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SCIE/NICE GUIDANCE DEVELOPMENT

**Qualitative research to explore the
priorities and experiences of
practitioners working with Looked
After Children and Young People**

REPORT C1

Prepared for:

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A. EXECUTIVE SUMMARY

The general picture

1. Services for LAC fall into five main fields: physical health, mental health, education, foster and residential care, and social care. The needs of LAC in these fields are met primarily by specialist agencies and individuals, and require specific interventions. Almost all respondents agreed that the ultimate aim of these services should be to provide as normal and stable a life as possible, while addressing the specific issues that they face. These issues may vary according to LAC's experiences and situations, but they were all said to have an impact on LAC's health and well-being.
2. Respondents' conceptions of a 'healthy' LAC were therefore much wider than good physical health alone; they stressed that LAC's needs overlap, and that what is done in one field can impact on their requirements in another. As a result, most believed in the importance of a holistic approach to service provision which cuts across these fields and which is implemented with a reasonable degree of consistency across the country as a whole, since many LAC are placed out-of-area. Such integration was also thought to be beneficial for agencies themselves, as it allows them to improve their performance.
3. Services for LAC have developed against a background of government initiatives and frameworks, which seem to have driven services in the same general direction but to have allowed, and even necessitated, a large degree of local variation. The realisation that LAC have specific needs which require specific services seems that have been relatively recent, as does the need for holistic services. There was said to have been a move, driven by government policy and local needs, towards multi-agency working and greater funding, and services were generally thought to have improved (often significantly) over recent years. But it was also clear that, due to a large range of factors, progress in this direction has been variable across different local authorities, and that communication and cooperation between agencies and between local authorities is more effective in some areas than others.
4. Perhaps related to this is the fact that most respondents felt they had little access to forums or channels for sharing best practice across England – they had local networks and contacts, but little on a national

scale apart from government frameworks. As a corollary to this, however, many felt that they had scope to innovate and try new approaches, and felt supported in doing so. This, in combination with local networks, meant that few seemed to feel isolated from advice or guidance.

5. Respondents had individual views on which types of LAC should be treated as priorities for services. The most frequently mentioned were: unaccompanied asylum seekers (particularly in larger metropolitan boroughs); LAC who have been placed out-of-area; babies and pre-school LAC; older (teenaged) LAC; LAC in residential care (who are likely to be teenagers anyway); LAC who are about to leave care.

6. **Physical health:** LAC receive an initial health assessment when taken into care, then routine checks every 6 or 12 months. The initial assessment is generally carried out by a specialist; it is designed to ascertain the state of an LAC's health and to inform a health plan. Routine checks are carried out with reference to this health plan by a range of medical personnel. Health promotion sessions are also available to LAC – apparently primarily those in residential care. Beyond initial health issues caused by neglect and abuse, most respondents in this field agreed that there is no reason why LAC *per se* should face on-going health problems once in care. This was confirmed to some extent by respondents in other fields who felt that good physical health is important, but largely taken for granted or at least less significant than other issues. The basic framework for health assessments and promotion was thought effective in theory, but in practice to be hampered by poor communication between agencies and a lack of continuity across different areas: records might be difficult to locate or completed improperly; consent for interventions might be difficult to acquire; out-of-area assessments might be given low priority.

7. **Mental health:** respondents across the sample felt that mental health problems are some of the most significant issues faced by LACs, yet the services which aim to address these often seemed less well defined, funded and developed than those for physical health. Comments from respondents in other fields also suggested that Child and Adolescent Mental Health Services (CAMHS) are not well understood by many, and not therefore well integrated into the 'family' of LAC services. The provision of CAMHS appeared to vary across the local authorities

visited: the 'most developed' were consistently staffed and well organised, had established clear referral pathways from practitioners in other fields and were able to commit resources to training for these professionals, and convened regular cross-agency meetings to discuss the mental health of individual LAC; others were less structured, had less developed relationships with other agencies, and might have to deliver services for other vulnerable young people as well. The former type of CAMHS seemed more able to address LAC's mental health issues quickly and effectively than the latter, who often got to the problem late and had to spend more time 'fire fighting'. That said, the varying and complex nature of LAC's problems means that there is little scope for a rigid framework within which to operate – interventions have to be tailored to individuals, and conditions often involve numerous overlapping issues. Early identification of these conditions was said to be key if they are to be treated effectively.

8. **Education:** the specific educational needs of LAC were thought to be recognised by most local authorities, but the importance of stability and achievement in education to an LAC's health and well-being seems to have been recent, and therefore varied across local authorities. Interventions from Looked After Children Education Services (LACES) aim to help LAC achieve some stability through school attendance, to overcome the educational disadvantages caused by their backgrounds, and to reduce or at least manage exclusion rates in schools. The way in which they were able to do this seemed to depend on the influence they could wield over schools and other aspects of LAC's care. The 'most advanced' LACES were able to ensure that mainstream schools understand the needs of LAC, and provide for these themselves, and to influence the decisions of other agencies. Others had less influence over decisions made by social workers to move an LAC out-of-area, for example, and seemed to rely more on direct interventions in schools. The reason for this variation was apparently partly due to funding, but perhaps more fundamentally due to the extent to which the local authority and practitioners in other fields recognised that stability and achievement in education impacts on an LAC's mental and emotional health.

9. **Social care:** Social workers are both central and peripheral to the health and well-being of LAC – they are responsible for ensuring that LAC benefit from the services offered by other agencies, but they do not appear offer many specific interventions themselves (beyond continuity of contact for the LAC on their books). All respondents acknowledged the importance of social workers to LAC's lives – at best they are key to ensuring a holistic approach to services; at worst they are a significant barrier to this. Those in other fields tended to regard social workers with a mixture of admiration for the work that they do and frustration at the frequency with which they change and move on.
10. **Foster and residential care:** The ideal form of care, for most respondents, is long-term foster care, especially for younger LAC. Long-term carers have responsibility for the 'parental' aspects of an LAC's care; most make significant emotional investments in their LAC, and often take on some of the official duties of social workers. Where long-term care is not immediately available, short-term or emergency foster care is generally the interim option. Residential care is reserved for those LAC who do not settle in foster care at all – they tend to be older (teenaged) and to show more challenging behaviours. Carers and homes are run either by the local authority or an independent organisation – the latter were said to be more expensive and reserved for the most difficult cases. Most carers felt that, besides a stable home, the main contribution that they could make to an LAC's health and well-being is to keep a constant eye out for problems and to deal with or know what to do about these when they arise. Many felt that, especially in the case of mental health, the accessibility and outreach of other agencies did not allow them to do this as they would have liked.
11. **Conclusions:** Three overarching themes emerge from this research: the need to provide as normal and stable an environment for LAC as possible; the need for communication and cooperation between agencies, and a degree of consistency in service provision between local authorities; and the need to recognise the degree to which the fields of mental health and education in particular have an impact on LAC's health and well-being, but are not always as integrated and effective as they might be. These and the other points made above are discussed in much greater detail below.

B. INTRODUCTION

1. **Research background**

The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) have been asked by the Department of Health (DH) to develop joint guidance on improving the physical and emotional health and wellbeing outcomes for looked after children and young people.

The guidance will be produced by early 2010; at this stage, initial research was commissioned to explore current thinking and practice in this area with a view to informing the guidance development process.

2. **Objectives**

The overall aim of this research was to inform the scope for LAC guidance by asking those working in the field, managers and policy makers what outcomes are valued, what difficulties, issues and barriers exist in achieving these outcomes, what characterises effective practice, and what practice hinders effective intervention.

More specifically, the research aimed to...

- explore practitioner views on the priorities for improving the health and wellbeing of LAC
- gather views on current practice, including approaches and interventions, targets and effective practice
- determine experiences and views on the acceptability, accessibility and effectiveness of current practice, including examples of 'good practice'
- identify current sources of information, evidence and good practice used in the field
- identify barriers and opportunities to effective practice and practice development
- inform the scope of the project, as supplement to the public consultation (25th June to 23rd July), in order to finalise the scope document by end of September 2008

- to explore practitioner views about the potential guidance, including priorities, potential usefulness and authority

3. **Method**

Respondents for this research were interviewed individually and in small groups, as described below. These interviews and groups followed a semi-structured, according to the topic guide appended to this report. Once the sample and locations had been finalised, the CRD research team identified appropriate practitioners and made contact to ask whether or not they would be interested in participating. Interviews typically lasted for between 45 and 60 minutes; the groups lasted for between 75 and 90 minutes. Fieldwork was conducted between 11 August and 26 September 2008.

The interviews and groups were audio-recorded and transcribed for qualitative content analysis. Content analysis involves careful reading of transcripts, discussion of findings between interviewers, identification of themes and cross-cutting issues, comparison of views within and across sample sectors, and the ordering and segmentation of findings according to an appropriate thematic structure. All interviewers were involved in initial discussions to sketch out the relevant themes; the detailed analysis was conducted by the project leader and author of this report.

4. **Sample**

- **local authority care providers:** 3 groups, each one involving between 4 and 6 respondents:
 - foster carers (2 in Groups 1 and 3; 1 in Group 2)
 - manager of fostering service (1 in all groups)
 - residential childcare workers (1 in Group 1; 2 in Groups 2 and 3)
 - line manager in a residential home (0 in Group 1; 1 in Groups 2 and 3)

- **independent-sector care providers:** 2 groups, each one involving between 5 and 6 respondents:
 - foster carers (2 in each group)
 - manager of a private fostering service (1 in each group)
 - residential childcare workers (1 in Group 4; 2 in Group 5)
 - line manager in a residential home (1 in each group)

- **children's service providers:** 18 interviews, as follows...
 - 1 GP with experience of LAC
 - 1 practice nurse with experience of LAC
 - 2 designated doctors
 - 2 designated nurses
 - 1 designated nurse (former health visitor)
 - 2 child and adolescent mental health service (CAMHS) professionals with responsibility for training other health, social service and education professionals
 - 2 social workers with responsibility for children and families
 - 2 senior local authority social care managers
 - 3 teachers and managers in Looked After Children Education Services (LACES)
 - 1 designated primary school teacher
 - 1 manager in a Sure Start nursery

- **organisations representing LAC:** respondents in policy and senior managerial positions, as follows...
 - National Voice
 - Who Cares Trust
 - Voice

Fieldwork was spread across England, taking into account variations in location type, LAC population and whether or not the local authority is a Children's Trust pathfinder. The following locations were visited...

- Brent (north London)
- Hertfordshire
- Birmingham
- Leicester
- Manchester/Oldham
- Newcastle/Gateshead

5. **Structure of this report**

This report begins by presenting an overview of our understanding of the services provided for LAC (divided into five broad 'sectors'), and respondents' priorities and views on the need for cohesion in these services, their opportunities for sharing of best practice, the groups of LAC who should be considered priority cases for services, and the impact of guidance from SCIE and NICE.

Each service 'sector' is then discussed in detail, with consideration given to the interventions and service models provided, the need for those interventions, the views of respondents in other sectors, and an assessment of the effectiveness of the services provided.

Finally, the concluding section attempts to draw these findings together, and to highlight interventions and measures which respondents in each sector believed would benefit the health and well being of LAC.

C. MAIN FINDINGS

These findings are based on an analysis of numerous interviews and group discussions with a wide variety of respondents. The quotations from individual respondents included in this report are intended to illustrate the points made in the text; they are not presented as evidence for these points.

1. **The general picture**

1.1 Services for LAC

In basic terms, the services intended to promote and secure the health and well-being of looked after children (LAC) were similar in all the areas visited during this research. These services fall into five main fields: physical health, mental health, education, foster or residential care, and social care. The specific needs of LAC in these five fields are met primarily by specialist agencies and individuals, respectively: designated GPs, nurses and health visitors for child protection, and paediatricians; LAC child and adolescent mental health services (CAMHS); LAC education services (LACES) or similar agencies with different names (such as EDLAC – Education Team for Looked After Children); local authority or independent foster carers and residential children’s homes; and social workers¹. In addition, practitioners such as GPs, teachers and youth workers provide LAC with services that are available to all young people.

There is clearly a high degree of interaction between these fields, and most respondents worked with colleagues from some or all of the other agencies in their local authority as a matter of course. For the most part, however, respondents’ comment in this research on the health and well-being of LAC, and the measures taken to promote this, was restricted to the fields that they worked in. There was some acknowledgement of the role and importance of other fields, and a number of respondents had opinions about how other agencies operate, but these were typically general in scope and low on detail.

The views and priorities of respondents with regard to each of these five fields are discussed individually below, as are specific interventions

¹ Throughout this report, the teams delivering services in individual local authorities are referred to as ‘agencies’, to avoid confusion with the service provided to LAC; this term does not denote subcontracting of services to the private or third sector.

that were mentioned. These sections focus on comment from those working in the field, but they include feedback from others where this arose (and indeed highlight a lack of feedback if this seems relevant). But respondents generally agreed that the extent to which agencies act together to provide a holistic, seamless service which cuts across these fields, and the extent to which services are implemented consistently across the country as a whole, has a significant impact on the effectiveness of the individual agencies and the experience of LAC themselves. It is therefore important to describe in general terms at the outset the way in which agencies tend to have developed over recent years, and how they currently interact with one another to meet the needs of LAC.

1.2 Respondents' view of the ideal service model

Almost all respondents agreed that the ultimate aim of the combined services for LAC should be to provide as normal and stable a life for them as possible, while at the same time addressing the specific issues that they face. The cause of these issues might be attachment problems, traumatic experiences, emotional and physical insecurity, physical harm and neglect, disrupted education or other experiences – they were said to vary greatly according to LAC's age and experience. But it was clear from respondents' reports that the effects of such issues often impact on a number of areas of their lives, including their physical and mental health, their attitudes to and attainment in education, and their ability or desire to live as part of a family.

"Stability – stability of placement, stability of social worker, stability of education, stability of healthcare provision, it's that which the children would get within their own families. You're not moving around left, right and centre, you know where you're going to be from one week to the next and so on. I think that's a challenge for us really with children in care."

Depth 4: social care manager, London

Most respondents recognised that all these factors (not just healthcare, for example) have an influence over an LAC's health and well-being: for instance, under-achievement and a lack of continuity in education was seen by many as being as damaging to an LAC's self-esteem and general feelings of security as placement with an unsuitable foster carer or care home, and inaction or the wrong action on both these points were said to have the potential for detrimental effects on his or

her physical or mental health (see below for further discussion of these points). In addition, some felt it is important that LAC feel they are involved in decisions made about their care, and that they have some influence over these, again as a way of increasing their self-esteem.

"It's important for their self-esteem, their confidence, that every aspect is regularly discussed with the child. We try to normalise as much as possible. Foster carers are trying as well."

Depth 9: social worker, Birmingham

"Sometimes we don't appreciate the child has a fair idea of what is best for them."

Group 3: independent sector carers, Birmingham

Respondents' conception of a 'healthy' LAC was therefore much wider than good physical health alone. Despite the fact that services are provided by individual agencies, they felt that the ideal service model should address an LAC's overall needs, rather than looking at physical health, mental health, education, home life and social care in silos, or, even worse, reducing the priority given to one or more of these fields.

"I am really pleased that people have started to realise you need a joined-up service for young people, same with elderly and disabled people, too. If you want a young person to thrive as well as being placed in social care, they do need all the professionals to link up together. That is a massive job... What we've been doing traditionally in this country is setting up some services and slotting the child into the services. It doesn't work."

Depth 1: representative organisation

In addition to this holistic approach to service provision within a local authority, most respondents felt that the way in which services are implemented should ideally be broadly consistent across the country as a whole. Many LAC are given out-of-area placements, for a variety of reasons, and many are moved from area to area, often fairly frequently. In the interests of giving them as much stability and continuity as possible under these circumstances, respondents felt that the protocols they encountered in a new area should be familiar rather than alien. On the other hand, they were keen to stress that local authorities differ in the LAC populations for which they have responsibility and the specific pressures and difficulties they face, so there is a need for flexibility in this.

Integration of services and continuity across the country were also thought to have significant benefits for the performance of the agencies

themselves. Most agencies are measured against targets or performance indicators of some kind (see individual sections below); the fact that LAC' needs spread across services, and that agencies in one local authority need to liaise with, and commission services from, those in another in which an out-of-area LAC has been placed, mean that individual agencies cannot act in isolation to meet these targets, or indeed to provide a good service for the LAC in their charge.

Communication and cooperation between agencies at strategic and individual levels, a recognition that LAC' needs are holistic rather than divided into silos, and the ability to relate directly to and work effectively with agencies in other parts of the country were therefore thought key to the successful provision of services to LAC by respondents working in all fields – in addition to the implementation of effective interventions by individual agencies. For many respondents, this idea of cooperation was summed up by the concept of corporate parenting, which refers to the duty of practitioners in all fields to assume responsibility for the care of an LAC rather than shifting the onus to others, and therefore for the local authority as a whole to assume the role of 'corporate parent'. More practically, perhaps, it is enshrined in the statutory LAC assessment, which involves a six-monthly review meeting to discuss the needs of an individual LAC, chaired by an independent reviewing officer and attended by all the practitioners involved.

“Corporate parenting is crucial to what we do. It is the duty of anybody working in the council to take a responsibility for the kids that belong to that council... Everybody who works with these young people has to feel that you are their parent, you are acting as a corporate parent. So that is what corporate parenting is about.”

Depth 5: LACES manager, Birmingham

1.3 The situation in practice

Services for LAC have developed, and are developing, against a background of government initiatives and frameworks, including *Quality Protects* (DfES), *Every Child Matters* (cross-government), *Care Matters* (DCSF) and *Promoting the Health of Looked After Children* (DH). All of these were mentioned by respondents across the sample as being important drivers behind aspects of their practice and aims (although many respondents did not talk about them very much). Yet, from respondents' reports, it seemed that many of these frameworks were

rather loosely defined and focused on outcomes rather than processes, and that the way in which they were implemented depended on local circumstances – for example, the numbers of LAC, staffing levels, local authority priorities and the drive and commitment of individual practitioners.

As a result, the general impression gained in this research was that services have developed organically, over time and in reaction to local needs (albeit within the statutory and country-wide targets set by these frameworks and the positions to which they encourage practitioners to aspire), and that this development has been led by dedicated individuals and small groups of people rather than any detailed and coordinated 'national plan'.

The realisation that LAC have needs that set them apart from other children and young people, and that these needs require dedicated services, appears to have been relatively recent; the idea (promoted by government policy but also practitioners' own views about what works) that agencies need to work together to provide a holistic service seems more recent still. Historically, agencies providing services for LAC have typically been attached to their local authority's 'parent' departments (health, education, social care etc), reinforcing a tendency to think and work in silos, and to regard the needs of LAC as related to those of other young people. Indeed, this is apparently still partly the case in many local authorities which do not have dedicated LAC CAMHS units, for example.

"I think what I've been able to achieve is actually embedding expectations within the organisation as a whole about services for looked after children that they are a unique group, they do have special needs and who need to be provided for in a way that is different to other children."

Depth 4: social care manager, London

Government priorities, policy and targets, and the reorganisation of services under the banner of Children's Services, have clearly forced LAC' needs up the agenda over the past five years or so, and the design of services, the resources available and communication between them were all thought to have improved over this time. There seems to be a general trend towards a multi-agency approach which promotes communication between services, and the most 'advanced' local authorities were said to be pushing for co-location of agencies to take this integration even further. Many respondents also said that there is

more money available to fund interventions, and for specific posts which coordinate services as well as those which deliver interventions.

“We have got a good record of partnership working and multi- agency working, what I think we haven’t done is moved as far as other authorities, smaller authorities, in co-locating, integrated working, so you know if you go to somewhere like Telford who are a sort of beacon council for the work that they are doing, they have got really truly integrated teams in the same place across their county. We are still a little bit working sideways... but we are moving in the right direction.”

Depth 5: LACES manager, Birmingham

“We’re going to have a looked after children service which will be teams of people that will specifically be dealing with children in care and care users, and it will be a through service, a seamless service working on the principle of one allocation.”

Depth 4: social care manager, London

But it was also clear that services have been developing for longer and more rapidly in some local authorities than in others, and that some local authorities fund their agencies more generously, and have a greater appreciation of the need to promote effective communication between them, than others. There are numerous reasons for this variation, not least differences in local LAC populations, the attitudes and priorities of elected members, and the dedication and persistence of individuals within agencies who have driven change forward. But the upshot of it is that communication and cooperation between agencies is not always as close as respondents felt it should be, and services provided in different local authorities operate in different ways. Statutory reviews for LAC do apparently take place with a fair degree of regularity, but even here some practitioners were said to be less likely to attend consistently than others.

“Effectively there isn’t one care system in England, there are 150, and everyone needs to bear that in mind when they are trying to make changes. Quite frankly, even central government when they do want to change something – and they do have the jurisdiction to alter 150 authorities – that still is a very haphazard thing. Anyone who comes up with a great idea or wants to implement something good, just communicating out to those 150 authorities is a huge task.”

Depth 1: representative organisation

In the same light, corporate parenting was widely thought to have receded as a priority for local authorities, especially among personnel who do not work directly with LACs but nonetheless have an influence on the services they receive. The idea created a stir when it was

introduced a few years ago, but the impetus behind it (both as a buzzword and as an ideal) was often thought to have died away recently. It seemed from respondents' reports that the effects of this have been felt 'behind the scenes', rather than impacting on individual services, but it was thought significant nonetheless.

"I think we have lost our way [with corporate parenting] a little bit but we need to just tweak that. I think we can probably do more in terms of employment, education and training."

Depth 5: LACES manager, Birmingham

Given what has been said above about the importance of communication and consistency, many respondents felt that, in addition to sharing best practice and advice on which interventions are effective, addressing this variation would significantly improve LAC' experience of services and agencies ability to perform as they would wish.

1.4 Sharing best practice

The organic development and variation described above is likely to be related to the fact that most of these respondents said they had little access to or awareness of forums or channels for finding or disseminating best practice across England as a whole. Indeed, the only national protocols or frameworks which were well known and used are those set out in *Care Matters* and other government documents. A few knew of and consulted publications from the British Association for Adoption and Fostering (BAAF), and others were aware of these and mentioned them in passing but did not seem to have used them. Many did not mention these publications, or any other non-governmental sources, at all.

"Implementation of the Care Matters White Paper': in here there are masses and masses of things which we should be doing. It's not just education, there is a whole section on health I think. Yes corporate parenting, family and parenting support. This is really the Bible, this is going to be directing our work, there is a section on care placements, there is a section on everything really."

Depth 5: LACES manager, Birmingham

"There are all sorts of things that have been produced over the years, different documents, Care Matters etc, but most of that is very general, it is applied to looked after children but still very general. We need to ensure that mental health is better."

Depth 15: physical health practitioner, Manchester

On a regional level, various networks have developed to allow practitioners and managers to ask for and give advice, and some local authorities seemed to be very active in this sense. But on the whole, best practice, and indeed the arrangement and provision of services in general, seems to have been developed with the local situation in mind, and on the initiative of individual practitioners and managers.

"We share expertise and strategies, because I think sometimes you get lost in your way of working and you don't tend to think outside the box, but seeing how other people do things and sharing that expertise is really useful for us."

Depth 9: LACES manager, London

"Good practice for looked after children, we share information at lots of conferences we go to. I speak at conferences about things that we are doing in here, I speak to other services and things."

Depth 5: LACES manager, Birmingham

"I think probably across the UK you could find hundreds of examples of good practice; it's whether there's a way of stoking those and pulling those together."

Depth 4: social care manager, London

Solid evidence for best practice was often thought to be lacking as well. This is largely due to the individual nature of the care required by LAC – their experiences, situations and needs differ greatly, as do the types of intervention they are prepared to accept – and the varying situations faced by different local authorities. But it was also due to the difficulty of measuring the effectiveness of interventions against targets which were often thought inappropriate and among cohorts of LAC which change from year to year (all this is discussed further below).

"The evidence base is quite difficult, how do you prove that something is useful? What can you actually measure that is a useful outcome measure? I suppose you could measure things like self-harming, but there are so many factors that feed into that, it would be difficult."

Depth 15: physical health practitioner, Manchester

As a corollary to this lack of systemic advice, however, most respondents in all fields felt that they have scope to innovate and try new approaches – at least in recent years, since funding has increased. Many talked of new interventions they had developed, piloted or introduced and their plans to extend these, of new posts that had recently been created, and of other ideas that had not been taken forward but had at least been considered. In some cases, these

practices have been adopted by other local authorities, but on an ad hoc basis rather than systematically.

On the whole, respondents felt held back by limited funding rather than rigid working patterns, and were optimistic that services would continue to develop and improve. Few seemed to feel isolated from advice or guidance because they were able to innovate and develop their own ideas, and to share these ideas with their colleagues in nearby local authorities if required. This is not to say that guidance would not be welcomed, however – see below.

1.5 Priority groups

There was of course some variation in respondents' views on the types of LAC which caused them most concern, and/or who are least well served by services. However, some groups were mentioned frequently by respondents from across the sample.

In the larger metropolitan boroughs, unaccompanied asylum seekers were said to be a new and increasingly numerous phenomenon, particularly by those working in physical and mental health. The needs of these people are complex and often grave: they have often experienced great trauma (that is why they have come to the UK); they have few records or details of their medical or education history; they may speak little or no English; they may have medical conditions which are unusual in the UK; their age may be uncertain (some apparently claim to be younger than they are in order to qualify for care); and there are various cultural issues to take into account. All respondents who mentioned unaccompanied asylum seekers said that this is a small but growing group, and some felt that the current procedures for LAC are inadequate in these cases.

"I think that we need to have a totally different system for the unaccompanied asylum seekers. I don't think slotting them into our current way is working. They have no records, they have different needs, there's a big thing about age assessment... I think they need a bespoke service, I think they need a one-stop shop where they have an identified clinic that we run for them, so that if they've not had their immunisations we do it there and then so they go out with as much sorted as possible.

Depth 14: physical health practitioner, Birmingham

A second priority group is out-of-area LAC, whose care is split between local authorities and who have been displaced, often by great

distances; respondents in all fields mentioned these. An out-of-area placement might be arranged for any number of reasons, for example special needs which can only be met in certain locations, a need to move the young person for his or her safety or the safety of others, or particularly suitable foster carers who live elsewhere. This situation presents practical challenges – in particular the transfer of information and continuity of service – and often has an emotional impact on the LAC which needs to be addressed.

Babies and pre-school children are another group whom some from across the sample thought should be given special attention, for two reasons. First, they do not have the same ‘history’ as older LAC, so it is important to give them stable placements as soon as possible to reduce the possibility that they will develop one. Second, they are more likely to form emotional attachments to short-term carers, increasing the wrench that they experience when they are moved to long-term care and making it more important to find them a stable placement to begin with. Both these measures were suggested with the idea that they would help prevent young LAC from needing other services when they became older.

“Stability of placement and trying to address issues of attachment, they’re going to be priorities [for young children] because they’re not coming in damaged in the same way. If you look at the older children, they’re coming in having lived in very damaging environments, whereas some of these babies that come in they haven’t lived in damaging environment at all and what we do for those is we keep them hanging around, so they’re forming attachments to foster carers and then having to move and I’m not sure that’s very good. There’s a different set of issues around the babies and those that go into care very young... I think most of the guidance that seems to come out about looked after children is really geared to those over five.”

Depth 14: physical health practitioner, Birmingham

Conversely, also from across the sample, older (generally teenaged) LAC were felt to be a priority group because they tend to be more resistant to interventions generally, and are less likely than younger LAC to want to fit into a ‘normal’ social structure. The fact that they have established patterns of living which often exclude education, healthcare and stability mean that it is more difficult to provide these for them.

Older LAC are also more likely to be in residential care than younger LAC, and this was another priority group for many – especially social workers, educationists and those from residential and foster care. This is partly because of the types of LAC who tend to be in residential care (generally those who have for some reason not taken to stable foster care, and have been moved around a lot), but also because the fact of being in a care home makes LAC more vulnerable to disruptive influences from others and tends to reduce their educational prospects (see below).

“The children who are in residential care tend to be teenagers who have been in foster care and the placements had broken down. They are the sharp end, they would be the ones that are probably the most vulnerable, and I would say that their needs are the greatest really because they probably are not able to live in foster care placements or they would need very specialised foster care in order to deal with some of their issues.”

Depth 5: LACES manager, Birmingham

Finally, although not strictly part of the audience for this research, LAC leaving care were frequently mentioned as a group which needs more support and attention. Respondents in all fields felt that LAC who have to leave local-authority sponsored care at 16-18, and are expected to manage on their own (albeit in supported housing with small maintenance allowances), are inadequately prepared for the transition and are more likely to encounter problems (crime, drugs, mental health problems, unemployment etc) than other young people who have more support.

“Our big gap is when they get to the end of Year 11 and they have finished from school. We don’t have any resources at the moment to deal with them when they go to college. We get them through their GCSEs and then they fall down a big black hole. We are asking for extra support, but at the moment this is something we absolutely hate: these children are encouraged to go into leaving care halfway through their GCSEs, they get a different social worker whose focus is on getting decent jobs not education, and then halfway through that, by the time they are 17, they are put in to semi-independent accommodation, which is very, very hard.”

Depth 9: LACES manager, London

“If we’re going to have this bespoke service with all these standards, then there needs to be something afterwards that continues and hand-holds them through the next stage.”

Depth 14: physical health practitioner, Birmingham

1.6 Support for guidance

Against this backdrop, there was a fair degree of enthusiasm for overarching guidance regarding the health and well-being of LAC. The trend towards integrated service provision has not been matched by guidance (statutory or voluntary) which draws together the various services, and although most respondents were keen to stress that what works in one area may not work in another, and that they could 'manage on their own', they were interested to see what SCIE and NICE would produce and could imagine how it might be useful.

"You don't just need the agencies to work together and plan, you need care pathways. That is probably the best that will come out of this review, to get people to think, establish care pathways. Having a care pathway in a service that is small is better than leaving it to chance."

Depth 12: CAMHS practitioner, Leicester

"I think if NICE comes out and says 'We have done the assessment and this is what we are recommending that will improve the general public health agenda for looked after children', people are likely to look at it. If they then say 'this seems quite manageable', I think they will do it."

Depth 15: physical health practitioner, Manchester

There were some caveats to this enthusiasm, however. The most common relates to the point made above: to be useful, the guidance will need to be flexible enough that it can be adapted to local situations. Equally, any best practice that is suggested will need to be feasible within the resources available – and funding for services is greater in some local authorities than others. Indeed, the wish of many respondents was for more money to implement services that they thought would work, rather than more advice on how to spend the money they had.

"It would be good to have a more national system as long as there is some flexibility within it to adapt to local conditions."

Depth 14: physical health practitioner, Birmingham

"NICE guidance that we've had on the whole has been useful. One of the difficulties has always been the funding for implementation."

Depth 14: physical health practitioner, Birmingham

2. **Physical health**

2.1 Service provision

The requirements of LAC in terms of their physical health, and the procedures in place for meeting these, seemed largely straightforward and consistent across the areas visited for the research. These procedures fall into three categories: first, addressing issues which have arisen during the period before a child is taken into care; second, ensuring that a child's ongoing health needs are met; and third, providing the type of health promotion and education that other children would receive at home.

On being taken into care, children and young people are registered with a local GP, and will see this GP for the same reasons as any other person. They will also have the same access to school nurses and other points of contact with the health services as other young people. In addition to this, LAC are given an initial health assessment on being taken into care, and subsequently routine assessments every six months for those under five or every year for those over five. This programme is statutory, following on from DH's 2002 *Promoting the Health of Looked After Children*; in most of the areas visited between 80 and 90% of health assessments were being carried out at the correct times, and physical health practitioners all felt these levels had improved in recent years.

The initial assessment is usually carried out by a specialist such as a paediatrician or designated doctor; its purpose is to ascertain the state of the child's basic health and development, and to check that he or she is up to date with immunisations. At this stage, a health plan is drawn up which sets out what should be done over the next year or so. Routine checks are then carried out with reference to this health plan by a variety of personnel, including practice nurses, school nurses and the GP with whom the LAC is registered, or specialists such as designated nurses or doctors. The aim was said to be to normalise these assessments as much as possible (for example by having them done by the school nurse) while ensuring that the appropriate care is given. In this way, LAC (theoretically at least) receive more routine and targeted healthcare than other young people, the point being to ensure that health problems are identified and do not go unreported.

"I think they value not being distinguished from other children. So they would like health intervention that somehow doesn't look different. Quite often they do miss out on very basic things – sex education, how your body works, periods etc – because they are in and out of school a lot or moving schools. Some of them would like a way back into that that was more individualised for them."

Depth 15: physical health practitioner, Manchester

Health promotion, in addition to what is encountered at school in PSHE and similar lessons, is the third aspect of the healthcare available to LAC; this was seen by physical health practitioners as most relevant to those in residential care, as there is an assumption that foster carers will provide some or all of it themselves. It is difficult to be sure from this research how widely such promotion is offered, but health professionals (apparently typically designated nurses) in at least some of the fieldwork areas were visiting residential homes and talking to LAC about smoking, nutrition, sexual health, pregnancy and other health education issues. These sessions vary in their structure, but tend to be group-based; they seem to be the only aspect of dedicated healthcare for LAC which involves group interventions.

"Anything they want to do, we do, like stop smoking we can get them patches if they want it. We talk about sexual transmitted infections, we talk about pregnancy or health related things like asthma, diabetes, epilepsy. Basically anything they want to talk about. We try and devise health promotion sessions rather than one to one... We give out condoms as well; we're hoping to be able to give out the emergency contraception, we haven't done that yet but we're hoping to get onto that."

Depth 16: physical health practitioner, Birmingham

In addition to their services for LAC, physical health practitioners in many local authorities offer training on health matters for practitioners in other fields – social workers and foster carers in particular. The aim of this training is to increase understanding of the health framework and to improve relationships and communication between agencies.

2.2 The need for interventions

The physical health problems faced by LAC vary according to the circumstances in which they lived before being taken into care, and their situation once in care. For example, unaccompanied asylum seekers and abused children are more likely to present initially with health problems than those taken into care for other reasons; and

those in long-term foster care are thought less likely to face on-going problems than those in residential care.

Physical health practitioners were reluctant to generalise about the health problems identified at the initial assessments, but issues related to neglect, such as missed immunisations, poor dental health, poor nutrition and physical development, and undiagnosed conditions or disabilities seemed common. Older LAC were often said to be resistant to healthcare at this stage because they had not received it before, and there was a general feeling that the types of issue that are concentrated on during these assessments are not of great interest to LAC themselves.

“Most will come with a poor history of accessing health services and other services, so it is about catching up with what they've missed. Immunisations are a big problem. Our immunisation rate is poor for looked after children but we do try and prioritise that. Their dental health is poor, the older looked after child can be quite resistant to any type of health intervention because they've never had that experience and don't see why we are interfering, thank you very much! Obviously there has to be a discussion with the young person about what it is we are trying to achieve.”

Depth 15: physical health practitioner, Manchester

“I don't think, especially when they become teenagers, they want those medicals. They don't see that as a priority. When you try to talk to them about sex education, about drugs awareness, they're not really interested – they think ‘Oh, we've heard it.’ They think they know better.”

Depth 8: social worker, Hertfordshire

Once in care, almost all agreed that there is no reason why LAC *per se* should face on-going physical health problems, and that once initial issues have been addressed, the state of their physical health and development is often, and indeed should be, similar to that of other young people. Some LAC (particularly those in residential care) were said to pay little attention to their own health and lifestyle because of generally low self-esteem and dissatisfaction with their situation, and to suffer some health problems as a result. But it is primarily on the mental health side that problems continue to manifest themselves, and require on-going attention; this area is discussed in detail in section 3 below.

“If you asked me at the end of the day what would you aim for in looked after children's health, I'd say I'd want them to be the same as the general population.”

Depth 14: physical health practitioner, Birmingham

“In terms of physical health most of the looked after children's physical health is not that bad. We obviously have some who have major disabilities, and their health needs are met by a team of people.”

Depth 15: physical health practitioner, Manchester

“There are things like immunisations that aren't up to date, they have physical illnesses that haven't been identified or followed up, they may have developmental mild disabilities that haven't been recognised, there's all of those things that should've been picked up that haven't. And then on top of that there's the emotional stuff which I think is probably predominant.”

Depth 14: physical health practitioner, Birmingham

Effective health promotion was said to be particularly important among LAC because of the environments they live in and the pressures they face. Influences such as peer pressure for those living in residential homes, a lack of self esteem and normalising experiences of harmful behaviour, in many cases combined with the lack of a stable family situation, were said to make LAC more likely to smoke, drink, take drugs, have unprotected sex and engage in other behaviours than other people of their age. Health promotion, education and advice in addition to what LAC receive as a matter of course in school was seen as vital if these types of behaviour are to be reduced or avoided.

“It's about its about having a discussion around age-appropriate health, and can include healthy lifestyle, diet, sports activities, social activities, how you're doing at school, the emotional health, personal sexual health education, relationships, drugs, alcohol, smoking, all those sorts of things that come into it. It's also an opportunity for young people to raise things that are worrying them.”

Depth 4: social care manager, London

2.3 Comment from those in other fields

Respondents from other fields inevitably mentioned physical health as being important to an LAC's health and well-being, and the basic procedure of routine assessments was widely familiar. Social workers in particular worked with physical health practitioners, often attending routine assessments, giving consent for interventions and holding medical records. Foster carers also had as much contact as they thought they needed – with the registered GP as well as designated practitioners. But, ironically perhaps, physical health often appeared to be taken for granted by other respondents (it was often not mentioned spontaneously, or only in passing), or seemed to be relegated beneath the need for stability and security as an influence on

an LAC's well-being, possibly because the procedures are well mapped out and thought to be effective (although see below). Indeed, as noted, most respondents saw no intrinsic reason why an LAC should be less healthy than any other child or young person.

"Generally children in care are healthy. They might have nits or bad teeth, but I haven't come across serious illnesses."

Group 1: independent sector carers, London

2.4 Effectiveness

Most respondents were satisfied that, if applied properly, the basic framework for health assessments and promotion is effective and meets the physical health needs of most LAC. The success of this framework, in terms of both the performance of the local authority and the experience of LAC, depends on the quality of communication between agencies within a single area and the consistency with which it is applied in different areas.

Most physical health practitioners thought that strategic communication and understanding between agencies had improved over recent years, but that information about individual LAC is not always transferred reliably between agencies within a local authority, and does not always follow them when they are moved from one area to another. The way in which the framework is applied also varies from area to area depending on the local population and resourcing; this results in a lack of consistency which some felt is unfortunate.

"A lot of PCTs followed the guidance Promoting the Health of Looked After Children, but a lot of PCTs didn't. They did it their own way, so there has to be something that people can follow."

Depth 16: physical health practitioner, Birmingham

The main problems faced by health professionals in carrying out health assessments were consistent across all the areas visited: difficulties in obtaining an LAC's records; poor quality information in those records; and difficulties in obtaining parental consent for interventions. All these issues were said to cause considerable delays in carrying out health assessments, and to contribute to difficulties in meeting targets.

Problems with LAC' medical records were twofold. Many LAC have no records when they are taken into care, particularly if they are unaccompanied asylum seekers, or if they have been moved around a

lot and their records have been lost. In this instance, there is no reliable way to know whether immunisations are up to date, whether there are pre-existing conditions, or even how old an LAC really is (some immigrant LAC were said to lie about their age, claiming to be under 16 in order to qualify for care). This makes it difficult for physical health practitioners to assess their health and development; immunisations, for example, often have to be started from scratch on the assumption that they have not been given, regardless of an LAC's age.

Once an LAC is in care, medical records and health plans often move around the 'system' slowly, and there appears to be little consistency as to who holds them: parents, foster carers, previous GPs and social workers are all options. This situation is not helped by the fact that many GPs were said to refuse to register LAC as permanent patients, preferring to list them as temporary since they are expected to move on before too long. Records of temporary patients are apparently more elusive than permanent ones. Practitioners giving routine assessments often therefore find that they have no access to records, and do not know how to obtain them. Since an assessment cannot be carried out without an LAC's record, this causes delays.

"We do have problems getting parents to let us have the red book for the under 5s and the personal health records, and then getting information out of GPs or who has got the immunisation record, where is it held and so on. Its different everywhere: sometimes the GP has got it, sometimes the health visitor has got it, sometimes it's buried and we have to go back years or whatever."

Depth 4: social care manager, London

"My biggest difficulty is GPs, trying to get information. We have difficulties getting them registered. Obviously if you register as a private patient, the GP has to send for the previous notes and a lot of them don't want to do that. They want to register as a temporary patient. I say no, please register them as a permanent patient. They will tell you by the time they've got medical records, they've moved on. So the records are always in the system somewhere."

Group 3: independent sector carers, Birmingham

Alternatively, information in the record of a LAC who has moved from a different area may seem to be incomplete or inadequate because practitioners in different areas use different forms, and feel that different amounts of detail are required. The BAAF assessment form is widely but not universally used, and some felt that all the available assessment forms are inadequate or poorly suited to the needs of LAC.

Consent for interventions to take place for the under-16s is another widespread source of problems. It was unclear in what circumstances the consent of social workers, foster carers and parents is required, but most practitioners commented on difficulties they had experienced in obtaining parental consent in particular, and the delays and extra work that this had caused.

“Consent is a nightmare, it is a nightmare because [parents] will refuse to sign the forms or they don’t get asked, it is a real issue at the moment with people refusing to do health assessments unless they’ve got parental consent... The consent issue holds us up time and time again in terms of getting assessments done, and social workers battle to get parents to sign consents. I’d [like to see] something around presumed consent: the child is in care so presumed consent is with local authorities with the proviso that they consult and advise, and their parents know. That would be the way that I’d look at developing it.”

Depth 4: social care manager, London

“We think the foster carers should be able to give consent for routine things... There should be some guidance about it; we have done some on what foster parents can consent to and what things they can’t, some things like general anaesthetics and so on that they can’t.”

Depth 14: physical health practitioner, Birmingham

A third issue raised by respondents was the variation from area to area in the way in which health assessments are implemented, resourced and prioritised. As noted, influences on this were said to include the nature and size of the local looked-after population, the size of the area covered, the financial and personnel resources available, the relative priority accorded to LAC, and the personalities and drive of the designated practitioners. As one of the clearest indications of this variety, in ‘well-served’ areas all assessments (initial and routine) were being carried out by paediatricians or designated practitioners because ‘generalist’ practitioners (GPs, practice and school nurses, health visitors etc) were not felt to have sufficient understanding of what LAC have been through to allow or encourage them to undertake a thorough assessment, or indeed to carry out the assessment in a sensitive manner. In other areas, however, these ‘generalist’ practitioners carry out routine assessments (but not the initial ones), albeit often after some instruction and training.

“We knew from the previous experience that the quality of healthcare assessments done by GPs for looked after children was abysmal, and so we said we weren’t going to do it that way.”

Depth 14: physical health practitioner, Birmingham

“I think some GPs don’t have the understanding of children being looked after – where they’ve come from, what they’ve gone through, their life experiences – and there’s a sort of perception that looked after children are mad, bad and dangerous to know, and they’re not. It’s having an understanding of the issues that are relevant, they’re not like other children, they’re not growing up in their own home, they may have been abused, they may have been hit, they may have emotional trauma and domestic violence or whatever it might have been. If a GP is looking at them, ticking boxes or whatever and all they’re interested in doing is earning their £60 or £70 for filling in the form, they don’t take that holistic approach.”

Depth 4: social care manager, London

This variety in service provision has implications for local authorities and LAC themselves. Local authorities which find it difficult to meet their assessment target were often said to prioritise their own LAC’ assessments over those of out-of-area LAC for whom assessments had been commissioned by the responsible authority. Thus local authorities can be penalised for the perceived shortcomings of other local authorities, over which they have no control. Equally, practitioners in some local authorities where all assessments are carried out by designated personnel were less happy to have out-of-area assessments conducted by ‘generalist’ practitioners, if this is the arrangement.

“One of the problems that we come up against is that other authorities don’t give the same local priorities to out of borough children, so it will take us longer to get a health assessment from Liverpool than it would for their own [LAC].”

Depth 4: social care manager, London

From LAC’ point of view, variation in the way in which health assessments are administered means that a system they know may be replaced by an unfamiliar one if they have to be moved to a new area, to the detriment of the stability and continuity of their situation.

3. **Mental health**

3.1 Service provision

As noted above, mental health problems were thought by respondents from across the sample, including those in representative organisations, to be among the most significant and on-going issues faced by LAC –

and certainly more serious and widespread than poor physical health. Yet despite this, the services which aim to address mental health issues often seemed less well defined, less well funded and less well developed than their physical health counterparts.

Based on respondents' descriptions of the mental health services they were able to offer, and thought they should be offering, the most effective model appears to be one in which the referral pathways are clear and established, teams are well organised, consistently staffed and allowed to specialise in LAC, and practitioners are able to undertake preventative work as well as reacting to problems once they had arisen. Some practitioners are specialists (psychiatrists, consultants etc); most are lower-level health workers based in the community (nurses, health workers etc). In practice, however, it seemed that in many areas the service falls short of some or all of these requirements.

In local authorities with CAMHS provision which more closely approaches this ideal, units are organised with team managers, single points of access for all referrers, practitioners who are used to dealing with LAC and the particular issues they often present with, and established relationships (at both strategic and individual levels) with other agencies in the local authority. In recognition of the impact that all aspects of an LAC's life can have on his or her mental health (see below), practitioners from these other agencies are brought together for regular meetings to discuss the mental health of individual LAC, and the contribution that all agencies could make to improving it. These meetings are convened by CAMHS practitioners, and are held in addition to health assessments, statutory reviews and other such forums.

Referrals to these CAMHS units come from a number of quarters, but predominantly social workers who have concerns about a LAC in their charge; physical health practitioners, educationists and residential home workers also refer fairly frequently. Training is offered by CAMHS practitioners to those who might refer LAC to help them to know when to do so; concern might be raised by an LAC's behaviour (either overt, such as self-harming, or covert, such as depression) or following completion of a routine Strengths and Difficulties Questionnaire (SDQ) which is designed to identify potential mental

health issues. In either case, the LAC is referred quickly and CAMHS (ideally) have the opportunity to diagnose and address problems, and to prevent them from developing further.

"If you meet a foster carer when they don't need you, I find that when they do need you. They are much more relaxed, they trust you more. You know what to expect, you know who might flap more. But you need to invest a lot to reach that point."

Depth 12: CAMHS practitioner, Leicester

CAMHS units which are further from this ideal tend to be less structured, having expanded over time as funding became available, rather than being planned from the outset. They are more vulnerable to staff absence and loss (especially as many practitioners are specialists in their field, and therefore difficult to replace). Their relationships with referrers and agencies tend to be less developed, as are the mechanisms for making referrals, with the result that referrals are often more erratic and delayed, and CAMHS practitioners spend more time 'fighting' problems which have become established and have less opportunity to do preventative work. Moreover, their resources may be stretched because their services are required for all vulnerable young people – the homeless, young offenders etc – rather than solely LAC.

"If we had a pot of money to set up a new team, we may have looked at things differently. How we did it here, money came along for initiatives, like this month we get funding to work with youth offending court diversion scheme, so that post will be attached."

Depth 12: CAMHS practitioner, Leicester

"We are always having this double bind. If you have a crisis in your service [preventative projects] are the parts that nibble their way out. What happens, you haven't the relationships, then referrers come to you in a messy way. You don't know people, they get cross with you etc."

Depth 12: CAMHS practitioner, Leicester

Having said all this, however streamlined and established a CAMHS unit may be, the nature of LAC and the issues they present with means that there is little scope for a rigid framework within which to operate (as, for example, there is in physical health). LAC' mental health problems are individual, borne of individual experiences and circumstances; moreover, they are complex, often involving more than one 'recognised' condition. Some can be dealt with quickly, with minimal counselling; others require ongoing and innovative care, with continuity of contact again being

important. Some LAC respond well to attention from CAMHS practitioners; others reject this and react against it. Individual solutions therefore have to be found in each case (almost all intervention is individual), and one of the two respondents believed strongly that there is little firm evidence or guidance that can be used to inform these solutions. There are also few targets for CAMHS units to meet, beyond generic ones such as '18 weeks to referral'.

"It is not that they have specific problems – they have several problems. So in a stable family I would see things like school refusal, a defined anxiety, fears, eating disorders. Not easy necessarily. But here you will see three, four, five problems at the same time. They are more enmeshed. So you don't easily get straightforward depression, you get it with behavioural problems."

Depth 12: CAMHS practitioner, Leicester

"What evidence isn't available is what works, preventions and services. And that is what all the noise is about at the moment. It is the same with the National Council review. We all have an opinion. And fairly good consensus there but it is actually not based on evidence. So just this morning I typed up everything and at the end put 'Actually if you push me I am not sure if it is based on evidence or if it is my opinion.'"

Depth 12: CAMHS practitioner, Leicester

3.2 The need for interventions

Broadly speaking, the mental health problems LAC face have three main sources: their experiences before being taken into care, such as abuse, traumatic events or the death of parents; their situation while in care, which can lead to insecurity, low self-esteem, reactions to a lack of love and attention, and attachment issues; and underlying conditions such as ADHD and autism which have not been diagnosed before because of neglect. One CAMHS respondent estimated that between 20 and 25% of the LAC in her local authority receive CAMHS services at any one time.

Older LAC – those in their teens – were said to be much more likely to require CAMHS services than younger children, for whom it was hoped that mental health problems might be avoided altogether if a suitable and stable foster placement could be found quickly. As noted above, older LAC are also more likely to be in residential care than younger, which probably adds to their need for CAMHS attention.

The types of problem that CAMHS practitioners encounter are varied, complex and often difficult to diagnose, partly because they stem from

disparate and on-going sources. Psychosis, arguably the most serious type of mental health issue, was said to be rare but straightforward – it is a recognised condition, and there are evidence-based ways to deal with it. Much more common, and much more difficult, are behaviours such as self-harming, persistent disorder or aggression; these need to be handled on a more ad hoc basis, and ideally in conjunction with other agencies which might be able to resolve some of the pressures that are causing the behaviour.

Whatever the problem, early identification by people who live and work with LAC was thought to be key. The worst case scenario would be an LAC who is displaying low-level suspect behaviour going unnoticed, and getting to a point where emergency interventions are required. By this point, young people were said to be unlikely to engage with or accept treatment, making the task much more difficult.

“One of the first things I learnt was that unless you, in some way, go to them, it doesn't work. If you wait for other things to happen, they either get distorted through the system or move on. You have to have some kind of direct route. That route gets better if you have a relationship with it, for example with the children's home. [Otherwise] they stop referring and only refer if there is a huge crisis.”

Depth 12: CAMHS practitioner, Leicester

3.3 Comment from those in other fields

Although many respondents from across the sample mentioned the importance of mental health, and by extension the work of CAMHS units, few seemed to have a clear idea of how CAMHS units operate or what services they provide. There were therefore few comments from other respondents, and in this sense CAMHS seemed more isolated from the ‘family’ of LAC services than any other type of agency, despite the acknowledged significance of the work that it does.

Perhaps the main and most widespread concerns about CAMHS regarded difficulties with accessing the service. On a basic level, waiting times for referrals were sometimes said to be long, with priority being given to ‘emergency’ cases at the expense of those with less urgent but nonetheless significant issues to address. This was usually put down to a lack of funding and difficulties recruiting and retaining staff.

"We have a specific service, clinical psychology service for looked after children who've been extremely understaffed in the last year and only been dealing with emergencies. The more preventative is not happening."

Depth 15: physical health practitioner, Manchester

More specifically, one or two respondents in representative organisations and foster care claimed that CAMHS units would refuse to accept an LAC if he or she had not been in stable accommodation for a year or more. These respondents could appreciate the impact of instability on an LAC's mental state, and therefore the desirability of diagnosing conditions against a stable background, but they argued that since such instability is a common feature of LAC' lives, it is unrealistic to expect a year's stability in all cases, and impractical to try to remove instability from the potential causes of a LAC's mental health problems. Indeed, they argued, delaying care until a LAC had been in a stable placement for over a year risks leaving underlying problems unchecked and issues resulting from instability going undetected.

"There are two extreme positions, One is quite traditional, sometimes therapists say you have to be stable to have therapy. Of course it gets social services very angry a lot of the time. The other extreme is if they are not safe, you can't do therapy, for example, you know the placement is breaking down, they may be going back to their parents and it is unsafe. It is abusive to encourage them to talk about what upset them in the first place because they may go back to it."

Depth 12: CAMHS practitioner, Leicester

A further issue highlights the variability of CAMHS provision across England, and the degree to which some local authorities are able to provide services that are unavailable in others. Social workers and others cited the need for specialised mental health expertise as one of the reasons for moving LAC out of area: unlike social workers or educationists, CAMHS practitioners do not seem to travel to meet the needs of their own out-of-area LAC, so those who need their services have to come to them. More unified CAMHS provision across the country would, some respondents thought, reduce the need for this displacement.

A final point in relation to referrals to CAMHS, and general recognition of mental health problems among practitioners from other agencies, was that a standardised SDQ would be useful. Apparently these differ in their complexity and effectiveness, and some respondents were reluctant to take them up because of this.

“The one bit that I thought was maybe missing [from the draft Scope] was in terms of emotional wellbeing, how safe children feel, their ability to feel safe from abuse, safe from bullying, emotional wellbeing. There’s nothing really about that so maybe that that might be picked up if you recommend a standardised SDQ or something like that for mental health.”

Depth 14: physical health practitioner, Birmingham

3.4 Effectiveness

The effectiveness of the services and interventions offered by CAMHS units was thought very difficult to assess. Interventions are individually tailored; the issues that LAC present with are varied and often complex; there are few (if any) firm targets against which performance can be measured; and in many cases there seem to be only loose operating frameworks in place.

It was clear, however, and perhaps unsurprising, that CAMHS units which are better funded, dedicated to LAC cases, and have established closer links to other agencies, seemed more upbeat about their performance and less dominated by the need to ‘firefight’ cases when they are referred.

Of the types of condition mentioned above, the most serious (psychosis, self-harming etc) were said to receive priority, and to be referred to CAMHS and dealt with quickly and relatively effectively. Division of responsibility between the various agencies for lower-level conditions, however (such as behavioural problems brought on by attachment or displacement issues, which require CAMHS attention and psychological counselling but which are less ‘acute’ and obvious to non-specialists), was said to be more confused. Whether through a reluctance to engage with CAMHS unless absolutely necessary, a belief that they could ‘handle it themselves’, or simply a lack of realisation that there is a problem, practitioners in other fields were said to be less likely to refer these cases to CAMHS quickly, making them more difficult to address when they are referred.

“In terms of the health and welfare of young people, I think we are picking up some of the attachments and the separation that comes with being in care, I think we are picking up those quicker, more quicker or more quickly. I think that has been a benefit, I think we are starting to pick up some of the emotional and wellbeing issues and the wellbeing of kids now, the mental health issues, but it’s probably a bit slow.”

Depth 5: LACES manager, Birmingham

4. Education

4.1 Service provision

The specific educational needs of LAC, and their influence on health and well-being, were thought to be recognised by most, if not all, local authorities. But it seemed that recognition of the importance and impact of education services has in many cases been more recent than for other services. As a result, the extent to which they are integrated into the ‘family’ of LAC services, taken seriously by practitioners in other agencies, funded appropriately by the local authority and able to achieve what they want to achieve seems to vary considerably across the country. A corollary to this is that the services provided in different local authorities, and indeed the focus of these services, also vary, as does the funding available to education services.

“It does depend on resources. Some places are better resourced than others, and I think if there was more of a protocol where all looked after children got the same service no matter where they are placed, I think all young people would benefit ultimately. At the moment sometimes you could say it is like a postcode lottery.”

Depth 9: LACES manager, London

The basic goals of Looked After Children Education Services (LACES) or other agencies with similar functions are threefold: to ensure that LAC achieve some stability and normality in their lives through their school attendance; to help LAC overcome educational disadvantages that their background has left them with, and to take and do well in mainstream exams; and to reduce exclusion rates of LAC, or at least to manage exclusion in as sensitive a manner as possible.

“I think sometimes school is the only stability that is in their lives. I think it can be difficult to move young people. My view is that the more stability they have the better.”

Depth 5: LACES manager, Birmingham

“All children want to be normal, and they want to be seen to be going to normal school and if we can get them to sit exams, that makes them more normal. It gives them a chance to be like other people.”

Depth 9: LACES manager, London

As far as direct interventions with LAC are concerned, respondents in all the areas visited reported similar initiatives. One-to-one interventions included private mentoring, tuition and encouragement, both in and out of school; group sessions included homework clubs,

'virtual schools' which offer tuition and educational support in addition to that received in school, and activities to encourage the development of other interests and provide wider group support for LAC. The range of these 'extra-curricula' group activities was striking, and their inventiveness showed that LACES practitioners often have plenty of scope to innovate. Indeed, LACES seemed to be the only agencies to plan and operate activities outside their strict field.

"We put on a lot of projects, so I think they appreciate the fact that we give them a lot of opportunities for enrichment. We have done two weeks this term, and this year in the summer holidays they can spend a week doing activities – outdoor activities, music, dance, all sorts of things that are going on."

Depth 5: LACES manager, Birmingham

"We are really, really pushing those other activities because when the children come to us, it is not like having a classroom of children or a school of children, most of them don't really know each other very well and the only thing they have in common is being cared, and it is a cohort that is kind of quite mixed and varies in terms of ability. One of the things that we want to push is for them to support each other so we want to run all of those out of school programmes."

Depth 9: LACES manager, London

Interventions in schools are given by the school's designated teacher (if available) or teachers or classroom assistants who work for the LACES team and go into schools to help LAC. They tend to consist of help with work, and support and advice on school and social issues. The aim of such interventions is primarily to help LAC to progress in mainstream schools, to achieve against the same standards as other young people, and to remain in a stable education environment.

All respondents stressed the importance of ensuring that such direct interventions are unnoticed by LAC's classmates and peers. LAC were generally said to appreciate the extra support and attention they were given, not least because it showed that someone cared about them, but only on the grounds that other young people did not find out that they were in care. This requirement was managed the same way in all the areas visited: support is given privately, out of school hours and often out of school; or in groups at school where one pupil is looked after and the rest are not, and none of the other pupils know that he or she is in care. LAC are rarely pulled out of class individually, for instance; neither are they given obviously special treatment in class.

“They don’t like being singled out. I mean, any of the events we do, they don’t mind coming to the events in the summer holidays and things. What they don’t want is to be identified as looked after in schools, they want to be treated like the other school kids.”

Depth 5: LACES manager, Birmingham

“They don’t want to be treated differently, they want to be the norm and I think they really appreciate what is done, as long as it is not seen to be done in front of their peers.”

Group 3: independent sector carers, Birmingham

All the local authorities visited appeared to have LACES provision of one form or another; the variation in the way in which these teams were able to operate, and what they were able to achieve, came in the extent to which they could influence the schools themselves and other aspects of an LAC’s care. In what might be called the ‘most educationally advanced’ local authorities, the role played by LACES seems as much consultancy and regulatory as it is hands-on. As well as direct interventions, these LACES aim to ensure that mainstream schools understand the needs of LAC and provide much of the support themselves, and help schools to reduce exclusion rates by funding additional staff and other ‘hands-off’ measures. They are also able to influence the decisions of social workers and other LAC agencies, for example as to whether or not an LAC should be moved out-of-area at a particular time (see below). These LACES were well funded by their local authority and worked closely with the other LAC agencies, often as part of a multi-agency model.

“What my team do really is support these young people. What we try and do is make sure that the schools are held accountable for their role. Social workers are held accountable for what they have to do, the kids aren’t moved around too much. So we are not doing it for them but making other people responsible for their bit in terms of the jigsaw.”

Depth 5: LACES manager, Birmingham

LACES in ‘less educationally advanced’ local authorities were less well funded and less integrated with other LAC agencies. They seemed to have less influence over schools, relying instead on their own direct interventions, and less influence over other agencies – social services who wanted to move an LAC out-of-area in particular. Tellingly, they operated more on a caseload model than their ‘more advanced’ counterparts, and since they placed more emphasis on the need to put their case to the local authority for funding and decisions, they seemed almost to be operating outside the system. This arrangement clearly

reduced these LACES' capacity to support LAC's education in and out of school, and to maintain stability of school placements, as respondents from them recognised.

"One of the things that we do very well is negotiate our way through the systems. We are all pretty clued up on special educational needs and special needs protocol. But it is complicated by regulations and the fact that the children are from one borough but in an other, and that borough has to provide things and files get lost and it gets very complicated."

Depth 9: LACES manager, London

"We have to negotiate everything we do. We are very polite and we check everything, because we are guests in schools."

Depth 9: LACES manager, London

"What we don't try and do is have caseloads for all these kids. For example, what the education welfare lead practitioner does is she makes sure that the whole of education welfare services prioritises looked after children, and the same with education and psychologists, so they are there as lines of communication with the existing teams to make sure that these kids don't slip through the net."

Depth 5: LACES manager, Birmingham

4.2 The need for interventions

LAC in mainstream education typically face a number of disadvantages, compared to other young people. As with health challenges, these relate to their lives before going into care, their current situations, and their future prospects.

The education LAC receive before going into care is often disrupted and discontinuous; most respondents said that many have fallen behind other young people of their age when they are taken into care, and have to make up this ground if they are to enter and progress in mainstream schooling. Those who are unable to make up this ground, (perhaps because they have fallen too far behind, they have learning difficulties which have never been diagnosed, or they are unable to fit into a mainstream school) may be given a statement of special educational needs and the opportunity to attend a pupil referral unit or special needs school. But the aim of LACEs seems to be to prevent this from happening if possible, and keeping the LAC in mainstream education by helping him or her to fit in.

“They have differing needs but I think from my experience it is the kids who have missed a lot of school and then are back in that environment who need a lot of support.”

Depth 9: LACES manager, London

Once they are in mainstream education, many LAC were said to find it difficult to keep up with the progress of other young people, perhaps because they do not have a stable home life or their self-esteem is low and they do not believe that they can achieve against the same standards. LAC in residential care were said to be particularly vulnerable in both these senses; LACES practitioners visit residential homes to try to address this, and some homes offer in-house schooling.

Finally, LAC' disrupted lives and low self-esteem mean that many are reluctant to, or simply forget to, sit for exams or obtain other qualifications. LACES practitioners take it upon themselves to encourage such LAC to study and sit for exams, either directly or through their influence with the school.

“What we are trying to do is give them the key skills and part of it is just remind them that actually it is a good thing to have exams.”

Depth 9: LACES manager, London

LAC therefore often require considerable levels of support if they are to achieve in mainstream schooling. The effects of their experiences at school on their general health and well-being, rather than simply on their educational attainment, were recognised by all respondents working in this area, but, as noted, were thought to have been taken into account only recently by many local authorities.

“What I like to see is the total chaos when they come in: they hate everybody, they won't relate to authority, they are not ready to do anything. And then when we have done some work with them, we reassess them, we test them and there they are, they have got high levels of self esteem, they are more confident and more able to adjust to authority, to accept authority.”

Depth 5: LACES manager, Birmingham

The goals of LACES practitioners – progress and achievement at school, and long-term attendance at that school – were said to be beneficial for LAC on a number of levels. School might represent the most stable and 'normal' aspect of an LAC's life, especially if he or she lived in a residential home. Achievements help to improve self-esteem, which was said to be low in many cases. School provides an opportunity to be with other young people, to form friendships and

other social benefits which other young people take for granted. Qualifications help to ensure that an LAC's future prospects are as bright as possible. For all these reasons, LACES practitioners wanted to keep LAC in stable school placements wherever possible; moving or removing them was seen as a last resort.

"You are looking at health, you are looking at all aspects, but I think education really has to be up there as part of health. When the child is in school they are safeguarded and they have got a chance for a better future, so I think we have got to look at stability in education... I think that is really, really key."

Depth 9: LACES manager, London

"A lot of the children we deal with have challenging behaviour. They may have been in that school for a number of years. Rather than have to get them used to a different school, having to mix with different people who don't understand how to work with them, it works out expensive, you may have to get an escort to go with them. For their own safety. They are in a new environment, so they try to keep some things the same. At least the schools and people who have been dealing with them might be long term, a continuity is still there."

Group 3: independent sector carers, Birmingham

4.3 Comment from those in other fields

As if to highlight the extent to which some educationists felt removed from other LAC agencies, and to which education was seen as separate from other issues that LAC face, few other practitioners had much to say about it. Physical health practitioners often had links with schools, but through school nurses rather than education itself. Mental health practitioners had little to say beyond the importance of stability in general to an LAC's mental and emotional state, and the role that continuity in schooling has to play in creating that stability. Social workers in this sample appreciated the role that school and education plays in an LAC's health and well-being, but on the evidence of educationists this is not always the case.

"If they're engaged in education, they're somewhere behaving normally and they've settled. In a lot of cases either the placement's unstable or they're not performing in school."

Depth 8: social worker, Hertfordshire

Foster carers were often not aware of the work of LACES teams (if indeed the schools their LAC attended had such provision). Their own input into LAC's education varied, with some playing an active role in

securing nearby school placements and others leaving this to social workers. On a day-to-day level most long-term foster carers seemed to adopt a similar role to parents – helping with homework, providing encouragement and support, and motivating LAC for exams. They did not seem to be involved with the types of interventions provided by LACES and described above. Short-term foster carers and residential carers were typically less closely involved in their LACs' education, on both these levels.

Respondents from representative organisations were keen to stress the importance of education, and tended to agree with the points made above about its recent and uneven elevation up the agenda.

“Education is crucial. It is almost as if you should force a child to access education. That sounds terribly draconian. Because it is later on in life we are picking up the pieces. We haven't a brilliant educational record within the country. And within that group, children in care, have the worst record. They are failed educationally. Because they go from one school to another.”

Group 3: independent sector carers, Birmingham

4.4 Effectiveness

Respondents were sure that their capacity to support LAC in their education had improved over recent years, but they generally found it hard to say for certain how effective their interventions had been. Individual LAC' needs and situations vary greatly, and there is no 'service model' which can be applied to all. One year's cohort of LAC may be easier to support than another, so apparent success will not necessarily be repeated. Moreover, the targets against which the performance of a local authority's LAC are measured are apparently the same as for all young people (based on numbers achieving A* to C grades etc), which was widely thought inappropriate and unrealistic, given the challenges faced by LAC (especially since schools are judged against the numbers of pupils *taking* exams, whereas LACES are apparently judged against *all* looked-after pupils, regardless of whether or not they actually sit for exams).

“We want the same outcomes [as for other young people], we want the kids to be successful, happy, safe, all those things, but I think we have to readjust the balance so if kids have missed out on their education we need to go that extra mile and give them a bit more to help them catch up with the kids who have had more conventional upbringings.”

Depth 5: LACES manager, Birmingham

"In my 2005 cohort that we were judged on, 35% had statements and they expect me to try and get 5 A stars to C the same as all kids. It's unrealistic."

Depth 5: LACES manager, Birmingham

As might be expected, the impact that respondents from the 'most educationally advanced' local authorities felt they were having on LAC' school experiences was greater than that of those from the 'less educationally advanced' authorities. Both were providing direct interventions to LAC, as described above, and both thought these were effective. But the workload of the former was being supplemented by the efforts of the schools themselves, and, crucially, the latter felt their work can be undermined by the actions and attitudes of practitioners in other agencies and insufficient funding.

The most extreme way in which LACES work is undermined was said to result from social services not taking an LAC's need for stable education into account when considering a change in placement – particularly an out-of-area move. LACES respondents accepted that LAC may need to be moved for any of a number of reasons, but felt that this move should take place at an appropriate educational juncture, such as the beginning of a school year, so that disruption to education and life can be minimised, and other pupils do not suspect that the LAC is in care. LACES respondents who felt they had insufficient influence over other agencies said that they were often unable to put this arguments to social workers, and that the latter were mainly concerned with finding a placement as quickly as possible, regardless of where or when that might be. Those with more influence, in local authorities where the importance of a stable education had greater recognition, felt that they could urge social workers to consider the wider picture.

"If the planning is made and the preparation is done so [they are moved] when everybody else goes in then fine, but I think midway through to take kids out is, it just doesn't work it causes a lot of disruption."

Depth 9: LACES manager, London

"One of the things they used to say when I first came in to the job was that social workers' famous words were: 'Well we won't bother about education because they are too upset and they won't be attracted to education'. That is a load of rubbish. They feel so isolated and expelled and excluded, and if they can go to school it is like therapy because they have then got a social group and people that like them."

Depth 9: LACES manager, London

This issue is linked to that of school exclusions. LACES with less influence in schools seemed to feel that exclusion was a first option for LAC who are disruptive in some way, and that schools do not always consider the circumstances which might have led to this disruption or ways in which it might be addressed without resorting to exclusion. The disruption which results from this policy was thought to have an impact on the LAC's mental and emotional state, as with other forms of instability. More influential LACES felt that they could persuade schools to adopt the second of these positions; they saw the degree to which exclusions are reduced as a good measure of their success.

"I think I can look at it and say... permanent exclusions are down, so schools are much more tolerant now, they go the extra mile with our kids before they chuck them out. The social workers have started to prioritise education, so I think that they now think what are we going to do about this schooling, how are we going to keep them in this, this child in their school if we move the care placement, so there is a lot more thought going into some of the planning. I think that has been improved now."

Depth 5: LACES manager, Birmingham

Other restrictions on what LACES practitioners could do resulted from the arrangements for out-of-area LAC. Those LACES which took a mainly 'hands-on' approach to supporting LAC in their area found that they often had to supply a similar service to their out-of-area LAC because the new authority arranged its education support differently, or simply could or would not provide the type of service required. This meant that, like social workers, LACES practitioners had to travel to support their out-of-area LAC. Since they could only do this on a limited basis, the service they could offer was inferior to that available to other LAC, but they were still measured by the exam performance of out-of-area LAC. Respondents from 'more educationally advanced' local authorities seemed less concerned about this, partly because they had more money to help find a 'local' solution to out-of-area LAC' needs.

“The kids that are placed out of city, we can’t physically go and support them because they are all over the country, so we have what is called a bursary system. It’s got quite strong criteria and strict criteria about what we use it for. For example, say there is a child who is having behaviour difficulties, got emotional needs, social difficulties, the school would contact us and say perhaps we are nearing permanent exclusion, we think this child needs a statement. So what we might say to them is ‘what would stop you permanently excluding this child’, and they might say well ‘we would like to put a teaching assistant in for 20 hours in the week until we have finished the statementing process’. That would be say 26 weeks or 18 weeks whatever, so we would say, ‘write up your PEP, your personal education plan, put a bid in for what you want, tell us how much it’s going to cost and then we will consider it’, they would employ the person who would invoice us and we would pay.”

Depth 5: LACES manager, Birmingham

“We try to visit our out-of-borough kids as well – that is something that we have been able to do as our team has expanded. But with our current Year 11s what we are doing is ensuring that we visit them at least once a term.”

Depth 9: LACES manager, London

“We share the caseload, so we divide the names up between us so we all have responsibility for our kids. We are going to do a lot more sort of structured work in terms of preparation for exams and everything. It is much more difficult for us obviously to reach out-of-borough, but where we can go into schools [we are] keeping on top of it.”

Depth 9: LACES manager, London

5. Social care

5.1 Service provision

Social workers are, in many ways, the hub around which other LAC agencies operate, and the portal through which LAC access services. The services they themselves offer are a mixture of ‘behind the scenes’ tasks, ranging from finding care placements to locating health records, and frequent face to face meetings with LAC and their foster or residential carers to discuss ongoing issues or matters arising. They are ideally present whenever LAC have appointments with practitioners in the other fields described above, and are themselves responsible for LAC’ routine six-monthly reviews which (again ideally) involve all the practitioners providing services for them.

It follows from this description that social workers actually seem to offer few specific interventions or procedures (apart from the statutory routine reviews), and that much of their work involves ensuring that

LAC benefit from the interventions of others. As such, the contribution they make to the health and well-being of LAC is both central and peripheral: almost all respondents acknowledged the importance of social workers to LAC' lives and experience of services, since although they do not directly influence any tangible aspects of LAC' health, they are at best key to ensuring that the holistic approach to service provision is achieved, and (apparently) at worst a significant barrier to this.

That said, however, social workers do make some direct contributions to the health and well-being of LAC. Perhaps the most important is continuity of contact, and therefore an element of stability and reassurance. It is with a view to maintaining this continuity that social workers frequently and regularly travel to visit out-of-area LAC. The importance of this continuity should not be underestimated; as noted with regard to education, providing stability and certainty in LAC' lives by whatever means possible is seen as crucial to their health and well-being. Another contribution is organising activities for LAC, often in groups, which give them an opportunity to expand their interests and their social circles.

“Every child is different. Some children are into horse-riding, or there are musical things, and we take that on board. Some children aren't... We give all the opportunities for children in care to have the same sort of things as if they were living at home.”

Depth 8: social worker, Hertfordshire

5.2 The need for interventions

An LAC's need for a social worker is clear – someone has to take an overview of his or her situation, to negotiate services from various agencies, to provide some stability, continuity and reassurance, and generally to look out for his or her interests in the absence of parents. Long-term foster carers can fulfil some of these roles to some extent, but they do not have the same training or understanding of how the 'system' works. Many LAC have no one else to advocate for them.

5.3 Comment from those in other fields

Respondents in other fields tended to regard social workers and the work they do with a mixture of admiration and frustration. Most fully appreciated the challenges and pressures that social workers face, the

fact that their caseloads are larger than they might ideally be, the range of issues that they have to address, and the difficulties in dealing with some LAC on a frequent basis. As noted, they recognised the importance of social workers' contribution to the care of LAC, and for the most part they felt that social workers do a good job under difficult circumstances. But notwithstanding this, many were also critical of a number of aspects of social care, both in general terms and through their own experience of individual social workers.

Perhaps the most generalised comment, made by respondents from all sectors of the sample, regarded a lack of continuity in social care. Social workers were, on the whole, thought to be transient and prone to leave their posts after short periods of time, either to work in other areas (the tendency of neighbouring local authorities to offer differing rates of pay, rather than a level rate across a whole region, was identified by some more informed respondents as a reason why social workers move around) or to leave social care altogether (respondents' acknowledgement of the pressures they face also explained to them why some do not last for long in the profession). This transience was thought by many to be exacerbated by the tendency of local authorities to resort to agency staff on short contracts to fill vacancies quickly.

"My social care colleagues haven't got a lot of capacity, they have difficulty recruiting and retaining staff. It's a very tough job at the sharp end, at the child protection end, it's hugely accountable. If you imagine the decisions you are making about these young people, they are life and death decisions in social care. They are not in education; if I make a decision about something educational, OK it might have some sort of impact, but it's not life and death. It's such an accountable job, social work, so I can understand that people are more and more reluctant to take that level of accountability and responsibility. It's tough, they have huge caseloads."

Depth 5: LACES manager, Birmingham

"It is about continuity. I think if we're looking at improving outcomes for looked after children, we talk a lot about stability and placement but what we don't do is talk about the stability of social worker and stability of the team around a child."

Depth 4: social care manager, London

The effect of such transience on other practitioners was to inhibit communication with the very sector which should coordinate the work of all the LAC agencies. On a day-to-day level it meant that practitioners could not be sure who they would be dealing with, and made mis-communication more likely; in the longer term it made it

more difficult to build relationships and to plan strategically. The effect on LAC themselves was expected to be disruptive and distressing, since it suggested that social services did not care about them enough to keep the same social worker for them.

"We had one lad and the social worker was forever saying she was going to come [but didn't]. She did decided to turn up. 'I don't want to see you.' What respect are you showing there for the child? I am here and I am the person that has caused you to have a job. If I wasn't in care you would need to look after other kids and you can't do me the courtesy of turning up or listening or answering my phone calls. It varies from social worker to social worker. It is not a criticism of the individual – she had a case load. But it is about making time for the young person. He didn't care about her caseload. He cared about the fact that 'I am waiting for her, where is she?'"

Group 3: independent sector carers, Birmingham

More specific comments tended to regard the attitudes and priorities of social workers. Educationists, as noted, sometimes thought that social workers did not take an LAC's education and experience at school as seriously as they should, and that they did not communicate with or involve LACES or teachers in decisions about LAC' placements. Some physical health practitioners felt that social workers were unreliable in providing medical records or in preparing LAC for their health assessments.

"I remember taking [an LAC] home after booster classes and dropping her off, and the next thing I knew she had been shunted down to Kent. Apparently the social worker just appeared at her door and said 'you are going', and there was no way of [us] knowing why. She spent the whole time trying to get back to London."

Depth 9: LACES manager, London

"Social care really has to get their act together by reminding everybody that education is essential, and the placement and education [go hand in hand]. One of the big arguments that we make is if you have a stable school placement, you will keep the care placement. If the child is not in school you will lose it. They don't recognise it enough."

Depth 9: LACES manager, London

"Social care doesn't always pass the information that it has about children's health and wellbeing onto us. If the social worker doesn't come to the appointment, we might not have it."

Depth 14: physical health practitioner, Birmingham

CAMHS and some physical health practitioners wanted to ensure that social workers understand how and when to refer LAC, perhaps with training in Tier 1 mental health, and are able to complete SDQs and

other methods of simple diagnosis of mental health issues. Foster and residential carers sometimes disagreed with a social worker's assessment of an LAC, and felt that social workers often did not spend enough time with LAC to understand them properly.

"I think there are gaps about mental health. Basic mental health training, for example what are the physical signs of a child being depressed? Different changes in their eating, sleeping patterns, interest in things. Many people haven't even had that basic level, particularly social workers. A social worker is the one who sees them most regularly so they are the ones who need to be spotting these changes. Tier 1 mental health training is a big one."

Depth 15: physical health practitioner, Manchester

"Social workers generally don't have children. They don't have the files, they don't know the children at all. But they hold all the power. They are the ones that can make decisions."

Group 3: independent sector carers, Birmingham

5.4 Effectiveness

Social workers all felt their work is measured by numerous targets and deadlines, such as the time taken to place an LAC in long-term care and the need to ensure that statutory reviews take place on time, and that the onus is on them to ensure that many of the services provided for LAC by other agencies run smoothly and efficiently. As a result, the amount of paperwork that they have to complete was said to have increased greatly over the past decade.

"I think the drive is the placement of children, but when the inspectors come in the drive is meeting figures and numbers and the targets are drawn by the Government. As you will understand, all children in care need medicals and they want exact dates and everything, dot the i's, cross the t's, a lot of paper exercises and that limits the time that we spend with the children."

Depth 8: social worker, Hertfordshire

Despite this feeling of responsibility, however, the effectiveness of social workers' work seemed to depend greatly on the actions of practitioners in other fields (just as the performance of other agencies depends on the effectiveness of social workers), over whom they felt they had little or no control.

"I think what is important is trying to get across the corporate message at all levels, the importance of planning. When I came into post, reviews were running at about 60% overall on time. Last month we achieved 100% and we're up in the big 90's on average of reviews being on time. There was a culture of 'Oh, it doesn't matter, they can be put off' or whatever, so changing that and raising the importance of planning."

Depth 4: social care manager, London

"It can be difficult at times. People have annual leave or they're off sick, not attending the reviews. Sometimes the doctors may not attend. Sometimes we have their reports, which helps, but it's not direct. There's education, and the police, and various authorities who are involved, who would be at the review."

Depth 9: social worker, Birmingham

A shortage of good, committed foster carers was cited by all social workers as an issue which increased the time taken to find long-term placements, and therefore the degree to which LAC are moved around in short-term care. Equally, it was said to be fairly common for an LAC who has been successfully placed in long-term foster care to change his or her behaviour for some reason, and for the foster carers to insist that he or she should be moved. Social workers said that they could do little about this if the foster carer were adamant.

"It's that key match initially, and trying to get that stability as early as possible, instead of not having the right match. With emergency foster carers, it's for two weeks or a week initially. They could be having that bonding and then they have to be disrupted again and move on to the next stage. Then that might not work and so they're back to square one again."

Depth 9: social worker, Birmingham

"The downside is the lack of placements, the lack of places for children in the care structure and sometimes how committed the carers are – some are in for the money only. That's one of the frustrating things, having to move children around."

Depth 8: social worker, Hertfordshire

"The target is not to move children all the time. But nothing's permanent in foster care. There's always a chance that a child could be in the same place for five years and suddenly there's hassle and the foster carers say this child has to be moved. There's nothing we can do to stop it happening. We put the resources in, but sometimes that's not enough."

Depth 8: social worker, Hertfordshire

Shortages of foster carers were matched by shortages of social workers as a hindrance to their work: all felt that their caseloads were too large to allow them to give individual LAC the attention they really

needed. This was thought to be due to a combination of insufficient funding of posts, and difficulties attracting people into the profession.

"We are really stretched within our teams, so it's a matter of trying to do the best you can under the strains of the resources. There seems to be a lot of need and there seem to be not enough resources to fill the need."

Depth 9: social worker, Birmingham

"I am an educationist and I work very closely with my social care colleagues, but that's because looked after children crosses over both. Social services here has never been funded properly; education has been funded very well, and the outcome has improved. But social care has lagged behind, and they have got to start to address some of those issues."

Depth 5: LACES manager, Birmingham

Placements in foster and residential care seemed to be the issue which exercised social workers the most, but the problems they faced are not all outside their own control. Communication of the availability of foster carers to social care managers is apparently not always as effective as perhaps it should be, so that the message that a suitable carer is available sometimes does not reach a manager who needs to place an LAC by the end of the day and is about to resort to emergency or out-of-area foster care, or residential care, because something needs to be organised.

6. Foster and residential care

6.1 Service provision

Beyond the basic fact of providing a home for LAC, foster and residential carers differ in the services they provide and the types of LAC to whom they provide them. For most respondents, including social workers who had responsibility for placing LAC, the ideal form of care is long-term foster care, especially for younger LAC, provided that this suits the LAC in question. Long-term care lasts for many years, often starting when the LAC is young and ending when he or she becomes an adult. The aim is to provide a stable and loving family life which matches as closely as possible that of other young people. Long-term foster care is also said to be the cheapest form of care available.

Long-term carers, in conjunction with social workers, have responsibility for 'parental' aspects of an LAC's care: these include taking an interest in health, education, relationships, behaviour and emotional state, as

well as providing a home and family environment. They are contracted either to the local authority or to independent fostering organisations; the impression gained in this research is that local authority foster carers are the initial preference for a placement, largely because they are cheaper, but that the independent sector is turned to if no suitable local-authority carers are available, or if the LAC in question is challenging in some way. Although employed to provide care, long-term carers inevitably make significant emotional investments in their LAC and are driven not so much by targets as by the desire to see them overcome the issues they face and succeed in life. The more committed seem to take on some of the official duties of a social worker, such as finding and registering with GPs and schools.

"I think when you make a sort of milestone, where there's achievements with someone, when they're taking something on board and you're getting somewhere, I think that just makes you feel better. That someone is taking on what you're doing, and you know you're getting something out of the job."

Group 1: independent sector carers, London

Successful long-term foster care involves matching an LAC with an appropriate carer or family; this often involves a move out-of-area, and the displacement this involves is generally thought worthwhile. But long-term care is not an option in all cases, perhaps because a suitable match cannot be found or because an LAC is not able to settle with a family which is not his or her own. In some cases, this only becomes apparent after some time, when a long-term placement breaks down. For LAC in this position, short-term or emergency foster care, lasting for a few days or weeks, is generally the first option. Clearly the stability and emotional commitment that short-term carers can offer does not compare with that from long-term carers, but this often the only practical solution given that a carer needs to be found quickly.

Residential care offers a home, often for long periods, to LAC who for some reason do not settle in foster care at all. These LAC tend to be older (usually in their teens), and to have been taken into care when older, than those who stay with foster carers. They also tend to show challenging behaviours which have meant that foster carers have been unable to look after them. Residential homes vary in size, with some housing only one or two LAC. As with long-term foster carers, they are run either by local authorities or by independent organisations, with the

latter being more expensive but more able to take on more challenging cases.

“One of the differences between residential care and foster care is the term of stay, and also the type of children we cater for. Inevitably foster care is the first line of call for a child who goes into care. When foster care breaks down, they tend to move to residential care. That is not good for every child but I think you would probably agree it is necessary for some.”

Group 3: independent sector carers, Birmingham

In addition to housing, residential homes offer a range of tailored services to LAC, including in-house tuition and schooling for those unable to integrate or progress in mainstream schools, healthcare and health promotion, and group activities. They typically appear to be more bound by rules and regulations than foster carers, who are more likely to act on their own instinct and according to their own principles. Both types of care are subject to OFSTED inspection, but most respondents did not dwell on this.

6.2 The need for interventions

A LAC's primary need is for somewhere to live; beyond this it is for an environment which is as stable as possible while accommodating their particular issues. It seemed that the default approach is to find long-term foster care for all LAC, and to regard placing them in residential care as second-best, and almost an admission that foster care has failed. But some respondents, from representative organisations in particular, felt that this does residential care a disservice, and that residential care may be the best option in many cases because of the additional services it provides. That said, many respondents were keen to stress the disadvantages of living in residential care – primarily the fact of living close to others who are likely to be a destructive influence, and the greater likelihood of adopting destructive behaviours as a result – and highlighted LAC in residential care as a group which requires particular attention.

6.3 Comment from those in other fields

Most respondents acknowledged the importance of foster and residential carers to an LAC's health and wellbeing, and recognised that the degree of stability and support that carers provide for LAC helped them in their own fields as well. Practitioners in all fields said

that they offered training to foster and residential carers on issues relating to their field, both for the direct benefit of LAC and to facilitate their own work.

"We work with foster carers about what they're going to be doing to provide that support, additional learning, health needs and making sure they're going to the dentist or for a hearing test or to the opticians or whatever. The things that parents do."

Depth 4: social care manager, London

"They need someone who can really advocate for them, and who when we say this child needs their immunisations makes sure it happens. I think the foster carers are the unsung heroes to be honest, they're the ones that often hold it together."

Depth 14: physical health practitioner, Birmingham

CAMHS workers aimed to improve carers' ability to spot mental health problems early, for example, and educationists stressed the importance of LAC doing homework and conforming to normal school life as far as possible. Social workers, as noted, felt strongly that there are insufficient foster carers, and that their quality is variable (although they were keen to point out the value of good carers).

"We don't have enough carers. We don't have enough foster parents. There isn't a big enough push on it for people to become foster parents. When I told my friends I was going to become a carer, it was: 'What do you want to do that for?'"

Group 1: independent sector carers, London

"There are always areas to improve on. Closer networking really, I suppose, social workers working with the foster carer on a regular basis."

Depth 9: social worker, Birmingham

Mental health was perhaps the main field in which practitioners thought foster and residential carers could be more effective, given the need to identify behaviours and deal with them early. Residential care workers apparently receive NVQ training in mental health, but staff turnover in residential homes was thought to be too high for such training to 'bed down' and for experience of using it to develop. Many foster carers were said to receive training from CAMHS practitioners, as noted, but this seemed variable across the country, and often organised on an informal basis.

“They have their training through social services. NVQ training. Although it tends to be brief, and there is a huge turnover of staff. They have a brief training, are in and out, that is a national issue. With children's homes it is very difficult to have anything sustainable on a large scale because they have shifts and staff shortage, very difficult to get loads of staff out. We have adapted a training to each children's home but that is a lot of time.”

Depth 12: CAMHS practitioner, Leicester

A further issue for which more training was suggested was nutrition and cooking – especially for residential workers. Physical health practitioners in particular felt that the food cooked in residential homes is too often of the ‘fried eggs and chips’ variety, because that is what care workers might cook for themselves at home, and because they do not have the skills to cook more healthily.

“The other thing that is a big concern is children who live in residential units, because they are the most damaged normally. Even things like healthy eating initiatives are quite difficult with them. Sometimes because the staff end up doing the cooking and they cook what they cook at home which might be three fried eggs and chips. Even training for staff at home is quite important in terms of just basic things.”

Depth 15: physical health practitioner, Manchester

6.4 Effectiveness

Foster and residential carers appear to be regulated heavily, with a duty to record numerous aspects of LAC’ development, but to have few specific targets to meet themselves. In light of this, most respondents felt that they were being effective if the LAC in their charge made progress in the other fields discussed above. They thought that the best way to help LAC to achieve this is by providing a stable home environment and playing their own role in supporting physical and mental health, education and social development.

Most carers felt that the main contribution they could make to LAC’ physical and mental health and education, besides stability, is to take advantage of their understanding of their LAC and the on-going relationship they have with them to keep a constant eye on their development and deal with issues as they arise. Carers often felt that their relationship and understanding gave them a different perspective on an LAC’s needs from specialist practitioners, and wanted to make use of this. The extent to which they thought they were able to do so in practice varied, and many carers (particularly those in the independent sector) were critical of the services offered by LAC agencies, feeling that

the services were not performing in the way they should, and that carers were not able to contribute as they wished.

“You get the child and it doesn't fit the report... The child is totally different. Sometimes we might see a little bit of what they are saying, but nothing as near as what they are saying... Then you get the social worker saying: 'Excuse me, you are supposed to be working towards the report because this child is like this.' You are saying: 'No. This child is not that at all. He may have been seven years ago, two years ago, or even six months ago, but today as this child stands it is not that same child.'”

Group 3: independent sector carers, Birmingham

“Sometimes I think the social worker doesn't always listen to the people who are actually working with the children. They've got pre-conceived ideas or methods that they use which is not always appropriate or correct.”

Group 4: local authority carers, Birmingham

The prime example of this was (as elsewhere) mental health. Carers felt that CAMHS services are variable and largely inaccessible to them, and that referral can be difficult. They also believed (as did CAMHS practitioners) that carers are best placed to identify behavioural issues and to start to address these issues, as they know the LAC in their charge well and already have a relationship with them. Most carers felt they had access to substantial amounts of training on a variety of issues, either from the local authority or the organisation for which they worked, but mental health was one field in which they seemed to be less well served.

“There's a lot of training around that you can go to. Before we went on the smoking course we went on a training course for smoking and how to deal with it. There is a lot of stuff around. There is a lot of training for us to go on.”

Group 1: independent sector carers, London

Another area in which carers felt impeded was physical health, often in simple situations such as wanting to give mild medicines (Calpol etc) but needing consent from someone else, but also in more serious cases such as not fully understanding treatments and medicines that they need to dispense at home. Some also felt unable to give health promotion advice as effectively as they wanted to, as they did not know what they should be covering.

“Foster carers are not seen or are not given permission to consent to health treatments, you’ve got to get permission. I think if foster carers or anybody caring for a child is going to be able to do a good job of parenting, they need to be able to do all the things that a parent would do and expect them to do. So, you go to the dentist and you sign for the dental treatment to be done, you sign as guardian.”

Depth 4: social care manager, London

“There’s so much red tape. Like they say they want to abolish adventure playgrounds because they don’t want a kid to get hurt and somebody is going to want to sue. You can’t give a kid Calpol no more because they’re not allowed to do it. You can’t go into the bathroom and help a kid to wipe his bum no more. All this red tape... Everybody is supposed to do their job and that is it. They don’t go that extra mile they just do their job. You can’t go the extra mile. You’ll get into all sorts of trouble. ”

Group 1: independent sector carers, London

Social care issues such as not having access to a full picture of an LAC’s background or disagreeing with a social worker’s assessment were also mentioned frequently. Many seemed to want to take a less proactive role in education, but from their descriptions of the services that their LAC received it seemed that the LACES-type interventions described above were often lacking.

“Finding out as much of their background, what happened to them, their own families, what their grandparents were like – all of that helps you as the carer to understand the traumas that the child has been through and what brought them to your home. By understanding that you are then able to help the child.”

Group 3: independent sector carers, Birmingham

“If you go to education or the health service, they have no awareness at all. It is amazing. They treat these children, they normalise these children by treating them like the little boy sitting next to them who has a stable family life. So when this little boy kicks off because of the trauma he has suffered, he is just the horrible, naughty child that was sent out... Sometimes it is the educators who need educating. They have no idea.”

Group 3: independent sector carers, Birmingham

Finally, it seemed from this research that communication and understanding between independent-sector and local authority carer providers is not strong. Carers on both sides felt that the other had a ‘better deal’ in terms of access to training and best practice (local authority carers were thought to be more plugged in to national networks; independent carers were thought to be better supplied by their organisations because they had more money), but that the service

provided to LAC by their own side is better. Transfer of information between the two did not seem to be effective. Independent carers also felt more isolated from 'the system' than their local authority counterparts – they were more likely to be proactive in registering with GPs and schools, for example, but less likely to feel that they would be prioritised or treated seriously by LAC agencies.

"The private sector is certainly frowned upon. It is almost as if we are here just to grab the money. We are always asked to measure our outcomes. How do you measure an outcome? Yes, I can tell you the child is getting bigger and heavy. You don't see the developmental growth."

Group 3: independent sector carers, Birmingham

"I think with the individual organisations you get better staff. The voluntary organisations, they get better training and if it's a large organisation there is a system out there and they seem to be able to access."

Group 4: local authority carers, Birmingham

"It is not a level playing field. We are in business, we provide a service. We do our own in-house training. Have our own staff. There is a cost to everything. There is almost a reluctance to pay this cost. They will actively look for the cheapest place."

Group 3: independent sector carers, Birmingham

These types of concern meant that most carers felt undervalued and undermined in terms of their contribution to LAC' health and well-being. All could see the importance of providing a stable environment; the most proactive and involved wanted to extent this to work in the specialised fields discussed above, but felt restricted in their ability to do so.

"One thing that annoys me is how the boroughs don't speak to each other too well... When that child leaves one borough, they don't want to know. It's so sad.. They don't care. They care about their money and how it looks good. They don't even pretend to care when somebody dies. Everybody flaps and people lose a couple of jobs and a couple of headlines, and it all goes quiet again... That's how the world is run. We're just a few little people, and there's a couple more little people like us out there trying to do our bit."

Group 1: independent sector carers, London

D. CONCLUSIONS

1. **Overview**

Three overarching themes regarding current practice around promoting the health and well-being of LAC have emerged from this research. The first, and perhaps most basic, is the need to provide as normal and stable an environment for LAC as possible, while taking into account their particular needs. The second is the need for communication and cooperation between LAC agencies, and a degree of consistency in service provision between local authorities. The third is the need to recognise the degree to which issues in the fields of mental health and education impact on an LAC's health and well-being, and the fact that practitioners in all LAC agencies can and should contribute to efforts to address these types of issue.

These three themes are discussed in more detail below, followed by a list of specific points about the main issues and needs which emerged for each of the five fields.

2. **Normality and stability**

Providing a stable environment in which LAC can live, study, socialise and develop is clearly fundamental to their progress in individual fields and to their overall health and wellbeing. Stability allows LAC to start to deal with traumas they have experienced before going into care, to develop self-esteem and confidence, to look forward to the future as well as the present and the past, to achieve at school, and to develop socially. The health benefits which flow from and depend on stability are wide-ranging, for example: mental health issues can be addressed against a stable background; greater self-esteem makes LAC more likely to pay attention to their physical health; achievements at school feed this self-esteem and make for a brighter future. Equally, instability is likely to have the opposite effect: undetected and worsening mental health problems; inattention to personal health; failure in education and risk of destructive behaviour and social exclusion in later life.

There are a number of aspects to stability. Most obvious is the care placement. Long-term foster care is thought ideal, provided a suitable match can be found and the LAC in question takes to it. Short-term foster care is thought disruptive but often necessary, until a long-term

placement can be found. Residential care is often seen as a 'last resort' if foster care breaks down completely – it is often fairly stable in itself, but it involves close contact with other disruptive LAC – but it may be the best option for some LAC who require special attention.

Perhaps the next in importance is school placement, since young people spend significant periods of time here: long-term attendance and progress at a local school is ideal, and can be facilitated by LACES services (see below); exclusion and/or a move out-of-area is disruptive to stability as well as education. A third important aspect to stability is continuity of service, be it an LAC's social worker or the service framework he or she encounters when moving out of area.

Alongside stability, normality is clearly key to LAC' acceptance of interventions. The stigma of being in care is strong, and many LAC, especially teenagers, want their status to remain a secret from their peers. This means that interventions need to be designed and given in as unobtrusive a manner as possible, while remaining effective. In practical terms, this means health interventions being given at the GP surgery or at school, rather than in hospital, and education interventions being given out of school time or anonymously in classroom groups.

3. **Communication and consistency**

It is very clear from this research that 'health and wellbeing' relates to a much wider set of issues than physical health alone. Indeed, physical health seems to be better provided for, and less widely salient, than many other fields. Specific aspects of LAC' health and wellbeing in this wider sense are addressed by agencies which specialise in these areas, but it is clear that a holistic approach to service provision is more effective than one which operates in silos. The fact that education can impact on mental health, and that living environment can affect physical health, for example, is widely recognised and highlights the need for agencies to communicate and cooperate with one another. The beneficiaries of such cooperation are the LAC themselves, who receive a service which takes account of their overall situation, but also the individual agencies, which are able to perform better against their own targets and measures. Communication between agencies seems to be improving in most areas, but the rate of this improvement appears variable, and there are numerous specific areas which might be addressed in the guidance (see below).

The consistency with which agencies operate in different local authorities is important to the stability of LAC' experience of services (as noted above) but also to the efficiency with which agencies are able to deliver those services. Again, various specific areas which might be addressed are noted below, but in general discrepancies between agencies in different areas result in incompatible record-keeping, more travel for practitioners to out-of-area LAC, more displacement of LAC to other areas offering specific services, and difficulties in disseminating best practice because the situations in which it is to be implemented vary.

4. **Mental health and education**

These two fields need to be highlighted for different reasons. Mental health is recognised as the aspect of LAC' health and wellbeing that is perhaps most widespread and certainly most difficult to address. Practitioners in all fields – physical and mental health, education, social work, foster and residential care – feel that they have some contribution to make to the identification and treatment of problems. But CAMHS services themselves appear to be some of the least accessible, least well understood, most arbitrarily funded and most variously structured agencies in the 'LAC family'; and other practitioners often feel unable to address, or play their part in addressing, mental health issues due to lack of training, understanding of the system or consistent tools.

Education is also recognised as important to an LAC's health and wellbeing because of the stability, normality, self-confidence and future prospects it provides, but this recognition seems to be recent and variable. Practitioners felt that education services would be more effective, and therefore help to improve outcomes on these levels, if their importance were recognised and they were resourced and regarded more appropriately.

5. **Specific issues**

The following is a list of interventions and ideas which respondents believed would benefit the health and wellbeing of LAC.

5.1 Systemic issues

- a multi-agency approach to service delivery, involving close and long-term contact between practitioners in the various agencies
- ideally, a move towards co-location of services, to improve communication between agencies and make them more accessible
- greater dissemination of guidance and locally developed best practice by a credible source, provided that it remains optional, flexible and adaptable to local circumstances
- increased funding of agencies (and no concomitant decrease in freedom to innovate) to allow them to implement this guidance and best practice

5.2 Physical health

- greater consistency as to who holds an LAC's medical records – requiring GPs to register LAC as permanent patients would be helpful here
- greater consistency across local authorities and types of practitioner as to the type and amount of medical information recorded, and indeed the type of form used for this
- greater clarity around who should be able to give consent for interventions – social workers, carers, parents etc – and a move away from parental consent for minor interventions
- greater consistency across local authorities in the way in which physical health services (routine assessments etc) are delivered
- individual interventions offered in 'normal' settings, such as GP surgeries or schools, rather than hospitals
- an emphasis on health promotion activities (group and individual), particularly among LAC living in residential care

- more effective coordination of health promotion between school, health professionals and carers, so that each knows what they should be doing

5.3 Mental health

- improved relationships with other agencies, so that practitioners who want to refer LAC know how their CAMHS unit works, whom they should contact and what will happen
- greater emphasis on preventative measures, such as training for non-mental health practitioners to help them identify and address mild problems themselves
- greater consistency of CAMHS provision across England, to reduce the number of LAC who have to be moved out-of-area if the service they need is not available locally
- flexible individual interventions which acknowledge an LAC's circumstances (ie, not necessarily requiring a stable placement for a year before intervening)
- services dedicated to LAC and experienced in their particular types of problem (ie complex, multi-stranded), rather than being divided between them and other vulnerable groups
- a routine SDQ which all practitioners could use to help them to refer LAC if necessary
- more advice for practitioners in all fields on how to deal with attachment issues, both initially when leaving parents and when moving in care
- regular meetings which involve all agencies and focus on mental health (akin to those in place for physical health and social care)

5.4 Education

- greater recognition of the importance of education to LAC across all agencies – ie, taking schooling needs into account when making decisions about care placements
- emphasis on the need for LACES to work 'within' the local authority system rather than outside it
- greater efforts to persuade LAC that academic qualifications may not be the most appropriate route for them, and to persuade local authorities that this is a legitimate approach
- for LAC: help with work, extra tuition, advice about how to cope with school, extra-curricula activities to develop outside interests and peer support
- for LAC: a mix of individual and group support offered out of school (ie in care homes, 'virtual schools', at home, as part of extra-curricula activities) and anonymously (ie, as part of a wider group of pupils) in school
- for schools: hands-on involvement with LAC from LACES practitioners, consultancy from LACES staff on how to deal with LAC' needs, greater ability of LACES to influence schools' attitudes towards LAC
- for carers: greater emphasis on the need to support LAC in their education – ie, ensuring that they do their homework, sit for their exams etc

5.5 Social care

- greater continuity of social care – lower turnover of social workers
- improved communication between social workers and all agencies
- more training and advice on how to deal with attachment issues, for when LAC are moved from a long-term foster placement
- greater numbers of social workers to reduce caseloads

5.6 Foster and residential care

- greater autonomy to allow the most proactive, committed foster carers to operate as they would like
- greater influence over health and social care assessments – carers felt they had a significant perspective on the LAC in their care which should be taken into account
- improved communication between the local authority and independent sectors to share ideas and best practice
- a faster system for notifying social workers when placements become available
- greater numbers of foster carers

Appendix

NB lower priority areas in italics**1. Introduction**

- current role and client group, length of time in position, rewards and challenges of role; previous positions
- briefly, what are the main drivers of practice in your field – policies, targets etc
- what other practitioner / professional groups do you work most closely with; how does this relationship work

2. Healthy LAC and young people

RECOGNISING THAT WE WILL SPEAK DIRECTLY TO CHILDREN AND YOUNG PEOPLE LATER, IN THE PRACTICE SURVEY, AND THAT RESPONDENTS CANNOT NECESSARILY SPEAK FOR CHILDREN AND YOUNG PEOPLE...

- what do you understand to be a healthy looked after child – how do you define this?
- what health outcomes do you think are valued by LAC and young people themselves; which are less important to them; what is your basis for saying this
- which of these health outcomes do you think most need to change or improve; what effect on LAC and young people do you believe these changes would have (probe representative organisations for their views on behalf of LAC)
- are there any particular groups of LAC which should be prioritised for the guidance; your rationale for this – most vulnerable, least well provided for currently etc

3. Good practice

- do you feel there is a general consensus in your field about what works and what constitutes good practice; why / why not
- *what about the other professional groups that you work most closely with – what do they think?*

- what types of interventions / programmes / services do practitioners use to improve the health of LAC in their care; what works well?
- *probes could include asking about local services and activities that promote the health welfare and well being of looked after children and young people such as:*
 - *community interventions / one-to-one interventions with LAC or their carers or families*
 - *interventions and services specifically for LAC*
 - *activities and services available for all children and young people as well as those for vulnerable groups of children and young people*
- *in your professional opinion which other types of intervention do you think work particularly well*

4. **Opportunities for change**

- overall, how acceptable and accessible do you feel that current services are for LAC and their families and carers; if necessary, how could this be improved
- what have been the main improvements in your field in the last 5 years; what do you feel you are doing better / well; what effect do you think that this has had on outcomes for LAC and young people

5. **Gaps**

- are there areas of your practice where there is little guidance / support / evidence available; would help to have better evidence / guidance / support in these areas
- what might this additional guidance / support / evidence involve
- are there areas in which you need extra support (e.g. information, training, resources, structural changes or policy)
- *if so, whom would you expect to provide this support, and from whom would it be most valuable*

6. Challenges

- what are the main challenges in your area of work
- have developments/changes over the past 5 years improved your work / practice, or made it more challenging to do a good job; why do you think this is

7. Use of evidence and guidance

EXPLAIN THAT SCIE AND NICE ARE PRODUCING JOINT GUIDANCE ON IMPROVEMENTS FOR LOOKED AFTER CHILDREN AND YOUNG PEOPLE.

- what do you feel it would be most helpful for this guidance to cover; what would you expect it to cover
- what is your view of the importance of guidance from NICE and SCIE; what effect on work in your field do you think it will/should have
- what national and local protocols / guidelines do you find most useful in underpinning your work with looked after children and young people; what sources of information and/or evidence do you use (reassure respondents that this is not a test, to find out how much they know, but to find out what they find useful and not so useful)
- how do you follow examples of good or promising practice in your work; how do you identify these examples; is this easy to do in your work; if not, why not
- is it possible / feasible to be innovative in your practice; is there room to adopt examples of best practice, or to experiment and develop your own
- *how do you think that joint guidance from NICE and SCIE will be taken on by practitioners in your field*
- *what activities might help to implement this guidance, and maximise its take-up*

8. Summing up

- is there anything you would like to ask / add