concerns at their HAs, due to their carers or parents being present.

The LAC nurse spoke in detail about the bureaucratic problems with organising HAs for LACYP who are placed out of area. The payment by results system and service level agreements caused delays and confusion. However this stakeholder was confident this would improve given recent changes in policy and guidance.

### **8.1.3. INTERVENTIONS TO IMPROVE HEALTH AND WELLBEING**

The evidence base for interventions to improve the health and wellbeing of LACYP in both the short and longer term has expanded considerably in the last decade. BwD already have the most effective programmes in place and no additional appropriate effective programmes were identified to be missing in BwD. There are programmes in place in BwD around KEEP, MTFC and family interventions that are based on recent robust evidence.

Currently the strongest evidence for effective programmes appears to be for programmes that support both foster parents' and children's general mental wellbeing and behaviour, often mediated by improving placement stability. Although evidence supports the KEEP intervention, which provides group-based training to help foster parents manage behavioural and emotional problems may have some positive outcomes (see section 3.1.2), other parent training programmes that focus solely on foster parents alone are limited. Better results are obtained from relational or attachment-based approaches that work with both the foster parent and the looked after child to build stable and nurturing relationships, with a sound evidence base for established programmes such as Parent-Child Interaction Therapy, Incredible Years or Attachment and Bio-behavioural Catch-up (see section 3.1.3 for programme details). These programmes do, however, focus primarily on younger children, identifying a clear need for effective interventions that support the relationships between foster parents and older (including adolescent) LACYP. For those LACYP who require support for mental health issues or specific behavioural problems, therapeutic approaches such as CBT or Treatment Foster Care have shown efficacy.

On the other hand, support for the educational outcomes of LACYP is more limited. Although recent evidence has highlighted the potential efficacy of mentoring programmes to support educational attainment in particular, further research is needed to identify the best approaches for selecting mentors, and the core elements of mentoring support that relate to outcomes of interest. Evidence from the USA is beginning to suggest the value of programmes that support LACYP in accessing higher education, and the utility of these approaches in the UK context should be explored.

Whilst our rapid literature review (section 3) describes interventions that focus on a variety of outcomes such as educational attainment, criminal justice involvement or delinquency, mental health and parenting and attachment, there is a clear lack of programmes aimed at improving the physical health of LACYP, such as levels of physical activity, diet or weight.

It is evident that more research is needed, particularly research conducted in the UK. Whilst there are some similarities with the cultural context in the USA, notable differences such as the lack of a universal and free at the point of delivery health service cannot be underestimated. The current evidence is plagued with some general limitations, including relatively small samples sizes, data collection processes not blinded to study condition (in the case of study designs with comparisons to control groups), and a lack of longer-term follow up data. The research base mainly focuses on foster carer training to support the outcomes for both carers and LACYP. Measures examining the transferability of training (i.e. how well foster carers are able to apply what they have learned in training to their home lives and relationships with their foster children) are also needed.

Although there are examples of established programmes that were initially developed for other populations which have been adapted for use with foster carers or LACYP (e.g. Incredible Years Parent Training), questions remain as to the suitability of these approaches. Box 8.1 provides a brief summary of some of the barriers that may limit the adaptability of established programmes for other populations of children and young people. Adaptation may be more challenging for certain approaches or outcomes, such as the prevention of substance use (see section 3.1.1.3)

#### BOX 8.1: BARRIERS TO ADAPTING PROGRAMMES OR APPROACHES FROM OTHER POPULATIONS FOR USE WITH LACYP

Although some of the evidence in section 3 refers to programmes or approaches that were initially developed for other (often at-risk) populations and have been adapted for use with LACYP, the following barriers to successful adaptation can be identified:

- LACYP are a heterogeneous population with a very diverse range of experiences and inter-related needs. Poor outcomes for LACYP may have developed prior to their placement in care, as well as possibly relating to, or worsened by their experiences of being looked after.
- Lack of continuity of care and housing instability can have a profound impact on both access to programmes and services, but also on retention of participants within interventions. Approaches that are traditionally delivered over the longer-term may therefore not be suitable for LACYP, who may require programmes to be delivered over the shorter-term, or to be broken down into smaller elements that may still be beneficial if only completed as stand-alone modules.
- Based on actual or perceived negative experiences (either personally or through family members or peers), LACYP may exhibit a general lack of trust in statutory services, which can be particularly damaging to the rapport building that is necessary for the successful implementation of many therapeutic approaches. Additional efforts may therefore be required to counter these existing negative perceptions, before LACYP are able to fully engage with interventions.
- Child welfare systems are typically characterised by high caseloads and high staff turnover, making it potentially very difficult to sustain the use of effective interventions within this context [5].

## 8.2. PLACEMENT STABILITY, OUTCOMES AND CONTINUITY

Issues regarding placement stability, outcomes and continuity were explored with participants from the key cohorts within each element of the research.

### 8.2.1. LACYP IN THE CARE OF BwD

The evidence from this research reflects the transient nature of LACYP's lives. Evidence from the quantitative data show that one third of LACYP in BwD had been in care for longer than one year and that just under half (41.8%) were on their first placement. Just under a third of LACYP in BwD had three or more placements and the majority (80.4%) of these LACYP were placed with a foster carer. The majority (92.2%) had no missing from care episodes recorded (times where they were reported missing by carers). The number of missing episodes ranged from zero to 37, with six LACYP (4.2%) having had five or more.

Stakeholders who were involved in mapping the journey of children in the care of BwD all agreed that referrals to the service were most often multi-factorial and very complex. It was acknowledged that teenagers are often not placed in planned placements, and evidence from the qualitative research highlighted that it was often difficult to plan support for LACYP who are placed as an emergency, and that more training regarding some of the most common physical and emotional health needs of LACYP may be useful for carers. Achieving permanency in residence at an early stage was felt to be very important in terms of achieving positive outcomes for young people. Stakeholders mapping the journey of a LACYP in BwD agreed that there were very positive local relationships between stakeholders, and that statutory and voluntary support was provided as necessary, dependent upon need. Stakeholders highlighted a number of issues for consideration when understanding the journey of LACYP, particularly noting the complexity, trauma and challenges that children have faced upon entering care. Stakeholders felt strongly that they should ensure the feelings and values of the child were placed as a priority alongside the importance of ensuring processes and procedures were followed.

LACYP who took part in the qualitative interviews reported access to support as important in ensuring they achieve positive outcomes. All LACYP involved in the interviews and focus groups felt they had someone to speak to if they needed help or support, describing that they could speak to their carer and that they had good access to their social worker. The school was recognised by the LACYP as a particularly important source of support and stability, and the literature review revealed a number of interventions delivered in school-based setting that may be applicable; e.g an education support programme in England that aimed to provide LACYP with access to a range of different learning opportunities, including residential weekends. There is some evidence that such programmes could have positive impacts (e.g. improving wellbeing and self-esteem) beyond educational attainment [46].

The importance of continuity of social work support was highlighted by young people in care in BwD and the majority discussed strongly disliked when they had to change social worker. LACYP generally were distrusting of a new social worker and LACYP reported it was confusing, upsetting and frustrating when their personal social worker changed. Trust was very important to LACYP and they were unlikely to talk to social workers about their health, worries or any problems if they did not trust them. However BwD has a social worker turnover rate (16%) comparable with the North West (14%) and England (16%) rates. This has increased slightly in the last year due to a remodel of the service, however vacancies and caseload were lower than regional and national rates [146].

Although young people living with foster carers felt they as individuals had a say in their care and an input into decisions about their care they did not always feel they were allowed what they requested. The young people in the children's home described the importance of having frequent house meetings, and felt they could have more input into decisions that were made about their care within the home.

### **8.2.2. LACYP LIVING OUTSIDE OF BwD**

Compared to LACYP living in BwD, LACYP living out of area had spent more time in care and experienced more placement changes. This suggests a higher turnover of placements for LACYP living outside of BwD than for those living in the area, and may reflect the finding that more LACYP living outside of BwD were looked after due to family dysfunction.

Stakeholders discussed their concerns regarding the stability and outcomes for LACYP living outside of BwD, particularly in terms of quality and continuity of care. Stakeholders described that some areas offer therapeutic treatment but that they need to rely on mainstream support, not LACYP services, which can cause delays in LACYP accessing support. Similarly, the process of procurement and commissioning support services for LACYP living out of area was felt to be a barrier which delayed access to support. Stakeholders mapping the journey of LACYP placed outside of BwD felt that there was good communication with LAC nurses and child sexual exploitation teams (where these existed) across the different areas. Although stakeholders described BwD as having a good level of service provision in comparison to other areas. Lack of provision in other areas was viewed as a barrier to those placed out of area, particularly in terms of providing continuity of care where services do not exist. An example was provided of the work undertaken by the BwD Engage team in terms of protecting children from sexual exploitation. Here, stakeholders acknowledged that this service is not provided if LACYP are placed in an area without a similar team. This topic was also discussed in the stakeholder interviews, where one professional raised the importance of the Engage team, and described that the relationships developed between them and other health professionals helped to increase knowledge of the local area and to understand potential associated risks. This stakeholder acknowledged that this intelligence was crucial to ensuring the safety of children at risk of sexual exploitation, and that there is a gap when this intelligence is not available for LACYP placed out of area.

Despite the concerns raised by stakeholders, the LACYP living outside of BwD who participated in the qualitative research felt that living out of area did not impact on the quality of the care they received. It was discussed that there had initially been communication barriers and confusion between social workers and carers but that this was no longer a problem. They felt they had a voice and were able to speak to their carer and social worker and that they had an input into decisions made about their care, however these young people acknowledged that ultimately the majority of the decisions about their care were made by adults.

### **8.2.3. CARE LEAVERS**

In terms of placement stability, quantitative evidence show almost two thirds of care leavers (who left care 1<sup>st</sup> January 2012 – 31<sup>st</sup> December 2014) had previously spent over a year in care, and their last placement was most likely to have been within BwD. Just under half of care leavers left care because they reached the age of 18. A third returned home to live with parents or relatives; more care leavers whose last placement had been in BwD returned to live with their parents or relatives, compared to children placed out of area. This is likely due to the characteristics of the care leavers' needs, rather than the fact that proximity to BwD aided this return.

The care leavers who participated in the qualitative interviews reflected on their time in care, and felt that continuity of care was not always achieved in terms of their experiences of developing relationships with social workers. Carers and stakeholders described concerns that high turnover and changes of social workers could impact negatively on LACYP; this was deemed particularly important in terms of building and maintaining trusting relationships. Care leavers echoed these views, describing their experiences of regularly changing social workers. Care leavers described how this made it difficult to build relationships, particularly when compared to their current experiences with their leaving care advisor. However, as discussed above BwD now has social worker turnover rates comparable with the North West and England rates.

None of the care leavers involved in the research were still living with a foster carer and reported that the personal advisor was a big source of support for these young people. The care leavers interviewed described the positive relationship they had currently built with their personal advisor, and contrasted this with relationships they had struggled to develop with social workers. Care leavers met their personal advisor at least once every six months to complete a pathway plan, and felt they could get ad hoc support as and when needed. The care leavers described how they did not feel they were listened to when they were in care and were only listened to when they were in trouble. The young people felt they had much more of an input into their care as care leavers and were given options on where they could live; whether they wanted to continue to live supported or live independently.

Stakeholders involved in mapping the journey of care leavers described the specific support that is available in BwD to young people aged 16-21 years, including social work and personal advisor support. All stakeholders agreed that care leavers received timely and effective health assessments, but highlighted that they felt practical support was required to provide care leavers with basic skills. This finding was also echoed in the interviews with carers and stakeholders who felt that care leavers could be better equipped to live independently and manage their lives effectively upon leaving care. Some foster carers felt that care leavers lacked specific life skills required to look after themselves independently, and required support to help build resilience. Foster carers acknowledged that there was a broad selection of training available to them, but that it is the LACYP themselves who need support to build resilience. Although this issue of training and support was not raised by the care leavers, it is important to acknowledge that care leavers with less confidence may have been less likely to participate in this research, and that the carers views are important to acknowledge.

Stakeholders and foster carers felt that it would be good for young people aged 14-18 to receive mentoring support from older care leavers. The rapid review elicited examples of a number of mentoring programmes that had been delivered with LACYP, and found that this can be beneficial for improving confidence and self-esteem. However, outcomes depend upon the background of the mentor (for example social work graduate students [39] or people with experience of being in care [40]) and the length and scale of mentoring support. Evidence has shown that limited mentoring can have a less positive impact than no mentoring at all [41]. Natural mentors are thought to be particularly beneficial for those LACYP who may have difficulties in forming trusting relationships. Consideration should be given to allowing mentees to select their own mentors.

Care leavers described the networks and groups that were available to them, and the importance of these in terms of providing stability and support. Conversely, LACYP described accessing a number of youth groups and networks but were not involved in activities which were specifically designed for LACYP. Although groups are offered, older LACYP described that they wished to participate in the same activities as their peers; this finding was echoed by stakeholders and carers who acknowledged that not all LACYP would want to take part in activities that 'single them out' as being looked after, or have the desire or confidence to take part in user

groups such as the participation groups. Younger LACYP (aged under 11) were more interested in taking part in activities with other LACYP and felt their shared background made it easier to talk and support each other.

#### **8.2.4. FOSTER CARERS AND PROFESSIONALS**

In terms of supporting positive outcomes for LACYP, carers described the immediate health needs of the children and young people they had looked after, with knowledge of health and medical issues such as allergies not always been understood for the first few weeks they are in care. Carers acknowledged that emergency placements were particularly challenging in this regard. The carers agreed that the care list and Health Passport made transition between placements much easier, and that this information was very important in ensuring the child feels safe and settled as early as possible. All carers had concerns regarding healthy eating, reporting that children came into their care with very unhealthy eating habits and they struggled to change the young people's unhealthy diets. Additional training could equip carers with the knowledge and confidence to support LACYP to change their behaviour in a supportive and positive environment. Carers and stakeholders described the range of support available to encourage positive outcomes for LACYP, for example the Youth Zone was highlighted as a good example of varied provision.

Stability and continuity of support were agreed by all stakeholders to be important for mental wellbeing. Emotional health needs of LACYP were described by carers, who felt more could be done within the system to support mental wellbeing, resilience, and prevention of crisis amongst LACYP. Some carers described their experiences of looking after children with attachment issues, and said that they had used SCAYT to support them to form relationships with the child they were looking after. This was viewed as an extremely useful service.

All carers and stakeholders acknowledged the importance of ensuring LACYP had opportunity to participate in networks and groups, and the opportunity to input into decisions made about their care; the importance of feeling listened to was a common recurring theme. Peer support was also cited as very important to foster carers. The FCA and BwD training were integral to this, and were viewed as very positive, supportive and useful.

Generally, stakeholders and foster carers felt that multi-agency working was good, and that communication was clear. It was agreed that LACYP have multiple complex needs and that collaboration between agencies was integral to ensuring stability, continuity and positive outcomes were achieved. Carers described that communication in MTFC was very good, and felt that learning could be taken from this approach and embedded into mainstream fostering. Stakeholders described the positive relationships they had developed with other agencies, however acknowledged that constraints on resources could make it difficult to meet all of the needs of their service users.

The issues of short break care was raised by a number of the foster carers who took part in this research; this was felt to be important for both children and carers, in terms of ensuring stability and positive outcomes. Although some carers acknowledged that short break care had improved, many felt it was difficult for them and LACYP to take a break. Some described how they were unable to ask a friend to look after their foster children, as they might with their birth children, which made it difficult to attend social events. Carers felt more access to residential breaks for LACYP would be beneficial, and that this was particularly true for those looking after LACYP with challenging behaviour. It was, however, recognised that short breaks for those caring for children with challenging behaviour was more readily available to MTFC carers. Access to short breaks from caring for LACYP is often rated as an important type of support by foster carers [147] and is linked to retention of foster carers [148] However respite care can be interpreted negatively by LACYP who may feel their carers

need a break from them. The Mockingbird Family Model, which is being trialled in the UK<sup>33</sup>, has been shown to provide supportive and positive short break care for LACYP [149].

### 8.3. SYSTEMS AND PROCESSES IN PLACE TO MONITOR OUTCOMES FOR LACYP

This research highlights that there are currently processes in place to collect, store and access information regarding LACYP in BwD. A number of teams within and external to the council have access to the Protocol and Tribal databases at varying levels, and other teams and organisations receive summary statistics from the databases as required. During the stakeholder events, some partners indicated that they were not able to access data that would provide them with an overall picture of the health and wellbeing needs of LACYP.

HA data are currently collected on paper based forms which are scanned onto the shared drive; however many HA forms are not scanned or are only partially scanned so information is not available. Although some of this information is held in on Protocol, stakeholders described difficulties in accessing, using and updating this information. Inputting these HA data into the database, as opposed to electronically scanning, would facilitate data sharing between organisations. Electronic storage and transfer of data can reduce unnecessary delays in data sharing process and would enable all data held on LACYP to be easily accessible, presenting a clearer picture on this population and their health needs.

HA questions are mandatory and topics covered are not within the control of BwD. However the way these forms are completed, stored and used could be amended to allow local partners to access information on the health and wellbeing of LACYP more readily. Many of the fields on the HA form are open text boxes and completion detail varies. Consistent full completion and scanning of all HA forms would ensure this information is stored centrally and more easily available. Key information to be stored could include data items from the HAs such as those used in this report (e.g. health concerns, alcohol, sexual health, smoking and drug use) along with a unique identifier to link the information to the Protocol database which records details about LACYP (e.g. demographics) and their care (e.g. placements).

Stakeholders acknowledged that it would be difficult to access data on LACYP's presentation at local health services. Whilst some services (e.g. Brook or Lifeline) collect data on LACYP that may be useful to partners these data could be better used to monitor the needs and health of this population; currently, for example, information on sexual activity is self-reported but the assessment does not provide information on referral or service use. Where possible, it is important that health services record attendees as LACYP. Although representatives from health attend and contribute to multi-agency case tracking and management panel meetings, there is the potential to link health data with data held on Protocol and Tribal. A unique reference number is used for LACYP on the Protocol database (Tribal uses unique pupil numbers, which is also stored on Protocol). Whilst most datasets could link to Protocol, not all data collected on LACYP use this unique reference number, which prevents the linkage of data.

Some data systems use NHS numbers (which are stored on Protocol), meaning that certain health system data could be potentially linked to the information stored on Protocol. Some health services, such as sexual health services and Lifeline, give clients unique reference numbers, but these reference numbers are not then linked to other sources. Some services use initials, date of birth and partial postcodes to identify LACYP, which make

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<sup>33</sup> Mockingbird uses the concept of a dedicated 'hub home' of specially recruited and trained carers offering respite care, peer support, regular joint planning and social activities to a 'constellation' of six to 10 families of foster and kinship carers living in close proximity. See [www.fostering.net/news/2015/innovation-fund-award-bring-mockingbird-uk#.VXbHSs9VhBc](http://www.fostering.net/news/2015/innovation-fund-award-bring-mockingbird-uk#.VXbHSs9VhBc)

it technically possible to link data sources; however, using the LACYP reference number (as used on Protocol) would enable timely sharing of data and ensure data are shared without breaching confidentiality. All services need to ensure that appropriate data sharing agreements are in place to cover any data sharing between services. The use of a unique reference number (such as that used on Protocol) would ensure that data sets can be collated so a picture can be built up of the care of LACYP and the needs of this population.

BwD are encouraging young people to participate in health and leisure activities, including the beeZ card, however the use of these services by LACYP is not monitored. Recording this information would allow for an examination into the uptake of this scheme and consequently would allow for an evaluation of its effects on this population.

There is currently no systematic way of accessing or recording the education or employment status for LACYP within BwD, however, this is recorded for care leavers. Recording this education or employment information may be of use for monitoring this population further and consideration to collecting this information should be made.

Additional information could be sought from care leavers, who complete an annual health care questionnaire, which examines if sexual health services were accessible. A Health Information Passport is also completed for care leavers. Unfortunately we were not able to access the information held within these for the purposes of this report.

Apart from referral figures provided by Lifeline, no further data were available that identified how many LACYP had substance misuse problems, or who had received interventions for substance misuse problems. These data are not included in the 903 return to the Department for Education (see section 4.1) as this information is not shared by local health services with BwD Borough Council. If this information was recorded, so that LACYP could be identified in the data, this could be used to further understand need and develop services to address substance misuse within this population. Currently the only information available on substance use is taken from the HA for young people and this is reliant on self-reporting and is held in an inaccessible format. Given that the information in this form is collected face to face by a health professional, the data collected may underestimate the extent of substance misuse.

## **8.4. RESEARCH LIMITATIONS**

### **8.4.1. SAMPLING AND RECRUITMENT**

Due to the nature of the research, the qualitative recruitment approach was supported by social workers, health professionals and carers. Although care was taken to ensure that LACYP (including care leavers) with a range of experiences would be invited to participate in this research, it is likely that those who agreed to participate were more confident and perhaps more stable than some children and young people. LACYP who are more confident and in stable placements may have different experiences and needs to other more vulnerable LACYP.

Carers and stakeholders raised some concerns regarding health issues, gaps in support or issues affecting continuity. Although these were not all specifically raised by the LACYP who participated in this research, it is important to acknowledge that these are important issues which need to be considered within the recommendations. Despite the relaxed and friendly approach of the researchers, LACYP may not have felt able to raise these issues with strangers or may have not been able to express their needs, especially around mental health and wellbeing.

#### 8.4.2. DATA ISSUES

Receiving data on LACYP for analysis was dependent on partner engagement with the research project and availability and accessibility of data, consequently data were only received from BwD Borough Council (Protocol data extract), Youth Justice Service (YJS) and Lifeline. We were unable to access any additional data which would enable the analysis of the health outcomes of LACYP and consequently were unable to make a comparison with the general population in Blackburn with Darwen.

Additional data fields (not presented in this report) were available within the Protocol extract, but for these fields data quality was low, and consequently these fields had to be removed from analysis (see section 2.1.3.2). For example, many care leavers had more than one leaver activity reported, however it was not apparent which activity was the most recent activity, so we were unable to include this field in our analyses.

Where possible, the 'in care data extract' was supplemented with data from the individual's latest HA (see section 2.1.3.1). There were however issues with this data due to the nature in which HAs are stored (collected on paper based forms and scanned onto the shared drive; see section 8.3) as HA records were not available for all LACYP who were in the care of BwD, and some HAs were only partially completed or scanned. Consequently the sample size for these questions was low. Other information on the health needs of LACYP was recorded within the HAs however this was qualitatively recorded and therefore unsuitable for analysis.

There are a number of other data sources that would potentially enable further examination of the health and wellbeing needs of LACYP, that we were not able to access to for this project. For future such consider if and how such data could be accessed. Such data sources could include:

- Care quality commissioning/Ofsted inspection reports;
- Education records, including: educational attainment and episodes of absence from school;
- Education/employment status of those aged 16-18;
- Pathway plans (completed when a young person is due to leave care or when they turn 16).
- Health data sources such as school nurse records or accident and emergency department attendance data.

## 9. RECOMMENDATIONS

### 9.1. STRATEGIC RECOMMENDATIONS

#### 1. Continuity of support

Many of the LACYP, carers and professionals described concerns regarding the high turnover of social workers, and the impact this may have on health and wellbeing. Whilst it may not be feasible to consider increasing capacity within this area, it is important that all social workers and wider stakeholders are aware of this, and effort is made to develop and sustain strong trusting relationships with LACYP. Although turnover is in line with national averages, regular changes in social workers was reported as having a negative impact on the wellbeing of many LACYP. This is important to ensure that LACYP feel able to share their thoughts, behaviours and questions regarding health-related issues. A lack of trust in their social workers causes LACYP to be reluctant to talk to their social worker, seek support and help or discuss their health. Information regarding 'life stories' of LACYP would be useful for social workers, in ensuring they have full information about the history and challenges a young person has faced before the social worker meets with them.

#### 2. Ensure a coordinated approach to services

Stakeholders felt that access to CAMHS could be disjointed and that a more coordinated approach between services could be developed. Foster carers suggested communication within the MTFC was good, and that learning could be taken from this approach and embedded into mainstream fostering. Although MTFC was regarded very positively, all stakeholders and carers felt it was important to address the emotional needs of LACYP before they reach crisis, to prevent them from needing intensive support within a programme such as MTFC.

Issues were raised regarding CAMHS not being available for young people who were not in settled placements; although this is when they may be most in need of support. All partners need to be aware of the criteria so young people are not inappropriately referred to services. Although services such as SCAYT are available, they work with families rather than individuals, suggesting a possible gap in provision.

#### 3. Health Assessments

Although HAs are regularly conducted, the data available here do not currently provide a robust and comprehensive assessment of health need. Review ways to encourage consistent full completion of the HA forms; if sections are blank ensure reasons for this are provided. All forms should be fully scanned and held on Protocol. Explore possibility of entering the data from the HA form onto a database to allow overview of population level health and to understand changes in health/needs for individual LACYP over time.

#### 4. Annual Children in Care Reviews

The LACYP experiences of their annual reviews varied, with some describing how they no longer wish to attend. The annual reviews are a vehicle to capture information regarding health and wellbeing and could be re-shaped to better suit the needs of LACYP. In particular, carers and stakeholders described how the formality of the process was felt to cause stress and upset to young people, and it was suggested that a more informal process may be more suitable. These thoughts were also echoed by care leavers, who felt it was often difficult to talk about their feelings in review meetings. Where possible, consider undertaking the reviews in an informal young person friendly setting rather than in school or Children's Services' offices.

Carers and stakeholders also felt that LACYP may not wish to raise concerns regarding their care or their health and wellbeing at reviews, when the foster carers are present. It is important that LACYP are encouraged to take up the opportunity to share their views privately with their social worker/independent reviewing officer to capture these in advance of the meeting.

#### **5. Data monitoring**

This research has confirmed that processes are in place to monitor and share data (via Protocol and Tribal). These methods could be enhanced by supporting the linkage of data. All data collected on LACYP could use the unique reference number which is allocated and recorded on the Protocol database. Using the LACYP reference number (as used on Protocol) would enable timely sharing of data and ensure data are shared without breaching confidentiality. All services need to ensure that appropriate data sharing agreements are in place to cover any data sharing between services. The use of unique reference numbers such as those used in Protocol would ensure that data sets can be collated so a picture can be built up of the care of LACYP and the health needs of this population.

#### **6. Consider ways to improve knowledge of out of area services**

Stakeholders viewed BwD as having a good level of LACYP service provision when compared to other areas, and that not all areas have the same provision. This difference in availability of services was viewed as a barrier, particularly in terms of providing continuity of care where services do not exist. This finding is particularly pertinent as half of BwD LACYP are placed out of area, however LACYP living out of area themselves did not feel particularly disadvantaged by living out of the borough.

## **9.2. POPULATION SPECIFIC RECOMMENDATIONS**

#### **7. Provide a preventative approach to build resilience and mental wellbeing**

A number of stakeholders and carers acknowledged that LACYP may not recognise when they require emotional support. Carers felt that mental health support was often not available until the young person had reached crisis. Carers felt that, although they were offered training to support the health and wellbeing of LACYP, mental wellbeing and life skills training should be offered to LACYP themselves. Evidence from our findings suggests that LACYP will have varying needs, depending on factors such as their age and length of time in placement.

Arts-based approaches have been shown to help develop resilience in LACYP, and focus on encouraging children to use their imagination as well as identify and explore their thoughts and feelings. Barnardo's recommends that interventions to support resilience should be flexible, so practitioners can work to meet the needs of each child and their family, and developed in collaboration with other professionals such as teachers and psychologists. The report also recommends the importance of ensuring that the outcomes of the intervention are appropriately captured.

#### **8. Practical and emotional support for young people preparing to leave care**

Stakeholders and carers described concerns regarding the current support available for young people preparing to leave care. Carers felt that it would be useful to offer practical training to support young people to live independently and deal with the setbacks that they may face. Support around independent living, life skills and how to access health services may increase resilience and wellbeing. Such support should be considered when LACYP are preparing to leave care, and when they have left care. Training could be made

available to foster carers, as many of the necessary skills can be taught by the foster carers themselves. Such training could also promote the importance of teaching life skills in everyday interactions in the home.

### **9. Peer mentoring for care leavers**

Psychological resilience is an important quality for young people preparing to leave care, which can be increased and strengthened through support and learning important life skills. A lack of such skills and support may lead to fear and ignorance of how to access health services and also how to lead a healthy lifestyle, thus impacting on the health and wellbeing of the young person. As well as support from foster carers, support could be provided by peer mentors or a neutral, non-statutory organisation. This may help to encourage young people who do not engage with existing BwD care leaver services and do not 'trust' social service to access supports. For those still engaged with BwD leaving care services these networks and groups could act as a forum in which such support could be delivered. Peer mentoring could be explored as a way to provide this support, advice and guidance from those who have first-hand experience of care themselves. Existing successful peer mentoring programmes (see section 3.1.1) could be considered as examples of best practice.

### **10. Promote the health impacts of drugs, alcohol, novel psychoactive substances (legal highs) and sexual risk taking to LACYP, carers and professionals**

Few participants involved in this research discussed the impact of drugs, alcohol or sexual risk-taking on the health of LACYP, and was not seen as a priority or issue of concern for many. The detrimental impact of these lifestyle factors on health needs to be promoted to those who care for and support LACYP; including social workers, foster carers and children's home staff. Novel psychoactive substances were raised as a major issue of concern by the LAC nurse, further research into the use and availability of NPS for LACYP in BwD would enable the council to understand the potential impacts of this emerging area of concern.

### **11. Health related behaviour change**

A number of health-related behaviour concerns, such as dental and physical health needs, were raised by carers and wider stakeholders. Carers had concerns regarding the challenges of ensuring that LACYP have a healthy diet, with issues such as takeaways and sugary drinks being described here. Although carers knew what kind of food LACYP should be eating they struggled to change their unhealthy diets. Social workers should avoid taking LACYP to McDonalds and should try to use venues that promote healthier choices. Carers could be provided with examples and training on how to address poor eating habits of LACYP. Although there were no examples of interventions which specifically addressed this issue with LACYP within the rapid evidence review, evidence from wider literature supports the use of family-based and school-based approaches.

### **12. Advocacy**

LACYP mentioned finding it difficult to discuss placement issues at their review, and care leavers mentioned that they found it difficult to have a voice at the review meetings and that they had little trust in the care system. Foster carers and social workers also talked about how young people are sometimes nervous and reluctant to raise concerns in front of carers and parents during their Children in Care annual reviews. BwD commission Child Action North West to provide advocacy services to all children and young people in the borough. BwD should ensure all LACYP, foster carers, children's home staff and social workers are aware of the services available to LACYP, through more active and widespread promotion.

### **13. Having a say about their care**

Generally, LACYP felt they have adequate opportunities to voice their concerns and suggestions about the care they receive; however these views and requests are not always acted upon. LACYP living in the children's home expressed the importance of ensuring that regular house meetings took place. These were viewed as

important in terms of ensuring they had a say in their care and the running of the home. Anonymous collection of views may be considered here, such as using a 'suggestions box' in children's homes.

Professionals and carers should ensure that all LACYP have knowledge regarding their rights and the opportunities available to them. Creating a document which outlines the support that LACYP should expect to receive, and are entitled to, may support this. A number of Foster Carer Charters have been produced to support their role as carers (e.g. nationally, by Department for Education, 2011; and by local authorities e.g. Wiltshire Council, Northamptonshire Council). We would suggest that replicating a Charter and aiming this towards LACYP in BwD would support them to feel empowered about their rights.

#### **14. Feedback about decisions made**

Our findings revealed that LACYP, carers and stakeholders view feedback as very important. All actions taken by carers and professionals as a result of feedback received by LACYP needs to be evidenced and shared with the children and young people. This information could be circulated electronically and via leaflets, in the form of a 'You Said, We Did' type of document. Equally, actions not addressed should be shared with LACYP, along with an explanation of reasons why.

The care leavers and carers in particular felt strongly that they wanted to know what would happen as a result of the research. We would recommend that BwD provide LACYP and foster carers with the findings of this research, along with an implementation plan and regular updates on progress.

#### **15. Ensure that the benefits of Foster Carer Association (FCA) support is promoted to all foster carers**

The FCA and training were viewed as central to the support received by foster carers. Peer support was felt to be very important here. Some of the foster carers felt that there were carers who were not involved in the FCA and did not attend meetings; they felt it was important to raise the fact that this would make it difficult to ensure all foster carers have access to the information and support that is available to them. Good practice and strategies to improve LACYP health and wellbeing are regularly shared between carers who are part of the FCA. We recommend that the benefits of the FCA are appropriately marketed to all foster carers.

## 10. GLOSSARY

ABC	Attachment and Bio-behavioural Catch-up programme
ACC	Assessment Checklist for Children
ASQ	Ages and Stages Questionnaire
BAAF	British Association of Adoption and Fostering
BME	Black and minority ethnic
BwD	Blackburn with Darwen
CAMHS	Child and adolescent mental health service
CBCL	Child Behaviour Checklist
CBT	Cognitive Behavioural Therapy
CELCIS	Centre for Excellence for Looked after Children in Scotland
CHIP-AE	Child Health and Illness Profile-Adolescent Edition
CPH	Centre for Public Health, Liverpool John Moores University
CSE	Child sexual exploitation
ELCAS	East Lancashire Community Adolescent Services
DBT	Dialectic Behaviour Therapy
DCSF	Department for Children, Schools and Families
DH	Department of Health
FACES	Foster Care Alumni Creating Educational Success
FAM III	Family Assessment Measure
FCA	Foster Carer Association
GIS	Geographic Information Systems
HA	Health assessment
HAP	Holistic Arts-based Program
IY	Incredible Years
IRO	Independent reviewing officer
KEEP	Keeping Foster Parents Trained and Supported
KITS	The Kids in Transition to School
LA	Local authority
LAC	Looked after children/child
LACYP	Looked after children and young people
LCFT	Lancashire Care Foundation Trust
LEASE	Locate and Evaluate Affordable, Safe and Effective Housing
MI	Motivational interviewing
MTFC/TFC	Multi-Dimensional Treatment Foster Care/ Treatment Foster Care
NICE	National Institute of Clinical Excellence

NPS	Novel psychoactive substances (also known as 'legal highs')
PCIT	Parent-Child Interaction Therapy
PedsQL	Pediatric Quality of Life Survey
RCT	Randomised control trial
SBIRT	Screening, Brief Intervention and Referral
SCAYT	Supporting young people and children together service
SCIE	Social Care Institute of Excellence
SDQ	Strengths and difficulties questionnaire
SIBS-FC	Supporting Siblings in Foster Care
TF-CBT	Trauma-focused cognitive behavioural therapy
TFC	Treatment foster care
TSS	Transition support services
YJS	Youth Justice Service.

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## 12. APPENDICES

### APPENDIX 1. ORGANISATIONS REPRESENTED AT STATEHOLDER EVENTS

Blackburn with Darwen Clinical Commissioning Group

Brook Blackburn

Child and Adolescent Mental Health Services

Cherry Tree Children's Home, Blackburn with Darwen Borough Council

Child and Families Health Service, Lancashire Care NHS Foundation Trust

Children's Services, Blackburn with Darwen Borough Council

Connexions

Lifeline Project

Public Health, Blackburn with Darwen Council

School Nursing Team, Lancashire Care NHS Foundation Trust

### **BwD: Looked after Children and Young People – Information collection**

Please complete the following questions to the best of your ability, if you are unsure of an answer please specify 'unknown'.

Your organisation:

Your role:

Contact details:

#### **Data access**

1. What data on Looked After Children and Young People (LACYP) do you currently hold/have access to? (i.e. education records, children looked after return) *(please specify all data you have, identifying if you have access to this (A) or hold it (H))*
  - a.
  - b.
  - c.
2. If you previously had access to or held other data please list this and specify when access to this ended.

For **each of the data sources** you identified in question 1, please complete the questions on the following pages (copying the questions for each additional dataset you have listed), identifying which data set your answer applies to:

#### **Data source name:**

3. Who owns the data that you currently hold/have access to?

#### **Data collection**

4. Who collects the data that you currently hold/have access to? (e.g. nurse)
5. Who is the data collected from? (e.g. LACYP, Parent/Carer of LACYP)
6. From which groups is this data collected from? (e.g. all clients, LACYP only, at risk groups)
7. When is the data collected? (e.g. at first point of contact)
8. How is this data collected? (e.g. face to face discussion)
9. What format is the data collected in? (e.g. paper based survey/electronic database)
10. Are there any specific survey or data collection tools used to collect this information? *(If so, for the purpose of this study are you able to share a blank version of this information collection form with us for our records?)*
11. What frequency is the data collected? (e.g. weekly/monthly/quarterly)

## Data sharing

12. Who shares this data with you? *(If you own the data please specify N/A)*
13. Who do you share the data with? *(If you do not share the data please specify N/A)*
14. How is this data shared? (E.g. electronically, password protected format). Please detail if and how this varies by partner/group.
15. What frequency is the data shared? (E.g. weekly/monthly/quarterly). Please detail if and how this varies by partner/group.
16. How is the data housed and stored? (e.g. secure servers in locked rooms with encrypted access only)
17. Do you currently have a data sharing agreement in place for this data? If yes, who is this agreement between? How and when was this data sharing agreement established? Can we view a copy of the data sharing agreement?
18. Do any data protection/confidentiality issues exist when sharing this data? *(If yes, please explain)*
19. Are there any data sharing issues that you are currently aware of? *(If yes, please explain)*
20. Did you previously encounter data sharing issues with this data? If so, what were these? And how were they resolved?
21. Is this data available to anyone else? *(If yes, please identify whom and how)*
22. Is feedback provided to anyone on what the data says or how it is used? *(If yes, how frequently is this provided?)*

## The data

23. Does the data include personal identifiable information?
24. Is there a unique reference number which links this data to other data sources? If so, which data sources are able to be linked?
25. What information is available within this data set? *(If you are able to provide an example of the information collection form/tool, please leave this blank)*
26. Are there any issues regarding data completion? *(If yes, please explain)*
27. Is this data specific to LACYP in BwD? *(If no, please explain)*
28. What is the primary use for this data? (e.g. assess health of LACYP)
29. Are we able to access the data for the purposes of this project? If yes, how?
30. Are there any other data sources which you would like access to? *(If yes, please explain)*

*If there are any further comments you would like to make please do so below. For example, are there any ways the data collection process could be improved, would it be useful to collect more/less data, should the data be shared in a different manner:*

Thank you. We are very grateful for your support with this project.

### APPENDIX 3. DATA FIELDS RECEIVED FROM PROTOCOL

#### LACYP Dataset at 31/12/2014

Unique ID  
Unique pupil number  
Gender  
Ethnicity code  
Ethnicity  
Age of child (years)  
Is the child an Unaccompanied Asylum Seeking Child?  
Does the child have a disability?  
Date the child started to be looked after  
Child's category of need  
Legal status of the child  
Start date of most recent placement  
Placement type  
Placement provider  
Postcode placement provider  
Date of latest health assessment  
Date of latest dental check  
Date of latest Child Looked After (CLA) Review  
Number of previous placements  
Length of previous placement in days  
Postcode of home address  
Strengths and difficulties (SDQ) score  
Number of missing from care episodes

#### Fields added in to the LACYP dataset from the HA

Worries for their own health (including weight issues)  
If the LACYP is eating well (any form of disordered eating was classed as No).  
If the LACYP is sleeping well (any disordered sleeping i.e. nightmares was also categorised as No).  
If the LACYP is attending any of the following health services: Health Visitor/School Nurse, Dentist/orthodontist, Paediatrician, CAMHS, or Other services.  
If the LACYP is beginning to take responsibility for his/her own health needs (any level of responsibility that was indicated was included in the Yes categorisation, including where LACYP ask for support when it is needed)  
Use or exposure to smoking/alcohol or drugs (inclusive of previous/current use)

#### Ceased Looked After Children Dataset (three year period from 01/01/2012 – 31/12/2014)

Case number  
Unique pupil number  
Gender  
Ethnicity code  
Ethnicity  
Age of child (years)  
Immigration status  
Is the child disabled?  
Child's category of need  
Period of care start date  
Period of care end date  
Period of care end reason

Legal status  
Legal status start date  
Placement provider  
Placement start date  
Postcode of last placement  
Leaver main activity

TABLE A1: INFORMATION COLLECTED ON LACYP

Organisation	Data/information on LACYP Hold (H)/Have access to (A)	Who owns the data	Who the data is shared with
Brook (Sexual health service)	Clinical records (H)	Brook	
	Brook counselling records (H)		
	Brook Education and Training Team workbooks (H)	Engage and Children's Services	
	Brook Practitioner based in Engage (A)		
	Brook Vulnerable Young People Sexual Health Worker (based in Children's Social Care) (A)		
BwD Borough Council	SSDA903 (The children looked after return for the Department for Education) via Protocol which includes children looked after data and health data (A)	BwD Borough Council	Department for Education and Senior Leadership Team in BwD
Cherry Tree Children's Home	Health assessments (H)	Children's Home	Social Workers
	Risk assessments including behaviour management plans and handling plans (H)		
	Individual placement plans completed by the young person (H)		

	Pathway plans completed when a young person is due to leave care or when they turn 16 (H)		
	Placement information plans and care plans 1 and 2 when young person admitted into care/foster (H)	Children's home/BwD Borough Council	
	Personal Education Plan (PEP) plans in line with the young person and education. Entered onto protocol (H)		
	Protocol (A)	BwD Borough Council	
BwD Borough Council: Review and Quality Team, Safeguarding Unit	Health Assessments (A)	BwD Borough Council	Health
	Education Reports (A)		
	Legal Reports and Records (A)		
	Looked after Child review records (Protocol)(H)		
	All LACYP records (Protocol) (A)		
BwD Youth Justice Service (YJS)	Youth justice data on individual LAC on our Child View case management system (H)	YJS	
	Education and Social Care records(A)	BwD Borough Council	
	Number of LAC (H)	LCFT	

Designated Nurse for Looked After Children, Lancashire Care NHS Foundation Trust (LCFT)	Number of review health assessments (H)		Child and Family Health Services (LCFT) and BwD Borough Council
	Number of completed health assessment (H)		
Project BME Lancashire LTD	Initial assessments, legal letters and case notes that clients have provided when they need signposting to a service or when they do not understand a child protection proceeding (A)	Client owned	
BwD Children's Services, Principal CAMHS	Protocol (A)	BwD Borough Council	BwD Borough Council and Senior Leadership Team
	ELCAS (H)		
	CIOC CAMHS and SDQ data (H)		
Lifeline East Lancashire	Substance use data (H)	Lifeline	NDTMS
	Child View (A)	YJS	
	Social care systems (Protocol) (A)	BwD Borough Council	
BwD Children's Services: Fostering, Adoption, Residential.	Foster carer records (A)	Children's Services/BwD Borough Council	Those with access to ICS system and at Multi-agency reviews (e.g. Lifeline, Children in Our Care/LAC Nurse)
	Protocol (A)		
	Children's home records (A)		
	Assessments and records of children on the MTFC (Multi-Dimensional Treatment foster Care) Programme (A)		

	Foster carer and adopter assessments (A)		
Lytham Road & Apple Trees Short Break Units	Placement information plans and care plans 1 and 2 (A & H)	Social workers	BwD Borough Council, Social Workers and parents when appropriate
	Short Break Information Plans (A & H)	Social workers/Child Support Officer for Apple Trees Lytham Road owns short break plans that staff complete.	
	Statement of Special Education Needs (A)	Education/schools	
	Assessment and review model for young people who access Lytham Road as a tool to evidence positive outcomes and to produce measurements of how the service has improved their family life (H)	Lytham Road	
	Service Agreements (H)		
	Individual Care Plans for young people accessing Apple Trees for both looked after and CIN cases (H)	Apple Trees	
	Risk Assessments, management plans and handling plans for both services (H)	Lytham Road/Apple Trees	
	Protocol (A)	BwD Borough Council	

	Referrals, allocations and closures for Lytham Road in order to collate information for the annual report (H)	Lytham Road	
	Young person's plans (A & H)	Social workers/Child Support Officer	
	Child Protection Plans (A)	Social workers/Reviewing officers	
	Medical and leisure consents (H)	Lytham Road/Apple Trees	
	Evaluations and feedback (H)	Lytham Road	
	Books that record missing from home, young people meetings and serious incidents (H)	Lytham Road/Apple Trees	
	Accident forms (H)		

