



Factors associated with the ability of the care system to meet the physical and mental health needs of young people looked after in England: a mixed-methods study.

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Glossary of terms for the purpose of this study

Care Leaver

The Children (Leaving Care) Act 2000 defines care leavers as individuals who have been in the care of a local authority for a period of 13 weeks or more spanning their 16th birthday. The services and support available to them during their transition to independence will depend on their status.

Children and/or young people in care (Looked After Children)

Children and young people are legally defined as being 'looked after' under the Children Act 1989 if they have been in local authority care or provided with accommodation by the local authority for more than 24 hours (under Police Protection or as subject to a care order). Children and young people only cease to be 'looked after' if a court discharges the care order, they are placed for adoption, they become subject to a Special Guardianship Order, or when they reach their 18th birthday, at which point they become defined as a 'care leaver' under the Children (Leaving Care) Act 2000. This study refers to 'looked after children' as *children and/or young people in local authority care* as recommended by the youth advisory panel and research participants.

Child in need

A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health, development and well-being, or whose health, development and well-being is likely to be significantly

or further impaired without the provision of services. It may also include a child with a disability.

Corporate Parenting

The term corporate parenting comes from the Children Act 2004 and refers to the collective responsibility of local authorities and their partner agencies to provide the best possible care and protection of the children and young people in their care (looked after children). They are expected to act in the same way as a birth parent would.

Health behaviour

These are behaviours that effect an individual's health. These can be positive behaviours (eating healthily and taking regular exercise) or negative behaviours (not brushing teeth or eating unhealthily).

Looked After Child (LAC) review

Children and young people in care are required to have reviews that bring together the professionals (and where appropriate, birth parents) to review the care that they are receiving and to document how they will be cared for going forward. The first review is held after 20 working days of the child or young person entering the care system and the second review (if they remain in care) must take place within 3 months of the first. After this, reviews are held bi-annually.

Personal Education Plan (PEP)

Personal Education plan or PEP meetings are held to bring together the professionals and child or young person to look at their educational outcomes and achievements and to review what support they may need going forward.

Risk-taking behaviour

These are behaviours that put individuals and their health at risk. For the purpose of this study, risk-taking behaviour includes smoking, self-harm, substance misuse, and criminal activity.

List of abbreviations

ADCS: Association of the Directors of Children's Services

CCG: Clinical Commissioning Group

CHCR: Child Health Computer Records

CLAD: Children Looked After Dataset

CQC: Care Quality Commission

GP: General Practitioner

IRO: Independent Reviewing Officer

LAC: children and young people in care

NHS: National Health Service

NPD: National Pupil Database

PEP: Personal Education Plan (involves a meeting)

SDQ: Strengths and Difficulties Questionnaire

UASC: Unaccompanied Asylum-Seeking Child (or young person)

Abstract

Background: Evidence suggests that children and young people in the care system have exceptional physical and mental health needs. Before entering the care system, they are likely to have experienced childhood poverty, child abuse and/or neglect, domestic violence and other adverse experiences, all of which have been associated with adverse health outcomes in adulthood. Government initiatives have endeavoured to meet the health of needs of children and young people in care in England by developing nationwide specialist health services to assess and monitor their health. However, little is known about how well the health needs of children and young people in care are met, or how children and young people in care experience specialist health services.

Methods: The aim of this study was to explore what factors were associated with the ability of the care system to meet the physical and mental health needs of children and young people in care, and to consider the barriers that prevent them accessing or engaging with routine and specialist health services. Drawing on Bronfenbrenner's ecological systems theory as the conceptual framework, this convergent mixed-methods study, undertook statistical analyses of the English Children Looked After Database (SSDA903) and National Pupil Database to identify characteristics and care or educational experiences that were associated with health assessments, dental checks, and immunisations being up to date. These statistical analyses also explored factors that were associated with young people having mental health difficulties, substance misuse problems or criminal convictions. Visual and creative methods were employed during extensive, in-depth interviews, in which eight young people in care (aged 12 to 18) collaged life-size human bodies to represent their own health and health experiences.

Results: Analyses of the data in this study revealed several factors associated with the ability of the care system to meet the health needs of young people in the care system. The interviews with young people in care suggest that children and young people enter the care system with a poor understanding of normative

health care (such as primary care, dental care, healthy eating, and sleep and exercise routines). The statistical analyses revealed that young people who had been in care longer were more likely to be up to date with immunisations but less likely to be up to date with health assessments. Moreover, young people who had experienced multiple placement changes, had been placed in residential care, had received a fixed-term exclusion or had a special educational need were more likely to have mental health difficulties, substance misuse problems and criminal convictions. The results also suggest that young people begin to disengage with specialist services due to their desire to feel normal and not wanting to be treated differently to their peers in the general population.

Conclusion: The results suggest that, at least to some extent, the care system is providing compensatory health care for those children and young people with the greatest needs. However, this study has also shown that the current data collection for the Children Looked After Database (SSAD903) does not facilitate the understanding of some key issues relating to the health needs of children and young people in care, such as the range of physical and mental health issues they may have and whether they have access to other specialist services (such as outpatients) to ensure that any identified health needs are met. Moreover, young people in care are striving for normality and yet do not understand how to navigate normative health services such as primary care. These findings may inform future interventions to promote the health and well-being of children and young people in care.

Dedication



This thesis is dedicated to my little my sister who gained her angel wings during my DPhil journey. This is one of my favourite photographs of you because despite looking so angelic you had just had a cheeky moment. You told me to go and get you more coca cola, so I asked the lovely family sitting next to us to keep an eye on you and when I returned you were all giggling and my coffee cake had vanished! When I asked you if you had eaten my cake you simply said 'yeah' and smiled angelically before giggling again. You taught me some of the most valuable life lessons: I have never met anyone who is so loving, caring, cheeky, and happy despite everything you went through. You taught me how to love, to be kind and grateful, to see the good in everything and everyone, and to think positively without dwelling on the past. I would not be where I am today without you so to you, I owe everything. Words cannot describe how much I love and miss you, but I am so grateful that I got to call you my sister. I will treasure our memories together forever.

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Chapter One: Study background

My enthusiasm for this research stems from my own experience of growing up in local authority care because my first memory of the health care system was a traumatising experience. I was just seven years old when the police arrived at my house to escort my birth mother and me to the local paediatric hospital. They believed that I was being physically abused but they needed evidence before they could apply for a police protection order. I lived with my birth mother and stepfather in a three-bedroom house, along with my two younger sisters. My sisters and I all had the same biological father although we did not have contact with him at the time. My sister (the next eldest child) suffered from severe epilepsy and as a result had complex care needs, my other sister was still a baby. Only I was taken into the care system initially. But when her health declined my sister was also taken into care but by another local authority as my mother had moved. My youngest sister remained with my birth mother and stepfather who later had three children of their own. Due to my sister's medical conditions, we were unable to stay together in the care system; I was placed within a foster family, and she was placed in a residential unit for children with disabilities.

In attachment terms, my relationship with my birth mother and stepfather was somewhat *disorganised* (Main & Hesse, 1990). If ever I was in need or distressed and craving the comfort of my attachment figure, I would be met with a leather belt, wooden spoon, rolling pin or any other object that was in reach.

This would escalate my level of distress and would leave me feeling alone and anxious. Howe (2005) suggests that abusive parents feel stressed as a result of being faced with the needs of their child, and they are likely to become *disorganised* and out-of-control. My mother and stepfather had not adopted a strategy in which to deal with their own or my arousal, resulting in an outburst of hostile behaviour. As time went on, I recognised several factors that triggered their aggressive behaviour. If either my sister or I cried, tried to talk to them or wandered too close to them, they would react in an aggressive manner; thus, suggesting it was in fact our attachment behaviour that caused their violent outbursts. Moreover, and reflecting Pianta, Egeland, and Erickson (1989) findings on the cycle of maltreatment, my birth mother had been neglected and emotionally abused and my stepfather had been abused during their own childhoods. My stepfather grew up in the care system as a result of abuse, and his younger sister had died at the hands of her abusers. I assume these to be unresolved traumas which compromised their ability to parent us. By activating our attachment systems, my sister and I would also activate their attachment system thus causing their arousal. Consequently, this activated their earlier unresolved attachment trauma, which left them feeling disorganised and distressed and led them to have a hostile outburst (Atkinson & Goldberg, 2004; Howe, 2005). My birth mother and stepfather's behaviour resembled what Lyons-Ruth, Bronfman, and Atwood (1999) call '*Negative-Intrusive Behaviour*', they would often inflict pain on me, followed by teasing or laughing and if I cried they would hastily snatch my ear and pull me towards them before pushing me away again. They continually attempted to humiliate me.

As I grew older, I learned that my desire to be cared for was causing me more harm than good and I began to adopt strategies to protect myself. When both my birth mother and stepfather were at home, I had no choice other than to comply with their every demand. I became withdrawn and was constantly on guard; whenever possible I would avoid contact with them in the hope of reducing the risk of triggering an outburst. This type of behaviour can be compared to *Compulsive Compliance* (Crittenden & DiLalla, 1988): in order to avoid an abusive outburst, I would be highly compliant, and constantly tried to evaluate and anticipate their moods. When my stepfather went out and my birth mother was left at home with us, my behaviour appeared to change. I would talk down to her and challenge everything she said; this was the time that I was able to get everything that my sister and I needed, such as food (which I would often hide). One day, my stepfather had to go away overnight, so I used this to my advantage. I managed to trick my birth mother in to going out into the back garden and I immediately locked her out of the house. I left her there and went and made something for my sister and I to have for dinner. I carried my sister down from her bedroom to the living room and we sat and watched 'Beauty and the Beast' while my birth mother remained in the garden. Once it had finished, I gave my sister her medication and a bath, and put her to bed. I then let my birth mother back into the house, saying '*that will teach you for being naughty*'. Crittenden and Claussen (2000) refer to such behaviour as *Compulsive Self-Reliance*.

The medical examination that the police escorted me to probably saved my life but it later impacted on my readiness to engage with the health care system. Various adults dressed in white coats stood around the examination bed where I lay naked, humiliated, and paralysed with fear. The examination felt like it lasted a lifetime because the paediatricians had to count, measure, and photograph every single bruise, cut, abrasion and cigarette burn that was on my body. One paediatrician even put a torch on his head and inspected my genitalia for any abnormalities or signs of sexual abuse. They also kept asking me how I had received my injuries, but I was too petrified to answer because my birth mother was standing right next to me. She had told me on several occasions that if I told anyone that she or my stepfather had hurt me, she would hurt or kill my little sister. Luckily for me, the police decided that my injuries were non-accidental and as a result, I was taken into emergency foster care that day and placed on a full care order when I was eight (Kelly, 2016). The plan at that time was for me to be slowly transitioned into my father's care. However, my placement broke down and I moved to live with my father a few months before the planned date. Living with my father did not turn out to be a good experience. My father had a short temper and did not know how to parent me. He would lather me with gifts, we had fast food for every meal, and I had a shoebox filled with sweets that I could eat whenever I liked, but he lacked the warmth and affection I needed to overcome my past trauma. He also lacked any awareness that childhood trauma could still have been impacting on my emotions and behaviour. On top of this he was a heavy smoker and drank alcohol every evening. I once witnessed him push my social worker down the stairs after he had tried to give me a letter from my mother (as directed by the

court). Social workers stopped coming to visit me after this and I became more and more terrified of my father, always trying to avoid triggering his anger. He soon got bored of being a stay-at-home father and after just a month he was sending me to live with various families while he went to work for weeks at a time. He even worked with one family to forge a court document saying that my care order had been discharged. After another lengthy court case I was placed back into care and at the age of nine my father stopped attending contact sessions to see me.

Being in care meant that I had to attend health assessments at the hospital every six months. I could never understand the point of these assessments. I just wanted to be like my friends but instead I would have to miss school and go to the hospital where I would be told to strip down to my underwear and perform tasks, such as standing on one leg. I never knew why I had to do these things but at the time I was compulsively compliant and self-reliant because my previous experiences had taught me that if I did not do as I was told I would be beaten. I did not have the ability to say 'no' or to challenge what was being asked of me. On one occasion I tried wearing a pair of tights instead of socks in the hope that I would not be told to take them off – but I was. If the paediatrician had given the option of keeping my tights on that day then I probably would have continued to attend my health assessments but instead, at the age of 11, I just started refusing to go. My self-reliant behaviour was the type of behaviour that became most apparent when I was in the care system. I would not allow adults to care for me; I did not trust them, so instead I continued

to look out for myself. This was one of the main challenges my foster carers faced when trying to help me overcome my past traumas:

“Attachment trauma damages the safety-regulating system and undermines the traumatized person's capacity to use relationships to establish a feeling of security”

(Allen, 2001, p. 22)

As a child I very rarely caught coughs or colds. I only ever attended the doctors' surgery for the odd immunisation or asthma check-up. My General Practitioner (GP) seemed to change every time I had an appointment, so they were just strangers to me. I did not trust adults at that time so I certainly would not have listened to any health advice they would have given me. Looking back though, I wonder whether the health assessments would have been more useful during adolescence because no one had talked to me about health or puberty at that time. I was far too embarrassed to go and ask the GP questions because for some reason they were always male and I was still afraid of men at that time. Plus, they never read my notes and they would become visibly uncomfortable if I told them that I was in local authority care or that I had been abused as a child. At that time, I was often very blunt about my experiences because as a child in care I felt like I was always having to explain why I was in care. But I was ashamed of the fact that I was in care because it meant admitting that I was not loved or wanted. I did not feel like I belonged anywhere back then, and at the age of 13 I eventually ran away from my foster family back to my birth mother and stepfather. I spent a year living with my birth mother and stepfather,

but the abuse started again after just a couple of weeks. They both drank excessively, would get into fights with each other and would take their anger out on me. They also made me responsible for my siblings and if they became too loud or misbehaved, I would be punished. I eventually managed to run away, and thankfully social services found me a foster home.

I lost my way for a while after this; I started self-harming and got in with the wrong crowd. I knew that they were a bad influence on me, but I desperately needed to feel accepted. I distanced myself from my foster carer and in times of distress I would lock myself away in my room – outwardly people thought that I was fine. I had not received any guidance about my emotions, and I lacked the understanding about why I felt the way I did. By the time I was fifteen my birth father was back on the scene and I was having regular contact with him including overnight stays. Sadly, he died of a heart attack just a few weeks before my GCSE exams. I was completely devastated at this point because I felt like I was alone in the world. The only thing that got me through was knowing that my little sister (who had complex health needs and disabilities) needed me. I was now the only person who could give her a positive future, and this motivated me to study so that I could go to university. My earlier childhood experiences and my multiple placement changes (which meant I sometimes had to also change school) resulted in me falling behind peers educationally, and my teachers did not expect me to achieve my GSCE's. Fortunately, I received extra tuition and spent time studying, which meant that I received the five GCSE's I needed to go to college.

I initially undertook a BTEC diploma in Early Years Development but I had not been told that it would not provide enough UCAS points to apply for university. So, I later undertook an access to higher education course and I was offered a place to study a bachelor's degree in Applied Psychology and Sociology at the University of Surrey. However, my time in higher education was extremely challenging and I faced several adverse circumstances. Despite being so self-reliant I struggled to transition into independence, and I found it particularly difficult seeing the support that my friends received from their families. The holidays were the worst because everyone would head home to his or her families and I would be left alone on an empty campus. I developed some close friendships during the first year of my undergraduate degree. Despite initially hiding my care leaver status from them due to feelings of shame and the fear of being stigmatised, they helped me to talk through and better understand my experiences. I also had to work a large number of hours in order to support myself at university and I struggled with my academic work. I failed several modules and eventually I had to retake my first year. When I handed in an essay about naturists instead of nativism my tutors suggested that I be tested for dyslexia, which was diagnosed about one year later.

My biggest challenge though, was dealing with my little sister being admitted to hospital and having to be put on life support multiple times. I often travelled the 320 miles round trip just to be with her because her doctors always told me that I had to 'prepare for the worst'. My own health eventually deteriorated, and in 2011 (with the help of the designated nurse for looked after children) I was diagnosed with narcolepsy. The designated nurse was a godsend because I

did not know how the health care system worked and I was still trying to complete the final year of my undergraduate degree. When trying to seek help from the GP, they would often assume that there was nothing wrong with me and would tell me that I must be depressed because of my childhood. I found this very frustrating because I did not believe I was depressed.

During the final year of my undergraduate degree, I chose to do the module on Health Psychology, and I was receiving high grades for this. I found my personal experience gathered from my time in care inspired my research interest in the health of children and young people in care. I decided that I wanted to undertake the master's in Health Psychology but was devastated when I discovered I was less than 2% away from the grade needed to do it. With nothing to lose I decided to go and speak to the course director to explain my situation. I was delighted when she agreed to give me a chance and accepted me onto the course. The master's in Health Psychology allowed me to develop a range of research competencies such as conducting systematic reviews and applying psychological theories to practical situations as a means of promoting health behaviour and compliance to treatment. Completing my masters was exhausting as I had to work a full-time job to pay for my full-time course. The only time I was able to complete my assignments was overnight. When my sister was admitted to the intensive care unit for status epilepticus, I decided to write my systematic review assignment on the use of vagal nerve stimulation as a treatment for status epilepticus. My sister had always had severe epilepsy and medications had never been very effective. As a teenager she was one of the first child patients to receive a vagal nerve stimulator as part

of a clinical trial. This was a very under-researched area, but I found several case studies that had found that temporarily increasing the electrical current had stopped the patient's episode of status epilepticus. I went to my sister's consultant with my findings, who spoke to a specialist about what I was suggesting. They both agreed to try increasing the voltage of my sister's vagal nerve stimulator and fortunately it worked, and she returned home just a week later. For my dissertation I decided to use surveys to compare the eating behaviour of young people in care and their peers in the general population, with a focus on the role of their perceived early childhood attachments. I was motivated to do this because of my own experiences of being fed 'easy' foods in care and struggling to understand what I should be eating as an adult. I would find that my diet was all or nothing and finding a balance was challenging and when I was in care I had been considered a 'fussy' eater. After speaking to other young people in care I discovered that I was not alone.

I successfully completed my masters in 2013 and I was awarded the Ann McPherson Fellowship to work with the Health Experiences Research Group at the University of Oxford. I really valued working in an environment of qualitative research expertise and it provided me excellent training in and experience of conducting qualitative research. Throughout my fellowship I continued to reflect on how challenging it was for me to navigate the health care system and to learn how to take control of my health, and I wondered how other children in care were finding the health care system. Since I have left care there have been many positive changes to the services available to children and young people

in care. However, they continue to withdraw from these services and their health status remains poor. Hence, I was keen to explore how we might better promote the health of children and young people in care. I was delighted when I was offered a place to do my Doctor of Philosophy (DPhil) in education with the Rees Centre and received a doctoral scholarship from the Wellcome Trust.

I started my DPhil in 2014 and during my first year I made lots of connections with healthcare professionals through conferences and other events. I also joined the fostering panel for a local authority as an independent member. However, in 2015 my progress dramatically slowed down because my sister was diagnosed with breast cancer in September. Her mastectomy had to be delayed several months because she developed a chest infection and needed specialist surgeons because of her other complex health needs. She eventually had her mastectomy a few days before Christmas but in January 2016 her consultant broke the news that the cancer had spread to her lymph nodes and she had stage four, grade three cancer. Chemotherapy and radiotherapy were considered to be too risky due to her other conditions, so the focus turned to palliative care.

A few months later I had one of my annual check-ups with my neurologist for my narcolepsy. I explained what had been happening with my sister and he told me that she might have a genetic condition called Ataxia-Telangiectasia. I had never heard of this before and immediately started reading about it when I got home. The condition fitted my sister exactly, so I decided to contact her

consultant and adult social care to ask for her to be tested, which they agreed. Unfortunately, my sister passed away on the fourth of July 2016, but we later discovered that she did in fact have Ataxia-Telangiectasia. Although this is a degenerative and life limiting condition, I felt my sister had been let down because she did not have a parent figure advocating for her or fighting for answers so that her full needs were known and could be met. For example, knowing that she had a poor immune system would have meant that she was better protected in care homes and perhaps might not have been admitted to hospital for chest infections and pneumonia as often as she was.

A couple of years after my sister's death I decided to apply to foster older teenagers. Fostering has shown me a completely different side to the challenges of meeting the health needs of young people in care and how the challenges faced may differ for each young person. For example, discovering that unaccompanied asylum-seeking young people can face significant delays in receiving immunisations because of needing to be tested for tuberculosis first, having to fight to get any kind of mental health support for older teenagers with complex mental health needs and being on long waiting lists despite significant self-harm and suicide attempts, and the challenge of trying to teach young people how to live healthy lives and adopt healthy coping strategies with limited input from professionals. This has not been the case since I have been approved to foster children of all ages, with children and young people under the age of 16 I have been offered an abundance of support. This suggests that there may be a lack of understanding around the ongoing needs of young people transitioning out of care.

My experience of the care system and my sister's own experiences of unmet health needs have motivated me to embark on a lifelong career to explore how the care system can better identify children's physical and mental health needs and ensure that they are met.

Chapter Two: Introduction

It has long been recognised that children and young people enter local authority care with exceptional health needs due to their earlier adverse experiences. Legislation and national policies focusing on the health needs of those in local authority care have developed over time, placing emphasis on the need for specialist health services. Despite the development of specialist health care services for children and young people in care, there is a substantial body of evidence that suggests that their health outcomes in adulthood are still poor.

This study set out to explore what factors were associated with the ability of the care system in England to meet the physical and mental health needs of the young people it looks after. The author undertook a secondary analysis of the national data routinely collected concerning access to health services and mental health or risky behaviours among the care population in England by using the Children Looked After Dataset (SSDA903). By linking the Children Looked After Dataset with the National Pupil Database the study also explored whether certain characteristics (such as gender) and care or educational experiences (such as length of time in care or number of school changes) were associated with young people's access to specialist and routine health services, and which groups of young people were most likely to have mental health difficulties, substance misuse problems or criminal convictions. The study further employed visual and creative research methods to gain qualitative data from eight young people in care (aged 12-18) to explore their perceptions of health, including how they believe they learn to be healthy or why they may turn

to substances, and why young people might not gain access to or engage with specialist and routine health services. Young people took photographs and produced artwork (life-size human collages) to represent their own health and health experiences and they also presented key messages that they felt professionals should know to promote the health of other children and young people in local authority care.

Children and Young People in Care (Looked After Children)

How and why do children become looked after?

Local authorities in England were responsible for some 80,080 children and young people on the 31 March 2020 (Department for Education, 2020), (the most recent available data). Figure 1, developed for this study, shows that children and young people may enter care in a number of ways:

1. Under a Police Power of Protection (Under Section 46 of the Children Act 1989) whereby the police remove a child as they believe the child is at risk of immediate and significant harm.
2. Under an Emergency Care Order (under Section 44 and 46 of the Children Act 1989) whereby the court grants the local authority shared parental responsibility for eight days (can be extended for a further seven days).
3. Under an Interim Care Order (under Section 38 of the Children Act 1989) whereby the court grants the local authority shared parental responsibility for eight weeks (there is no limit to the number of interim care orders the local authority can apply for).

4. Under a Full Care Order (under Section 31 Children Act 1989) whereby the court grants the local authority parental responsibility until the child or young person reaches eighteen.
5. Under a Voluntary Agreement (under Section 20 of the Children Act 1989) whereby parents/guardians or the young person themselves voluntarily agree for the child or young person to go into care.

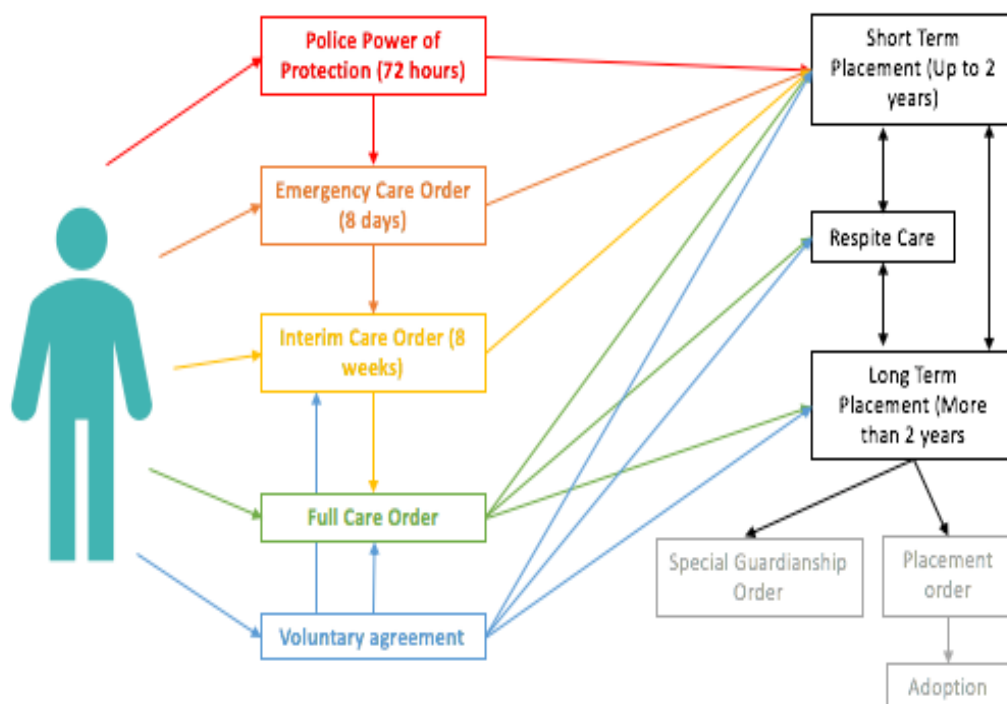


Figure 1: Pathways through care

However, young people in care are not a homogenous group (Sinclair, Baker, Lee, & Gibbs, 2007). Some young people may leave and re-enter care a number of times while others may move from short-term to long-term care. Moreover, some young people may be able to live in the same home for their

entire care journey, while others may experience multiple placement changes (Ward, 2009).

This study focuses on young people who have been in local authority care for a minimum of twelve months. National statistics show that of the 80,080 children and young people looked after in England on the 31 March 2020, 61,320 (76 per cent) were subject to a care order (interim or full care order), 13,600 (17 per cent) children and young people were looked after voluntarily and 4,850 (6 per cent) children and young people were subject to a placement order, which allows a child to be placed for adoption (Department for Education, 2020). The number of children and young people looked after under a care order has increased from previous years, and children and young people looked after under a voluntary agreement has decreased.

Evidence suggests that children and young people who are provided with permanency and the opportunity to develop a sense of belonging go on to achieve positive outcomes later in life (Bada et al., 2008; Frey, Cushing, Freundlich, & Brenner, 2008). For example, it has been found that placement instability in care can have a direct impact on young people's mental health, regardless of their past maltreatment or trauma (McGuire et al., 2018). In the past it could take years for the court to decide whether a child or young person should be subject to a care order, placement order or special guardianship order (McSherry, Larkin, & Iwaniec, 2006). However, The Children and Families Act (2014) set out a 26-week time frame for those decisions to be made. Although proceedings can be extended by up to eight weeks at a time, it is only

at the court's discretion. This development was to ensure that children and young people have a sense of permanency as soon as possible.

As shown in Figure 2, of the 80,080 children and young people who were looked after on the 31 March 2020, 51,780 (65 per cent) were in care due to abuse or neglect, 11,230 (14 per cent) due to family dysfunction (parenting capacity was reduced long-term), 6,090 (8 per cent) due to their family being in acute stress (parenting capacity was reduced due to a temporary crisis), 5,330 (7 per cent) due to absent parenting, 2,180 (3 per cent) due to the child's disability, 2,300 (3 per cent) due to their parents' illness or disability, 1,070 (1 per cent) due to socially unacceptable behaviour, and 110 (less than 1 per cent) due to low income (Department for Education, 2020). Of the 5,330 children and young people in care due to absent parenting, 5,000 (94 per cent) were unaccompanied asylum-seeking young people.

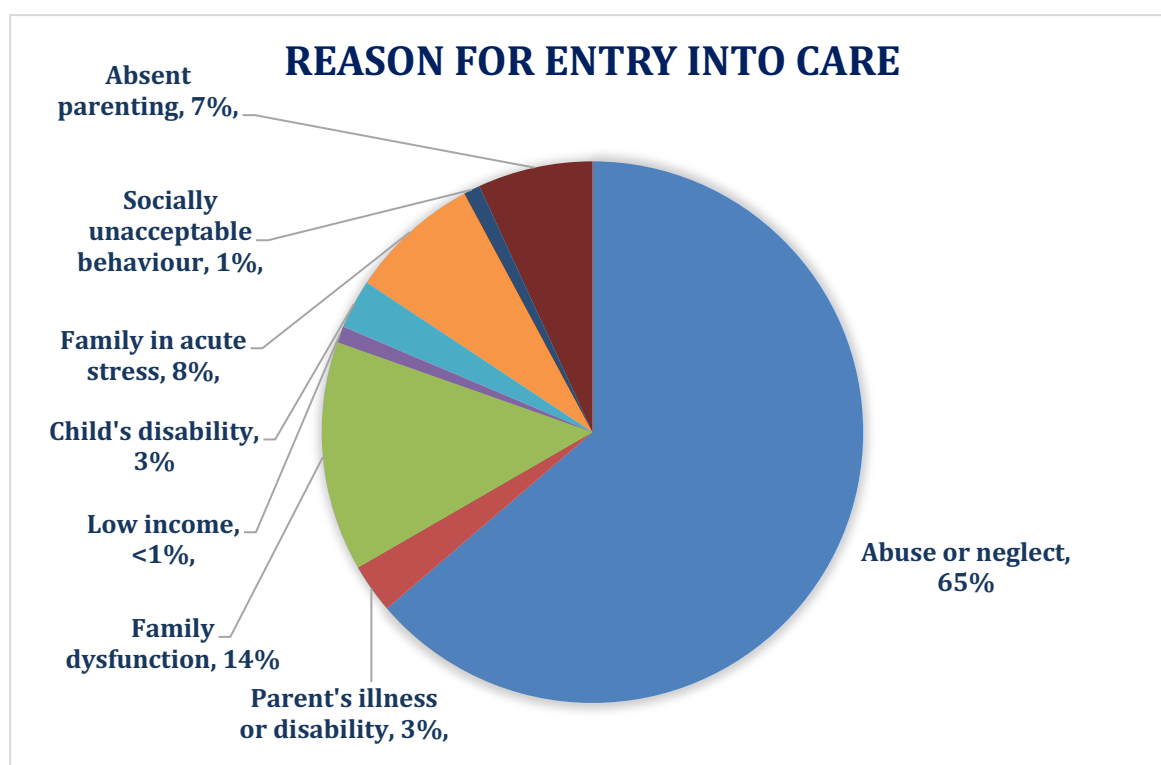


Figure 2: Reason for entry into care

Figure 3 shows that on the 31 March 2020 the majority of children and young people in care (72 per cent) were living in foster placements, with 16 per cent of these children and young people placed with 'family and friends' (kinship) carers. Ten thousand, seven hundred and ninety (12 per cent) children and young people were placed in secure units, residential children's homes and semi-independent living, and 5,400 (7 per cent) children and young people were placed with their parents (Department for Education, 2020).

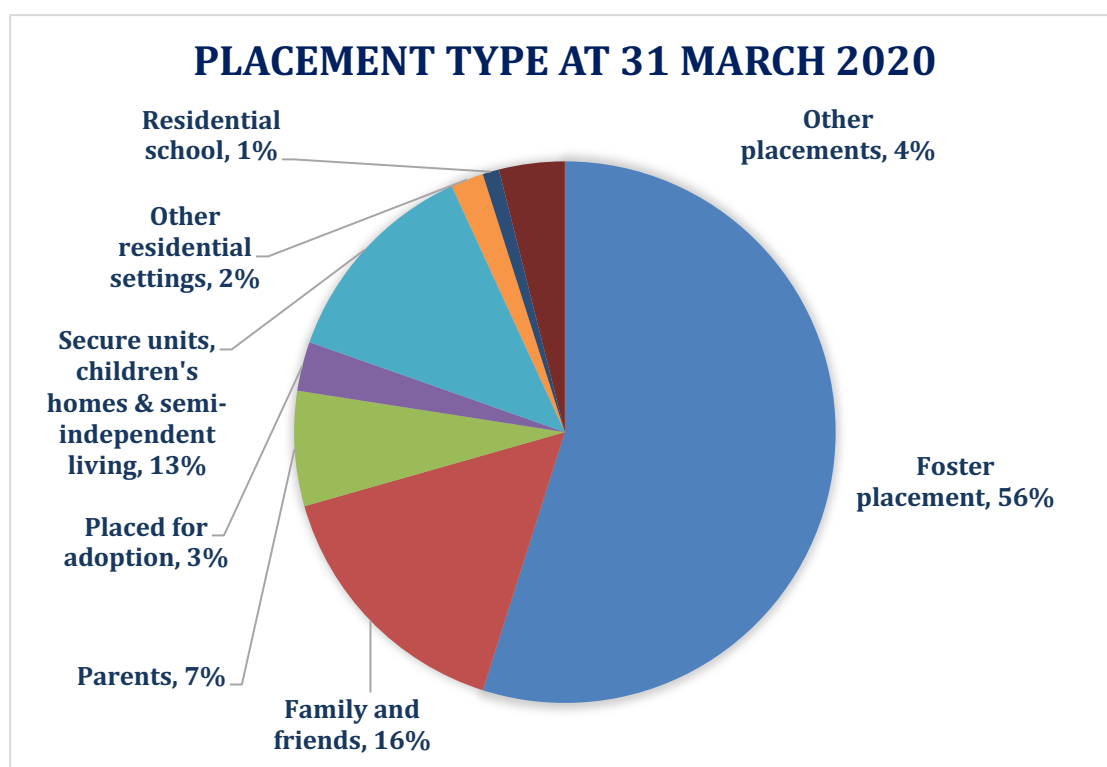


Figure 3: Placement types

National statistics also show that on the 31 March 2019, 52,890 (68 per cent) children and young people had remained in one placement during the year, 17,160 (22 per cent) had lived in two placements, and 8,110 (10 per cent) had lived in three or more placements. Furthermore, 43,190 (55 per cent) children and young people were living within their local authority boundary while 29,390 (37 per cent) children and young people were living outside of their local authority boundary on the 31 March 2019. In 2014 Ofsted completed a thematic inspection in which they analysed the effectiveness of local authorities in discharging their duties to the children and young people in their care who lived outside of the local authority boundary. They found that most children and young people had been placed out of the area due to a shortage of carers closer to home. They also found that there was poor communication between agencies when a child or young person was placed out of area, and quite often

local authorities had failed to notify the relevant agencies that a child or young person had moved to their area (Ofsted, 2014). Although children and young people in care are not a homogenous group (Sinclair et al., 2007) and have different routes into and through the care system, research has consistently shown that as a group they are at greater risk of poor outcomes, such as poor physical health and poor mental health and well-being (Baldwin et al., 2019; Berzin, 2010; Braciszewski & Stout, 2012).

The exceptional health needs of children and young people in care

There is a growing body of literature that recognises the importance of physical health on the life outcomes of children and young people in care, and the greater incidence of their exceptional physical and mental health needs has been substantiated (Dixon, 2008; Grant, Ennis, & Stuart, 2002; Leslie, Gordon, Lambros, et al., 2005). Research has established a high prevalence of acute and chronic health conditions among children and young people in care, which is also far greater to their peers in the general population. Such health conditions may include asthma, eczema, developmental delay, kidney problems, problems with sleep, problematic eating behaviour including obesity, and risky behaviours such as smoking, teenage pregnancy, and substance misuse (Anderson, Vostanis, & Spencer, 2004; Braciszewski & Colby, 2015; Brown, Bonnett, & Welbury, 2005; Bruskas, 2010; Committee on Early Childhood & Care, 2002; Council on foster care adoption and kinship care, Committee on adolescence, & Council on early childhood, 2015; Festinger & Duckman, 2003; Rodrigues, 2004). Research also suggests that children and

young people in local authority care have greater mental health needs compared to their peers in the general population (Meltzer, Gatward, Corbin, Goodman, & Ford, 2002). This suggests that as a group, children and young people in local authority care have exceptional physical and mental health needs, compared to their peers in the general population.

Research suggests that the exceptional health needs of children and young people in local authority care may also persist into adulthood (Ahrens, Garrison, & Courtney, 2014a; Fowler, Toro, & Miles, 2009; Zlotnick, Tam, & Soman, 2012). There is some evidence suggesting that adults who have transitioned from care also have exceptional health needs when compared to adults in the general populations (Ahrens et al., 2014a; Viner & Taylor, 2005). For example, research has found that adults who have transitioned from care are significantly more likely to experience homelessness, to have a high number of hospital admissions, to be overweight or obese, to regularly smoke and/or drink alcohol, and to have a criminal conviction (Fallesen, 2013; Schneider et al., 2009). It is thought that this also puts adults who have transitioned from care at greater risk of other health conditions such as Type 2 diabetes, hypertension, and high cholesterol.

Risk and protective factors

Although there is a growing body of literature outlining the exceptional health needs of children and young people in care, fewer studies have examined any risk or protective factors linked to their health needs. However, the care system is thought to act as somewhat of a protective factor, and evidence suggests

that once children enter the care system, they are likely to catch up with their developmental milestones and their percentiles for height and weight (Olivan, 2003). As well as protecting children and young people from harm and maltreatment, the care system is also responsible for screening and regularly reviewing the health needs of the children and young people it looks after. This means that being in care is likely to also highlight extensive health problems which may have previously been overlooked, particularly for those who have been in the care system for a long period of time (Sullivan & van Zyl, 2008).

Adverse Childhood Experiences (ACEs)

Poor mental and physical health in adulthood are known to be closely related to adverse childhood experiences such as abuse, neglect, and living in a family where substance misuse, mental health problems and domestic abuse are prevalent (Almuneef, 2014; Chapman et al., 2011; Thompson, Flaherty, et al., 2014). For example, Chapman et al. (2011) found that adults with adverse childhood experiences were 2.1 times more likely to have difficulties falling asleep or staying asleep, and 2 times more likely to report feeling tired after a good night's sleep. Other research reports a link between adverse childhood experiences, risk-taking behaviour, and poor physical health (Ramiro, Madrid, & Brown, 2010). Pretty, O'Leary, Cairney, and Wade (2013) also report a significant association between adverse childhood experiences and fast heartrate, high body mass index, and high waist circumference.

Almost all children and young people in care will have had a number of recognised adverse childhood experiences or will have been subject to some

other form of trauma before entering care (Simkiss, 2019). However, it is not clear how far the experience of care exacerbates these problems or protects children and young people from more serious physical and mental health problems. Poor experiences of care, such as continued abuse, or unstable placements are, however, likely to compound the impact of previous adversity.

The legal and policy context

The exceptional health needs of children and young people in local authority care have long raised concerns for government and professionals working with children and young people in care. Legislation relating to the welfare of children dates back to the early 19th century as the state gained more power to protect children from harm. However, the first major piece of legislation that recognised children's health and development was The Children Act 1989. It identified a new framework for children in need (see glossary for definition) and local authorities were required to support and protect children's development. Children in care also became clearly defined as 'looked after children'. Since then, there has been a number of initiatives that aim to promote the health and well-being of children and young people in care (these will be explored more fully in Chapter Six):

- ***Quality Protects 2000:*** In 2000, major changes occurred, and more emphasis was placed on the outcomes of children and young people in care.
- ***Promoting the health and well-being of looked after children 2002*** (*Department for Education & Department of Health, 2002*): This was

the first statutory guideline developed on promoting the health of children and young people in care.

- ***Care Matters: Transforming the lives of children and young people in care 2006 (Department for Education, 2006)***: this set out the role of corporate parents (see glossary for definition) and stated that they had a responsibility to support those in care to: stay safe, be healthy, enjoy and achieve, make a positive contribution and achieve economic responsibility.
- ***Statutory Guidance on Promoting the Health and Well-being of Looked After Children 2009 (Department for Education & Department of Health, 2009)*** : This was also statutory guidance, it was a regulatory framework for professionals and was underpinned by law. This gave professionals a framework to inform practice.
- ***Promoting the health and well-being of looked after children 2015 (Department for Education & Department of Health, 2015)***: The new guidance is much more concise as the government wanted to ensure that it was easily accessible. Government policy states that statutory guidance does not need to contain practice guidance – so the newest guidance no longer has recommended content for health assessments.

Recent legislative developments have established new guidelines for local authorities, clinical commissioning groups (CCGs) and strategic health authorities in order to meet and promote the exceptional health needs of children and young people in local authority care (Department for Education & Department of Health, 2015; Dixon, 2008). The Statutory Guidance on

Promoting the Health and Well-being of Looked After Children (2015) is issued to local authorities and clinical commissioning groups under Section 10 and 11 of the Children Act 2004, and they must adhere to it in their practice (Department for Education & Department of Health, 2009, 2015). Local authorities must also follow the guidance of Section 7 of the Local Authority Social Services Act 1970 in discharging their duties to promote and safeguard the health and well-being of the looked after children and young people in their care. As such, local authorities are required to arrange for children and young people in care to undergo initial and review health assessments and to ensure that each individual has an established healthcare plan that sets out how their health needs will be addressed. Furthermore, local authorities are also required to give their children and young people a voice by including them in policy developments to inform the commissioning, planning, delivery and evaluation of children services.

In addition, clinical commissioning groups have a duty to support local authorities to carry out their responsibilities to 'looked after children' (Royal College of Nursing & Royal College of Paediatrics and Child Health, 2015). Each CCG is also required to provide evidence of their commitment in promoting the health and well-being of children and young people in local authority care. This includes recording children's attendance for immunisations, dental checks, and statutory health assessments and writing up reports about their health status (Department for Education & Department of Health, 2015). Such information must then be reported by each CCG annually and this information is stored on the Children Looked After Database (SSDA903). It is

of some concern, however, that these statistics merely report children and young people's attendance and do not include information about their health status, or the services they receive following a health assessment. As such, further research is needed to uncover the factors that influence young people's access to and engagement with statutory health assessments and routine health services.

Moreover, the responsibilities of NHS England should ensure that children and young people in local authority care are registered with a General Practitioner (GP), have access to a dentist (a shared responsibility with local authorities) and that when a child moves to a new GP their GP-held clinical records are fast tracked to the new practice (RCN & RCPCH, 2015). However, a large proportion of children and young people move placements each year and it is not known how this effects their engagement with primary health services, although there is some evidence that when children move placements, health services such as out-patient appointments, routine dental checks and GP registration may be disrupted (see Ward, Jones, Lynch, and Skuse (2002)).

The team around looked after children

Children and young people in local authority care have a collaborative team of professionals and frontline practitioners supporting them through the care system, all of whom have a collective responsibility for promoting their health and well-being. When making decisions about the lives of children and young people in care it is good practice for these professionals to ask themselves

'Would this be good enough for my child?' (Department for Education and Skills, 2003). The team around the looked after child may include:

- Foster carers/residential workers;
- Birth parents/family;
- Designated health professionals for looked after children;
- Specialist/named health professionals for looked after children;
- Independent reviewing officer;
- Optician;
- Practice nurse;
- Community paediatrician;
- General practitioner;
- Health visitor;
- Teacher;
- Teaching assistant;
- School/education department;
- Virtual school head
- Child and Adolescent Mental Health Services (CAMHS);
- School nurse;
- Health commissioner;
- Social care commissioner;
- Social worker/personal advisor;
- Designated teacher (LAC);
- Family nurse/midwife;
- Youth worker;
- Educational psychologist;

- Police;
- Physiotherapist;
- Medical advisor;
- Youth offending team;
- Dentist.

Due to the number of professionals involved in the lives of children and young people in local authority care, there can often be miscommunication between professionals and assumptions that someone else will follow up a health action. Children and young people may also struggle to build positive relationships with key health professionals. For this and other reasons, young people in local authority care are at greater risk of health inequalities and poorer health outcomes than their peers. This has led policy makers to develop statutory guidelines for professionals working with young people in care to ensure that their health and well-being is being promoted (Department for Education & Department of Health, 2015).

Stability in the care system

Changes in placement can be either planned or unplanned. Some young people may have been placed in a short-term placement while a long-term placement was looked for (planned), others may have had to move suddenly because their carers could not cope with their behaviour or meet their needs (unplanned). It is unplanned placement changes that are thought to be more damaging to young people in care because there is not time to plan a smooth

transition in which young people can visit their new placement before moving in.

Wherever possible, local authorities will attempt to place children with family or friends to allow them to remain with someone with whom they have a pre-existing relationship and who they already trust (CoramBAAF, 2017). But most family and friends' carers are called upon in a crisis or emergency situation and at this point it can be unclear whether the child will be going home shortly or whether they will need to be cared for long-term. If there is no one within the family or a family friend to look after the child, then the local authority will seek a placement with their own local authority foster carers. In an emergency situation the child or young person may only be placed with foster carers for a few weeks while an alternative placement is found. If the local authority does not have any foster carers available, then they will approach local independent fostering agencies. Failing this, the originating local authority will also approach other local authorities and independent fostering agencies outside of their local authority boundary. If a child or young person has additional needs requiring specialist care or has a high level of challenging behaviour, then other types of placements including residential care will be sought. The local authority will always aim to return children and young people home if the child is not at risk of significant harm. Before this happens, they will draw up a care plan for the child and set out how they will monitor the child's wellbeing and what support they will provide. Research looking at the age a child enters care and health outcomes could not be found.

When the local authority is trying to find a new placement for a young person, residential care is usually considered as a last resort (Hart, 2015). Over the years, more emphasis has been put on providing children and young people with therapeutic care – care in which foster parents are equipped with the knowledge and skills to provide a loving, caring and structured environment for children and young people who present with challenging behaviour as a direct result of their previous experiences. Such placements are thought to help them learn how to regulate their emotions and to promote their social skills. Evidence suggests that this reduces the likelihood of them committing a crime or partaking in risky behaviours later in life (Narey & Owers, 2018).

Health Assessments

The law requires that children and young people entering local authority care receive an initial health assessment within 20 working days. Thereafter, children and young people aged five and over attend a review health assessment annually. Children under five are required to attend a bi-annual review health assessment that incorporates a developmental element. However, the latest national statistics reveal that only 92 per cent of 10- to 15-year-olds and 83 per cent of 16- to 18-year-olds had an up-to-date health assessment (Department for Education, 2020). In addition, research has previously suggested that young people in care are less likely to be registered with a GP than their peers in the general population (Rodrigues, 2004). As a result, children and young people in local authority care often have incomplete medical files, allowing physical and mental health problems to go undiagnosed. Accurate health information is also vital to young people when they are trying

to develop and make sense of their identity. Moreover, their medical history is also important if they become parents themselves.

Further concerns are raised around the content of review health assessments. In the latest statutory guidance, professionals are offered guidance about areas that need to be addressed. This includes recording information about:

- The child's current state of health;
- The child's medical history (including family history);
- The effect of the child's health on their development;
- Any existing arrangements for the child's health and dental care, and any planned changes to these arrangements;
- The responsibilities of each professional in promoting the child's health and well-being.

However, this statutory guidance simply recommends general areas that need to be addressed during health assessments and does not offer a standardised format for information to be recorded. This means that health assessments undertaken between local authorities may vary enormously and may also unnecessarily promote health inequalities (Brown et al., 2005).

Furthermore, placement changes are common in the social care system. Due to their traumatic pasts, children and young people in care can often present unusual and challenging behaviour, resulting in the breakdown of a placement. However, a high proportion of placement moves (43%) are not initiated by the

carer or the child or young person, but by the local authority, as part of the case management process (Ward, 2009). These changes in placement can result in lost or incomplete health information and treatment because children and young people will usually need to transfer to a new GP (Kools, Paul, Jones, Monasterio, & Norbeck, 2013b). Research demonstrates that comprehensive health assessments can improve the likelihood of children and young people in local authority care being referred to suitable services (Hill & Thompson, 2003; Nathanson, Lee, & Tzioumi, 2009). However, they do not always have an advocate (birth parent or foster parent) who will request assessments and follow up treatments on their behalf (Bonfield, Collins, Guishard-Pine, & Langdon, 2010). Therefore, it is essential that health and social care services work together holistically to ensure that the children and young people in their care can access the services they need in a timely manner (Glisson, 1994). Further complications are likely to arise if young people in care are excluded from school, as they are then unable to access the health services provided by schools, including social, health and personal education interventions (Jones et al., 2012).

Despite these government initiatives, some young people in local authority care are still failing to engage with the healthcare system and research suggests that they continue to experience poor health outcomes (Rodrigues, 2004; Simkiss, 2012; Simkiss & Jainer, 2018). Local authorities have a responsibility to provide their children and young people with exceptional health care, which is better than that which they received in the care of their birth parents. This includes meeting any medical, dental, developmental and mental health needs. Yet,

young people in local authority care often view statutory health assessments negatively and once they are deemed to have 'sufficient understanding' many will refuse to attend (Jones et al., 2012). It has been noted that further research is needed to explore the allocation of resources and to compare them with the distribution of need and use of services (Hansen & et, 2004). But, in order for this to be achieved, it is necessary to enhance professional knowledge of the health outcomes of young people in care, explore their access to health services and consider their involvement in the decision-making around their health, lives and care.

How do children and young people learn to be healthy?

Previous studies on children and young peoples' health perceptions and health behaviour have focused on three main areas:

1. The child or young person's background and characteristics such as demographics, developmental stage, gender and personality traits;
2. Extrafamilial agents such as the child or young person's peer group, school environment and mass media; and
3. Relationships and interactions with parents and family.

Most attention has been given to point 3 in which studies have found that parents and families provide models of health perceptions and health behaviours by demonstrating, teaching and reinforcing their own health attitudes and behaviours (Tinsley, 2003). Children and young people are thought to learn these concepts of health and health skills through repeated opportunities to practice health behaviours (for example, what types of food to

eat, how and when to brush teeth, and when to seek help for health concerns). However, children and young people in local authority care are likely to have come from suboptimal environments whereby birth parents are pre-occupied with their own issues, and therefore do not demonstrate or encourage their children to practice everyday health behaviours such as when and how to brush their teeth.

Rationale for the study

Previous research suggests that children and young people in local authority care have more extensive health needs than their peers in the general population (Kohler, Emmelin, Hjern, & Rosvall, 2015). Moreover, it appears that they do not receive health services in the way that the statutory guidance on Promoting the Health and Well-being of Looked After Children recommends (Department for Education & Department of Health, 2002, 2009, 2015; Risley-Curtiss & Stites, 2007) and that they have less access to health services in comparison to their peers in the general population (Rodrigues, 2004). Despite recent emphasis being placed on the importance of involving young people in local authority care in health-related decisions as a means to promote healthy lifestyles and compliance to treatment (DfE & DH, 2015), research suggests that these young people still fail to engage with the health care system. It is plausible that this is the reason why young people in local authority care continue to have worse health outcomes than their peers in the general population (Bruskas, 2010; Croft, 2011; Dixon, 2008; Hunter, McCartney, Fleming, & Guy, 2008; Schneiderman, 2004, 2008; Schneiderman, Arnold-Clark, Smith, Duan, & Fuentes, 2013; Schneiderman, Brooks, Facher, & Amis,

2007; Schneiderman & et, 2010). It is also possible that they have worse experiences of health services, and due to complex and time-consuming policies and procedures, are treated inefficiently or inappropriately (Dixon, 2008; Schneiderman, Smith, & Palinkas, 2012; Simkiss, 2012). This is likely to impact on young people's perception of the role of health services and may also explain why they fail to engage with them (Zima, Bussing, Yang, & Belin, 2000). Therefore, this study seeks to explore what factors are associated with the ability of the care system to meet the physical and mental health needs of the young people it looks after. Specifically, the current study seeks to explore how far young people in care access routine and specialist health services, and what barriers prevent access and engagement, and how young people experience these services. Moreover, it seeks to explore the health perceptions of young people in care, and to explore which young people are likely to have mental health difficulties, substance misuse problems or criminal convictions.

Outline of the Thesis

Chapter Three: Review of the Literature

Chapter Three explores the relevant literature available on the health of children and young people in care, their access to health services, and the prevalence of risk-taking behaviour among the care population. The chapter begins by specifically looking at research on the physical and mental health of children and young people in care and how their health compares with that of children and young people living with their families. It then goes on to look at the literature available on the impact of poverty on the health of all children and young people and its link to health in adulthood. The chapter then looks at

literature that links childhood abuse and neglect (child maltreatment) to poor physical and mental health. After this, the chapter looks at the development of literature on Adverse Childhood Experiences (ACEs) and its role in understanding access to and engagement with health services in adulthood. The chapter ends by identifying the gaps in research and more specifically, how the current study intends to address some of these gaps.

Chapter Four: Research Design and Methodology

Chapter Four outlines how a convergent mixed methods design was used in which qualitative and quantitative data were collected in parallel, analysed separately, and then merged together to provide an understanding of what was happening at a political level, and how those political initiatives were experienced by young people in care who were directly affected by them. The chapter also outlines how a pragmatic approach was taken to implement Bronfenbrenner's Ecological Systems theory (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006) as a conceptual framework for the thesis. The chapter outlines the aims of the study and the specific research questions it sought to answer. It goes on to explore the samples of the quantitative and qualitative aspects of the study, how the research was undertaken, and how the data were analysed. It also looks at the ethical considerations of the study and explores the strengths and weaknesses of the approach used, and the qualitative and quantitative datasets.

Chapter Five: Vignettes

Chapter five sets out individual vignettes for the young people interviewed for the study, providing information about their individual experiences before care, their experiences in care and their situation at the time of their interview. This chapter provides some context in understanding some of the key themes featured throughout the rest of the thesis.

Chapter Six: What are the physical health needs of young people in care?

Chapter Six explores the experiences that the young people interviewed for the current study had of parenting and health behaviours before entering the care system. In particular, it explores two concepts created by Bronfenbrenner to describe individual characteristics within his model. These are Demand (age, gender, ethnicity, first language) and Resource (mental and emotional resources including past experiences, skills and intelligence). The chapter goes on to look at the administrative data submitted for annual statistical returns to explore what role individual characteristics may play in young people's access to routine and specialist health services. The chapter also explores the young people's experiences of entering care, their understanding of the reasons they became looked after, what health meant to them, and their understanding of any additional level of health needs they may have or had, and how these experiences may lead children and young people to enter care with exceptional health needs.

Chapter Seven: What are the mental health needs of young people in care?

Chapter Seven explores the role of childhood trauma in the development of mental health difficulties and risk-taking behaviour and considers how Bronfenbrenner's ecological systems theory can help to explain why children and young people in local authority care are more likely to have mental health difficulties than their peers in the general population. The chapter then explores how the government is monitoring the mental health of young people in care and attempts to identify factors within young people's care and educational experiences and perceptions that are associated with mental health difficulties and substance misuse problems. Furthermore, the chapter attempts to disentangle the complex relationships between these negative outcomes.

Chapter Eight: How has the English government attempted to meet the health needs of children and young people in care?

Chapter Eight looks at how the government has tried to meet the health needs of children and young people in local authority care, and how the government has tried to monitor their access to health services. It evaluates the national guidance on promoting the health and well-being of children and young people in care and explores how this guidance is implemented in practice. The chapter then explores the relevance of the data that is collected at a government to monitor health and what the data reveal about the health status of young people in local authority care. Chapter Eight also explores data which show how far, at an exo-level, the care system might be ensuring that the health needs of the children and young in its care are met.

Chapter Nine: How do young people in care in England experience policy initiatives designed to promote their health?

Chapter Nine focuses on the interviews undertaken with young people in care and explores their experiences of the impact of national guidance on the health care of children and young people in care and attempts to identify those factors within their experiences and perceptions that make it more or less likely that their health needs will be met. A theme that runs throughout Chapter Nine is the tension between the exceptional health needs of this population of young people in local authority care and their desire for normality, as well of the role of stigma attached to their care status in their willingness to engage with specialist health services. The chapter explores the young people's understandings of why health assessments are undertaken and considers their experiences of them, including their understanding of informed consent. The chapter also outlines young people's experiences of and access to national health services, and their perceptions about when to access these services.

Chapter Ten: Concluding Chapter

Chapter Ten brings together the findings represented in Chapters Five to Nine to map out what factors are associated with the ability of the care system to meet the exceptional health needs of young people looked after in England. The chapter also explores the factors identified that may help or hinder young people's access to and engagement with routine and specialist health services. The chapter then reflects on the unique contribution of the thesis and considers the implications for policy and practice.

Chapter Three: Review of the literature

Introduction

Chapter Three explores the relevant literature available on the health of young people in care, their access to health services, and the prevalence of risk-taking behaviour among the care population. The chapter starts by looking specifically at research on the physical and mental health of young people in care and how their health compares with that of young people living with their families. It then goes on to look at the literature available on the impact of poverty on the health of all children and young people and its link to health in adulthood. The chapter then looks at literature that links childhood abuse and neglect (child maltreatment) to poor physical and mental health. After this, the chapter looks at literature on Adverse Childhood Experiences (ACEs) and its role in understanding access to and engagement with health services in adulthood, including initiatives to identify those with high ACEs scores within primary care settings. The chapter ends by identifying the gaps in research and how the current study intends to address some of these gaps.

Searching and screening

Research on the health of looked after children is distributed through a wide range of bibliographic databases. The researcher's approach to capturing the relevant material was to search 13 databases and 13 websites within the fields of health, social science and social care. In the first stage, terms relating to health and the population were used. These key search terms were:

“health belief” OR “health experience” OR “health assessment” OR “physical health” OR “health outcome”

AND

“foster care” OR “foster parent*” OR “foster famil*” OR “foster placement” OR “substitute famil*” OR “family foster home” OR “children’s home*” OR “secure unit” OR “out-of-home care” OR “out of home care” OR “group home” OR “looked after” OR “looked-after” OR “congregate care” OR “alternative care” OR “abuse” OR “neglect” OR “care leaver” OR “care experience*” OR “from care” OR “left care” OR “local authority care” OR “state care” OR “public care” OR “foster child” OR “adverse childhood”

NOT

“mental*” OR “emotion*”

The databases and websites searched were:

- Zetoc (MIMAS);
- Web of Science;
- Campbell Library;
- Conference Proceedings Citations Index and Social Sciences Citation Index;
- Cochrane Library;
- Educational Resources Information Center;
- International Bibliography of Social Sciences;

- Medline (ProQuest Research Library);
- American Psychological Association PsycInfo;
- SCOPUS (ELSEVIER);
- Social Care Online (via SCIE website);
- Social Policy and Practice;
- Social Services Abstracts;
- British Association for Adoption and Fostering (BAAF; now CoramBAAF);
- Centre for Excellence and Outcomes in Children and Young People's Services (C4EO);
- Casey Family Programs;
- Chapin Hall;
- Department for Education;
- Department of Health;
- The Evidence for Policy and Practice Information;
- The Fostering Network;
- Joanna Briggs Institute;
- National Foundation for Educational Research;
- National Children's Bureau;
- National Society for the Prevention of Cruelty to Children;
- Office of Planning, Research and Evaluation in Administration for Children and Families (USA);
- What Works Clearinghouse.

Searches were limited to the year 2000 onwards due to significant changes in policy around that time (see Chapter One for more details) and were not restricted by study type, or place of publication. However, searches were restricted to the English language, which is a limitation of this review as there may be key studies in other languages. This search process resulted in 4,796 retrieved citations (excluding duplicates). The 4,796 articles were then screened using the following inclusion/exclusion criteria (see figure 4): the population needed to comprise children in care, care leavers, victims of childhood maltreatment, victims of childhood sexual abuse, victims of childhood physical abuse, victims of childhood neglect, or those who had adverse childhood experiences; and the articles also needed to refer to physical health, health services, health risk behaviour or health promotion. Screening for relevance was initially undertaken at title and keywords level (see Figure 4).

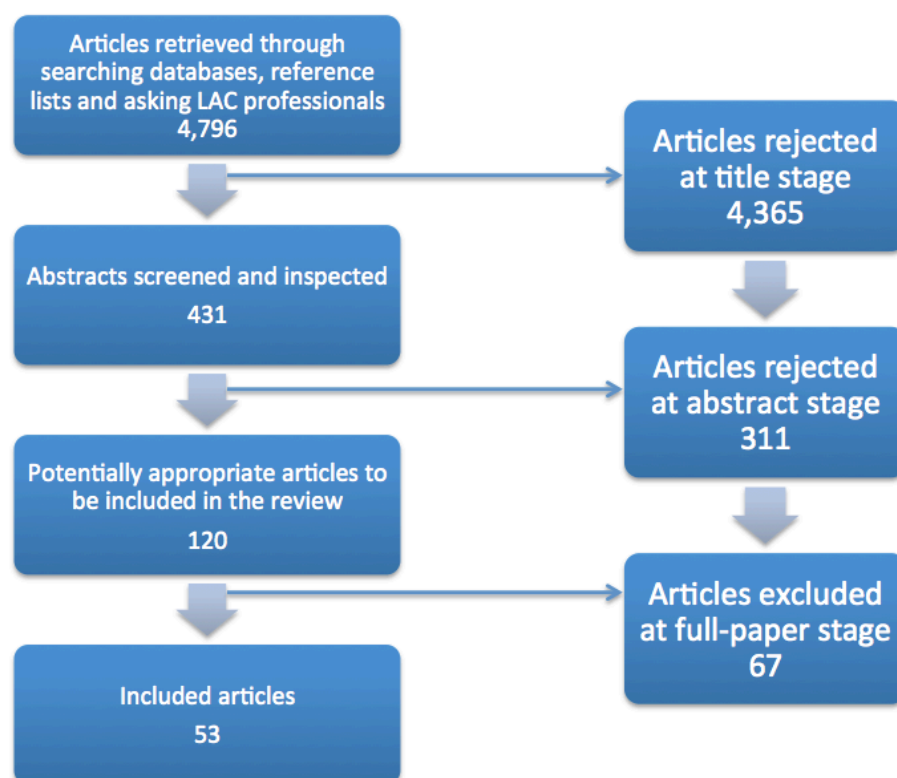


Figure 4: The literature search

Updated review of the literature

The analyses of the data revealed a number of additional issues. For example, the initial literature search explicitly excluded articles relating to mental health. However, mental health and well-being later became an emergent theme in the qualitative analyses. In order to ensure that the interpretation of the findings was adequately informed by the most recent literature, the researcher sought to update and expand the literature review by searching for reviews and including an additional 18 articles on the following topics:

- The impact of poverty on health
- The impact of child abuse/neglect (child maltreatment) on health (update)
- The impact of Adverse Childhood Experiences (ACEs) on health
- The physical health of looked after children (update)
- The emotional health and well-being of looked after children (brief overview of recent literature)
- Health outcomes of care experienced people

What do we know about the physical health of children and young people in care?

The health status of children and young people in care

There is a growing body of literature that recognises the importance of physical health on the life outcomes of children and young people in care, and the greater incidence of their health problems has been substantiated (Carbone,

Sawyer, Searle, & Robinson, 2007; Kools & Kennedy, 2003). Previous studies have established a high prevalence of both acute and chronic conditions among children and young people in local authority care. For instance, research conducted in East Surrey reported high levels of asthma, eczema, developmental delay, kidney problems, behavioural problems and caries (tooth decay) among children in care (Rodrigues, 2004). Likewise, in a descriptive analysis of 1551 medical charts, 86.7 per cent of children in care were found to have a recognised health problem. These health problems included: dermatological, respiratory, dental, haematological, auditory, visual, musculoskeletal, neurological, cardiac, genital/urinary, and gastrointestinal problems. Moreover, only 31 per cent of these children had just one health issue, while 30 per cent had at least two health issues, and 25 per cent had three or more (Leslie, Gordon, Meneken, et al., 2005). Although a direct comparison could not be found, Hagell and Shah (2019) report that only 23 per cent of young people in the general population aged 11 to 15 have a chronic health condition or disability. Children and young people in care appear to have exceptional physical health needs in comparison to their peers in the general population. However, more research is needed to document the number of young people in care with chronic health conditions, and to compare the rates of acute and chronic health conditions between children and young people in care and their peers in the general population.

Obesity

Much of the current literature on the physical health of children and young people in care pays particular attention to the extensive scale of childhood

obesity (Croft, 2011; Jones et al., 2014; Schneiderman, Smith, Arnold-Clark, Fuentes, & Duan, 2013). This is exemplified in the work undertaken by Schneiderman, Arnold-Clark, et al. (2013) who describe the prevalence of being overweight or obese in a group of children aged two to nineteen placed in long-term care in America. They found that almost 40 per cent of the care population were overweight and 23 per cent of the care population were obese. Again, (Hadfield & Preece, 2008) suggest that being overweight or obese is not related to the age that children enter care but the length of time they spend in care and suggest that those in care are following a similar increasing trend of being overweight or obese to those in the general population. Nearly half of their sample entered care before the age of five yet 35 per cent had become overweight or obese while in the care of the authority. This is of particular concern because obesity can lead to a range of other chronic conditions that could otherwise be avoided. Further research is needed to explore the reasons why children in care are not being protected from the dangers of obesity, despite their health needs being regularly reviewed.

Immunisations

Immunisations can play an important role in promoting the health of looked after children. As mentioned in Chapter Two, the invention of immunisations is a useful tool in the prevention of infectious diseases. However, what initially seems like an easy intervention can soon become complex when dealing with children and young people in care, due to their multiple placement changes and possible lack of engagement with health services (Department for Education, 2015a, 2015c; Miles, 2002). When children first enter care their immunisation

status is often not known and there may be disparities between the information recorded within different health records (Lorek, 2013). Despite the children in their study being looked after for at least six months, Barnes et al. (2005) concluded that children and young people in care were far less likely to have received the primary course of Diphtheria, Tetanus, Pertussis (DTP) and Polio, as well as the school leaver DTP and Polio course when compared to their peers in the general population. This is further supported by the work of Beasley, Harris, Hutchings, and Barnes (2015) who reported that young women in care are significantly less likely to have received the three-dose Human Papilloma Virus vaccination course compared to their peers in the general population. It has also been found that young people entering care later in their childhood exhibit higher levels of incomplete immunisations than those who enter care during their primary years (Kaltner & Rissel, 2011).

The mental health and well-being of children and young people in care

In 2002, Meltzer et al. (2002) carried out a survey to uncover the prevalence of mental disorders among the care population in England. A total of 1,039 child summary forms were completed by carers for children and young people in local authority care aged 5-17. They found that 45 per cent had a mental disorder; 37% had a conduct disorder, 12% had an emotional disorder, and 7% had hyperactivity. Later studies have focused on the subjective well-being of children and young people in care. For example, in a survey involving 1211 young people in care aged 11-18, Zhang and Selwyn (2019) have developed a reliable and valid measure of subjective well-being specifically for children and young people in the care system. They define subjective well-being as:

“feeling good and functioning effectively at both individual and inter-personal levels.”

(Zhang & Selwyn, 2019, p. 1)

In an earlier study, Wood and Selwyn (2017) worked with 140 children and young people in care split into 18 focus groups to understand what they felt was important to their subjective well-being and whether this differed to those in the general population. They concluded that children and young people in the care population require a specific measure for their well-being, one which considers facts specific to their care experiences. They suggest a measure containing four domains and 19 indicators:

- *“Relationships: satisfaction with contact with family members, having a good friend, ease of access to social workers, carer’s sensitivity, relationships with pets;*
- *Rights: Free from abuse, bullying, stigma and discrimination, knowing name of their social worker and the right to speak in private, feeling included in social work decision-making;*
- *Resilience building: feeling loved, sense of belonging, happiness, having a key trusted adult, enjoying school, support from carers for learning, access to the natural world, play, activities/hobbies;*
- *Recovery: getting a second chance after making a mistake, given the same opportunities as peers, feeling that life is getting better, support services to help with difficulties, learning life skills, having an age appropriate account personal history.”*

(Wood & Selwyn, 2017, p. 25)

In their initial survey involving 611 children and young people in care aged four to eighteen, Selwyn and Briheim-Crookall (2017) found that 83 per cent felt that their life was getting better now that they were in the care system. They also found that when compared to their peers in the general population, more

children and young people in care felt safe in their home, liked their school, and felt that their carers were interested in their education. However, they also found that children and young people in care were more likely to have low well-being than those in the general population. Low well-being was found to be associated with children and young people in care not feeling settled, not trusting their carers, worrying about their feelings and/or behaviour, not understanding why they were in care, and not feeling content with the frequency of contact with their biological families. This suggest that despite children and young people in care feeling that their lives are getting better, they still have exceptional mental needs related not only to their pre-care experiences but also to their experiences of the care system itself.

Risk-taking behaviour among the care population

There is an emerging body of literature outlining the increased prevalence of risk-taking behaviour among the care population and an abundance of literature outlining the link between mental health problems and risk-taking behaviour (Chartier, Walker, & Naimark, 2009). Such risky behaviours might include smoking, substance misuse, self-harm, suicidal thoughts, criminal activity, risky sexualised behaviour, and teenage pregnancy (Brook & et, 2015; Havlicek, Garcia, & Smith, 2013; Hayatbakhsh, Mamun, Williams, O'Callaghan, & Najman, 2013; Narendorf, 2010; Taha, 2014; Thompson & Hasin, 2011; Thompson & Auslander, 2011). For example, Leslie et al. (2010) found that among 993 adolescents aged 11-15, 45 per cent reported at least one risky behaviour. Moreover, in a secondary analysis investigating health risk behaviour, Gramkowski et al. (2009) found that children in residential homes

were more likely to adopt risky behaviours whereas children in kinship care were less likely to adopt risky behaviour. Some research suggests that mental health problems play a mediating role between pre-care experiences such as childhood abuse and child poverty and risk-taking behaviour (Chartier et al., 2009).

Risk and protective factors

While there is extensive evidence illustrating the exceptional physical and mental health needs of children and young people in care, fewer studies have explored the risk and protective factors for their poor health status. However, it would appear that the care system itself acts as a somewhat protective factor (Ahrens, 2008; Carbone et al., 2007). For example, when children enter care they may be below their normative percentiles for height and weight. However, research has shown that these children are likely to catch up with their peers once they are in the care system (Olivan, 2003). It would also appear that children and young people in care are more likely to have their health needs identified (Chambers, Saunders, New, Williams, & Stachurska, 2010), which may account for the larger proportion of children and young people in care having a diagnosed health condition compared to their peers in the general population. For instance, in an exploratory study, Sullivan and van Zyl (2008) discovered that the strongest predictor of having a medical condition was the number of months a child had been in care. Two groups also emerged from their data as being significantly different: children who had received fewer than seven visits from social care services (in which 31% had a diagnosed medical need) and children who had received more than seven visits from social care

services (in which 49% of them had a diagnosed medical need). This finding is further supported by Schneiderman, Leslie, Arnold-Clark, McDaniel, and Xie (2011), who also found the length of time a child was in care to be positively related to medical conditions and/or developmental delay being identified. Ahrens, Garrison, and Courtney (2014b) report that children and young people in care are at greater risk of medical conditions, above and beyond that which is afforded by exposure to economic insecurity. Risk factors such as these cannot necessarily be avoided as children usually enter care as a last resort. But it would appear that the children and young people at greatest risk of harm and maltreatment receive greater attention from children's social care services, and therefore are more likely to have any unmet health needs identified.

Although the care system is somewhat of a protective factor for the physical and mental health of children and young people in need of local authority care, some care experiences have been found to have a detrimental effect on their health. For example, Mekonnen, Noonan, and Rubin (2009) found that instability in the care system (multiple placement changes) had a deleterious effect on the health outcomes of children and young people. Moreover, children and young people placed in residential care have been found to be at greater risk of being overweight or obese than those placed in other types of care. Research also suggests that children and young people placed in residential care are more likely to have mental health problems and to adopt risky behaviours such as smoking, drug use and criminal activity (Fridrich & et, 2005; Hjern & Vinnerljung, 2002; Hunter, 2008; McCool & Stevens, 2011). Further research is needed to explore other risk factors within the care system that may

have a detrimental impact on the physical and mental health of children and young people.

Health outcomes in adulthood

As with the health of children in care, there is a growing body of literature demonstrating a high prevalence of health problems in adults who have transitioned out of care (Ahrens et al., 2014b). Zlotnick et al. (2012) suggest that care might be a sentinel event, signalling a high risk of health problems in adulthood. By way of illustration, Viner and Taylor (2005) followed up the 1970 British birth cohort at five, ten, sixteen and thirty years. They found that men who had been in care as children were not only more likely to be in poor general health as adults, but they were also more likely to have experienced homelessness and to have a conviction. Fallesen (2013) reported a significant association between duration of time in care and the number of hospitalisations during early adulthood. A history of care in childhood has also been associated with poor subjective health and smoking in adulthood. Schneider et al. (2009) reported that the odds of poor health were almost twice as high for women with a history of care than for women with a history of parental care. A history of care has also been associated with an increased risk of obesity in adulthood, thereby increasing the risk of other medical conditions such as Type 2 diabetes and hypertension (Thomas, Hypponen, & Power, 2008). Although research suggests that children and young people in care have exceptional physical and mental health needs, it is not clear how far the experience of care exacerbates the risk of poor health, or how far it facilitates the identification of existing health conditions.

Promoting the health of children and young people in care

Access to health services plays a critical role in promoting the health of children and young people in local authority care. Children and young people in care have been found to perform fewer health promoting behaviours (such as brushing their teeth daily) than children living with their parents (Kim, Ham, Lee, & Lee, 2009). Health services therefore play a key role in educating these vulnerable children about the benefits of healthful behaviours. By way of intervention, and as mentioned in Chapter One, children and young people in care in England are required by law to attend an initial health assessment within 20 working days of entering care, and review health assessments annually thereafter; children under the age of five are required to have bi-annual review health assessments with a developmental element (Department for Education & Department of Health, 2015). Yet compared to their peers in the general population, children and young people in local authority care are more likely to have experienced at least one change of GP, have incomplete immunisations and receive less health education (Barnes et al., 2005; Kohler et al., 2015; Lewis, 2000; Yassaee et al., 2017). Williams et al. (2001) report a trend for children and young people in care receiving less advice on exercise, diet, smoking, alcohol, drugs, sexuality, sex and contraception than their peers in the general population. Moreover, a discrepancy between foster carers' health concerns about their foster child or young person and the actual health needs of children and young people has been found, with carers reporting fewer concerns than identified by professionals (Kaltner & Rissel, 2011). Hence, the importance of specialist health services and resources in promoting the health-

related quality of life for children and young people in local authority care (Carbone et al., 2007). However, some research suggests that children and young people in care are reluctant to engage appropriately with the health care services provided to them (Rodrigues, 2004).

Moreover, it has not yet been determined how effective review health assessments are in ensuring that the ongoing health needs of children and young people continue to be met by the care system (Hill & Watkins, 2003; Nathanson et al., 2009). For instance, Rodrigues (2004) discovered that only 68 per cent of his sample of children and young people in care were registered with a general practitioner, an issue of considerable concern. Due to the poor recording of health information this study was also unable to determine how many children and young people were up to date with their dental checks. Children and young people in care have multiple records regarding their health and social care needs and often these records do not correlate. Lorek (2013) found disparities in the information held about children's immunisation histories between the GP records and the Child Health Computer Records (CHCR). Forty-four per cent of the GP records recorded fewer immunisations than the CHCR, 20 per cent of the CHCR recorded fewer immunisations than the GP records, and only 36 per cent of the records corresponded accurately. Local authorities responsible for children and young people need to ensure better inter-agency collaboration between health, education and social care services to ensure that all information regarding children and young people's health is up to date and that all children and young people receive adequate health education (Nathanson et al., 2009). In spite of this need, Schneiderman (2004)

found school nurses in America to be “*apolitical and insular*” (page 346). Although school nurses expressed a desire to provide holistic and preventive health care, they were not keen to make changes within their own service. Moreover, they did not recognise the broad determinants of health, and instead blamed the poor health of children and young people on the care system, thus suggesting the need for specialised and ongoing training on the health care needs of children and young people in care.

The views of looked after children

There is a dearth of research that focuses on the voices of children and young people in local authority care in relation to their health. However, children and young people in care have self-reported average health status, with girls reporting that they are less satisfied with their health and have more physical discomfort than boys. Furthermore, children and young people living in residential care have admitted to adopting more health risk behaviours, and to be more influenced by their peers than children in other types of placements. Similarly, children and young people in care with a history of physical abuse are also more likely to be influenced by their peers (Kools, Paul, Jones, Monasterio, & Norbeck, 2013a). When considering the meaning of health, children and young people in therapeutic foster care referred to physical fitness, weight control and the importance of relationships with family. One young person stated:

“A healthy person is someone who can live life and be relaxed – even if they drink or smoke.”

(Shannon & Broussard, 2011, p. 192)

These children and young people felt that most children their age drank alcohol, smoked marijuana and used cocaine, thus highlighting the need to target health-risk behaviours among the care population. In order to promote their health, the children and young people in this study believed that they needed better health education and early health interventions. They also felt that they could only rely on themselves for survival, and thus lacked any trust in the carers responsible for looking after them (Shannon & Broussard, 2011).

Notwithstanding the views presented in these two studies, the voices of children and young people in local authority care on the subject of health and their experiences with the health care system remain under-represented in the literature. The literature search only identified two studies which explored this issue.

What do we know about the impact of poverty on health?

Research suggests that children and young people living in poverty are over ten times more likely to enter the care system than their peers living in wealthier areas (Bywaters et al., 2018). So, it is of some concern that research has found that experience of poverty during childhood has been linked to a wide range of long-term health conditions including arthritis, respiratory illnesses, mental illnesses and hypertension. Cohen, Janicki-Deverts, Chen, and Matthews

(2010) suggest that these health conditions will likely persist into adulthood. In a survey involving 266 paediatricians from around the United Kingdom, the Royal College of Paediatrics and Child Health (Royal College of Paediatrics and Child Health, 2017) reported that all but one paediatrician felt that poverty was impacting on the health of some of the children they were treating. They suggested that poverty impacts children's health in a number of ways, including:

- Having limited access to healthy foods and other basic items (such as toothbrushes and toothpaste) due to the cost;
- Living in poor housing (for example, such as dampness or overcrowding) or homelessness (for example, being placed in a hotel with no cooker available), and;
- The worry, stress, and stigma a family faces in trying to pay for the basics, and the impact this has on the children.

The report also suggests that poverty exacerbates children's illnesses as their parents/carers may not have the financial means to call a GP, to purchase a bus ticket to visit a GP, or may not be able to afford to take time off work to visit their child in the hospital. Poverty also played a role in delaying children's discharge from hospital. Paediatricians gave some examples of why children's discharge had been delayed:

“[I was] unable to discharge a chronically unwell child requiring constant use of electrical equipment as the house only has one socket.”

“Family was unable to go home with a premature neonate due to damp in the house.”

“Difficulties discharging a child with diarrhoea and vomiting as sharing a room with multiple siblings, many families in the house and only one toilet.”

(Royal College of Paediatrics and Child Health, 2017, p. 15)

Poverty has also been linked to child maltreatment (Bywaters et al., 2016), suggesting that children and young people from deprived areas are more likely to have experienced abuse and/or neglect.

What do we know about the impact of childhood abuse and neglect (child maltreatment) on health?

The latest national statistics reveal that 65 per cent of children and young people were in the care system due to abuse and/or neglect (Department for Education, 2020). Research suggests that children who have experienced abuse and/or neglect are at greater risk of physical and mental health problems. For example, Norman (2012) conducted a systematic review and meta-analysis to explore the relationship between childhood abuse and mental and physical health outcomes in which they found a causal relationship between childhood abuse and mental disorders, substance misuse, suicide attempts, risky sexualised behaviour and sexually transmitted infections. Similarly, using data from a pre-existing survey, McCarthy-Jones and McCarthy-Jones (2014) found that children and young people who had experienced childhood sexual abuse or childhood physical abuse were significantly more likely to be obese, to have

mental disorders, to be dependent on alcohol or drugs, and to attempt suicide. Moreover, Child maltreatment has also been associated with hypertension (Gooding et al., 2014), smoking (Braciszewski & Colby, 2015; Fuller, 2012), and chronic health conditions, physical symptoms, and poor self-rated health (Schafer, Morton, & Ferraro, 2014). De Breto et al. (2013) compared the grey matter volume of children who had been maltreated with children who had not been maltreated. They found that children who had been maltreated had reduced grey matter in the medial orbitofrontal cortex and the left middle temporal gyrus, suggesting that maltreated children are more likely to have difficulties making decisions, regulating their emotions and retaining memories.

What do we know about the impact of Adverse Childhood

Experiences on health?

Research suggests that children and young people in care have experienced high levels of adversity, with the latest national statistics showing that 65 per cent were in care due to abuse and/or neglect, 14 per cent due to family dysfunction, 8 per cent due to their family being in acute stress and seven per cent due absent parenting (Department for Education, 2020). The term Adverse Childhood Experiences was coined by Vincent Felitti and Robert Anda during the 1990s following a study they conducted exploring the relationship between childhood abuse and household dysfunction, and the leading causes of death in adults. They proposed seven categories of childhood exposures to abuse and household dysfunction:

1. Physical abuse

2. Emotional abuse
3. Sexual abuse
4. Substance abuse within the home
5. Mental illness within the home
6. Mother treated violently
7. Criminal behaviour within the home

They concluded that adverse childhood experiences resulted in an increased risk of substance misuse, smoking, depression, poor self-rated health, sexually transmitted diseases, obesity, and chronic health conditions later in life (Felitti et al., 1998). Since then, the categories of adverse childhood experiences have continued to expand, and may now also include:

- Physical neglect
- Emotional neglect
- Divorce
- Racism
- Bullying
- Community violence

(World Health Organisation, 2018)

ACEs scores are calculated by summing up the number of adverse childhood experiences someone has had. Typically, ACE scores can range from nought to ten. The higher the ACE score, the higher the exposure to adverse childhood experiences.

During recent years emphasis has been placed on the role of toxic stress caused by adverse childhood experiences, and its impact on health outcomes. Research has found that prolonged activation of the body's stress response can affect children's brain development, immune system, and neuroendocrine stress response (Johnson, Riley, Granger, & Riis, 2013). For example, Danese and McEwen (2012) reported that maltreated children were showing a smaller volume of the prefrontal cortex, greater activation of the Hypothalamic-pituitary-adrenal (HPA) axis, and elevated inflammations than children who had not been maltreated. The prefrontal cortex lies at the very front of the brain and is responsible for attention-span, impulse control, planning, coordinating tasks, and regulating emotions. Children and young people with a smaller volume of the prefrontal cortex are likely to experience difficulties regulating their behaviour and emotions, and may struggle with concentration (Hodel, 2018). The HPA axis lies at the heart of the stress response system that produces cortisol. A healthy level of cortisol is thought to contribute to the regulation of blood sugar levels, the reduction of inflammation, regulating metabolism and memory formation. However, after a stressful experience cortisol is released into the blood for several hours, and repeated exposure to stress can lead to an unhealthy level of cortisol in the blood for a prolonged period of time. This can lead to weight gain, acne, thinning skin, slower healing of the body, muscle weakness, fatigue, irritability, difficulties concentrating, hypertension and chronic headaches (van Holland, Frings-Dresen, & Sluiter, 2012).

Most research suggests that adults with an ACE score of four or more are at greater risk of behavioural, physical and mental health problems later in life. For example, in a systematic review and meta-analysis Hughes et al. (2017) reported that those with four or more ACEs had an increased risk of a range of adverse health outcomes. They found a small to moderate association between ACEs and physical inactivity, overweight or obesity and diabetes; a moderate association for smoking, alcoholism, poor self-rated health, and cancer; and a strong association for substance misuse and interpersonal and self-directed violence. They also concluded that there was a generational risk as future generations were likely to also have adverse childhood experiences.

Some research, such as that by Reiser, McMillan, Wright, and Asmundson (2014), has also found a link between ACEs and health anxiety in adulthood, with adults worrying more about their health. Similar findings have been found by Thompson, Flaherty, et al. (2014) who used data available on 802 children who were at risk or had experienced maltreatment. They found that the majority of children in their sample had experienced three or more ACEs and also had a number of health worries, had needed or received medical care, and rated their health as poor.

Conclusion

This review of the literature on the physical and mental health and well-being of children and young people in care has shown that this population is likely to have exceptional health care needs, many of them related to experiences of poverty and abuse prior to entering the care system. Children and young people

who enter care are also less likely to have had access to routine health interventions such as immunisations and dental care than their peers in the general population. However, after entering care the research suggests that children and young people are likely to have their unmet health needs identified. This suggests that the care system may be somewhat effective in meeting the physical and mental health needs of the children and young people it is responsible for. However, further research is needed to explore how far the care system is able to meet the health needs of this vulnerable population.

This study seeks to explore what factors are associated with the ability of the care system to meet the physical and mental health needs of young people looked after in England. The main purpose of this study is to identify how the health needs of children and young people in care might be better addressed and where policy and practice in this area might be improved. The methods used in order to achieve these aims are outlined in the next chapter.

Chapter Four: Research Design and Methodology

Introduction

This mixed methods study aimed to explore what factors were associated with the ability of the care system to meet the physical and mental health needs of young people in care; the barriers that prevent access and/or engagement with health services; which young people in care are most at risk of having a mental health problem, or adopt risk taking behaviours (such as substance misuse problems or criminal convictions), and why they may turn to risky behaviours. A convergent mixed methods design was used in which qualitative and quantitative data were collected in parallel, analysed separately, and then merged together to provide an understanding of what is happening at a national level, and how these policy initiatives are experienced by those they directly affect. In the study, secondary analysis of data from national datasets was used to explore how far young people were able to access routine (dental checks and immunisations) and specialist (health assessments) health services and, in particular, whether any characteristics and care or educational experiences were associated with young people not being up to date. The quantitative databases were also used to explore which groups of young people in care were most at risk of mental health problems, substance misuse problems or criminal activities (based on characteristics and care or educational experiences). The qualitative interviews allowed the researcher to better understand these results by exploring the health perceptions of young people in care, why young people may disengage with health services, and why young people may turn to substances. By using both statistical analyses and in-depth

qualitative interviews the researcher was able to gain a richer understanding of the access young people in care in England had to routine and specialist health services and also why they may not gain access or disengage with them. Using a mixed method design also allowed the researcher to explore which groups of young people in care were most at risk of developing mental health problems and why young people in care may turn to substances.

Research question

The literature review showed that while there has been a substantial amount of research on the mental health needs of young people in care in England, and some research on their physical health needs, young people's access to routine and specialist health services has been under-researched. Thus, the aim of this study was to explore what factors were associated with the ability of the care system to meet the physical and mental health needs of young people in care, including the barriers that prevent them accessing or engaging with routine or specialist health services. Therefore, this study sought to answer the following research question:

What factors are associated with the ability of the care system to meet the physical and mental health needs of young people in care in England?

Within this overarching question, the study sought to explore six sub-questions:

1. How can pre-care experiences and experiences of entering the care system affect the health development of young people in care?

2. What health-related information is collected for the Children Looked After Dataset (CLAD) and what can this information tell us about young people's access to routine and specialist health services?
3. Are any characteristics or care and educational experiences collected for the CLAD and National Pupil Database (NPD) associated with young people's access to routine and specialist health services?
4. Are any characteristics or care and educational experiences collected for the CLAD and NPD associated with young people having mental health difficulties, substance misuse problems or criminal convictions?
5. What are the health perceptions of young people in care and how do these perceptions relate to their engagement with health services?
6. Do young people understand why health assessments are undertaken and how do they experience them?

Philosophical Worldview and Conceptual Framework

Every researcher holds a set of beliefs about the world and nature of their research that influences the decisions they make about the design of that research (Laughlin, 1995). In order to pursue the study, the researcher had to consider some philosophical issues, such as engaging with a theoretical perspective. In order to engage with a theoretical perspective, epistemology (the theory of knowledge) and ontology (the study of being) were considered, both of which informed the theoretical perspective and methodology (Crotty, 1998).

The current study was conducted from a pragmatic philosophical worldview. Implementing a pragmatic approach allowed the researcher to address not only what access to health services young people in care had, but also why they were not able to access or engage with them. Pragmatism draws on elements of different theoretical perspectives and believes that these perspectives sit on a continuum. This pragmatic study draws on aspects of social constructionism (the notion that all knowledge and meaningful reality is constructed through human interaction) (Vygotsky, 1978). For social constructionism, reality is unknowable and has no external validity. It is the belief that we can never know 'true' reality, even when our social group reaches a consensus (Humphrey, 1993; Merleau-Ponty, 1962). It considers that our knowledge is subjective, and it depends upon what experiences we have had (Brentano, 1973). It also considers knowledge to be relative because it depends upon our social groups to justify that knowledge. Knowledge can also differ between different social groups (Husserl, 1931) as Crotty explains:

"Each of us is introduced directly to a whole world of meaning. The mélange of cultures and sub-cultures into which we are born provides us with meanings. These meanings we are taught and we learn in a complex and subtle process of enculturation. They establish a tight grip upon us and, by and large, shape our thinking and behaviour throughout our lives."

(Crotty, 1998, p. 79)

It could also be argued that it is this world of meaning that shapes young people's health perceptions, influencing their willingness to access and engage with health services. Young people in care are likely to have constructed very

different meanings and understandings of their worlds compared to their peers in the general population. Young people in care have often been subjected to adverse childhood experiences and therefore may have constructed very different meanings of the role of an adult compared to their peers in the general population. Although young people from non-hostile environments may understand the role of health professionals to be that of healers, it is plausible that young people in care lack this understanding and may be more cautious of trusting adults. Moreover, and in line with Crotty (1998) the health perceptions of young people in care may have been passed down through generations.

Bronfenbrenner's ecological systems theory

This pragmatic approach also provides an ecological account of the research topic which was central to the analysis as it allowed the researcher to consider the social, historical, political and other contexts necessary for fully understanding the issue in hand. The study drew on Bronfenbrenner (1979) and Bronfenbrenner and Morris's (2006) ecological systems theory as the conceptual framework for the thesis (drawing on elements from both his earlier and later work). Bronfenbrenner (1979) suggests that children's development is enmeshed within a complex system of relationships. He divides these systems into six exosystems:

- ***The individual level:*** the child's individual characteristics and previous experiences. For example, in this study these might include ethnicity and the reasons why a child may have entered the care system.
- ***The microsystem:*** the child's most immediate environments such as home or school. For children in care this may include the foster or

residential home, school and their birth parents' home or their contact with birth parents in other settings.

- ***The mesosystem:*** the interaction between the child's different environments. For example, the relationship between birth parents and foster parents and any tension between the two.
- ***The exosystem:*** environments in which the child is not present but that may still affect the child's life indirectly. This would include everything that happens in the background for children in care. For example, decisions being made at the social worker or court level and the impact these may have on their foster or birth parents as well as the child.
- ***The macrosystem:*** composed of cultural patterns and values including political and economic systems. For this study a key part of the macrosystem is the stigma behind being a looked after child and how children experience this.
- ***The chronosystem:*** the dimension of time and changes in the child's life. For example, the age in which a child enters care and the length of time they have been exposed to abuse, neglect, or other adverse situations.

Bronfenbrenner suggests that in order to understand a child's development it is necessary to consider each level of the ecosystem and consider how they may individually impact on a child's development.

Attachment Theory

Bronfenbrenner's ecological systems theory formed the conceptual framework for analysis. However, two themes that emerged from the interviews (and also reflected the researcher's own experience in care) were the difficulties that young people experience concerning attachment and their repeated experiences of stigmatisation. This required additional theory to help understand and explain young people's experiences.

The following paragraphs give brief summaries of theories concerning attachment and stigmatisation. Theories of attachment reflect Bronfenbrenner's microsystem in which personal relationships play a key part in child development. According to attachment theory infants are born into the world equipped with innate behaviours designed to maximise their survival and these behaviours have been found to be fundamental to their development (Bowlby, 1979). Forming secure attachments allows children and young people to feel safe and protected, and as a result they are confident in exploring their psychological and social worlds. When children feel secure in their relationship with their caregiver they are able to invest their energy into understanding and making sense of their world (Bowlby, Ainsworth, Boston, & Rosenbluth, 1956). These children also develop the ability to recognise and understand their own and other people's emotions. Caregivers who form secure attachments with their children explain and reflect on their own and the child's emotional state and are better able to guide them through the development of strong mentalising capacities, which enable them to label, make sense of and regulate

their own emotions. This allows children to become resilient in the future when they are faced with stress or challenges.

However, many of those who enter the care system lack this feeling of security either as a result of abuse or simply through their separation from their caregiver. This lack of security is referred to as an insecure attachment and can result in children becoming fearful. Insecure attachments prevent children from having the self-confidence and self-esteem needed to explore their world (Fosha, 2003). Their psychological efforts may become concentrated on survival and protection, thus compromising the development of their 'self' (Fonagy et al., 1995). Insecure attachments can include the following:

- ***Avoidant attachments***: children with avoidant attachments tend to avoid their caregivers and may present behaviours such as withdrawal when stressed. These children tend to suppress negative emotions and avoid seeking help and support (Muller, 2009).
- ***Ambivalent attachments***: children with ambivalent attachments are likely to have experienced inconsistent care – their needs may have been met some of the time but love and care may have been withdrawn at times or only offered as a reward for something. Children with ambivalent attachments often have a deep desire to be loved and cared for but are also fearful of this. These children have learned that love will be withdrawn because they are not worthy of it (Cassidy & Berlin, 1994).
- ***Disorganised attachments***: disorganised attachments are most often seen in children and young people who have been abused. These children and young people have learned that caregivers do not meet

their needs and their caregivers' inconsistent and unpredictable behaviour results in them fearing for their safety. Children with disorganised attachments will struggle to understand or regulate their emotions and may present with more extreme challenging behaviour in the care system (Shemmings & Shemmings, 2011).

Those children in the care system face several challenges in forming secure attachments: they have often experienced adults who are untrustworthy, frightening or rejecting and may have developed insecure attachment styles that can push their caregivers away. Thus, high quality caring is essential in the care system in order for children and young people to feel safe and protected, in an environment in which they can learn to trust adults to meet their needs and keep them safe. Children and young people who have been exposed to adverse childhood experiences are at greater risk of not understanding their own or other people's emotions and may be poor at managing their arousals. This can result in them developing unhealthy relationships and social difficulties in the future. Caregivers who explain and reflect on their own and the child's emotional state, are better able to guide them through the development of strong mentalising capacities, which enable them to label, make sense of and regulate their own emotions. Fonagy, Gergely, Jurist, and Target (2002) refer to this as 'mentalisation' and this is thought to be the starting point for emotional self-regulation. Those who develop strong affect regulation are increasingly able to deal with higher levels of stress. Moreover, those who are capable of understanding their own and other people's emotions have been found to be

more empathetic, socially orientated and better able to create healthy friendships (Fonagy, Steele, Steele, Moran, & Higgitt, 1991).

The Theory of Stigma

During the nineteenth century there were deliberate attempts to stigmatise paupers in order to discourage dependence (Cannan, 1895). Paupers were adults and children who were dependent on the state. To some extent this stigma has survived and children and young people in care now experience stigma because their families have been unable to support them. A stigma can be understood as an attribute (such as care status) that makes a person different from others and allows others to discredit them from society (Goffman, 1997).

Research suggests that children and young people in out-of-home care are likely to experience stigma (Stein & Carey, 1986). In a recent survey, Coram discovered that adults were more likely to believe that children in care were a bad influence on other children (12%) than they were to think that children in care were a good influence on other children (7%) (Taylor, 2021). Although the survey showed that a large proportion of individuals felt sympathetic to children in care it also revealed some of the negative stigmatising comments children and young people in care, and care experienced adults, are likely to be subjected to. These comments suggested that children in care are:

“[T]oo shielded from the real world, very arrogant, no respect for others especially the elderly.”

“Unloved; Abused; Troubled; Challenging; Orphan.”

(Taylor, 2021, pp. 5-7)

This stigma may also mean that they are targets for bullying and teasing (Broad, Hayes, & Rushforth, 2001). Some research has shown that when children and young people are conscious of their care status and are aware that their home lives are different to their peers in the general population, they are more likely to notice stigma and be sensitive to comments (Aldgate & Bradley, 1999). This may even lead children and young people in care to fabricate their life story as a means of fitting in with their peers (Crumbly & Little, 1997), or to be more cautious about who they tell their life stories to (Hunt, 2018). Other research suggests that children and young people placed in residential care are more likely to be targeted for bullying or teasing than children and young people placed in kinship or foster care placements (Messing, 2005). Such stigma highlights the importance of developing a sense of normality within the care system. Anglin (2014) suggests that developing a sense of normality within the care system is essential for children’s on-going development. This sense of normality is likely to support the development of their sense of belonging, self-esteem, self-worth, self-confidence and trust in others.

As I go on to show below, analysis of the data collected in my research revealed that many of the young people’s experiences could be better understood within the contexts of attachment theory and stigmatisation. The conceptual framework for analysis therefore included these theories alongside the Bronfenbrenner’s ecological systems theory.

Research Design

The current study adopted a convergent mixed-methods design in which qualitative and quantitative data were collected in parallel, analysed separately, and then merged together. This mixed-methods study sits across the two paradigms of medical research; it offers a narrative approach to medicine through young people who experience routine and specialist health services and also offers an evidence-based approach to medicine through statistical analyses of administrative data.

Strategies of Inquiry

This study included a secondary analysis of data from the Children Looked After Dataset known as the SSDA903 (<http://data.gov.uk/dataset/children-looked-after-data>) linked with the National Pupil Database (NPD), and qualitative interviews with eight young people in care aged 12 to 18. The quantitative analyses were undertaken to explore how far young people in care had access to routine and specialist health services, their experiences of these services, and which groups of young people were at greatest risk of mental health problems and risk-taking behaviours (such as substance misuse problems and criminal activities), as well as their experiences of routine and specialist health services. The qualitative interviews were undertaken to explore the reasons why young people might not engage with routine or specialist health services, and to explore young people's health perceptions and the reasons why they might develop mental health problems and misuse substances.

In recent years, emphasis has been placed on including the voice of children and young people in local authority care in the policies and procedures that directly affect them. However, listening to children's and young people's voices has only been acknowledged as a process that is limited to the spoken word. In order to really listen to children and young people it is necessary to acknowledge the 'voice' as a process that is open and flexible to the many creative ways that they use to communicate and express themselves (Clark & Moss, 2005, 2015). The current study employed visual and creative research methods in order to allow young people to communicate in ways with which they feel comfortable. Young people were seen as 'beings' in their own right, who were also:

- *"Experts in their own lives;*
- *Rights holders;*
- *Meaning makers."*

(Clark & Moss, 2005, p. 5)

The aim of incorporating such methods was to facilitate participation for a group of young people who may ordinarily find it difficult to take part in research and verbally express themselves, to reduce the need for eye contact, and to allow young people to feel in control over the information they provided (Darbyshire, MacDougall, & Schiller, 2005). These visual and creative methods included young people taking photographs of stimuli (for example; places, people, objects.) that they considered important to their health and creating life-size human collages using these photographs and other images cut out from magazines or printed off of the Internet (Greene & Hogan, 2005). Young

people's vignettes and artwork (full size human collages) can be found in Chapter Five.

Research Methods

Quantitative Data

The quantitative aspect of the study utilised the dataset created for 'The Educational Progress of Looked After Children in England' (Sebba et al., 2015). The study linked national data about the educational attainment of children from the National Pupil Database (NPD) with the Children Looked After Dataset (CLAD, also known as SSDA903) in which local authorities in England collect data on their children and young people's experiences of care. The data collected by local authorities is used to provide the government with information that can be used to evaluate any outcomes of policy initiatives, whilst also allowing them to monitor objectives for children and young people in care. The dataset contains data that represent a snapshot of young people's care experiences on the 31 March each year (for example, where they were placed at that time) and also longitudinal data representing what had happened during each year (for example, how many times they had moved placements).

Sample

The current study used the 'longer stay' care sample identified in Luke et al. (2015). This sample consisted of 4,847 young people who started school year 11 (aged 15-16) in September 2012 and who had been looked after continuously for at least 12 months at 31 March 2013. The sample does not include young people who had been in care for less than 12 months on this

date, young people who had been in care at an earlier date but who were not in care on 31 March 2013, or young people who were 'in need' but not in care (see glossary for a definition of child in need). Of these 4,847 young people, 2,143 (44%) were female and 2,704 (56%) were male. There is currently no option for local authorities to record when a child or young person identifies as a different gender to the one assigned to them at birth. In this case, the local authority records gender type as according to the young person's wishes.

Table 1 shows how many young people in the cohort were in care on the 31 March each year between 1997 (when the young people in this sample were born) and 2012 (when all of the young people in the sample had entered care). The table stops at the year 2012 as the young people in the sample had been in care for a minimum 12 months, and so figures for the year 2013 are the same as the year 2012. Data collected before 2012 contains a smaller number of young people as not all of the sample had entered the care system at that time (for example, only 48 young people from the sample were in care on the 31 March 1997, whereas 3416 young people were in care on the 31 March 2010). It is important to note that some of these young people may have entered care and returned home, only to return into care at a later date.

Year ending 31 March	Number of young people from the sample in care	Percentage of the total sample
1997	48	1
1998	139	3
1999	223	5
2000	322	7
2001	476	10
2002	674	14
2003	986	20
2004	1258	26
2005	1559	32
2006	1891	39
2007	2210	46
2008	2546	53
2009	2924	60
2010	3416	71
2011	4003	83
2012	4847	100

Table 1: Number of young people from the 2013 cohort in care between 1997 and 2012

Outcome data variables

Access to routine and specialist health services

The CLAD contained three variables that could indicate young people's access and engagement with routine and specialist health services (See Chapter One for more information about the statutory requirement of health assessments). These variables were:

Annual health assessment up to date – whether or not young people had received their annual health assessment (undertaken by a doctor or other suitably qualified professional) during each year ending 31st of March.

Dental check – whether or not young people had visited the dentist at least once during each year ending 31st March.

Immunisations up to date – whether or not young people had received all of their immunisations according to the immunisation schedule produced by the Department of Health for each year ending 31st March.

Health risk behaviours

The CLAD also contained five variables that could highlight aspects of young people's health related risk-taking behaviour and their access to and engagement with interventions following this. These were:

Young Mother – whether young women have given birth or are due to give birth to a child. There is currently no option for local authorities to record whether young men are fathers.

Strengths and Difficulties Questionnaire (SDQ) Score - the SDQ (Goodman, Ford, Corbin, & Meltzer, 2004) is an emotional and behavioural screening tool designed to identify children and young people (aged 4 to 17) experiencing difficulties of sufficient significance to require clinical referral. It consists of five subscales:

- Emotional problems
- Conduct/behaviour problems
- Inattention/hyperactivity
- Peer relationship problems
- Pro-social behaviour

Total scores can range from 0 to 40; young people with a score of 0 to 13 are considered to be within the 'normal' range, young people with a score of 14 to 16 are considered to have a 'borderline' level of difficulty, and young people with a score of 17 to 40 are considered to have an 'abnormal' level of difficulty which may require input from mental health services. These categories have since been updated but these were the valid categories when completed by the sample in 2013. Local authorities are required to use the SDQ to make annual assessments of the emotional health of all children who have been looked after for a year or more and submit the Total Difficulties scores on 31 March each year.

Young person identified as having a substance misuse problem – whether or not young people had been intoxicated by (or regularly excessively consumed, and/or had become dependent on) psychoactive substances, which led to social, psychological, physical or legal problems during each year ending 31 March. Psychoactive substances refer to illegal drugs, illicit use of prescriptions drugs, volatile substances, and alcohol (if combined with drug use) (Department for Education, 2015c). The definition does not include tobacco use. This variable and the variables below are binary variables where 0=No and 1=Yes.

Young person offered a substance misuse intervention – whether young people who have been recorded as having a substance misuse problem have been offered a substance misuse intervention. This variable is a binary variable where 0=No and 1=Yes.

Young person refused a substance misuse intervention – whether young people who have been recorded as having a substance misuse problem has been offered a substance misuse intervention and refused the intervention. This variable is a binary variable where 0=No and 1=Yes.

Final outcome variables used for analyses

There were Six variables created to allow the researcher to explore whether any characteristics or care and educational experiences were associated with a change in the outcome variable. These were:

- Proportion of health assessments up to date
- Proportion of dental checks up to date
- Proportion of immunisations up to date
- Mean Strengths and Difficulties Questionnaire (SDQ) score
- Substance misuse problem recorded
- Ever received a criminal conviction

The young mother variable was withdrawn as a measure due to the small sample size (only 88 young women were recorded as being a young mother).

Proportion of health assessments, dental checks, and immunisations up to date

As young people had a range of available years of data for a maximum of five years (as they had been in care for different amounts of time), variables were created to capture the proportion of potential health assessments, dental checks, and immunisations that had been up to date during their time in care.

This was done by summing up the number of years that they were noted as being up to date on each outcome and dividing the total by the total number of years of data that they had available. The result was a score between 0 and 1, with 0 representing 0 per cent and 1 representing 100 per cent. Findings are presented in Chapter Nine.

Mean SDQ Score

As young people also had a range of available years of data on SDQ scores for a maximum of five years (as they had been in care for different amounts of time), a variable was created to capture the mean SDQ score of young people during their time in care. This was done by summing up their SDQ scores and dividing the total score by the total number of years of data that they had available. Findings are given in Chapter Seven.

Substance Misuse Problem Recorded

For each of the years from 2009 to 2013 data were available recording whether or not young people had a substance misuse problem. To simplify the analysis a new variable was created to capture which young people had ever been recorded as having a substance misuse problem. For the final variable, 0 represented young people who did not have a substance misuse problem recorded between 2009 and 2013 and 1 represented young people who had been recorded as having a substance misuse problem for one or more years between 2009 and 2013. The findings are presented in Chapter Seven.

Criminal Conviction Recorded

For each of the years from 2009 to 2013 data were available recording whether or not young people had received a criminal conviction. To simplify the analysis a new variable was created to capture which young people had ever been recorded as receiving a criminal conviction. For the final variable, 0 represented young people who did not receive a criminal conviction between 2009 and 2013 and 1 represented young people who had received a criminal conviction for one or more years between 2009 and 2013. The findings are presented in Chapter Seven.

Predictor data variables

Data from the Children Looked After Database and National Pupil Database were used to explore whether any individual characteristics or care and educational experiences were associated with young people's access to and engagement with health services, and which young people were most likely to present with health risk behaviours. Variables are the same as those used by Luke et al. (2015), except where stated. The predictor variables used are outlined in Table 2.

Variable name	Original/New variable	Original values (if altered)	Final values
Demographic data			
Gender	Original		1=Female 2=Male
Ethnicity	Original		1=White British or Irish 2=Asian 3=Black African 4=Black Caribbean and mixed White Black Caribbean 5=Other mixed 6=Traveller 7=Other 8=Ethnic origin not known
Ethnicity not known	New	Values for ethnicity	1=Ethnic origin known 2=Ethnic origin not known
Income Deprivation Affecting Children Index 2004	Original		On a scale from 0 to 1. Higher scores indicate a higher level of local deprivation.
Eligible for free school meals in 2004	Original		0=No 1=Yes
Primary reason for entry into care	New	1=Abuse or neglect 2=Child disability 3=Parent ill/disabled 4=Family stress (family are going through a temporary crisis and parenting capacity is diminished) 5=Family dysfunction (parenting capacity is chronically inadequate) 6=Child's anti-social behaviour 7=Low income 8=Absent parent.	1=Abuse or neglect 2=Reduced parenting capacity (combining categories 3, 4, 5, and 8) 3=Child's anti-social behaviour 4=UASC (Identified using the UASC variable to separate from the absent parenting category) 5=Child's disability
Age at first entry into care	New	A scale of 0 to 16	1= 0 to 4 years 2= 5 to 9 years 3= 10 to 16 years
Age at last entry into care	New	A scale of 0 to 16	1= 0 to 4 years 2= 5 to 9 years 3= 10 to 16 years
Stability in care			

Number of periods in care	Original		A scale of 1 to 371.
Time in care in years	New	A scale of 366 to 6187 days.	Days were converted into years. A scale of 1 to 16 years
Last placement length in years	Original	A scale of 0 to 5991 days	Days were converted into years. A scale of 0 to 16 years.
Number of placements	Original		A scale of 0 to 92 placements.
Proportion of time in respite placements	Original		A scale of .00 to (0%) to .99 (99%) representing the proportion of time young people had been in respite placements.
Placement history			
All placements history	New	This variable was derived from the variable 'placement type'. Using existing categories for placement types (scored as 1 where a placement represented a particular placement type, and zero where it did not fall into this placement type), a mean was calculated across all of the young person's care placements for each placement type. A score of zero meant they had never spent any time in that type of placement; 1 meant they had always been in that placement type; and a score between zero and 1 indicated they had 'ever' spent time in that placement type.	1=Ever residential care 2=Always foster or kinship care 3=Other combinations of placements
Ever placed with parents	New	Derived using the same method as above.	1=No 2=Yes
Proportion of time spent at home	New	This variable was derived from Luke et al.'s (2015) variable 'time at home' which recorded the number of days a young person had spent outside of the care system since their first entry into care (i.e. the total amount of time spent at home in between periods in care).	A new variable was created to capture the proportion of time a young person had spent at home out of the total amount of time since they had first entered care. The variable was on a scale from 0 to 1 (though a score of 1 was not possible, since this would indicate that they had been outside of the care system 100 per cent of the time since first entering care). Proportion of time spent at home ranged from .00 (0%) to .88 (88%).
Placement provision			
Placement location at Key Stage 2	Original		1=Within own local authority boundary 2=Outside of local authority boundary
Placement location at Key Stage 4	Original		1=Within own local authority boundary 2=Outside of local authority boundary
Last placement provider	Original		1=Parents 2=Own LA 3=Other LA

			4=Independent or voluntary fostering agency.
Only ever own local authority provision	Original		1=No 2=Yes
Ever independent or voluntary fostering provider	Original		1=No 2=Yes
Ever other local authority provision	Original		1=No 2=Yes
Education			
Ever changed school	New	This variable was derived from Luke et al.'s (2015) variable 'school changes y8-11'. This was a continuous variable and summed the number of times a young person had changed school during school years 8 to 11, the final 4 years of compulsory schooling.	1=No change of school 2=Changed school
Proportion of fixed-term exclusions	Original		A scale of 0 to 1 (1=100% of possible school sessions were due to fixed term exclusions). Proportion of fixed-term exclusions ranged from .00 (0%) to .63 (63%).
Proportion of unauthorised absences	Original		A scale of 0 to 1 (1=100% of possible school sessions were missed due to unauthorised absences). Proportion of unauthorised absences ranged from .00 (0%) to .76 (76%).
School type at Key Stage 4	Original		1=Mainstream School 2=Special school 3=Pupil referral unit 4=Alternative provision 5=Other provision
Number of Key stage 2 points achieved	Original		A scale of 2.5 to 8.
Additional needs			
First language in 2004	Original		1=English 2=Other language
First language in 2013	Original		1=English 2=Other language
Special educational needs provision	Original		1=No special educational need 2=School action 3=School action plus 4=Statement of special educational needs
Primary special educational need	New	This variable was derived from Luke et al.'s (2015) variable 'Primary SEN at max' which represented the type of primary SEN that was	1=No special education need 2=Behaviour, emotional and social difficulty

		recorded during the young person's highest level of SEN provision. Only one type of SEN can be recorded, and these were grouped by Luke et al. (2015) into 8 categories: 1=No special educational need 2=Behavioural, emotional and social difficulties 3=Moderate learning disability 4=Specific learning disability 5=Speech, language and communication 6=Autism spectrum disorder 7=Severe or multiple learning difficulties 8=Physical, sensory and other disabilities	3=Other disabilities
Health risk behaviours			
Ever convicted	Original		1=No 2=Yes
Ever substance misuse problem	Original		1=No 2=Yes
Mean Strengths and Difficulties Questionnaire score	New	This variable was derived from the annual SDQ total difficulties score for 2009-2013.	The new variable captured the mean score for all 5 years for each young person (or the maximum number of years available, for those who had not been in care for the full 5 years) and was on a scale from 0 to 40. Higher scores indicate a higher level of difficulties.

Table 2: Predictor variables used for analyses

Analytic procedure for quantitative data

Initial analyses were undertaken to look for any relationships between the outcome variables and the predictor variables (See Appendix One). From this, further tests were carried out to explore whether any of the predictor variables were associated in a change in the outcome variables.

Initial analyses of continuous outcome variables

The outcome variables 'proportion of health assessments up to date, proportion of dental checks up to date, and proportion of immunisations up to date, and mean SDQ score' are continuous variables. So, in order to explore associations between these outcome variables and characteristics and experiences, the following statistical tests were used:

- Pearson's Correlation (for continuous variables)
- Independent samples t-test (for independent variables with 2 categories)
- One-way ANOVA (for independent variables with more than 2 categories)

Pearson's correlation measures the strength of relationship between two continuous variables. Its value can range from -1 (as one variable goes up the other variable goes down) to 1 (both variables move in the same direction). Cohen (1988, 1992) suggest that a result of .1 indicates a small effect size (accounting for 1 per cent of the variance), .3 indicates a medium effect size (accounting for 9 per cent of the variance), and .5 indicates a large effect size (accounting for 25 per cent of the variance). If there is a significant relationship between two variables, then the p -value will be less than .05.

The association between continuous outcomes and the following variables were assessed using Pearson's Correlation:

- Income Deprivation Affecting Children Index 2004
- Number of periods in care
- Number of years in care
- Length of last placement
- Proportion of time spent at home
- Number of placement changes
- Number of respite placements
- Number of fixed-term exclusions
- Number of unauthorised absences
- Number of Key Stage 2 points
- Mean Strengths and Difficulties Questionnaire score

Independent t-tests assess whether there is a significant difference between the means of the outcome variable for the two categories in the independent variable. For example, whether the mean score of proportion of health checks up to date is significantly different between females and males. The t value is the calculated difference between groups represented in units of standard error. Simply, the higher the t value the bigger the difference between groups. If the difference between groups is significant then the p -value will be less than .05.

The association between continuous outcomes and the following independent variables were assessed using t-tests:

- Gender
- Ethnicity not known
- Eligible for free school meals in 2004
- Unaccompanied asylum-seeking children
- Age at first entry into care
- Age at last entry into care
- In care at Key Stage 1
- In care at Key Stage 2
- In care at Key Stage 3
- Ever placed with parents
- Placement location at Key Stage 2
- Placement location at Key Stage 4
- Last placement provider
- Always placed with own local authority
- Ever placed with other local authority
- Ever placed with an independent or voluntary fostering agency
- Ever school change between years 8 and 11
- First language in 2004
- First language in 2013
- Secondary special educational need
- Ever convicted
- Ever substance misuse problem

A one-way analysis of variance (ANOVA) compares the variance between categories in the independent variable with the variance within each category.

If there is significantly more variance between the groups rather than within the groups, then the p -value will be less than .05. The F -value is simply telling us whether there is a difference between the means of multiple categories. As with the t -value, the higher the F -value the larger the difference between categories.

The association between continuous outcomes and the following independent variables were assessed using one-way ANOVAs:

- Ethnicity
- Category of need
- Placement history
- Special educational needs provision
- Primary special educational need

Tests to predict continuous outcomes

Stepwise multiple regressions were conducted to explore whether any characteristics and care or educational experiences were associated with young people in the 2013 cohort who were at risk of not being up to date with their health assessments, dental checks, and immunisations, or had a higher mean SDQ score. Multiple regression is a statistical technique which can be used to explore the relationship between one continuous outcome variable (for example, the proportion of health assessments that were up to date) and two or more predictor variables (for example, ethnicity, number of years spent in care, and reason for entering care). Multiple regression calculates which predictor variables can account for the variance in the outcome variable. It looks at the relationship between the outcome variable and a predictor variable while

also controlling for the other predictor variables in the model, allowing the researcher to understand how much each predictor variable contributes to the overall model. Stepwise multiple regression allowed the researcher to explore which characteristics and care or educational experiences could explain the variance within the proportion of health assessments, dental checks, and immunisations that were up to date and SDQ scores for the 2013 cohort. There is some controversy in the literature about using Stepwise regression, but much of this controversy is due to the fact that it allows you to enter a lot of different variables into the regression model and so typically it requires a large dataset (Field, 2018). As the researcher was using a large dataset and the data met the assumptions of linear regression stepwise regression was appropriate for this study.

Meeting the assumptions of linear regression

Before conducting the analyses, the researcher conducted a number of tests to ensure that the data met the assumptions of multiple regression. This was to ensure that the results would be as valid and reliable as possible.

Sample size

For stepwise regression, Pallant (2005) recommends a ratio of 40 cases for every predictor variable entered into the regression analysis. The current study included 48 variables (some of which were dummy variables for variables that had more than two categories) and so a minimum of 1,920 cases were needed. In the final model for the proportion of health assessments that were up to date there were 4,657 cases, for the proportion of dental checks that were up to date

there were 4,841 cases, for the proportion of immunisations that were up to date there were 4,842 cases, and for mean SDQ scores there were 4305 cases.

Multicollinearity

Multicollinearity refers to the relationships between the predictor variables, in which two variables are highly correlated. For example, within the current data it might be expected that the age that a young person entered care would be highly correlated with a young person being in care at specific time points – such as at KS1, KS2, KS3. This is problematic in multiple regression because it then becomes difficult to unpick which variable is a better predictor of the outcome variable. Three methods were used to ensure that multicollinearity did not exist within the regression models.

- Tolerance scores were a minimum of .96 for the proportion of health assessments that were up to date, .70 for the proportion of dental checks that were up to date, .30 for the proportion of immunisations that were up to date and .23 for mean SDQ scores. All of these were above the value of .10 as recommended by Menard (1995).
- Values for the Variance Inflation Factor (VIF) were a maximum of 1.04 for the proportion of health assessments that were up to date, 1.41 for the proportion of dental checks that were up to date, 3.38 for the proportion of immunisations that were up to date and 4.2 for mean SDQ scores. All of these were well below the value of 10 as recommended by Myers (1990).
- Residuals were used to determine the number of individual cases that were having an undue influence on the regression models. Residuals

represent the difference between the original and predicted values of the outcome variables. Cooks distance scores were .05 for the proportion of health assessments up to date, .01 for the proportion of dental checks up to date, .02 for the proportion of immunisations up to date and .02 for mean SDQ scores. These are all under the value of 1 as recommended by Cook and Weisberg (1982).

Outliers

Multiple regression is sensitive to outliers (extreme scores either side of the mean). Pallant (2005) suggests that any outliers be recoded with less extreme scores or removed from the analyses altogether. As recommended by Tabachnick and Fidell (2012) any cases within the current study that had standardised residual values above 3.3 or below -3.3 were removed from the analyses. In total, 179 cases were removed from the regression analysis for the proportion of health assessments up to date, and 1 case was removed from the regression analysis for the proportion of dental checks up to date and no cases were removed for mean SDQ scores. There were no outliers for the proportion of immunisations up to date.

The Regression Model

In stepwise multiple regression SPSS automatically enters and excludes variables from each block of the model depending on the ability of each predictor variable to explain the variance in the outcome variable. The model for the current study consisted of eight blocks:

- Step 1 consisted of demographic and early childhood factors:

- Gender
- Ethnicity
- Income deprivation affecting children index 2004
- Eligible for free school meals in 2004
- Step 2 consisted of factors relating to the young person when they entered care:
 - Reason for entering care
 - Age at first entry into care
 - Age at last entry into care
- Step 3 consisted of factors relating to the young person's stability while in care:
 - Number of periods spent in care
 - Time spent in care in years
 - Length of last placement
 - Number of placement changes
 - Number of respite placements
- Step 4 consisted of placement history factors:
 - All previous placement types
 - Ever placed with parents
 - Proportion of time spent at home
- Step 5 consisted of factors relating to placement provision:
 - Placement location at key stage 2
 - Placement location at key stage 4
 - Last placement provider
 - Only ever own local authority provision

- Ever independent/voluntary fostering agency provision
- Ever other local authority provision
- Step 6 consisted of educational factors:
 - Ever changed secondary school
 - Number of fixed-term exclusions
 - Unauthorised absences
 - School type at key stage 2
 - School type at key stage 4
 - Key stage 2 points
- Step 7 consisted of factors relating to additional needs:
 - First language in 2004
 - First language in 2013
 - Special educational needs provision
 - Primary type of special educational need
 - Secondary type of special educational need
- Step 8 consisted of risk-taking factors:
 - Ever convicted
 - Ever substance misuse problem
 - Mean SDQ score (not included in the SDQ regression)

Initial analyses of categorical outcome variables

The outcome variables 'ever substance misuse problem' and 'ever criminal conviction' are categorical variables (in which 0=no and 1=yes). So, in order to assess any associations between substance misuse problems, criminal

convictions and characteristics, or care and educational experiences, the following tests were used:

- Biserial correlation (for continuous variables)
- Pearson's chi-square (for categorical variables)

Biserial correlation is a correlational index that assesses the strength of a relationship between a dichotomous variable and a continuous variable. The results can be understood in the same way as Pearson's correlation.

The association between substance misuse problems and criminal convictions and the following variables were assessed using Biserial correlation:

- Income Deprivation Affecting Children Index 2004
- Number of placements
- Number of respite placements

Pearson's chi-square test is a statistical test applied for categorical data that evaluates how likely it is that the observed difference between the categories arose by chance. If the p -value is $<.05$ then we know that there is a significant difference between the categories.

The association between substance misuse problems and criminal convictions and the following variables were assessed using Pearson's chi-square:

- Eligible for free school meals 2004
- Unaccompanied asylum-seeking children
- Category of need

- Age at first entry into care
- Ever placed in residential care
- Always placed in foster care
- Ever placed with parents

Tests to predict categorical outcomes

Logistic regression was used to explore which characteristics or care and educational experiences were significantly associated with young people who had a substance misuse problem or criminal conviction between 2009 and 2013.

Assumptions of Logistic Regression

Before testing the data, tests were conducted to ensure that the data met the assumptions of logistic regression. New variables were created to represent the natural log of each of the continuous variables in order to test the assumption of linearity, these were: IDACI 2004, number of placements and number of respite placements. When entered into the regression as an interaction (for example, IDACI_2004 x LnIDACI_2004), results showed that the assumption of linearity had not been violated for these models.

Multicollinearity was then tested by running a linear regression and selecting the option for collinearity diagnostics. Tolerance values were a minimum of .60, well above the value of .10 recommended by Menard (1995), and the values for the variance inflation factor (VIF) were a maximum of 1.6 which is well below the Myers (1990) recommendation of 10. There were also no issues with the

variance proportions attributed to each eigenvalue. Using residuals to determine the number of individual cases with an undue influence on the models showed that both outcomes Cook's distance scores were < 1 as recommended by Cook and Weisberg (1982).

The Regression Model

Variables were entered using a hierarchical Forward: Conditional method;

- **Block 1** included variables relating to the young person's early childhood:
 - Income deprivation affecting children index 2004
 - Eligible for free school meals in 2004
- **Block 2** included variables relating to the young person's entry into care:
 - Reason for entry into care
 - Age at first entry into care
- **Block 3** included variables relating to the young people's placement types:
 - History of placement types
 - Ever placed with parents
- **Block 4** included variables relating to the young people's level of stability while in care:
 - Number of placement changes
 - Number of respite placements
- **Block 5** included variables relating to the young people's placement providers:

- Always placed in own local authority provision
- Ever placed in another local authority provision
- Ever placed with in an independent/voluntary fostering agency provision
- **Block 6** included variables relating to the young people's school experience:
 - Ever changed secondary school
 - Type of school at key stage 2
- **Block 7** included variables relating to missed education:
 - Number of school days missed due to fixed-term exclusions
 - Number of unauthorised absences
- **Block 8** included variables relating to special educational needs:
 - Type of primary special educational need
 - Type of special educational need provision received
 - Secondary special educational need
- **Block 9** included variables relating to risk-taking behaviour
 - SDQ mean
 - Ever convicted or Ever substance misuse problem

The findings from these analyses are presented in Chapter Seven and Eight and the full regression models can be found in Appendix Two.

Qualitative data

The qualitative aspect of the study employed visual and creative research methods to capture the voices of eight young people in care aged 12 to 18.

These in-depth qualitative interviews were undertaken to compliment and add depth to the statistical findings by exploring how young people experience policy initiatives such as health assessments. These interviews also explored the health perceptions of young people in care and examined how these perceptions related to their engagement with health services or risk-taking behaviour. Young people in care were also asked to complete a sleep and food diary for up to one week, logging what they had to eat and drink each day, what time they went to sleep and woke up each day, how many times they woke up during the night, how long it took them to fall asleep and to rate how well they felt they slept. The study also included analysis of key national policy and guidance documents relating to the health of children and young people looked after in England. These were:

- Promoting the health and well-being of looked after children 2002 (Department for Education & Department of Health, 2002): This was the first statutory guideline developed on promoting the health of children and young people in care.
- Statutory Guidance on Promoting the Health and Well-being of Looked After Children 2009 (Department for Education & Department of Health, 2009): This was also statutory guidance, it was a regulatory framework for professionals and was underpinned by law. This gave professionals a framework to inform practice.
- Promoting the health and well-being of looked after children 2015 (Department for Education & Department of Health, 2015): The new guidance is much more concise as the government wanted to ensure that it was easily accessible. Government policy states that statutory

guidance does not need to contain practice guidance – so the newest guidance no longer has recommended content for health assessments.

Recruitment of young people

An application was submitted to the Association of Directors of Children's Services (ADCS) who approved the research. The ADCS emails local authorities a list of approved studies and asks that the studies be supported where possible. Once the ADCS application was approved, the researcher emailed the directors of three local authorities in England outlining the research and asking for assistance in recruiting young people aged 12 to 18 who had been in care for a minimum of twelve months. The directors then allocated the task of recruiting young people to a manager within the looked after children teams. The managers then liaised with the researcher directly and information sheets were sent to them for the young people and their foster carers (see Appendix Three). Social workers then met with the young people to discuss the research and to see whether they wished to participate in the study. Social workers then arranged for the researcher to meet the young people interested in 'opting in' to the study at an activity day. Here the researcher explained the nature of the study and what would be involved. The young people who wanted to participate completed an information sheet and were given a camera and a folder containing a detailed information sheet, copy of the consent form, contact information for the research office, a list of questions that would be asked in the interview and a seven-day food and sleep diary (See Appendix Four).

a) Inclusion criteria

- The young person was aged 12-18 years old.
- The young person's placing authority was one of the three local authorities included in the research.
- The young person was on a full care order under Section 31 of the Children Act 1989.
- The young person had been in care for a continuous period of at least 13 months.
- The young person had attended or been offered their annual review health assessment (it was important that young people had been in care for a minimum of 13 months to ensure that they had been offered a review health assessment and not just an initial health assessment).

b) Exclusion criteria

- The social worker considered that participation was not in the best interest of the young person (for example they were experiencing instability or uncertainty).
- The young person had experienced a significant recent adverse event (e.g. a traumatic placement breakdown or the end of a significant relationship).
- The young person was looked after on a voluntary basis under Section 20 of the Children Act 1989.
- The young person was looked after on an interim care order under Section 31 of the Children Act 1989.

Sample

Managers in the three participating authorities identified twelve young people in care who met the eligibility criteria. However, as is common in research with a vulnerable population such as this, there was substantial attrition, and nine young people in the three different local authorities consented to participation in the qualitative aspect of the study. One young person later asked to withdraw their consent. Of the eight remaining young people, five were male and three were female aged between 12 and 18. The young people had been in care for between four and 11 years. Three of the young people had remained in the same foster placement since entering care, the other five young people had experienced three or more placements and two had moved into their latest foster home within the previous twelve months. One young person was also in the process of moving on to independent living.

Research Instruments

Before their in-depth interviews, the young people were given a digital camera and a folder containing a detailed information sheet, the consent form and questions for them to consider when taking photographs and a seven-day food and sleep diary. These research instruments were designed in consultation with the youth advisory panel. Questions were given to the participants in advance of interview to empower them to feel in control of the information they wanted to provide. The questions were presented in a folder with plastic wallets to allow them to collect other images. The food and sleep diaries were designed to provide a simple snapshot of what the participants consumed in a day and also

to act as a tool to engage them in a discussion about their own views on their eating and sleep behaviours. The questions were presented in a way that allowed them to store any cut outs from magazines that they wanted to include in their collage. Once all of the interviews had been conducted, a professional photographer took photographs of the young people's artwork for the researcher to use within this thesis.

Procedure

The young people who opted into the study were given an initial information sheet and provided initial consent. They were then given a minimum of two weeks to take photos of items that they felt represented their health. Meanwhile, the manager of the looked after children team provided consent for the young person take part in an in-depth interview. The researcher then contacted the young person directly to confirm that they still wanted to take part in the research and to arrange a time and place to interview them at their convenience.

Four young people were interviewed within their foster homes, two young people were interviewed in a youth centre, and two young people were interviewed in a local authority meeting room. Due to concentration difficulties, one young person wished to split the interview into two visits. One young person withdrew from the study before the interview, after taking photographs of stimuli they felt represented or were important for their health. These data were not used in the analyses.

The researcher spent approximately ten minutes 'catching up' with the young people in order to ease any anxiety and to build a rapport. The researcher then went through the information sheet and consent form with the young people and asked if they still wanted to participate. The researcher explained that they would be happy to answer questions not related to the study at the end of the interview but not beforehand in order to ensure their answers were not influenced. Once the young people had signed the consent form the audio recorder was turned on. The researcher clarified that names and identity would not be used in the study and asked young people to pick a pseudonym (Disney, cartoon, idol). The researcher then laid out the outline of the human body and showed young people the items available in the craft box (see figure 5) that they could use to decorate their collage. The researcher then set up the portable printer and printed young people's photographs while going through their folders in which they had answered some of the questions and to review their sleep and food diaries and ensure the researcher interpreted them correctly. Once the photographs were printed, the researcher encouraged young people to begin thinking about how they wanted to collage their human figure and what messages they wanted to portray. When young people were immersed in their artwork, the researcher began to ask questions about what health meant to them, and their experiences of health services. Interviews were designed to be led by the young people in order to ensure that they could talk about issues that were important to them.

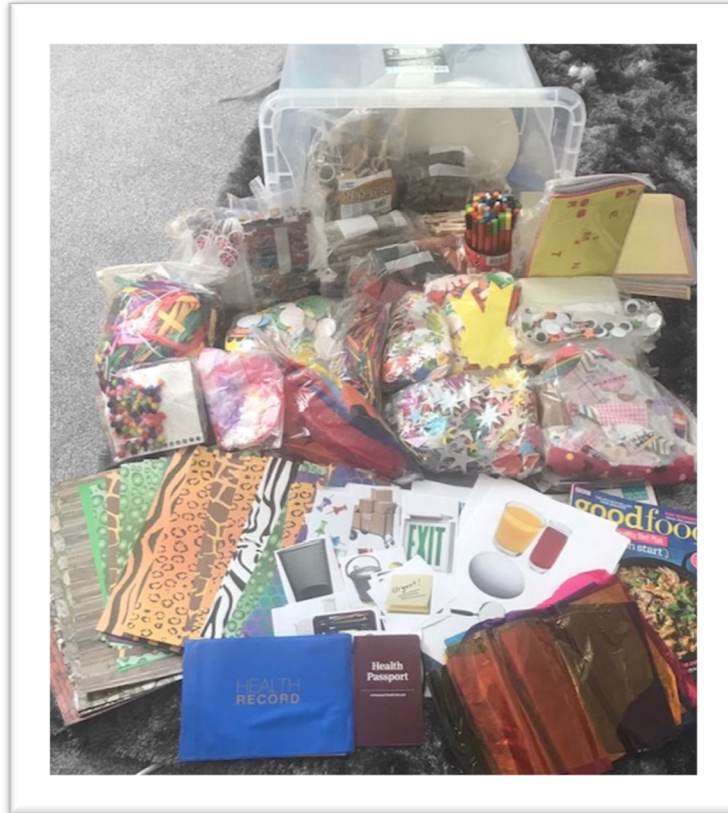


Figure 5: Example craft box

Once young people had finished their collage and the researcher had asked everything that they wanted to, young people were given the opportunity to ask the researcher questions. All of the young people asked the researcher questions; these included:

- *“Do people think you’re stupid because you grew up in care?”*
- *“Did people think you could go to university when you were in care?”*
- *“Do people think you’re badly behaved because you were in care?”*
- *“Are people shocked when they find out that you used to be in care?”*
- *“Do you think I’m clever enough to go to university?”*
- *“Do you feel different to friends now that you’re an adult because you grew up in care?”*

- *“Did people used to say that you were in care because your mum didn’t love you?”*
- *“Do you feel normal now that you’re not in care?”*
- *“Were you bullied when you were in care?”*

Before leaving, the researcher explained what would happen to their artwork ‘back at the office’ and confirmed whether they wanted their collage returned at the end of the study. The researcher also confirmed that they could get in contact should they have any further questions. When back at the hotel the researcher emailed the social work manager to confirm that the young person had taken part in the study, and to ask that the young person’s social worker contact them the next day to check they had not been unduly affected by talking about their past experiences. Two young people spent time completing all of the questions in the folder and asked if they could keep them. So, the researcher copied the folders once back in the office and posted their folders back to them.

Qualitative Analytic Procedure

Interviews were transcribed verbatim to produce an ‘original transcript’. Transcripts were then checked against the audio recording producing a ‘checked’ version. Finally, transcripts were anonymised producing a ‘final’ version that could be used for data analysis. Data were thematically analysed in accordance with the procedure identified by Ziebland and McPherson (2006) and went through a series of stages. Firstly, the researcher read through hard

copies of the transcripts making notes of any initial thoughts in the left-hand margin.

Once the researcher had undertaken initial analyses of the interview transcripts and the statistical analyses of the quantitative data, she met with the youth advisory panel. Some members of the advisory panel read through an anonymised transcript before the meeting. The researcher then discussed with the advisory panel which parts of the interviews they felt were really important to talk about in the thesis. When discussing the questions that young people in care had asked the researcher at the end of their interview, there was a strong consensus that key theme needed to be about the stigma of being a looked after child and the need for normality in an abnormal context.

After meeting with the advisory panel, the researcher then went back through the transcript to list any potential codes in the right-hand margin. This was repeated for the first few interviews and then a coding framework was developed based on the themes that had emerged. NVivo software was used to help manage the data and to assign data to codes. Codes were then grouped together to make overarching themes. In order to write about these themes the 'One Sheet Of Paper' method was employed, to find the story in these themes that also included all perspectives (Ziebland & McPherson, 2006). The visual data were thematically analysed and matched with the coding framework with the help of the youth advisory panel. The one sheet of paper method allowed the researcher to map out all of the participants' experiences and link themes

together to make a story while incorporating the views of the advisory panel (Ziebland and McPherson, 2006).

Reflexivity and addressing potential bias

User-led research has become more prominent within health research and some benefits have started to be recognised. For example, user-led research provides greater focus on issues and outcomes that are relevant to those experiencing them, researchers are better positioned to represent the voices of groups that may be easily ignored within research, the researcher is likely to be able to build rapport quickly, it can reduce issues of power and can allow participants to feel more in control over their participation and the information they provide, and the researcher is more likely to focus on benefits to participants (Torronen & Vormanen, 2014).

However, along with her personal experience the researcher brings the potential for bias in the design of the research questions and materials, and interpretation of the findings. For instance, as with most services, the health and social care systems are constantly evolving, and the researcher was aware that the services she experienced were not necessarily the services that young people experience today. The researcher was aware of and accepted the potential for negative research bias from the outset and therefore secured funding to develop a youth advisory panel to ensure that the voices of young people who were still in care fed into every step of the research. The youth advisory panel was made up of 10 young people aged 14 to 17 who were in local authority care. Six young people were happy to meet in a group, but two

young people preferred to meet the researcher as a pair and the other two young people preferred to meet the researcher individually.

In order to ensure that young people's participation on the youth advisory group was beneficial for them, the researcher spent the first meeting discussing the potential tasks of the advisory group and seeking their preferences. For example, looking at which research tasks would provide experiences that they could refer to in their Curriculum Vitae that might help them to achieve their future goals. The researcher's personal experience of the care system was beneficial in building rapport quickly and in reassuring young people that their participation on the youth advisory panel could be flexible to work around any challenges they were facing in the care system such as placement breakdowns or complex relationships with birth families.

The researcher met with members of the advisory panel a minimum of twice per year for two years. They received a £20 gift voucher for their time and their travel expenses were paid after each meeting. The youth advisory panel fed into the development of the research questions, interview schedule, information sheets and consents forms, and also the methods used in the interviews. For example, the researcher felt that interviews should be fun and use creative methods and used Pinterest looking for different ideas to present to the panel who then took the ideas one step further and suggested that interviews should consist of young people collaging life-size human bodies to represent themselves.

Members of the advisory panel added great meaning to young people's artwork by highlighting the importance of having the direct voice of participants when presenting the results. They felt that the life-size human body acted as a symbol of participants presenting their results alongside the researcher and also highlighted that they represented the direct voice of participants because their artwork would not be changed. This was not something that the researcher had considered. The youth advisory panel also played a key role in analysis of interview data, helping to bring out the key themes by reading anonymised interview transcripts and pulling out the information they felt was important to represent within the thesis.

Synthesising the results

The findings of the qualitative and quantitative aspects of the study were merged using the conceptual framework outlined above, adapted from Bronfenbrenner (1979) and Bronfenbrenner and Morris (2006). Table 3 lists the data collected and analysed for each of the different levels of Bronfenbrenner's ecological systems theory.

Level	Qualitative data to be collected	Quantitative data to be analysed	What this information might tell us
Individual level	- Pre-care experiences - Experiences of entering care - Health conditions - Additional needs	- Individual characteristics - Gender - Ethnicity - Special educational needs - Pre-care experiences - Age at entry into care - Reason for entry into care - Number of periods in care - IDACI	- What young people experience prior to entering care, and how these experiences may impact their health development.
Micro system	- Experiences of routine and specialist health services - Food and sleep diaries - Photographs	- Experiences of care - Type of care - Number of placements - Length of last placement - Number of respite placements - Experiences of education - School type - School changes - Proportion of fixed-term exclusions - Proportion of unauthorised absences - Mean SDQ scores - Substance misuse problems - Criminal convictions	- How experiences of care (such as instability) effect young people's health development and ability to develop secure attachments with their foster carers. - How young people experience routine and specialist health services. - The health perceptions of young people in care.
Mesosystem	- Policy and guidance documents	- No relevant data collected about communication between services.	- How professionals with different responsibilities should work together to promote the health of young people in care.
Exosystem	- Policy and guidance documents	- Proportion of health assessments up to date - Proportion of dental checks up to date - Proportion of immunisations up to date	- Whether it is clear who and how professionals are responsible for promoting the health of young people in care. - What the administrative data can tell us about young people's health and what the variables can

			tell us about young people's engagement with routine and specialist services.
Macrosystem	- Policy and guidance documents	-LA Ofsted rating	-How the statutory guidance aims to promote the health of young people in care.
Chronosystem	- Interviewees experiences of entering care at different ages - Interviewees experiences of stability in care and attachments with foster carers	- Time in care - Number of placements - Proportion of respite placements	- Whether the age that young people enter care or experiences of instability can effect their health development.

Table 3: Data collection items for the different levels of Bronfenbrenner's ecological systems theory

The researcher then worked closely with the youth advisory panel to identify key themes for each level (apart from the mesosystem as there was limited data available on the relationships and communications between the professionals involved in the lives of children in care) and to link the quantitative results with the qualitative results within the different levels of the ecosystem. For example, the quantitative analyses showed that instability in care was associated with multiple negative outcomes, the youth advisory panel then discussed the importance of ‘getting on’ with foster carers. If young people are given the opportunity to remain in a stable placement, they are more likely to develop a secure attachment with their foster carers. These relationships appear to be key in allowing young people to experience some normality in care. The approach taken in each of the five findings chapters is outlined below:

- **Chapter Five** – this chapter focuses on the individual level of Bronfenbrenner’s ecological systems theory. It presents individual vignettes for the young people who took part in the study, describing their experiences before care, their experiences while in care and their situation at the time of the interview. The chapter also displays young people’s artwork to allow the reader to better understand the experiences of those interviewed and how these experiences may have led to their current health perceptions.
- **Chapter Six** - this chapter incorporates aspects of Bronfenbrenner’s individual level in greater depth. Specifically, it uses Bronfenbrenner’s concept of proximal processes and attachment theory as a basis for analysing the data collected through the interviews conducted with young people in care and exploring how their pre-care care experiences

have affected their physical health development,. It also looks at the characteristics of the 2013 cohort included in the quantitative database and considers two types of characteristics coined by Bronfenbrenner – demand characteristics and resource characteristics and explores which characteristics may lead young people to experience additional stigma on top of their care status, and how this might impact on their engagement with health services. The researcher suggests that the characteristics included in this study are two-sided and can be considered as demand or resource characteristics.

- **Chapter Seven** – this chapter also incorporates aspects of Bronfenbrenner's individual and microsystem levels and also considers the role of attachment in young people's mental health. It primarily focuses on the mental health of young people in care and presents both quantitative and qualitative data. This chapter also explores the role of proximal processes on the mental health of young people in care. It explores the effects of pre-care experiences and experiences in the care system and education on young people's mental health and risk-taking behaviours while considering the impact that stigma can have on their mental health.
- **Chapter Eight** – this chapter primarily focuses on Bronfenbrenner's exosystem and chronosystem levels and explores how the government has attempted to meet the health needs of young people in care. The chapter presents the quantitative data which highlights the characteristics and care or educational experiences that are associated with health assessments, dental checks and immunisations being up to

date. Data from the interviews with young people illustrate the key findings. It also considers the importance of foster carers supporting children and young people to develop secure attachments once they enter the care system.

- **Chapter Nine** – this chapter focuses on Bronfenbrenner’s microsystem, to explore how young people in care have experienced the policy initiatives that directly affect them. Two key concepts coined by Bronfenbrenner explored in this chapter are acts versus molar activities. The chapter considers how these two concepts may affect young people’s engagement with and attendance at health appointments. The chapter also looks at the role of stigma in young people’s disengagement with health services.

Ethical Considerations

Young people in care are considered to be a vulnerable group due to their adverse childhood experiences. Thus, the researcher took several steps to ensure their well-being throughout their participation in the study in addition to adhering to the university protocol. The researcher also received enhanced clearance from the Disclosure and Barring Service. Social workers helped with the recruitment of young people in which they identified young people who were deemed to be emotionally stable. Young people who had experienced a recent adverse event were not invited to participate in the research. Information sheets and consent forms were developed by the researcher with the guidance of the advisory panel made up of experts-by-experience (youth panel); these were given to all participants, including their social workers and foster carers.

The researcher received training on interviewing young people and recognising early signs of distress. Participants were informed that while every attempt would be made to ensure their confidentiality and anonymity, the researcher would need to speak with their foster carer or social worker if they revealed any information that would suggest they were at risk of harm. They were informed that the researcher would speak to them about any concerns first and the researcher would not speak to their foster carer or social worker without their knowledge. Concerns were raised in three of the interviews in which two young people spoke about the need to self-harm and another young person spoke about trying illicit drugs and not being able to control their temper (in which they feared they may hurt someone). With the permission of the young people, these issues were raised with their social workers who confirmed that they were already aware.

The interview schedule can be found in appendix five of this thesis. It was drafted in consultation with the youth advisory panel. Interviews were designed to be at the pace of each young person. One purpose of the body mapping exercise was to allow them to share their views without the need for eye contact. Interviews were also designed to give young people maximum control over the information they wanted to provide. In talking about their experiences some sensitive issues were raised (for instance, their experience of entering care which was often considered traumatic). Although the researcher did not specifically ask young people to talk about their pre-care experiences or the reasons why they were in care, all of the young people spontaneously spoke

about them, often reflecting that being in care had been better than living at home. In order to reduce any emotional distress after the interview, the researcher finished each interview by focusing questions on what the young people wanted to do in the future.

Steps were also taken to ensure confidentiality and anonymity for participants. Nothing in this thesis enables any local authority, agency, service or individual to be identified. In relation to both qualitative data and data provided from the CLA database, all data has and will be kept confidential including by storing audio recordings on a secure university server. Young people chose a pseudonym that they wanted to represent their interviews and pseudonyms were stored separately from other identifying details. The researcher will also remove potentially identifiable details in publicly disseminated materials (thus complying with the Data Protection Act). Furthermore, all sensitive documents containing personal information were password protected.

Ethical Approval

Approval for the secondary analysis of anonymised quantitative data was given by the English Government's Department for Education solely for the specified purposes. An application was made to the Departmental Research Ethics Committee (DREC) in accordance with the procedures laid down by the University of Oxford for ethical approval of all research involving human participants. The research was judged as meeting appropriate ethical standards and approval was granted. Following this, a further application was made to the research group of the Association of Directors of Children's

Services (ADCS) Standards, Performance and Inspection Policy Committee in order to directly recruit participants through children's services (within local authorities). Approval was also granted by this body.

Informed Consent

The study used an 'opt-in' means to participation. Young people were initially given information about the study by their social worker who talked them through the information sheet. If they were interested in participating in the study, then the social worker arranged for them to meet with the researcher along with other young people at an activity day. The researcher initially met with young people as a group and the purpose of the study was explained and contact details of the research team provided. Young people were reminded that they did not have to take part if they did not wish to. The researcher checked whether they had any questions and reminded them that they could get in touch if they thought of any more questions before they left. Before arranging to meet the young people individually, consent was sought from the manager of the children in care team, and the researcher checked with young people if they still wished to take part. Informed consent was then sought on an individual basis at the beginning of the interview in which the researcher went through the consent form with young people and asked if they had any further questions. All of the young people who took part in the study received a £20 voucher for their time.

Strengths and weaknesses of the study

This is one of the first studies to analyse the Children Looked After Database specifically looking at how far young people in care gain access to routine and specialist health services in England. One weakness of analysing this dataset was that analyses were constrained by what data is collected by the government. However, by analysing the dataset and recognising the gaps, the researcher will be able to make recommendations on any further data that should be collected in order to better understand the health of young people in care in England. The researcher sought to overcome the data constraints by manipulating the available data to create new variables. The quantitative analysis also only explored the data of one cohort of young people in care. The sample for the quantitative aspect of the study was drawn from a retrospective study (care status was assessed at age 15 to 16). The researcher acknowledges that the findings might not be representative for young people with other types of care experience (for example, those who were in care at a younger age but who had left the care system by the age of 16).

Another weakness of the study is the small sample size for the qualitative interviews. The study had set out to interview more young people in care but due to the volatile nature of the care system, some young people moved placements before being interviewed and therefore no longer met the inclusion criteria. However, the researcher felt that data saturation was reached as the last few interviews did not reveal any new information. Even with the smaller-than-intended sample, the interviews were a rich source of data that addressed each of the research questions. The study specifically employed visual and

creative methods in which young people collected their own data and created collages during interviews. This is considered a strength because it took away the pressure of eye contact and created a relaxed atmosphere rather than the standard interview. By encouraging young people to collect their own data it was hoped that the young people would feel more in control of their interview, and the information they wanted to provide.

Some power dynamics could not be avoided, for example, the researcher being older than the participants. However, it was felt that this was counteracted by the researcher's own experience of the care system. Young people were informed of the researcher's care experience and the participants felt that this made the researcher one of them rather than a professional. They felt more able to talk about their experiences because they felt the researcher could relate to them in some way. However, the researcher's experience of growing up in care also brings the potential for bias. The researcher acknowledges this bias and took some steps to reduce this. This included employing a youth advisory panel to ensure that the researcher was not making assumptions about young people's experiences, informing young people that no two experiences are the same no matter how similar, asking participants to clarify what they meant, and allowing participants to ask questions at the end of their interview rather than during it.

Conclusion

Chapter Three has outlined how a convergent mixed methods design was used, in which qualitative and quantitative data were collected in parallel,

analysed separately, and then merged together to provide an understanding of what was happening at a policy level to meet the exceptional health needs of young people in care, and how those policy initiatives were experienced by those who were directly affected by them. The chapter defined the aims of the study and the specific research questions it sought to answer. It explored the samples of the quantitative and qualitative aspects of the study, how the research was undertaken, and how the data were analysed. It also explored the ethical considerations of the study. Finally, it ended with the strengths and weaknesses of the approach used, and the qualitative and quantitative datasets. The following five chapters present the findings from these analyses.

Chapter Five: Vignettes

Chapter Five focuses on the individual level of Bronfenbrenner's ecological systems theory by providing information on each young person's past experiences. According to Bronfenbrenner these past experiences help shape a child's development including how they experience events in the future and will be useful to the reader for understanding the rest of the thesis.

Introduction

Throughout the rest of the thesis the researcher will make use of the information gathered during the in-depth interviews with young people in care. In order to understand who was interviewed and to give voice to each young person it is important to provide some information about their individual experiences before entering care, their experiences in care and their situation at the time of the interview. Brief vignettes, including an example of their artwork, are presented below for each of the young people participating in the study. These vignettes have been developed from information gathered during the first meeting with the young people, their self-completed information sheet and their interviews. This information is critical in then appreciating subsequent findings presented in the rest of the thesis.

Baymax, aged 12

At the time of interview, Baymax had been in care for six years and had been living with his current foster family for five years. Baymax had been diagnosed with autism spectrum disorder and ADHD and found it difficult to stay focused for more than 30 minutes at a time. He also experienced difficulties with impulsivity around food and relied on his foster mother to moderate his portions. Baymax talked fondly about the pets in his foster home and felt that they were therapeutic for him because they cheered him up when he was feeling low. Baymax did not like attending his health assessments because he did not like seeing strangers and he did not like health professionals sharing his height and weight or health information with other

professionals without him knowing. Baymax had been referred to CAMHS but

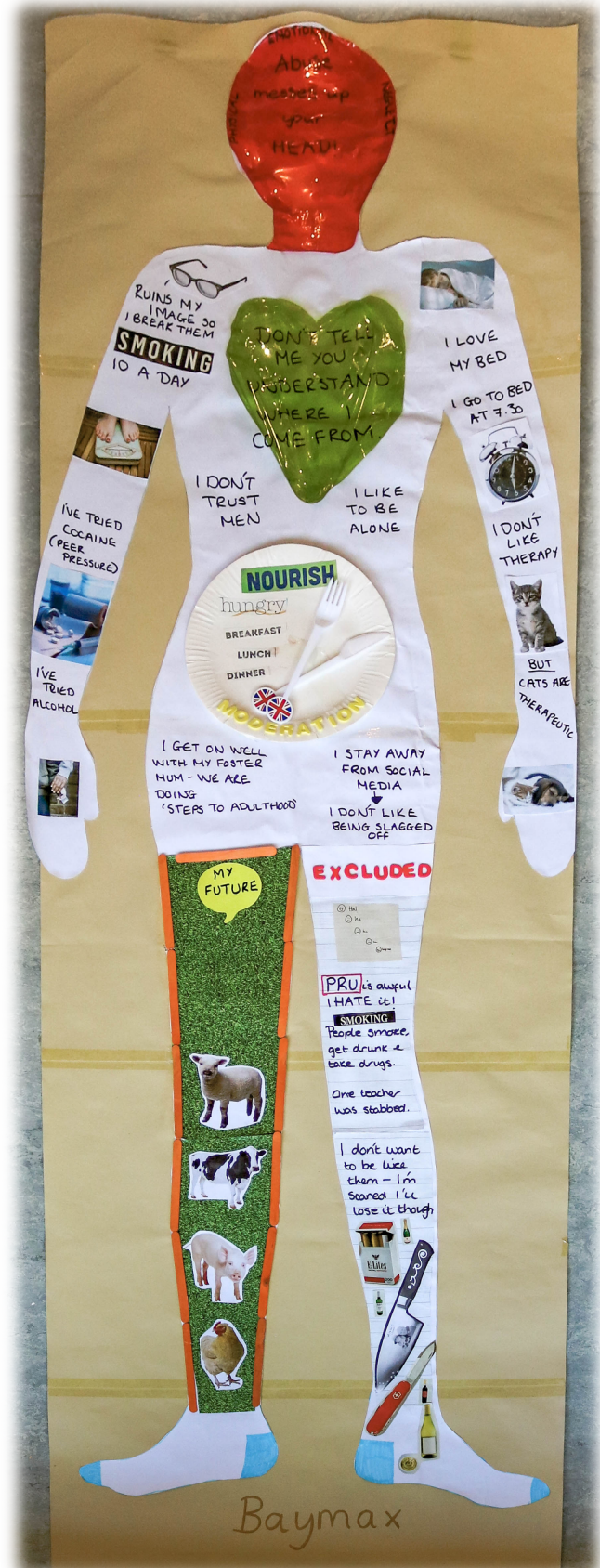


Figure 6: Baymax's artwork

refused to attend because he did not like the set-up of sitting opposite a counsellor and talking to them. He also refused to wear glasses despite needing them because he felt that glasses ruined his image amongst peers. Baymax was due to start a Pupil Referral Unit after being permanently excluded from his school. He expressed fears that he would not be able to control his anger and may end up stabbing someone because this had happened when his sibling was there. He had been a regular smoker for two years smoking around ten cigarettes a day. But he felt that he was more likely to use drugs or drink alcohol if attending a PRU due to peer pressure. Despite his difficulties, Baymax had built up a positive relationship with his foster mother. He still found it difficult to relate his foster father as he was fearful of men. However, they were both committed to caring for him until adulthood. Baymax' advice to health professionals was to understand that 'abuse messes with your head'.

Nemo, aged 13

Nemo is a 13-year-old male who had been in care for eight years due to physical and emotional abuse and neglect. His parents had not been able to keep him safe. When living with his parents, Nemo had smoked (at the age of five), believing it was 'normal' and 'the right thing to do' as both of his parents had smoked. Nemo had lived with three different families but had spent most of his eight years in care with his current foster family and felt part of the family. Although he felt part of the family, Nemo described how he had experienced more stigma around his care status as he had become older and by the time he started secondary school, he did not want others to be aware that he was in care. Nemo felt that the

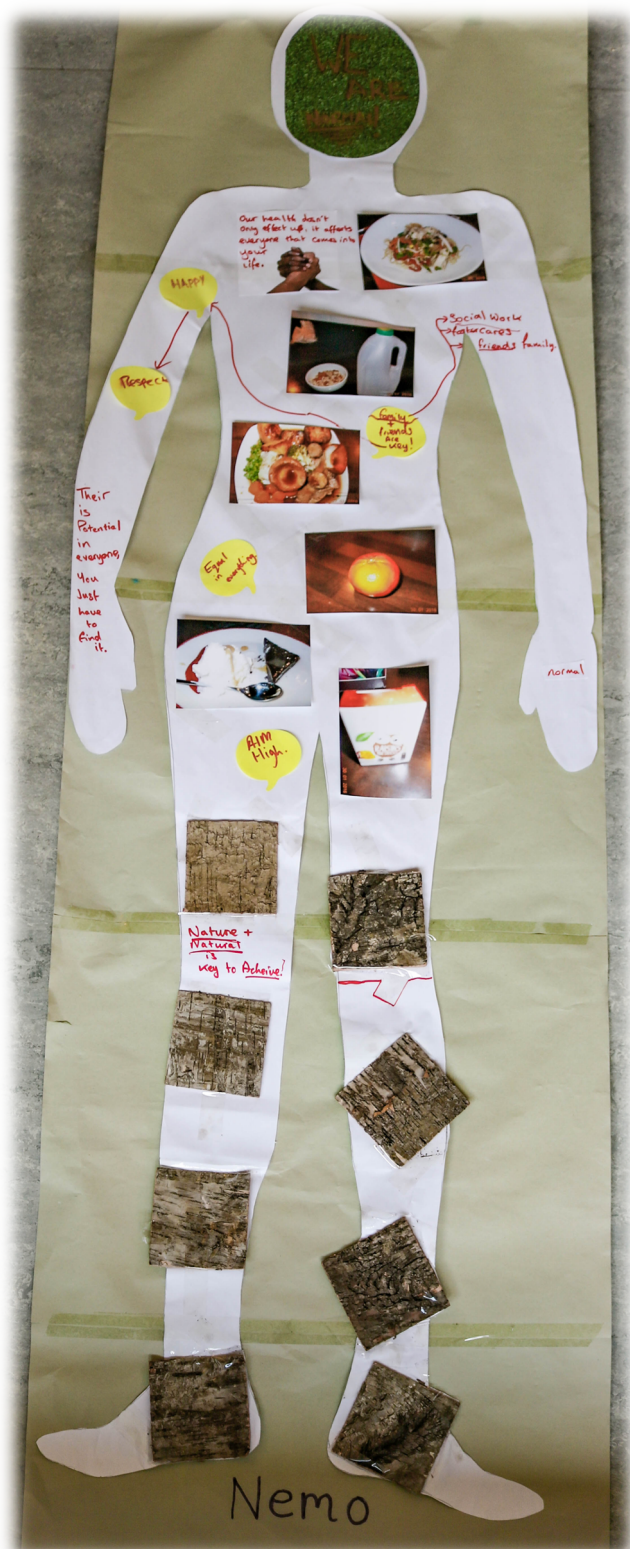


Figure 7: Nemo's artwork

public and peers viewed young people in care as being 'different' and

‘aggressive’ and felt his peers were less likely to talk to him if they knew about his care status. However, Nemo recalled previously being pulled out of class for meetings relating to his care status as well as his health assessments which allowed peers to question him about why he was allowed to miss class. At the time of the interview, Nemo was having his health assessments done at home and he welcomed the opportunity to have his height and weight measured and liked having a safe place to ask questions about his health. Nemo’s foster parents had played a key role in promoting his health by implementing a routine and boundaries and teaching him how to lead a healthy lifestyle. Nemo’s advice to health professionals was to ‘just treat us normally, like you would any other patient. We are normal’. He also wanted other children in care know that they should ‘aim high’.

Heather, aged 13

Heather is a 13-year-old girl who had been in care for over 11 years, and she did not have any memories of her life before the care system. Heather did not speak about her birth family during her interview and regarded her foster family of eight years as her 'real' family, referring to them as 'Mum, Dad, Nan, brothers and sisters. Heather had lived with several families before finding her forever family. Her previous placement had broken down and she held negative memories about her time with them. Heather experienced precocious puberty and began menstruating at the age of eight. Since then, she had experienced heavy menstrual bleeding and had been referred to a specialist as she found this particularly difficult to cope with.

Her specialist had recommended treatment around 6 months prior to her



Figure 8: Heather's artwork

interview but Heather was still waiting for her social worker to write a letter of consent. She found this frustrating and could not understand why her foster mother (who had been approved to care for her until she reached 18 and beyond) could not provide consent instead. She felt this would allow her to feel more 'normal'. Heather was also diagnosed with dyslexia and described herself as 'accident prone' as she frequently injured herself by accident. However, she aspired to be an athlete and was already part of an elite team. Heather felt well supported within her family as her foster mother was a health professional and helped her to lead a healthy lifestyle. This included eating a 'strict diet' of regular healthy meals, staying active by participating in several team sports, and sleeping 12 to 15 hours each night. Her aspiration to become an athlete meant that Heather was not keen to try cigarettes, drugs or alcohol. Heather spoke positively about her experiences of health assessments and appreciated having time with a nurse where she could ask questions. However, she did not recall ever being asked for consent. Heather recalled experiences of being bullied by her peers due to her care status but felt that her school had been very supportive at the time. She now advocated for other young people in care within her school and acted as a role model – showing other pupils that young people in care are capable achieving similar outcomes.

Bart, aged 14

Bart is a 14-year-old boy who had been in care for ten years due to physical and emotional abuse and neglect. His parents were unable to keep him safe and Bart remembered them making him hide in the dark and pretend that they were not home after the courts had granted a care order to the local authority. This had made his entry into care quite traumatic as the police had been involved and he did not reach his foster carers home until 10pm. Bart had lived with the same foster family since entering care and considered them to be his 'real' family, referring to them as Mum, Dad, and siblings throughout his interview. Bart had entered care with significant dental neglect, and he recalled needing regular treatment to

begin with. He now had braces and felt he was better able to look after teeth



Figure 9: Bart's artwork

because his foster mother had taught him how and when to brush his teeth. Bart felt his foster parents also played a key role in keeping him healthy as they limited his screen time, kept him in a routine with a set bedtime and introduced him to new foods. Bart found the health assessments ‘annoying’ and felt that the local authority only made them attend so that they had an official document about the health of children in their care. Despite remaining with the same family for the whole of his care journey, Bart had been bullied by peers due to his care status. He used humour as a way of coping with insensitive comments such as ‘your Mum doesn’t love you’. Bart had initially wanted to hide his care status but decided to inform his teachers that he was in care after one teacher told the class that they should be grateful that they did not have the same adverse experiences as those shown in an NSPCC video. At the time of the interview, Bart was proud of his care status and his message to health professionals and other children in care was ‘just do it’. He felt that every child in care was capable of achieving whatever they wanted to achieve in life.

Elsa, aged 14

Elsa is a 14-year-old girl who had been in care for five years due to chronic neglect. Elsa's mother had not been able to prioritise Elsa's needs over her own. As a result, Elsa had been a passive smoker due to her birth mother being a heavy smoker and had not had her basic needs met prior to entering care. Elsa's birth mother had a phobia of the dentist and this had meant that Elsa had not seen a dentist prior to entering the care system. She had also not been encouraged to regularly brush her teeth which led to her entering the care system with significant dental cavities. Elsa had been with her current foster family for around two years

and she hoped that they would be able to care for her until she reached 18 and



Figure 10: Elsa's artwork

beyond. She had built up a positive relationship with both of her foster carers but particularly liked the banter she shared with her foster father and stated that he was always able to make her laugh. The condition of Elsa's teeth had improved since being in care as a result of regular dental treatment and being taught and reminded to brush her teeth. She now had braces and felt that she was a little less anxious about visiting the dentist but still disliked the noises. Elsa still struggled with her mental health and described how she would worry about everything. She had visited several mental health professionals but preferred those who were able to offer her advice and not those who just sat and listened. Elsa also described needing to self-harm to get her anger out and was yet to find other effective strategies. Elsa added red tissue to her collage to represent mental health 'injuries' that cannot be seen by others. Elsa's sleep was inconsistent. Some nights she would sleep nine hours without waking until morning and other nights she would struggle to fall asleep and would wake a number of times during the night. Elsa felt that her disrupted sleep was due to worrying about things that were on her mind such as exams, friendship issues, or family issues. However, she also stated that she would drink coffee before going to bed but did not believe this would affect her sleep. Elsa had been bullied throughout her childhood and was now a target of bullying due to her care status. However, she had a close group of friends at school and stated that they all supported each other through it. Although Elsa described having lots of uncomfortable conversations about puberty with her previous foster carer, she felt that she had been well prepared for all of the changes she had experienced and overall felt that her health had improved as a result of being in care. Elsa's advice to health professionals was to 'dial it down'.

Jimmy, aged 16

Jimmy is a 16-year-old boy who had been in care for four years due to concerns around parental substance misuse, domestic violence and parenting ability. Jimmy was one of seven children; they all shared the same mother, but some had different fathers to Jimmy. Jimmy felt that the concern about his mother's ability to parent her children only began when she met Jimmy's stepfather - an alcoholic who was addicted to drugs. Jimmy described him as a violent man who often threatened social workers. Jimmy's mother also had chronic health needs and he felt responsible for ensuring she was okay. Jimmy felt that he and his siblings had been provided a healthy diet prior to his stepfather entering their lives.

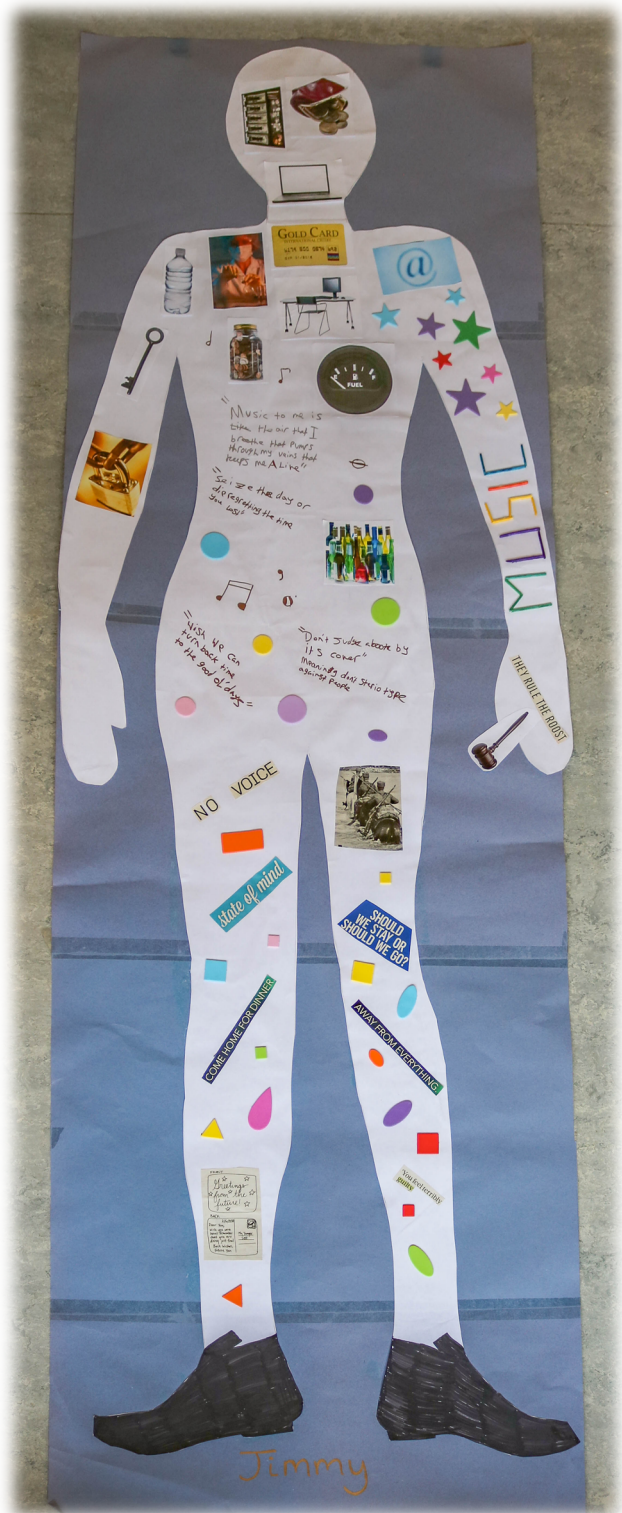


Figure 11: Jimmy's artwork

After that they struggled with finances and began having to eat fast food and

scraps, which led to his siblings becoming overweight and developing other health needs. Entering care had been a stressful experience for Jimmy; his mother's health had deteriorated, and his close friend had passed away. This led him to start smoking, self-harming, and even trying to take his own life and he frequently went missing from placement. Jimmy spoke negatively about social services throughout his interview. He felt that he should have been included in the decisions made about his life and resented social services for allowing his three younger siblings to be adopted as he was no longer allowed to see them. At the time of his interview, Jimmy was living with his third foster family which seemed to be a good match for him. He had a love of music and to help him express his emotions, his foster parents had converted their garage into a soundproof music studio. Jimmy described how he would go and play the drums to release his anger or other overwhelming emotions. Jimmy spoke positively about his current foster parents stating that he appreciated their support and their honesty in relation to decisions that were being made. His foster parents were experienced in looking after teenagers in the care system and came across as very warm and welcoming. According to Jimmy, they promoted his health by implementing a routine, ensuring he ate regular healthy meals and teaching him how to cope with his emotions. Jimmy described his health assessments as 'annoying, but something that has to be done.' Despite his earlier difficulties, Jimmy had career aspirations and wanted to be a role model for other children in care. Jimmy's advice to health professionals was 'don't judge a book by its cover, and don't let your assumptions affect how you work with a patient.'

Buzz, aged 18

Buzz is an 18-year-old man who had entered care as an unaccompanied asylum seeker at the age of 14. Buzz was loved and cared for by his biological parents and he described a loving and positive early childhood. However, his parents had paid for him to travel to safety in the UK due to ongoing bombings and violence in his home country. Buzz was just 10 years old when he left his parents' home and he experienced trauma during his travels to the UK: he witnessed and was the victim of violence, did not have a safe place to sleep, nor regular access to food and water. When he first entered care he was passed back and forth between local authorities until one took responsibility for him. Buzz described how stressful this had been for him because he did not speak the language and did not know why he had to keep moving. After this Buzz had lived with three different foster families – the last being the most stable. Buzz found it difficult living within a different culture but felt his last foster parents went above and beyond to try and help him settle, including teaching him English every evening and learning some words in his first language. Buzz struggled with his mental health and said he sought help from the GP when he realised his self-harm behaviour was becoming more of an issue. He did not like that the GP tried to prescribe him antidepressants straight away and felt that was all GPs do. He was also referred to counselling but stopped attending as he felt they were pressuring him to talk about the trauma he experienced during his travels. Buzz was adamant that sharing these experiences would not help and he worried that they would burden the person listening to him. At the time of his interview, Buzz had just moved into a flat and was living

independently. However, he wanted to move to a diverse city to find friends who shared his culture. He had managed to stop his self-harm behaviour on his own but still experienced low mood and significant issues with his sleep.

Mulan, aged 18

Mulan is an 18-year-old woman who had been in care for five years due to neglect. Mulan recalled that many of her needs had been unmet when living with her biological mother and she would be left at home alone all night. She would worry about her mother and would stay awake all night until she returned. Before entering care Mulan had not been taught to brush her teeth, shower or bathe and had limited access to food. Mulan found entering care stressful and did not like that she was told that it was for one night only to later be told that she would never be returning to her birth mother. Entering care at a later age meant Mulan struggled to adapt to routines and boundaries. She entered care with significant dental neglect that required

specialist treatment. Despite this nobody spent the time teaching her how to



Figure 12: Mulan's artwork

brush her teeth and her dentist would just tell her she needed to brush her teeth 'better'. Mulan also struggled to regulate her appetite and even five years after entering she would struggle to stop eating sweet treats and still struggled to remember to brush her teeth at night. However, she had found that doing exercise motivated her to eat healthily. Mulan did not like attending her health assessments as she did not see why she could not have a check up with the GP instead. She felt that social workers needed to let young people know that they did not have to attend a health assessment and felt cross that she only found out that she could refuse after she overheard two social workers talking. Due to her experiences before entering care Mulan still struggled with her sleep, averaging only 4-5 hours a night. She also found that bedtime was the time that she would reflect on her life. At the time of the interview, Mulan had lived with one foster family and felt part of the family. She had also enrolled in Pole Fit classes which she really enjoyed. Her foster parents had started teaching her how to cook in preparation for her transition to independence. Her message to health professionals was to 'normalise LAC health'.

Conclusion

Chapter Five has shown that all of the young people interviewed had experienced various forms of childhood adversity before entering the care system. Their pre-care experiences and their experiences in the care system varied. Some young people had entered care during infancy while others had entered care during adolescence. Those who entered care due to physical abuse entered care at a much younger age than those who entered care for other reasons. Some young people had remained living within one foster family

while others had experienced previous placement breakdowns. All of the young people recognised their removal from birth parents and being placed within the care system as a positive thing, even if they had not recognised it at the time of removal. The young people interviewed believed that their health had improved in care and despite some young people having ongoing health needs they all viewed themselves as being healthy. Several young people had entered the care system with significant dental neglect that had resulted in them needing ongoing or specialist dental care. Young people who had not had good access to food before care, later struggled to regulate their appetite and described impulsive eating habits. Most of the young people had experienced mental health difficulties and some spoke about their self-harms behaviours which included: substance misuse, smoking, going missing, cutting. All of the young people were living with in foster families at the time of their interview. Chapter Six will now look at young people's pre-care experiences in greater depth and consider how their adverse childhood experiences may impact their physical and mental health.

Chapter Six: What are the physical health needs of young people in care?

Chapter Six looks at the individual level of Bronfenbrenner's ecological systems theory in greater detail. It explores how factors at the individual level (such as pre-care experiences and individual characteristics) can impact a child's health development before they enter the care system.

Introduction

This second findings chapter explores how individual characteristics and pre-care experiences can affect the health development of children and young people in care and considers why they are likely to have developed exceptional health needs before entering the care system. Specifically, the chapter looks at the role of what Bronfenbrenner and Morris (2006) would term as 'proximal processes' in children's health development by exploring the experiences that the young people interviewed for the current study had of parenting and health behaviours before entering the care system. It also considers how young people's experiences of entering the care system and understanding of the reasons why they needed to be placed into the care system can affect their health behaviour. The chapter then goes on to look at two concepts coined by Bronfenbrenner and Morris (2006) to describe individual characteristics within their bioecological model and the role these may play in the development of children's health behaviour. These are *Demand* (characteristics that either encourage or hinder reactions from people within the child's environment), and *Resource* (biopsychological assets and liabilities that affect the child's capacity

to effectively engage in proximal processes). It then outlines the characteristics of the cohort analysed for the quantitative aspect of the study and suggests that these characteristics are in fact two-sided in that they can be considered to be both Demand and Resource characteristics. The chapter finishes by summarising the state of children's health at the point of entering the care system, which highlights the necessity for more attention to be given to the health status of children and young people in care.

Defining health development

For the purpose of the current study, health development is defined as an ongoing process in which children and young people learn how to lead happy and healthy lives. That being *"a state of complete physical, mental, and social wellbeing"* (World Health Organisation, 1948). The researcher considers health development to be a continuum in which developmental competence falls at one end and developmental dysfunction falls at the other end:

"The term dysfunction refers to the recurrent manifestation of difficulties on the part of the developing person in maintaining control and integration of behaviour across situations."

(Bronfenbrenner & Morris, 2006, p. 803)

Figure 13 shows some examples of the many health behaviours that may indicate whether a child or young person is experiencing developmental dysfunction or developmental competence.

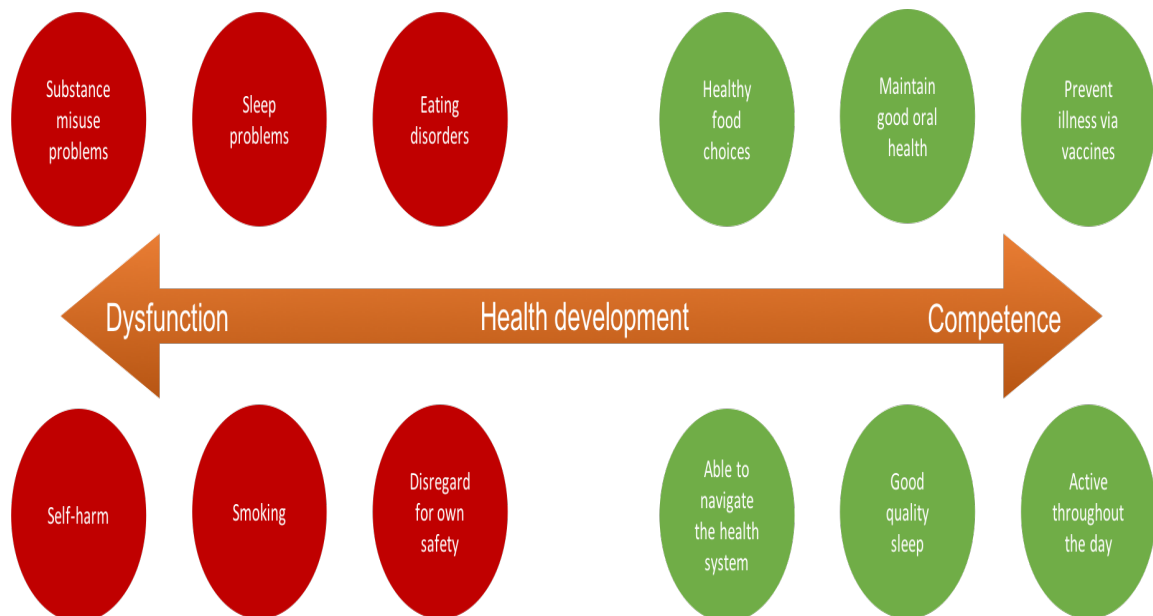


Figure 13: Scale of developmental competence versus developmental dysfunction

The role of proximal processes in children's health

development

One way to better understand how pre-care experiences can affect young people's attendance and engagement with specialist and routine health services, is to explore the role of proximal processes in children's health development. Within their model, Bronfenbrenner and Morris (2006) suggest that proximal processes (the interactions that children have with the people, objects and symbols in their immediate settings) play a vital role in children's development. For Bronfenbrenner and Morris, it is these interactions that shape the child's view of themselves and the world around them, and so these interactions can either help or hinder the child's ability to achieve developmental competence:

“Human development takes place through processes of progressively more complex reciprocal interaction between an active, evolving biopsychological human organism and the persons, objects, and symbols in its immediate environment.”

(Bronfenbrenner & Morris, 2006, p. 796)

Aspects of Bronfenbrenner and Morris’s bioecological theory also reflect attachment theories whereby the quality of children’s relationships with parents may affect their development. Both theories highlight the importance of children feeling safe and secure within their home environments and suggest that children living in stable and nurturing homes develop the capacity, motivation, understanding, and skills to engage in activities on their own and with others in the future, enabling them to become more independent over time. If applying these theories to health development, then it could be assumed that a child who is being raised in a stable and nurturing environment is likely to have their needs met and to have parents who want to spend quality time with them and encourage their ongoing development. Their interactions with their caregivers will be positive and they will be encouraged to explore their environment while being reassured that their caregiver is nearby for comfort should they need it. These safe and secure relationships with parents should result in the child developing self-confidence and self-esteem, which further promotes their developmental competence.

Moreover, and reflecting Bowlby’s (1980) definition of a secure attachment style, children living in stable and nurturing environments are likely to have a set routine and clear boundaries. They will know that they are going to receive nutritious food throughout the day and will be taught basic sleep hygiene from

a very young age through a bedtime routine. For example, a parent may introduce a bedtime routine whereby they give their child a bath, tuck their child into bed and read them a story, and then settle them down to sleep. They will have their teeth brushed from early infancy and will then be taught and encouraged to brush their teeth independently over time. They may also be encouraged to cook and bake with their parents and be given a well-balanced diet with a lot of variety in which they are also encouraged to try new things. According to Bronfenbrenner and Morris (2006), children who are raised in stable and nurturing environments experience positive interactions and are given new opportunities in response to their growing competence. Research has shown that securely attached children are more likely to reach their milestones on time and to have higher emotional intelligence and resilience in adulthood (Howe, 2005).

Conversely, children being raised in suboptimal environments are at much greater risk of experiencing developmental dysfunction because they are unlikely to have their basic needs met. These children are more likely to adopt insecure attachment behaviours. Their parents may be pre-occupied with their own issues and consequently, fail to recognise the needs of their child. These issues might include their own unresolved childhood trauma, mental health problems, domestic violence, substance misuse problems, or debt. This can result in the child experiencing negative and even frightening interactions with the people, objects and symbols around them. For example, they may regularly witness domestic violence, be physically chastised, or verbally abused by their parents, resulting in low self-confidence and low self-esteem. They may also

live in unkempt and unsafe homes in which they are exposed to dangerous items such as drug paraphernalia. Furthermore, the somewhat chaotic environment may mean that children do not have a set routine or clear boundaries and they may not know what to expect throughout the day. They may not have access to nutritious food or be given regular meals. They may not have a set bedtime or even a bedtime routine and so may not know how and when they should sleep. Further, they may not be encouraged or taught how to regularly clean their teeth and so may not know how to do so, or how often. Children who have insecure attachments with their parents may also have difficulties understanding and regulating their emotions. Their parents are unlikely to have labelled the child's emotions or equipped them with strategies in order to cope with any negative emotions. All of these aspects of insecure attachments can result in children developing behavioural, emotional, and social difficulties, mental health problems, tooth decay, sleep problems, eating disorders and more (Howe, 2005; Sempik, Ward, & Darker, 2008).

Experiences like these were evidenced by the young people who were interviewed for this study. Most of the young people interviewed spoke about how their lives had been different before entering the care system. They reflected on how much harder their lives had been when living with their birth families. For example, one young man who had entered care six years before his interview spoke about a life where he was physically and emotionally abused and neglected:

“[W]e didn't have any food at home, and I was always hungry. Sometimes I looked through next door's bin 'cos [birth parents] wouldn't let me go school with bruises and then I wouldn't get school dinner.”

[Baymax, aged 12]

Another young man who had entered care at the age of 12 described a life where he did not have access to nutritious food because his mother did not have the money and also lacked the understanding about what they should be eating:

“Cos when I was living at home with mum, like before she had the stroke and stuff and social services got involved, we were having like McDonalds every week and stuff like that, and then she'd like prepare food off scraps and stuff like that... my younger brother was getting bigger and bigger, and bigger every time. My mum was like, 'woah, what's going on?' sort of thing.”

[Jimmy, aged 16]

All but two of the young people described how they had also not experienced any kind of routine before entering the care system:

“It's like the routine of brushing your teeth, the routine of showering. Yeah, all that sort of thing, the routine of eating... I didn't have any of that before.”

[Mulan, aged 18]

This lack of routine meant that many of the young people interviewed had not been regularly brushing their teeth before entering the care system. Several of the young people had entered the care system with significant dental neglect.

One young woman recalled not being taught to regularly brush her teeth and described how her birth mother had not led by example:

"[M]y birth mum, she hasn't been to the dentist for like seven years. Her teeth are so bad! She smokes and I don't know whether she brushes her teeth or not. But since I was born 'til nine when I went into foster care, I barely brushed my teeth. So, it was pretty bad."

[Elsa, aged 14]

This lack of routine also meant that most of the young people interviewed did not have a set bedtime or a bedtime routine prior to entering the care system. In fact, only one young man recalled having a set bedtime and routine when living with his family. One young woman who had entered care at the age of 13 reflected on not being able to sleep at night when living with her birth mother:

"[G]rowing up, like my mum was out a lot at night and I'd be home alone, and I used to wait for her to come home, and I couldn't sleep before she did."

[Mulan, aged 18]

Another young man also talked about how he had adopted the same negative health behaviour as his birth parents, believing that it was the norm:

"Well if I was completely honest, when, before I was in care yeah, I did smoke... I'd see my parents doing it and I was influenced that that was the right thing to do... [I was aged] under five. I know, it's bad isn't it, when I think about it. At the time I thought, you know, it was normal."

[Nemo, aged 13]

The interviews undertaken with young people in care revealed that many of them had not had their basic needs met when they were living with their birth families; they were not given regular nutritious meals, they were not given routines and clear boundaries, they were not taught how to brush their teeth or how and when to sleep. Moreover, many of the young people were living in environments that were frightening; where they were physically and emotionally abused and neglected. Environments such as these mean that children and young people are more likely to enter the care system with insecure attachment behaviours. Their birth parents had also not been available as a source of comfort and reassurance when they were feeling distressed, and all but one of the young people had become insecurely attached and adopted self-reliant behaviours in order to survive. The other young man had also had to learn to be self-reliant as he travelled to England on his own at the age of 10.

The impact of pre-care experiences on health behaviour

Research suggests that children who have been raised in suboptimal environments (where their needs have not been met) live in a constant state of fear. According to Howe (2005) this can result in children developing disorganised attachments with their parents and this can lead to them becoming self-reliant, controlling, destructive, aggressive, impulsive, dissociative, hyperactive or showing a disregard for their own safety.

The young people who were interviewed for this study were able to reflect on how their pre-care experiences had impacted on their health behaviour once they had entered the care system. Specifically, the young people who had

experienced abuse or neglect did not trust the adults in their lives to meet their needs. Around three quarters of the young people experienced difficulties in regulating their appetite and had anxiety about if and when they might be given food. Food appeared to be an important topic for all of the young people interviewed. One young person described how he had hidden food when he first entered the care system:

“[N]ow I can't stop scoffing. I'm always hungry. But I don't hide food now 'cos [foster mum] lets me keep a snack box in my room. I still hid it at first tho 'cos I thought she'd take it away like what happened before.”

[Baymax, aged 12]

The importance of food was also reflected in a number of the young people's artwork and photographs. One young man had taken photographs of all the healthy food he now had access to:



[Bart, aged 14]

Another young man represented the importance of regular meals to avoid feeling hungry (a feeling he had frequently experienced before entering the care system):



[Baymax, aged 12]

One young man had also taken photographs of some of his favourite meals, treats and snacks:



[Nemo, aged 13]

All but one of the young people reflected on how they had not been taught how to brush their teeth and so they had entered care with significant dental neglect. One young woman spoke about how her birth mother had not taken her to the dentist or taught her to brush her teeth and so when she entered care at the age of nine her teeth had been in a bad way:

“I thought I’d have to have teeth out... ‘cos the first time I went to the dentist when I went into care, they said they were speechless.”

[Elsa, aged 14]

Another young woman reflected on the importance of being taught to brush your teeth properly when you enter the care system, regardless of your age, as she had entered care at the age of 13 and it was something professionals had assumed that she knew how to do:

“[Y]our teeth are in a bad condition simply because you don’t know how to clean them... I was never taught how to brush my teeth so every time I went, [the dentist] always told me, you know, there was something wrong with my teeth, that I need to start cleaning them better and it was also sort of, you know, I had quite sensitive teeth as well which you do get if you don’t brush your teeth for a while... Your teeth start to hurt when you eat, like I couldn’t eat apples I couldn’t eat raw carrots... because it could be quite painful.”

[Mulan, aged 18]

Around half of the young people had issues with their sleep (see Chapter Six for more). When reflecting on why they had difficulty falling or staying asleep, the young people interviewed felt that it was due to their pre-care experiences.

One young person tried to distract himself with music because he felt that it was when he was in bed that he began to worry about his family and his future:

“Sleep could be better... I have to listen to music now. I have to. The last couple of years now I’ve got into the habit of listening to music, like culture musics... sometimes it takes me very long before I go to bed. It depends like if I’m worried about things and it just, I’d never, it’s not easy to go bed. But, I just, even if it’s like too late I just go bed and I’m wide awake, and you just worry about things... what’s happened, what is gonna happen... about family and what’s happening with them... that’s the things going around in my head, big time.”

[Buzz, aged 18]

Another young woman felt that her sleep difficulties were due to her pre-care experiences in two ways – being in the habit of staying awake at night waiting for her birth mother to come home and also associating her bedtime with thinking about her past:

“I got into that routine of I don’t sleep because I’ve sort of, I’ve learnt that and it’s very hard to like get out of something like that... I just think of that every time I want to go to sleep, you know, there was always some issue or worry that was playing on my mind and actually just going to sleep made me think of [pre-care experiences] because like you’ve got to relax and it’s that sort of silence as well..., I didn’t want to [go to bed] because then I would have to like think about everything.”

[Mulan, aged 18]

One young man also talked about how his pre-care experiences had affected his mental health. For example, he found it difficult to manage his emotions and behaviour and consequently, had been expelled from school and was instead

attending a pupil referral unit. He also found it difficult to make and maintain friendships. His pre-care experiences were also represented in his artwork:



[Baymax, aged 12]

The interviews with young people in care showed that their pre-care experiences affected their health development in a number of ways. They had developed insecure attachments with their parents and due to a lack of routine and nurturing proximal processes they had entered the care system with significant dental neglect, they did not know how and when to brush to their teeth, they had issues with food such as overeating and hiding food because they were worried that they might not be given food again, they did not know how and when to sleep, and they were not used to having routines or clear boundaries.

The impact of young people's experiences of entering care on their health behaviour

Young people's health development may also be affected by their experiences of entering the care system, as well as their understanding about why they have been placed into the care system. Young people who remembered entering care had found the experience quite traumatic because they felt that they did not have any control over what was happening, they did not understand what was happening or why and did not know what to expect:

"[I]t was very stressful, you know, you can't see your family and you're never gonna see your childhood home again... it's hard to understand and get your head round and it feels really unfair... It's that sort of 'no, take me home' you know, 'I don't want to be here, you bunch of cunts', that sort of reaction. I wasn't going to be happy about it, you know, they were taking me away from my family and I didn't care about their reasons."

[Mulan, aged 18]

Mulan's anger and frustration about being taken into care meant that she felt resentful of the professionals in her life and she did not want to engage with them or attend any recommended appointments, such as her initial health assessment. Another young man felt reluctant to engage with professionals when he entered care because he had ambivalent feelings about the situation and felt a sense of responsibility towards his birth mother. He was the eldest of his siblings and many of his younger siblings had been placed for adoption:

"[I]n some ways I'd rather be at home with mum 'cos in my head I think she's struggling with life quite bad, and she needs someone there to support her in case she has like a fit or something, and when I'm not there it kind of worries me 'cos she's going out and about at 12 today, and I immediately think, 'well, what's going to happen on the way out?' and stuff like that, and it just runs through my head like that."

[Jimmy, aged 15]

One young man who was taken into care at an earlier age had found the whole experience quite frightening because it had been late at night due to his birth parents trying to prevent his removal from their care:

"My mum was in a court case and I was just at home and then I was taken by, I was taken from home in the car straight to [foster mother] and [foster father] and like that was, I don't really remember details as such. But I only just remember being taken and my parents turning off all the lights and pretending they weren't in... Ten o'clock I came into care; ten at night... Scary! Jam sandwich and a glass of milk and that was it, bed. I had a jam sandwich and a glass of milk that night, at ten o'clock and I went straight to bed."

[Bart, aged 14]

Despite Bart recalling that entering care had been a frightening experience, he had entered care at a much younger age than Mulan. This meant that he had adapted to and accepted the changes quite quickly, and he was able to engage with professionals and attend any necessary appointments. One of the other young men interviewed had travelled to England from another country on his own at just ten years old and arrived in England at the age of 13. Although he had been securely attached to his parents, during his travels he witnessed and was a victim of violence, had his money stolen and was not able to eat regularly

or drink clean water. There was also some confusion about which local authority was responsible for him:

“It wasn’t good but like, ‘cos you gotta learn the language... I’m just on my own. So, yeah that’s, that part is still in my mind but it’s still there and it’s never gonna go. It weren’t easy – I wouldn’t do it again... I got to England and then I got put into an emergency place and so when I was in the emergency place – I was there I think, a couple of weeks, and then I got moved from there to a different emergency place. So, I got there, and... then they sent me back here. So, I was going backwards and forwards.”

[Buzz, aged 18]

Although Buzz felt that he had experienced a stable and nurturing home with his birth family, he experienced significant trauma when travelling to England on his own. Moreover, the instability he experienced when he first entered care meant that some of his appointments had to be delayed. He also did not speak any English and so he felt that he did not understand what was happening, why certain decisions were made, or what the different appointments he had attended were for.

Through the interviews with young people it became apparent that their experiences of entering care and their understandings of the reasons for needing to be placed away from home directly impacted on their access to and engagement with specialist health services. In order to promote young people’s willingness to engage with professionals and to attend appointments it is essential that they understand the reasons why they have been placed into the care system. Other research suggests that children who enter care at an earlier age are at greater risk of not knowing why they are in care (Staines & Selwyn,

2020). It is also necessary to ensure that young people understand (age appropriately) what their different appointments are for and why they may need to attend. If English is not the child or young person's first language, then it is essential that an interpreter is accessed for them.

Young people's perceptions of health

The young people who were interviewed for the qualitative aspect of this study were asked what health meant to them. They felt that health involved being both physically and mentally healthy and felt that you could not have one without the other (see Chapter Seven for young people's definitions of mental health). When describing physical health all of the young people immediately stated that in order to be healthy it was important to have a balanced diet. When exploring this concept further young people struggled to define what a balanced diet consists of and were unsure what the different food groups were. However, one young man felt that it meant eating five fruits and vegetables a day:

"Where you have your five a day, you know the stuff that keeps you healthy in general... you shouldn't have too much of one thing."

[Nemo, aged 12]

One young woman felt that a balanced diet meant not eating lots of unhealthy foods:

"Like, not having too many unhealthy things, sort of a balanced diet really."

[Elsa, aged 15]

This young woman also represented her perception of health in her collage where she divided the body into two to represent healthy things (on the left) versus unhealthy things (on the right):



[Elsa, aged 15]

As shown in Table 5 the young people who participated in the interviews also completed a food diary. This showed that although they struggled to describe what constitutes a healthy diet, they all had access to a range of foods.

	Breakfast	Lunch	Dinner	Snacks	Drinks
Baymax (aged 12)	Honey cereal	Cheese sandwich	Spaghetti bolognaise	Apple Biscuits	Water Diet cola
Nemo (Aged 13)	Chocolate cereal	Sandwich	Pizza and chips	Crisps Chocolate bar Yoghurt	Tea Water Hot chocolate
Bart (Aged 14)	Toast	Sandwich Crisps Flapjack	Spaghetti bolognaise	Orange Apple Mousse	Milk Water
Heather (Aged 14)	Fibre cereal	Sandwich	Pasta and salad	Fruit	Tea Water Orange juice Squash
Elsa (Aged 15)	Chocolate brioche	Sandwich Crisps Biscuits	Lasagne and salad	Biscuit Popcorn	Milk Apple juice Water Coffee
Jimmy (Aged 15)	Toast	Sausage roll Crisps Chocolate bar	Chicken Potatoes Vegetables Gravy	Crisps Fruit	Water Tea Fizzy drink
Buzz (Aged 18)	Smoothie with protein powder	Subway roll	Chicken and vegetables	Apple Banana Pomegranate	Water Tea Mango juice
Mulan (Aged 18)	Fruit cocktail	Blueberries Banana	Casserole	Apple Pot noodle Chocolate	Water Alcohol

Table 4: Young people's food diaries

Young people also suggested that it was important to keep active and do some form of exercise every day in order to be physically healthy. One young woman felt that doing exercise also motivated her to eat healthily and suggested that these two things were also interlinked:

"I find after exercise I fancy fruit the most. It's just like, I'm hungry, so I'm like 'well, no, I'll wait a little bit because my metabolism will get faster from the exercise.'"

[Mulan, aged 18]

Sport and exercise were also represented in other young people's artwork. Before her interview, this young woman printed pictures off from the internet

and labelled each one as healthy or unhealthy to help her to illustrate her perception of health:



[Heather, aged 13]

Young people's definitions of physical health also included sleeping well (see Chapter Six for more about sleep). Although none of the young people knew how much sleep they should be getting, one young man felt that it was important to sleep in order to grow:

"I remember when I've gone to sleep, in the morning I woke up and then suddenly I feel much taller!"

[Nemo, aged 13]

The role of individual characteristics in health development

In their later work, Bronfenbrenner and Morris (2006) propose three different groups of characteristics that can affect a child's health development, of which only two are relevant for the current study. These are demand and resource characteristics. The third, 'force characteristics', refers to psychological differences between individuals such as temperament and motivation. It was not possible to explore these in the study as these characteristics are not captured in the CLAD and would require participants to complete psychological/personality tests.

Demand Characteristics

According to Bronfenbrenner and Morris (2006) one group of characteristics that can affect a child's development are Demand characteristics. According to Bronfenbrenner and Morris Demand characteristics:

"Invite or discourage reactions from the social environment that can disrupt or foster processes of psychological growth."
(Bronfenbrenner & Morris, 2006, p. 812)

These characteristics are said to include immediate stimuli that increase or decrease the likelihood of other people engaging in proximal processes with the child or young person. They are characteristics that are susceptible to bias and stigmatisation. For the current study these characteristics might include gender, ethnicity, special educational needs, early childhood deprivation, and reason for needing to enter the care system.

Resource Characteristics

Another group of characteristics that Bronfenbrenner and Morris (2006) suggest as affecting children's and young people's development, are Resource characteristics. They suggest that Resource characteristics are:

“Biopsychological liabilities and assets that influence the capacity of the organism to engage effectively in proximal processes.”

(Bronfenbrenner & Morris, 2006, p. 812)

These characteristics are said to impact how children and young people go on to engage in future proximal processes and are influenced primarily by past experiences. For example, any skills or knowledge that they have developed by engaging in activities. This is particularly relevant for the current study because as outlined in the first part of this chapter, children and young people in the care system are likely to have come from suboptimal environments. These experiences mean that children and young people in care are likely to respond to proximal processes very differently to children who come from stable and nurturing homes. Characteristics for the current study also include gender, ethnicity, special educational needs, early childhood deprivation and reason for entering the care system. The researcher suggests that all of these characteristics can affect both if and how others interact with a young person and also how the young person themselves responds to situations based on their experiences. For example, if a young person has experienced stigmatisation within health services based on their ethnicity in the past, this may impact on their engagement with health services in the future.

Characteristics available from the quantitative dataset

The characteristics of the current cohort that are available from the Children Looked After Dataset and National Pupil Database do not fit neatly into either demand or resource characteristics. The researcher instead suggests that these characteristics are two-sided – while they may affect the way in which others interact with the child or young person, they may also affect the health behaviour of the individual themselves. These will be explored throughout the rest of this chapter.

Gender

It should be noted that there is currently no option for local authorities to record when a child or young person identifies with a different gender to the gender assigned at birth. In such cases the local authority records gender type as whatever the young person wishes and identifies as. With more young people in care struggling with gender identity problems and its link to other mental health problems (Scannapieco, Painter, & Blau, 2018), the government may want to consider adding additional gender options in the future, such as a nonbinary/gender fluid option. In the current study, 44 per cent of the cohort were female and 56 per cent were male (see Figure 14). This is consistent with the national data that represents all children and young people in local authority care (Department for Education, 2020).

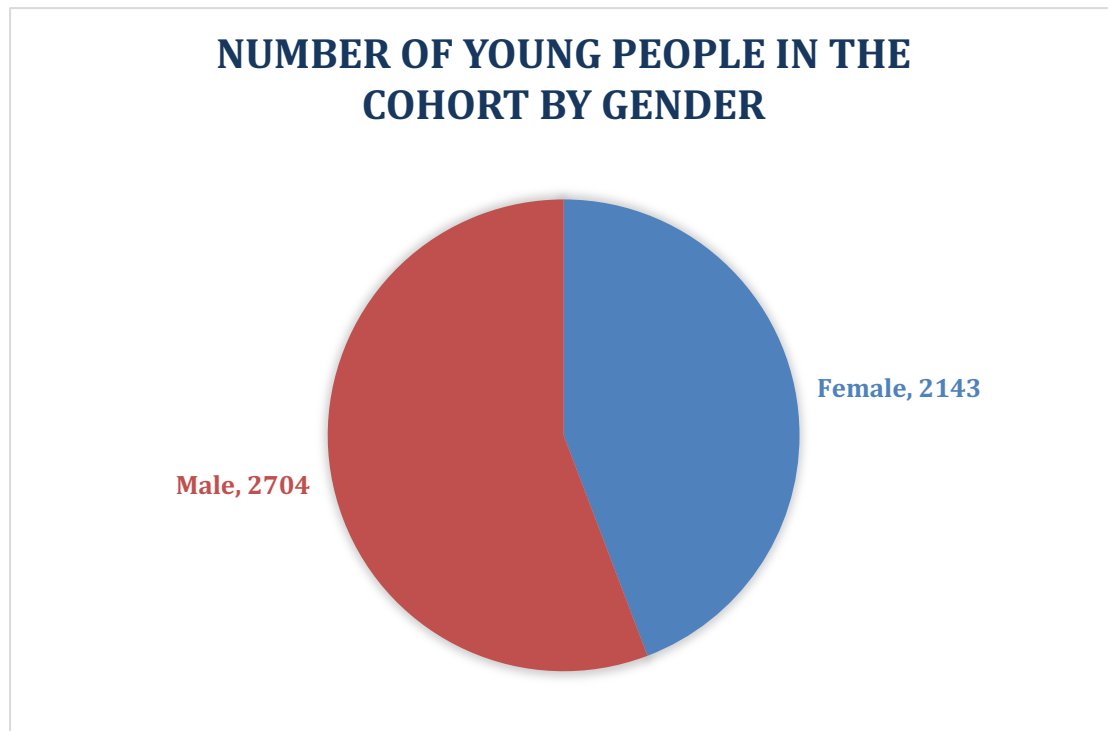


Figure 14: Gender of the young people in the 2013 cohort

If looking at gender as a demand characteristic, then research suggests that professionals' own gender bias can affect the way in which they care for and treat their patients. For example, Clerc Liaudat et al. (2018) found that within their sample of patients who received a consultation for chest pain, women were much less likely to be given an echocardiogram, to be referred to a cardiologist, to be admitted to hospital and to receive a confirmed diagnosis. Other research suggests that explicit gender stereotypes can affect the physician's assessment of children and young people. For example, assessing boys to have more pain than girls (Earp et al., 2019).

However, if looking at gender as a resource characteristic, then research on the general population has found that adolescent girls visit their General Practitioner around four to five times a year. This is twice as often as adolescent

boys who only visit their General Practitioner around two times a year (Balding & Regis, 2018). This finding would suggest that adolescent males in care are much less likely to attend their health assessment than adolescent girls in care, which only occurs once a year.

Health professionals working with young people in care may also need to take the young person's gender preferences into consideration in order to promote their engagement with health services. For example, one young person was particularly anxious around adult males because of the abuse he suffered at the hands of his stepfather:



[Baymax, aged 12]

A number of gender differences have also been found in the general population when it comes to adolescents' dental health and dental care. For example, the 2013 Child Dental Health Survey found that adolescent females were more likely to attend check-ups, to want braces, and to experience anxiety about

dental treatment. Whereas adolescent males were more likely to visit the dentist for existing dental problems rather than for check-ups, and they were also more likely to require dental treatment (Office for National Statistics, 2015). There is substantial evidence that children and young people enter the care system with significant dental neglect no matter what their gender, and this was also reflected in the interviews with young people who all entered care with dental problems (see (McMahon, 2018)). This may mean that there are gender differences among the care population and their attendance with dental services over time. For example, it may be that males attend dental checks to address dental problems when they first enter care but begin to disengage with these services once their dental problems are solved. Whereas females' attendance at dental appointments may be more consistent over time.

Research conducted by Hilber et al. (2010) suggest that immunisations are one aspect of health where any gender discrepancies are unlikely to occur. This would suggest that similar proportions of males and females in local authority care will be up to date with their immunisations.

Ethnicity

Using ethnicity in health research can be complex because individuals may identify with more than one ethnic group. However, research within the general population has found that the health perceptions and health literacy of different ethnic groups differ, affecting how and when they may seek health and dental advice or treatment. This reflects the resource side of ethnicity (Fagerstad, Windahl, & Arnrup, 2016; Forster et al., 2016; Niksic, Rachet, Warburton, &

Forbes, 2016). Figure 15 shows the proportion of young people in the 2013 cohort by ethnic group.

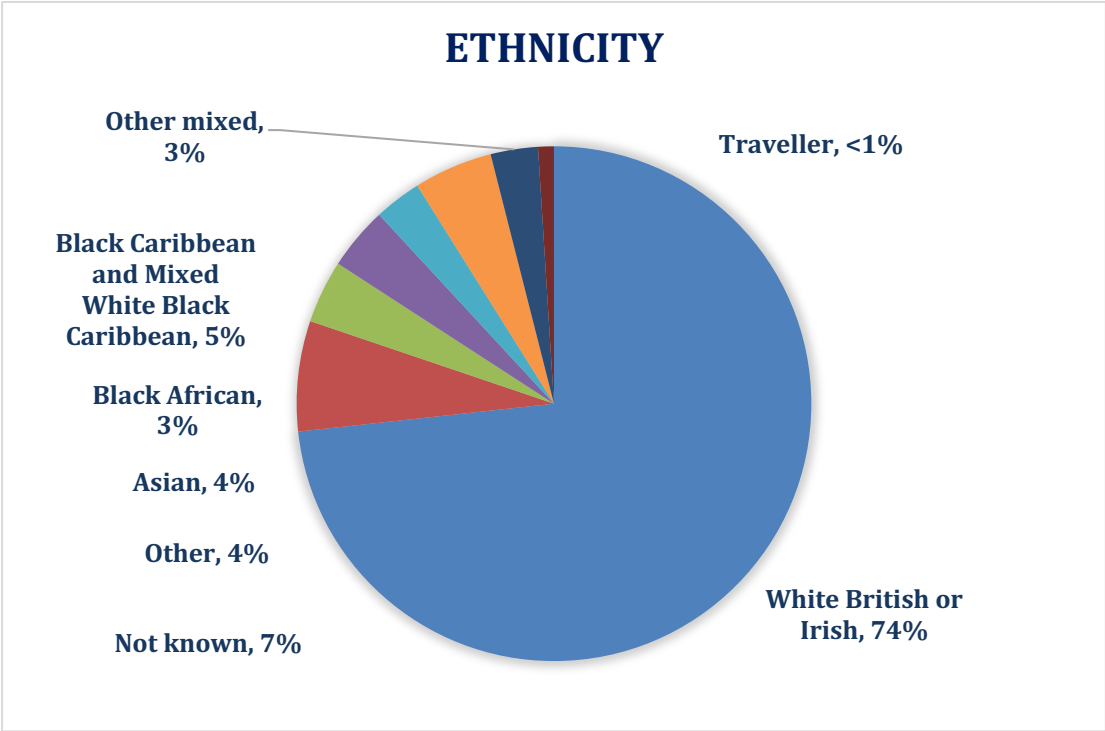


Figure 15: Ethnicity of young people in the 2013 cohort

If looking at ethnicity as a demand characteristic, then it might be assumed that the physician’s own racial bias will impact on how the patient is cared for and treated within health settings. Hagiwara, Slatcher, Eggly, and Penner (2017) revealed that professionals’ racial bias also affected the way in which they communicated with their patients. For example, physicians who reported a higher level of racial bias were more likely to use words that reflected social dominance when speaking to Black patients. Factors such as these are stigmatising and may be upsetting for young people who are already vulnerable. Moreover, interactions such as these may have a further impact on young people’s willingness to engage with health services again in the future.

Moreover, for children and young people with a history of abuse or neglect, such power imbalances may be detrimental to their self-worth and self-esteem. Drewniak, Krones, and Wild (2017) also found that some health care professionals do not make use of interpretation services and so some patients may experience communication difficulties which may affect their willingness to attend appointments again in the future. This was an issue experienced by one of the young men interviewed for this study, who had entered care as an unaccompanied asylum-seeker.

Again, if referring to ethnicity as a resource characteristic, then evidence suggests that people's health-related locus of control beliefs (who individuals believe are responsible for their health) are significantly different between ethnic groups. For example, some ethnic groups may believe that health professionals or chance events are responsible for their health while other ethnic groups may believe that they are responsible for their own health. Furthermore, evidence suggests that those who place the responsibility for their health onto others or down to chance events are less likely to adopt health behaviours or to vaccinate their children (Aharon, Nehama, Rishpon, & Epel, 2017). This would suggest that the proportion of health assessments, dental checks and immunisations that are up to date will differ between ethnic groups of young people in local authority care.

Special educational needs

Special educational needs can occur on a spectrum and so it can be difficult to link health behaviours to groups of young people with additional needs as a

whole. Within the current cohort, 72 per cent of young people in care had an identified special educational need. Figure 16 shows that just over half of the young people with an additional need were categorised as having behavioural, emotional and social difficulties. This may be linked to their pre-care experiences where they are likely to have experienced some degree of trauma and may not have experienced the nurturing proximal processes necessary for understanding and regulating their emotions.

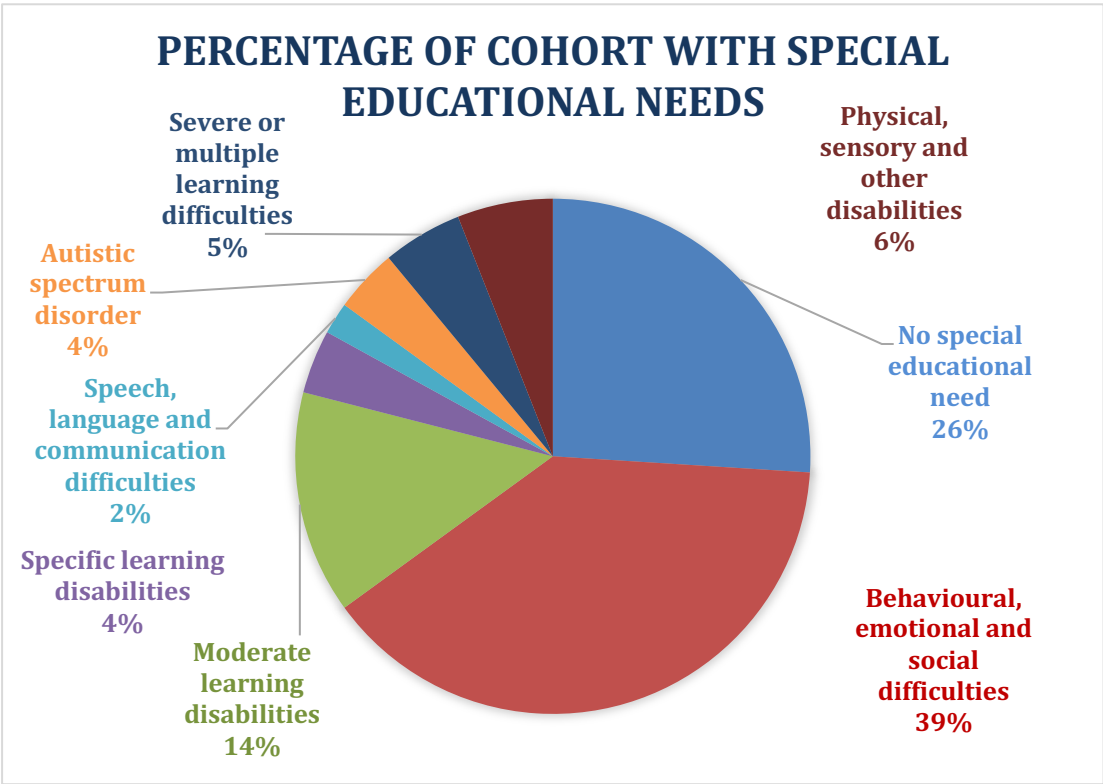


Figure 16: The special educational needs of the 2013 cohort

Evidence suggests that young people with special educational needs are at greater risk of physical health problems and chronic health conditions, and yet they also have limited access to health care services (Department for Education, 1999). If looking at special educational needs as a demand

characteristic then young people in care may have limited access to healthcare due to professionals refusing to treat them when they present with any kind of challenging behaviour (Stein Duker et al., 2017).

However, if looking at special educational needs as a resource characteristic, then Alborz, McNally, and Glendinning (2005) suggest that adults with learning disabilities experience difficulties in identifying their own health needs due to having poor bodily awareness and a reduced pain response, which may explain why they access health care less frequently than others. Other research has found that children experience a higher level of challenging behaviour during health-related appointments because they have increased anxiety linked to the exposure to an unfamiliar setting (Gandhi & Klein, 2014).

Children and young people in care who are diagnosed with behavioural, emotional and social difficulties may struggle with change and unfamiliar environments and so may be less willing to attend health assessments, dental checks and appointments for immunisations. They might also miss appointments because of frequent changes in placement (see Chapter Eight). Whereas children with speech, language and communications difficulties, or other more complex disabilities may not have the capacity to refuse their attendance at health assessments and other routine appointments and may even require someone else to consent on their behalf depending on their level of understanding.

Although only 72 per cent of young people had an identified special educational need, 86 per cent of young people had received special educational needs provision (see figure 17). This may be due to young people's pre-care experiences, in which they are likely to have missed a significant amount of school (for example, Baymax was not allowed to go to school when he had bruises). So, these young people may have needed additional support once they entered care to help them to catch up with their peers and are likely to have received support through School Action in which a lower level of support is implemented that does not involve external resources. School Action provides extra educational support for children making little or no progress in school. This support may include support from a teaching assistant and working in smaller groups. School Action Plus provides a higher level of support for children with more complex educational needs. This can include one to one support from a teaching assistant, having access to services from educational psychologists or speech and language therapists, and/or having input from a specialist dyslexia teacher. A statement sets out the child's individual needs and the special educational provisions they need to reach their full potential.

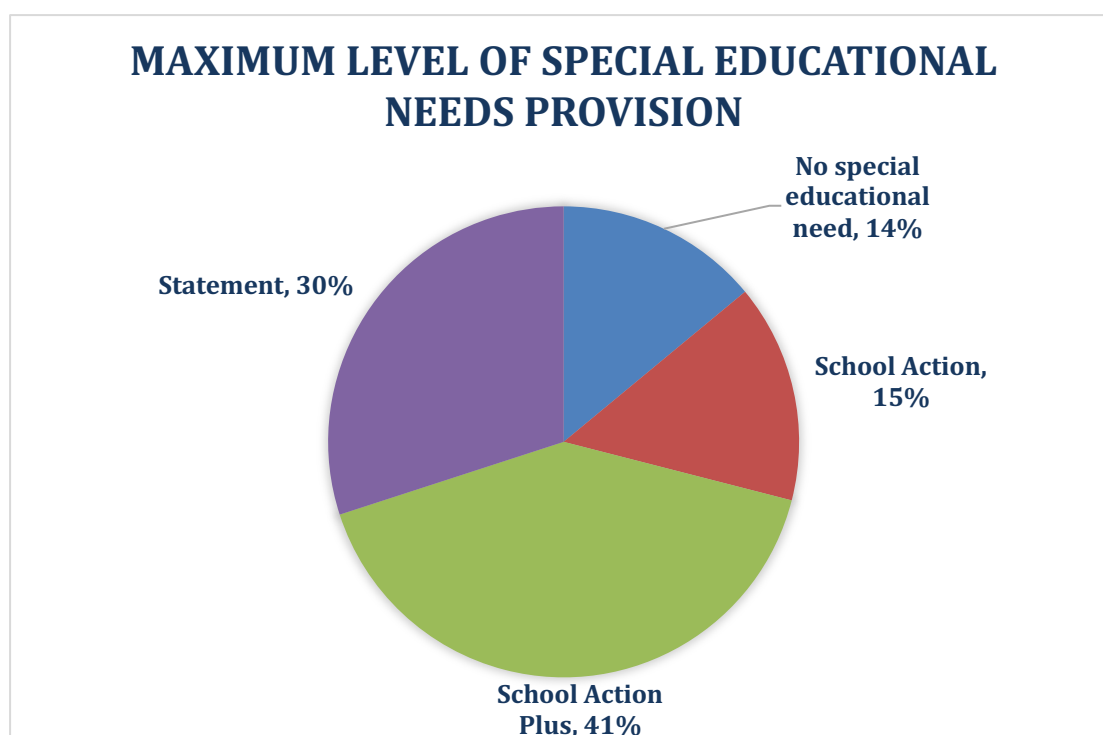


Figure 17: Level of special educational needs provision among the 2013 cohort

Childhood deprivation

While poverty is identified as the primary reason for entry into care for less than one per cent of children and young people (only 6 out of the 4844 young people in the current cohort), almost all children and young people in care will have experienced poverty to a greater or lesser degree (Bywaters et al., 2018). Research has found that children and young people living in poverty are exposed to poor housing conditions, poor diet, violence, stigma and bullying. Evidence also suggests that child poverty exacerbates health difficulties (Wickham, Anwar, & Barr, 2016). So, if looking at poverty as a demand characteristic, then professionals who are aware of the link between poverty and poor health may be more inclined to target health interventions at those who have experienced poverty to ensure their health needs are being met and any health conditions identified. Although this might be warranted in terms of

redressing the balance, it could also lead to stigmatisation of children from poorer backgrounds if they are singled out for 'special treatment.' This link between poverty and poor health means that children and young people are likely to enter care with:

- Malnutrition
- Obesity
- Asthma
- Tooth decay
- A low sense of well-being
- Difficulties sleeping

(Wickham et al., 2016)

The current study had access to two measures of childhood deprivation – children's scores on the Income Deprivation Affecting Children Index (IDACI) in 2004 (in which higher scores represent a higher level of neighbourhood deprivation) and children's eligibility for free school meals in 2004 (in which eligibility indicated family-level deprivation. If looking at poverty as a resource characteristic, then research suggests that those living in poverty are less likely to utilise health services (Jabbal & Buck, 2014). For the young people in the current cohort, those who entered care over the age of ten were also significantly more likely to have experienced a higher level of deprivation in 2004, $t(4438.601) = 3.481$, $p = .001$. So, these young people are unlikely to have utilised health services before entering the care system and may be more likely to refuse to attend health appointments when they are in the care system.

Figure 18 shows that children who were not in care in 2004 were more likely to have family level deprivation, whereas children who were in care in 2004 were less likely to have family level deprivation. This suggests that the care system protects children from family level poverty.

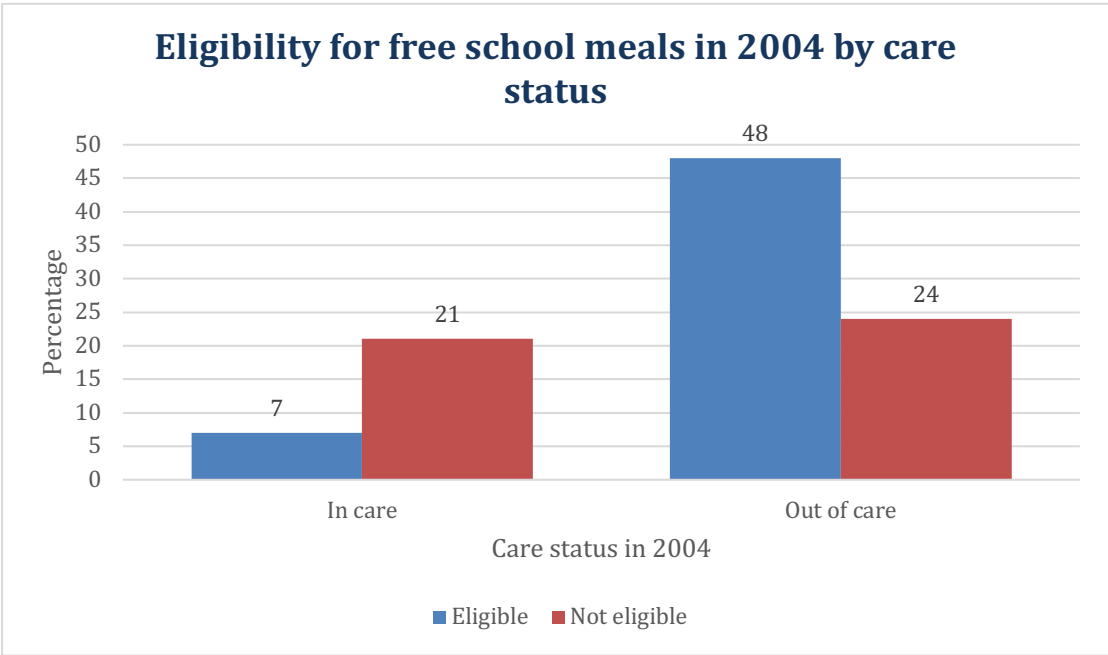


Figure 18: Eligibility for free school meals among the 2013 cohort by care status in 2004

Primary reason for entering the care system

Children and young people may enter the care system for a number of reasons. No matter what the reason, all children and young people are likely to have experienced some degree of trauma as a result of loss and separation from their birth family. Although some young people may feel a sense of relief when they enter care, many young people experience ambivalent feelings and struggle to understand or accept that the decision to place them in local authority care was necessary (Staines & Selwyn, 2020). Care status alone can

present a risk for children and young people experiencing stigma (see Chapter Nine).

As mentioned earlier, child maltreatment has been identified as a factor related to insecure attachments (Howe, 2005; Widom, Czaja, Kozakowski, & Chauhan, 2017). In the current study, 56 per cent of the young people were in care due to abuse (maltreatment) or neglect (not having their basic needs met), 32 per cent due to reduced parenting capacity (family stress or dysfunction, or absent parents), 2 per cent due to anti-social behaviour, 3.5 per cent were unaccompanied asylum seeking young people, and 6.5 per cent due to the child's disability (for example children with additional or complex needs who require specialist care) (see Figure 19). The young people interviewed for this study felt that there was stigma relating to the reasons why children and young people were in care. For example, they felt that the public assumed that all younger children were in care due to child maltreatment whereas all teenagers were in care due to their own challenging behaviour (see Chapter Nine).

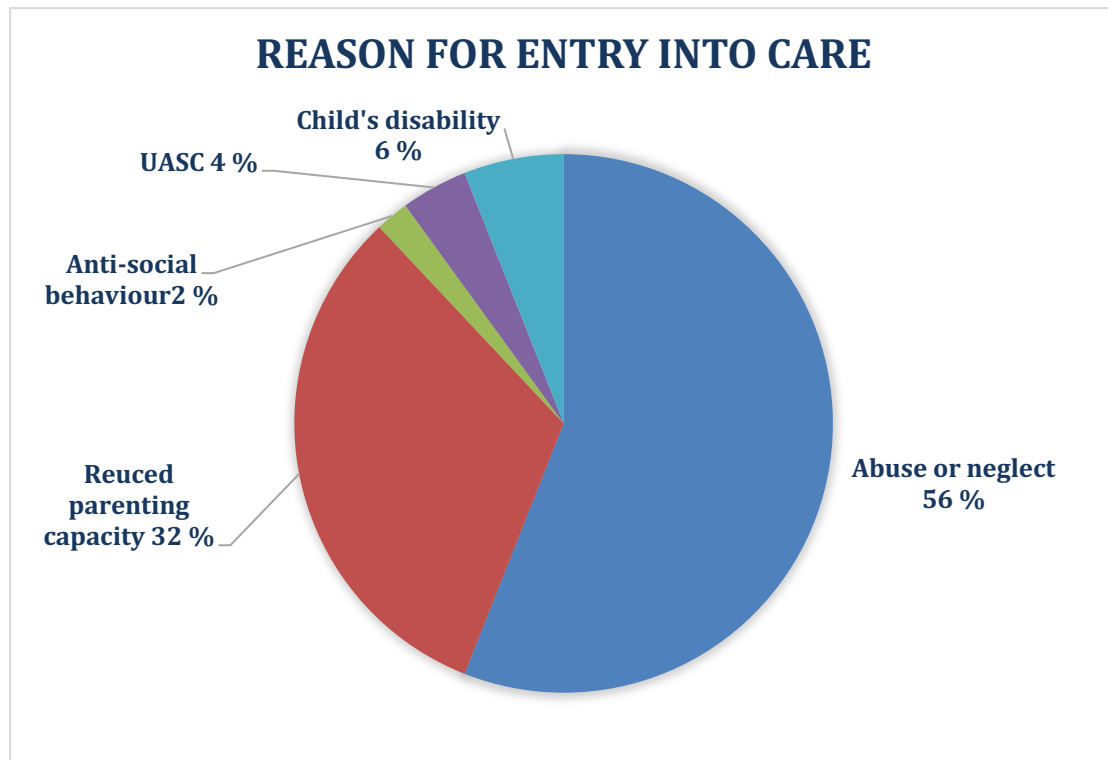


Figure 19: Reason for entry into care among the 2013 cohort

According to Howe, physical abuse can be described as:

“Physical injuries to a child caused by punches or kicks, shakes or smacks, burns or scalds, drowning or suffocating, bites or poisons. Bruises may appear. Bones may be broken. Cuts are caused. Illnesses arise. Even before they are born, some children are exposed to damaging levels of alcohol or drugs.”

(Howe, 2005, p. 69)

If looking at the primary reason for entry into care as a demand characteristic then it might be assumed that children and young people who have been physically abused receive medical treatment immediately, due to their physical injuries. More attention and encouragement to attend health appointments might also be given to ensure that no further medical problems arise. However, if looking at the primary reason for entry into care as a resource characteristic

then it could be assumed that children living in abusive or neglectful households are less likely to have been taken to the GP, either through fear of detection of maltreatment or as part of a broader experience of neglect.

Further analyses were conducted in order to better understand the characteristics of young people within each category of primary reason for entry into care. Analyses showed that similar proportions of young people who entered care due to anti-social behaviour (53%) and young people who entered care due to their disability (57%) had spent time in residential care. As residential care has been linked to other negative outcomes (such as poor educational achievement), these young people may be at greater risk of not attending health appointments. Moreover, nearly a third (30%) of the young people who had entered care because of their disability had been diagnosed with an Autistic Spectrum Disorder and so may also present with challenging behaviour (see Figure 20). Figure 20 also shows that similar proportions of young people who entered care due to abuse or neglect, reduced parenting capacity and anti-social behaviour did not have a diagnosed special educational need and a much larger proportion of unaccompanied asylum-seeking young people did not have a diagnosed special educational need. But larger proportions of young people who entered care due to reduced parenting capacity and anti-social behaviour were diagnosed with behavioural, emotional and social difficulties. A larger proportion of children and young people who entered care due to their disability were diagnosed with autism spectrum disorder and severe or multiple learning difficulties. Moreover, a larger proportion of children and young people who entered care due to abuse or

neglect were diagnosed with moderate learning difficulties compared to young people who entered care due to other reasons.

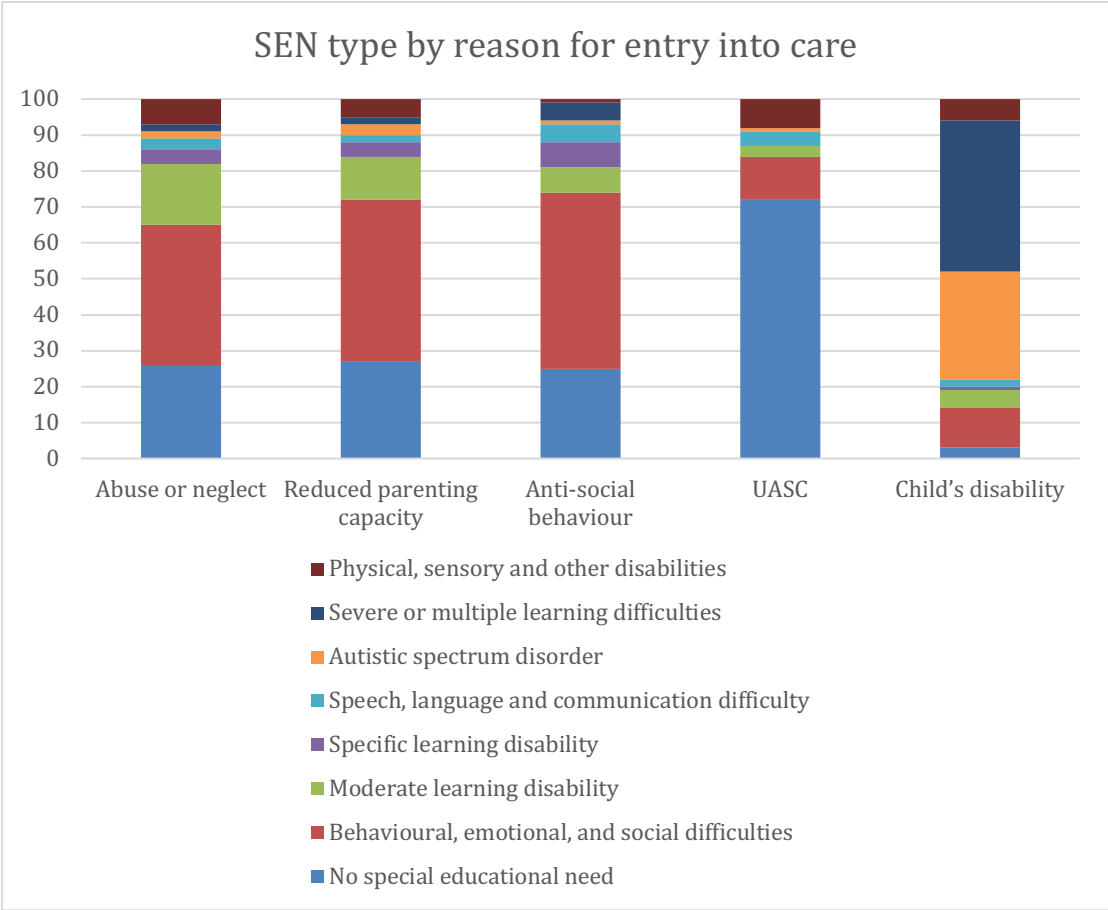


Figure 20: Type of special educational need by reason for entry into care for the 2013 cohort

Time

Another factor that needs to be considered within health development, is the amount of time that the child or young person has been exposed to suboptimal environments before entering the care system. According to Bronfenbrenner and Morris (2006) the length of time that young people are exposed to these environments will determine whether they go on to achieve developmental competence or continue to experience developmental dysfunction. The longer

children are exposed to suboptimal environments the more difficult it becomes to change their attachment or health behaviours. This was evidenced by one young person who entered care at the age of 13. She had not been taught to brush her teeth and had not been provided with a routine which incorporated brushing her teeth twice daily. Although she was taught to brush her teeth when she entered the care system, she often struggled to remember to brush them before bed:

“I forget sometimes you know... I wake up in the morning like ‘crap I forgot to brush my teeth’. You know, you get distracted by something or you fall asleep watching TV on the sofa after eating popcorn. You know, and you get, you wake up and you just go to bed.”

[Mulan, aged 18]

Yet, analyses of the data on young people in the cohort analysed for the quantitative aspect of the study, revealed that 52 per cent of the young people had first entered the care system aged 10 or older, 33 per cent of young people between the ages of five and nine, and only 15 per cent of young people had entered care under the age of five (see figure 21). These are similar proportions to the national data which includes all children and young people in care. This would suggest that a large proportion of young people in care have spent a significant amount of their childhood living in suboptimal environments. This may mean that they find it more difficult to change their health behaviours than children who enter the care system under the age of five.

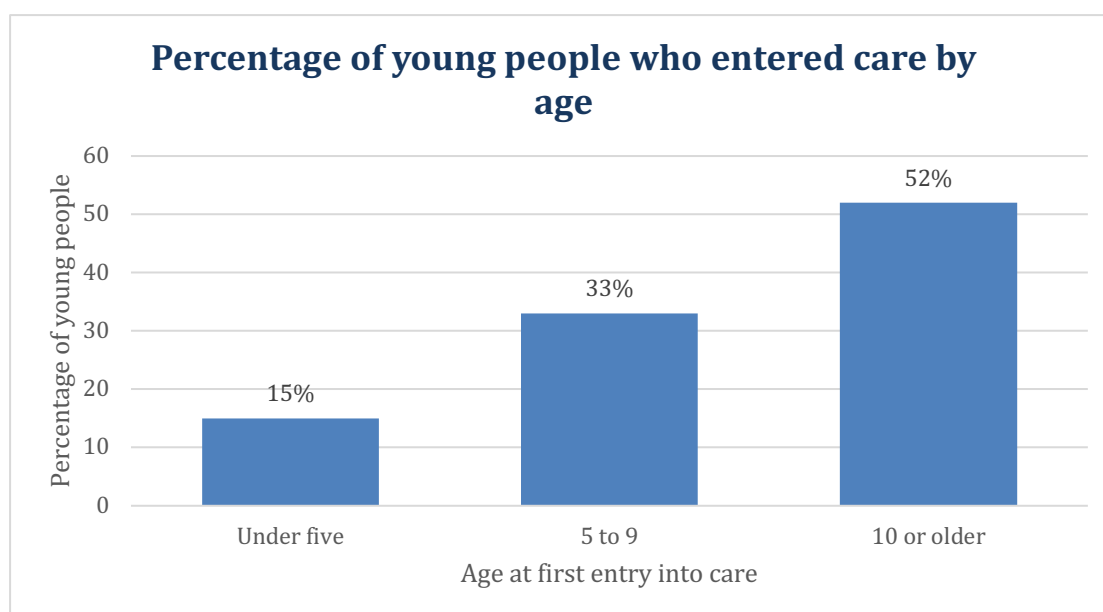


Figure 21: Proportion of young people that entered care by age group

Further analyses of the quantitative data also revealed that the age that young people first entered care was associated with the reason why they needed to enter the care system ($X^2(8) = 337.559, p < .001$). For example, 20 per cent of the young people who had entered care due to abuse or neglect had entered care under the age of five, compared to 11 per cent of young people who entered care due to reduced parenting capacity, 10 per cent of young people who entered care due to their disability, and no young people who had entered care due to anti-social behaviour or as an unaccompanied asylum-seeking young person. It is possible that children who are considered to be at risk of abuse or neglect are taken into care more urgently after any concerns are raised due to them being considered to be at immediate risk of significant harm. Whereas children who enter care due to reduced parenting capacity may have some of their needs met by their birth parents, allowing professionals to implement interventions that will allow the child to remain living at home for longer. Conversely, 88 per cent of young people who had entered care due to

anti-social behaviour entered the care system aged 10 or older, and 94 per cent of unaccompanied asylum-seeking young people entered the care system aged 10 or older. Figure 22 shows the percentage of young people that entered care within each age group for each category of need.

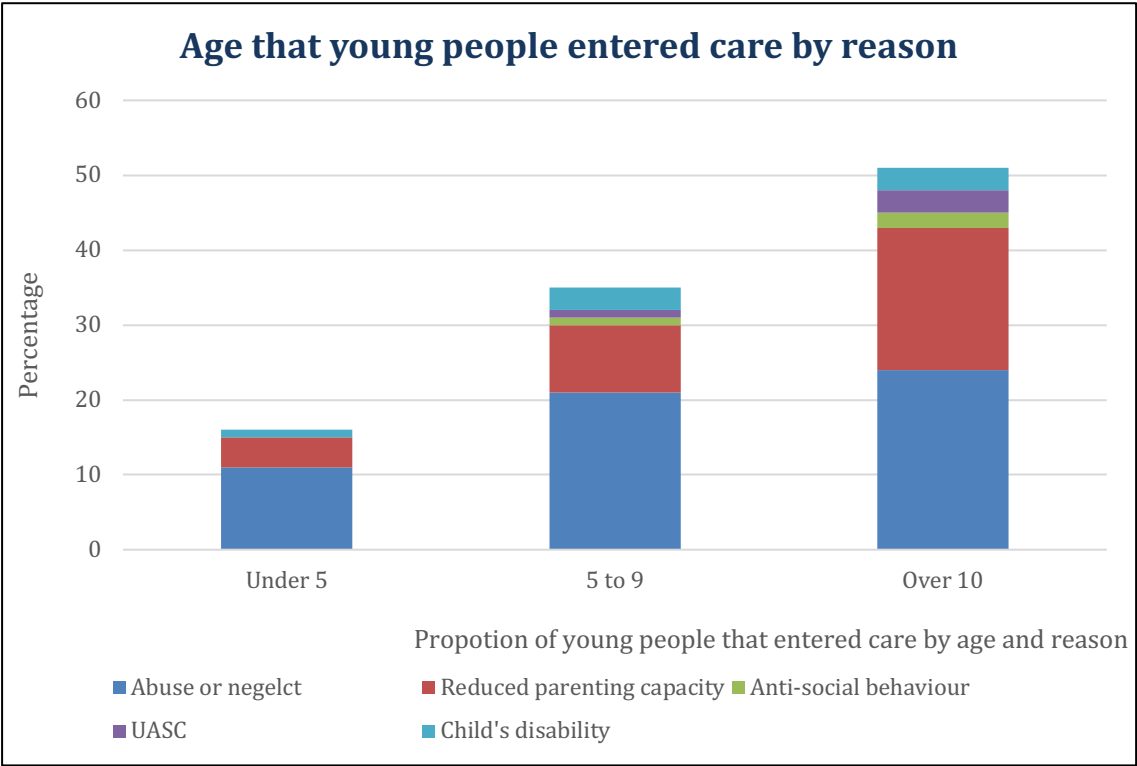


Figure 22: Age young people entered care by reason for entry into care for the 2013 cohort

Young people exposed to suboptimal environments for longer periods of time may face greater difficulties in changing their health behaviour, which may impact or affect their ongoing health development. This would also suggest that those who enter the care system at an older age are less likely to be up to date with their health assessments, dental checks, and immunisations. This will be tested in Chapter Eight.

Conclusion

This chapter has focused on the role of proximal processes and demand and resource characteristics and highlighted how these can all impact on young people's health needs and behaviour after entering care. For example, the chapter found that young people's pre-care experiences are likely to put them at considerable disadvantage in terms of their health development. Young people described suboptimal pre-care environments in which they were subjected to abuse and neglect and raised by birth parents who were pre-occupied with their own issues. This meant that all of the young people entered care with exceptional health needs and many of them would have developed insecure attachments and found it difficult to trust adults. At five years old, one young person was already regularly smoking. Other young people had not experienced any kind of routine or boundaries, had significant dental neglect, were hungry and unkempt, and did not trust that adults would look after them. They experienced difficulties with food in which they overate and hid food in fear that they may not be fed again. They had difficulty sleeping and lacked basic sleep hygiene awareness. They also had behavioural, emotional and social difficulties as a direct response to their pre-care experiences. Yet, some young people held loyalty to their birth parents and refused to accept the need to be placed into the care system. This meant that they did not want to engage with the professionals around them or attend any appointments related to their care status. Young people also experienced difficulties around understanding and regulating their emotions, due to a lack of nurturing proximal processes with their birth parents. Moreover, the findings in this chapter suggest that longer exposures to suboptimal environments could result in greater difficulties

in teaching young people to adopt healthy behaviours once they are in the care system.

The characteristics available for the cohort analysed as part of the quantitative aspect of this study can be viewed as both demand and resource characteristics – they can affect the way that professionals respond to children and young people and also how the children and young people themselves interact with their world. Research has suggested that males, ethnic minorities, those with special educational needs, those who have experienced childhood poverty, and those from abusive or neglectful backgrounds are at particular risk of not engaging with health professionals suggesting that their lack of engagement may in part be due to their fears of being singled out and stigmatised because they are in care, as well as the difficulties they experience in trusting adults. However, no data is collected on the specific health conditions that young people in care have and so their exact health status remains unknown. This makes it difficult to understand how their health needs are being met, whether their health improves over time, or whether their previous experiences lead to ongoing health conditions.

Although the exact health status of young people in care in England is not known, previous literature and the interviews with young people would suggest that they enter care with exceptional health needs. More attention needs to be paid to the physical health of this group of young people to ensure that they are not put at further disadvantage to their peers when they reach independence.

According to Bronfenbrenner and Morris young people can still overcome their past adversities:

“If persons are exposed over extended periods of time to settings that provide developmental resources and encourage engagement in proximal processes to a degree not experienced in other settings in their lives, then the power of proximal processes to actualize genetic potentials for developmental competence will be greater for those living in more disadvantaged and disorganised environments.”

(Bronfenbrenner & Morris, 2006, p. 819)

This suggests that by fostering positive relationships with young people in care and helping them to develop more secure attachment styles, professionals can promote young people's health development. This chapter has primarily focused on the physical health and health behaviour of young people in the care system and explored why their pre-care experiences may result in children and young people entering the care system with exceptional health needs. The next chapter will move on to the mental health and well-being of young people in care as well as their risk-taking behaviour (such as substance misuse problems and criminal convictions). These topics are also important to understand to ensure that the care system is able to meet all of the health needs of the children and young people in its care.

Chapter Seven: What are the mental health needs of young people in care?

Chapter Seven considers factors at both the individual (traumatic experiences prior to entering care) and micro-level (experiences of care and education) of Bronfenbrenner's ecological systems theory in relation to the development of mental health difficulties and risky behaviours of young people in care.

Introduction

Chapter Six looked at how pre-care experiences such as early childhood interactions can result in children and young people entering care with delayed health development and exceptional health needs. This chapter will now explore the role of childhood trauma in the development of mental health difficulties and risk-taking behaviour and consider how Bronfenbrenner's bioecological model can help to explain why children and young people in care are more likely to have mental health difficulties than their peers in the general population. The chapter will then explore how the government is monitoring the mental health of young people in care and attempt to identify factors within young people's care and educational experiences and perceptions that are associated with mental health difficulties and risk-taking behaviours (substance misuse problems and criminal activity). Furthermore, this chapter will attempt to disentangle the complex relationships between these negative outcomes.

What is good mental health?

There is a lack of consensus in the literature concerning the definition of good mental health and this is somewhat problematic for those attempting to monitor the mental health needs of young people in local authority care and commission services to meet their needs (see (Manwell et al., 2015)). Consequently, young people who participated in an interview for the current study were asked to explain what 'health' meant to them. For these young people, good health involved being both physically and mentally healthy (see chapter Four for more on physical health). All of the young people interviewed stated that good mental health could not be achieved without good physical health and vice versa:

"I think like it's more thinking healthily and eating healthily – they're sort of the same thing 'cos if you are healthy inside, you'll want to be healthy on the outside. Like, if you're mentally healthy, you'll want to eat healthily. 'Cos it's like mental health, if you were slightly panicky you might eat, like happy eating, if you know what I mean – like you're just eating because it makes you feel good - so that's mental health going into physical health."

[Bart, aged 13]

Young people's definitions of good mental health mirrored definitions of subjective well-being; in which individuals feel happy about their lives, feel settled and safe in their placements and feel positive about their futures (Selwyn & Briheim-Crookall, 2017). The young people in this study also described factors that suggest it is necessary for young people to form a secure attachment with a caregiver as a means to achieve good mental health. For example, they believed that in order to achieve good mental health it was essential to feel happy, to have time to relax, to be given opportunities to

develop interests and find hobbies, to have a hobby as a means to relieve stress, to have friends and family to cheer them up and to have someone that they trust available to confide in about any issues or worries that they are dealing with:

"[I]t's the way you feel. 'Cos if you feel happy with your life and happy with who you are then you're mentally healthy."

[Bart, aged 13]

"It's having a positive mindset... feeling confident about yourself."

[Heather, aged 13?]

"[Y]ou want people to cheer you up when you're upset and to like talk your issues through and all that... being sociable and active and doing something you like is definitely huge and helps mental health... [Y]ou've got to be able to enjoy yourself. That's huge. Like having fun is all about like mental wellbeing isn't it, that's looking after ourselves, having time to relax and like stress factors - getting rid of them."

[Mulan, aged 18]

"Getting the right amount of sleep, seeing the right people as well, like your family, and doing things that you want to do, like if you're interested in dance – 'cos I like dance".

[Elsa, aged 14]

All of the young people who created a collage represented their perceptions of good mental health within their artwork, including things that they felt were necessary to promote mental health and well-being. Bart illustrated his

understanding of good mental health and its link to physical health by creating a smiley face out of some photographs of fruit that he had taken:



[Bart, aged 14]

Elsa felt that family was the most important factor for promoting mental health and well-being. She emphasised this by adding a sticky note to the 'healthy' side of her collage and writing 'family' on it:



[Elsa, aged 14]

Nemo also highlighted the important role that friends and family have in promoting the mental health and well-being of young people in care, and he wrote this down on his collage to emphasise it. He also considered his social worker to be part of his family now:



[Nemo, aged 12]

Mulan described the importance of having people around her who can make her laugh and who she can confide in about any issues or worries. She wrote these on her collage to encourage other young people to laugh and to confide in others:



[Mulan, aged 18]

These descriptions of good mental health reflect Zhang and Selwyn's (2019) definition of subjective well-being:

"[C]hildren and young people's subjective well-being is about feeling good and functioning effectively at both individual and interpersonal levels."

(Zhang & Selwyn, 2019, p. 7)

Selwyn and Briheim-Crookall (2017) and Wood and Selwyn (2017) developed a survey to measure the subjective well-being of children and young people in the care system. This survey was based on the results of focus groups held with children and young people in care and their understanding of what it meant to have 'a good life'. Their Bright Spots model of subjective well-being, developed from the focus groups and subsequent pilot survey, has four domains:

- *“Relationships – being happy with how often they see family, having a good friend, having a pet, trusting the adults they live with, trusting their social worker, and not having multiple social workers.*
 - *Resilience – having a trusted adult, being given chances to show that they can be trusted, liking school or college, having carers who show an interest in their education, having fun/hobbies, having access to the outdoors, being given second chances, practicing life skills, and having access to the internet in their placement.*
 - *Rights – knowing that they can speak to their social worker on their own, knowing who their social worker is, being able to contact their social worker easily, not being made to feel different because they are in care, feeling safe in their placement, feeling included in decisions made about their lives, not being bullied at school or receiving support for bullying.*
 - *Recovery – understanding why they are in care, feeling settled in their placement, liking their bedroom, carers notice how they are feeling, confiding in carers about things that matter, doing similar things to their friends, not having any worries about how they feel or behave or being supported with these worries, and feeling happy with their appearance.”*
- (Selwyn & Briheim-Crookall, 2017, p. 7)

These indicators also reflect theories of attachment for which development depends on children feeling safe and secure as a result of developing trusting relationships with caregivers and where they are supported and given a safe and non-judgemental space to explore their emotions (Silver & Slater, 2019). The Bright Spots indicators were also found to be significantly associated with their four well-being scales: whether young people feel satisfied with their lives, whether they feel that their lives are worthwhile, whether they felt happy yesterday and how positive they feel about the future. For example, young people with low well-being were found to be six times more likely to be unhappy with their appearance, two and a half times more likely to not feel safe in their placement, and twice as likely to be fearful of going to school because of

bullying (Briheim-Crookall, Baker, & Selwyn, 2018). Dansey, Shbero, and John (2019) suggest that young people's perceptions of stigma led to secrecy around their care status which results in them adopting unhealthy attachment behaviours, impacting on their mental health. Some local authorities in England are now providing funds for the Bright Spots research team to analyse survey responses from the children and young people in their area in order to better understand the well-being of the children and young people in their care, and to review the quality of the care that they are providing them.

All of the young people interviewed for the current study referred to positive attachment figures and spoke about their lives in a way that may indicate that they have a good level of well-being. For instance, one young woman felt that her carers were interested in her education, she felt that she was able to confide in them, and she also felt safe in their care, suggesting she had built up a secure attachment with them:

"Well, [foster father] annoys me on a daily basis. He throws paper at me and just makes me laugh. My [foster parents] are interested in how school was and that sort of thing... If I had a problem, I'd talk to them about it and ask for their advice. They're there for me and support me, yeah, they make me feel safe... They say that I can come and talk to them when I need to."

[Elsa, aged 14]

Another young woman spoke about her carers enabling her to practise life skills:

“Recently, [foster mother] has been letting me cook with her. So, like I did cook with her Christmas day, helped out and I had my own little tasks, and then I cooked dinner for everyone the other day. I was so proud I took a picture.”

[Mulan, aged 18]

One young man had pets in his placement, and he described how they had promoted his well-being:

“[I’ve got] four cats. They’re very therapeutic. They really cheer us up, clambering up the curtains and stuff.”

[Baymax, aged 12]

However, all of the young people who were interviewed also spoke about their lives in a way that may indicate that they experience low well-being at times. For instance, one young woman who felt that she was stigmatised for being in care also spoke about how she was bullied at school and had been for some time:

“I get called Barbie. I got called Angelina Ballerina when I had my hair in a bun. I get the weirdest names at school... There’s a whole popularity thing at my school, there’s always, you know, the popular girls – they’re better than you, smarter than you. Well, they’re not smarter but you know, they’re better than us and they make fun out of me and my friends. At my school you get bullied for a lot of things. You get judged for things.”

[Elsa, aged 14]

Throughout his interview another young man described how he was unhappy with his contact arrangements with his birth mother and siblings. Three of his younger siblings had been adopted and he was no longer allowed to see them

– this was a constant struggle for him, and he dealt with this by running away from his placements:

“I’ve seven siblings, six are younger than me, and I can only see three of them – the other three have been adopted, so the most I see of them is pictures. [Sibling 3] lives with her dad so I have a limit as to when I can go and see her ‘cos her dad absolutely hates me...[When] I knew that I wasn’t going to be able to see my siblings anymore I thought, ‘right, I might as well make the most of what I have and go back to mum.’”

[Jimmy, aged 15]

The young people interviewed for this study appeared sensitive to stigmatisation and described avoiding certain appearances and behaviours that may draw attention to them. For example, one young man described feeling unhappy with his appearance when he had to wear glasses, explaining how he would break them to ensure that he did not have to wear them:

“I need glasses, never wear them though. They keep getting me new prescriptions when I purposely, ‘accidentally’, break them. But they keep getting me new prescriptions and it just carries on... It’s the image, people seeing me wearing glasses.”

[Baymax, aged 12]

One young person described how he worried a lot and how he was finding it difficult to overcome the trauma that he had suffered as a result of leaving his family and travelling to England on his own:

"I'm just on my own. That part [travelling to England] is still in my mind, it's still there and it's never gonna go. It weren't easy; I wouldn't do it again... In some respects [my well-being] has gotten worse, 'cos it's just like when you're not with your family, you're thinking about things too much and you start getting worried, and you start getting anxious."

[Buzz, aged 18]

Are young people in care more likely to have mental health difficulties than their peers?

In 2002 a survey was carried out by Meltzer et al. (2002) at the Office for National Statistics to uncover the prevalence of mental disorders among children and young people in the looked after population in England. The report used the term 'mental disorder':

"[A]s defined by the ICD-10, to imply a clinically recognisable set of symptoms or behaviour associated in most cases with considerable distress and substantial interference with personal functions."

(Meltzer et al., 2002, p. 9)

The survey found that just under half (45 per cent) of the looked after population had a mental disorder; 37 per cent had a conduct disorder, 12 per cent had an emotional disorder, seven per cent had a hyperkinetic disorder and four per cent had less common disorders (such as autism, vocal or motor tics or eating disorders).

In 2004 a similar survey was carried out by (Green, McGinnity, Meltzer, Ford, & Goodman) at the Office for National Statistics to uncover the prevalence of mental disorders among children and young people (aged 5-16) in the general

population in Great Britain. This survey found that only 1 in 10 children (10%) had a mental disorder; four per cent had an emotional disorder, six per cent had a conduct disorder, two per cent had a hyperkinetic disorder and one per cent had less common disorders. Figure 23 shows the prevalence of conduct, emotional, hyperkinetic, and less common disorders among the looked after and general population and illustrates that children in the looked after population (45%) are more likely to have a mental disorder than their peers (10%) in the general population (some children had more than one disorder).

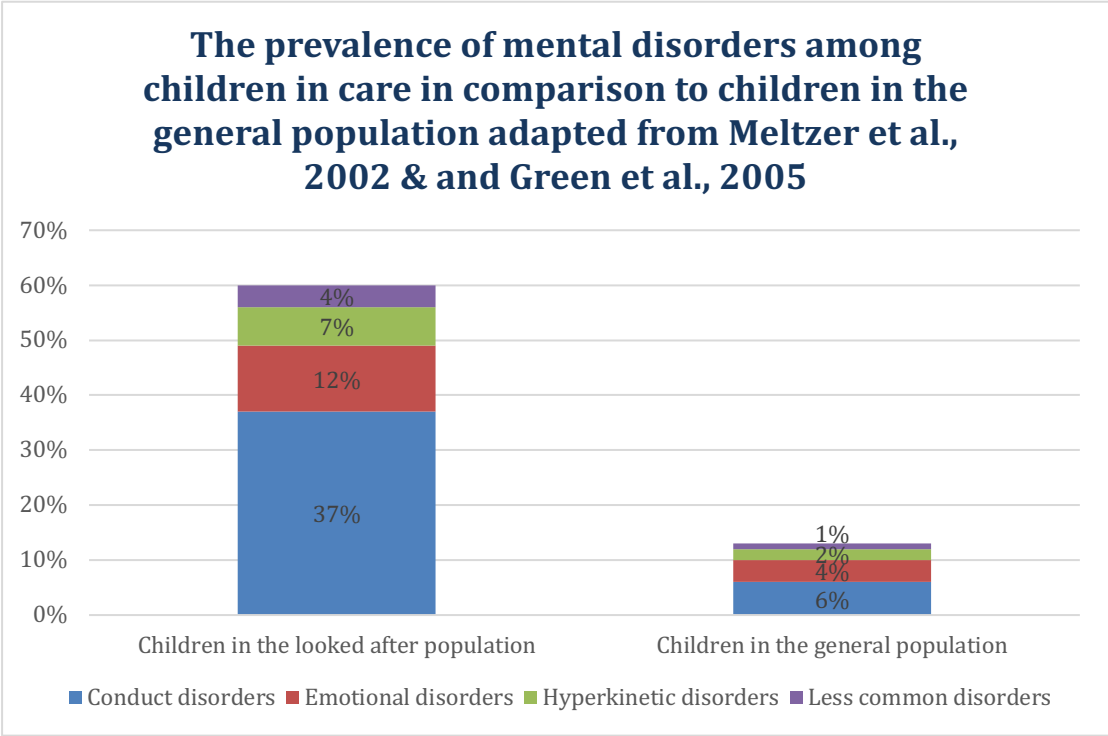


Figure 23: Prevalence of mental disorders among children and young people in the care population versus the general population

The role of proximal processes in emotional regulation

There are many possible causes of mental health difficulties such as genetic predisposition, underlying health conditions and traumatic experiences (see (Woolgar, 2013)). However, there is growing evidence that suggests that

emotional regulation can help protect individuals from mental health difficulties (Berking & Wupperman, 2012). Difficulties with regulating emotions is one plausible explanation for the development of mental health difficulties among children and young people in care because (as shown in Chapter Four) many of them have not been provided with the nurturing environment and opportunities required to develop the necessary skills that later enable them to understand and regulate their emotions. Emotional regulation has been defined in many different ways within the literature. However, one author suggests that:

“[M]ost conceptualizations of emotion regulation point out that successful management and modulation of emotional experiences across time and across situations to accomplish a specific goal are important emotion regulation abilities.”

(Brumariu, 2015, p. 34)

A key part of Bronfenbrenner and Morris (2006) bioecological model was the role of proximal processes in children’s development. In chapter Four the role of proximal processes (the interactions that children have with the people, objects, and symbols in their immediate settings) were discussed as being a key factor in children’s health development. But proximal processes may also play a key role in promoting the mental health and well-being of children and young people. This is because the quality of children’s interactions with their birth parents can determine whether they develop the capacity to understand and regulate their emotions, which is key for children to learn how to manage stress. Infants are born with a survival function whereby they seek the attention of their parent to meet their needs and keep them safe. For example, an infant will cry if it requires feeding, changing, or comfort. For children living in nurturing

homes, their parents will become their safe base in which they build the confidence to explore their growing world. But it is also through these safe interactions with their parents that children learn about their different emotions, what their emotions are called, and different strategies to manage any negative emotions. For example, nurturing parents are likely to encourage their child to express their emotions, respond to their child calmly when they become angry or upset, label the different emotions that their child might be feeling and why they might be feeling the way that they do. They will also teach their child a range of strategies that they can use to calm down if they feel angry or upset and will be available to comfort them until they feel ready to continue with their day. It is also through proximal processes that children can begin to learn about how those around them may be feeling. For example, if a child takes a toy away from their friend or sibling, a nurturing parent is likely to step in, give the toy back to the other child and explain to their child how their actions may have made the other child feel. These nurturing early childhood experiences mean that these children develop emotional awareness, the ability to identify and label their emotions, and the ability to draw on strategies to help them deal with negative emotions or stress in the future (Brumariu, 2015).

The role of childhood trauma in emotional dysregulation

Conversely, children raised in suboptimal environments are more likely to develop emotional dysregulation. This is because these children are more likely to have lived in unpredictable or frightening environments and to have had parents who were pre-occupied with their own issues (such as mental ill health or substance misuse problems). This can result in children responding to their

emotions in a very different way. They may not understand how they are feeling or know how to manage negative emotions or stress, and they are likely to respond to stressful situations differently from those with nurturing parents. For example, rather than seeking comfort from their parents some children may try to suppress their feelings and withdraw from their surroundings, while other children may need to work harder to get their parents' attention and display undesirable behaviour (Howe, 2005).

Moreover, when a child experiences an event or events as being physically or emotionally harmful or threatening it can trigger their fight, flight or freeze response (an automatic internal protective response to extreme stress, threats, or danger). This tells the child whether they should fight or flee, and if they are unable to do either then to freeze and emotionally shut down as a means of protecting themselves from the threat (Thompson, Hannan, & Miron, 2014). Traumatic experiences can include domestic violence and/or abuse, physical, sexual, and emotional abuse or neglect, bereavement, an accident, or a parent's physical or mental illness and/or substance misuse problems.

Childhood trauma can leave children with an ongoing sense of fear, vulnerability and helplessness which can then have an adverse effect on their development and physical, social, and emotional well-being. Over time children are likely to adopt specific behaviours that allow them to survive their suboptimal environments (for example, stealing food when they are not given meals, or hiding, cowering or emotionally withdrawing when voices become

raised) (Howe, 2005). These experiences can also affect children's internal working model (Bretherton, Ridgeway, & Cassidy, 1990) – how they see the world (for example, they may not see adults as being able to keep them safe and protect them from harm), and how they see themselves (for example, they may not feel worthy of love and care), which can affect how they see their future (for example, they may not have aspirations to achieve because they do not feel that they are capable) (Morton, 2018). Ultimately, this can influence how children respond to new environments and relationships, particularly when they are removed from their familiar environment and enter the care system. According to the Substance Abuse and Mental Health Services Administration, in order to give children the best chance of overcoming trauma, those working with them need to understand that any undesirable behaviours presented are “*normal reactions to abnormal situations*” (SAMHSA, 2014, p. 35). This understanding is necessary to safeguard children from feeling responsible for the trauma that they have previously experienced and to ensure that they are not labelled as being ‘bad’ or ‘naughty’ for behaviours that have enabled them to survive their once hostile world. Despite being removed from their suboptimal environments and being placed into the care system, children with a history of trauma may experience trauma related symptoms for some time. These can include, but are not limited to:

- Living in a state of fear, experiencing dissociation and/or being hypervigilant (whereby they are in an enhanced state of sensory sensitivity).
- Having flashbacks – sometimes caused by sensory stimulus such as a smell which can take the child right back to their previous trauma.

- Having difficulties concentrating and/or retaining information.
- Having sleep difficulties including difficulty falling and/or staying asleep, having nocturnal enuresis, having nightmares/night terrors, or oversleeping.
- Feeling a loss of control over their life, the way they feel, their body, and/or their own safety.
- Feeling guilt and/or shame about the events that have happened and the way in which they have tried to survive those events.
- Feeling angry – often directed towards those who have caused their trauma, but also towards others if they feel threatened or they are reminded of their previous trauma.

(Howe, 2005; SAMHSA, 2014)

Therefore, it is crucial that those responsible for their everyday care receive training on the impact of childhood trauma to allow them to understand how the brain responds to threats, and the importance of utilising calming techniques before discussing the event with the child or young person. If children and young people are not able to live in a calm, safe, and nurturing environment in which their carers allow them time to calm down in a safe and non-judgemental way, they may not be able to overcome their previous trauma, resulting in lifelong mental health difficulties (Jackson et al., 2016; Kolar & Davey, 2007; Wright, Crawford, & Sebastian, 2007).

Assessing the mental health needs of young people in care

The first part of this chapter has highlighted the greater prevalence of mental health difficulties among children and young people in the care system and explored the role of trauma and pre-care experiences in the development of these difficulties. Given the complexities around each child and young person's individual pre-care experiences, the government has a rather challenging task in monitoring their mental health. Although it has become a somewhat controversial measure of mental health difficulties, the latest guidance on 'Promoting the health and wellbeing of looked after children' (2015) states that a Strengths and Difficulties Questionnaire (SDQ) (Goodman et al., 2004) is completed once a year for every child and young person in care (aged 4-16) by their primary carer. This is to ensure that professionals can identify children and young people who are in need of specialist mental health support. The SDQ consists of 25 questions that fall within five scales:

1. Emotional symptoms
2. Conduct problems
3. Hyperactivity/inattention
4. Peer relationship problems
5. Prosocial behaviour

A total difficulties score, which sums the scores for scales one to four, can range from 0 to 40; a score between 0 and 13 is considered to be 'normal', a score between 14 and 16 is considered to be 'borderline' and a score between 17 and 40 is considered to be 'abnormal'. Higher scores represent a higher level of difficulty. This score is also submitted by the local authority as part of the

administrative data allowing the government to monitor the prevalence of mental health difficulties among children and young people in care. Scale five measures positive behaviours that benefit others. Scores can range from 0 to 10; a score between 0 and 4 is considered to 'normal', a score of 5 is considered to be 'borderline', and a score between 6 and 10 is considered to be 'abnormal'. These were the categories relevant to the 2013 cohort at the time, but they have since been updated. This subscale is not included in the data submitted to the government.

Although collecting SDQ scores has provided a good starting point for understanding the prevalence of mental health difficulties among children and young people in the care population, it does not have the capacity to show professionals where the young person's specific difficulties may lie, or what their individual strengths are (Goodman et al., 2004). The SDQ is also a generic measure and has not been adapted to take into account the circumstances and experiences that are specific to children and young people in the care system (Bazalgette, Rahilly, & Trevelyan, 2015). Another major flaw of the SDQ is that it is not able to measure the level of difficulties that young people who internalise their emotions may be experiencing (for example, whether young people are self-harming or have suicidal thoughts) (Ryder, Edwards, & Clements, 2017). Moreover, despite the SDQ being used with the aim of identifying those who need mental health support, no data are collected to monitor which young people are receiving specialist support from Child and Adolescent Mental Health Services (CAMHS), school counselling services, or voluntary support services.

The SDQ is usually completed by carers for each child and young person in care prior to and in preparation for their health assessment. Older teenagers may also complete an SDQ for themselves, or with the support of their carer. If their difficulties score is considered to be 'abnormal' then their teacher may also be asked to complete an SDQ. However, it is not clear how often this happens from the data available. During their health assessment young people may be asked about how they are feeling, whether they have any worries, whether they have a friend, and what their interests are. However, the forms completed during a health assessment are not yet standardised. Some local authorities pay for a licence to use the CoramBAAF forms, but other local authorities have created their own version, or have adapted the CoramBAAF forms. This promotes unnecessary inequalities in the standard of services young people receive when having their mental health needs assessed.

SDQ scores for the cohort analysed in the current study

There were up to five years of SDQ scores available for the current cohort, depending on how long they had been in the care system and whether they had an SDQ undertaken for the years that they were in care. The findings presented in Figure 24 are based on the proportion of young people that fell into each category if they had been in care for a minimum of 12 months on the 31 of March of each year. They do not include young people who had not yet entered care or young people who had been in care less than 12 months. They also do not include young people who were in care for 12 months but did not have their

score recorded by the local authority. For example, young people who did not want to complete the questionnaire.

As Figure 24 shows, there was a high prevalence of difficulties among the cohort for each of the five years of data that were used in the analyses, with approximately half of the cohort who had been in care for 12 months on the 31 March of each year having an ‘abnormal’ or ‘borderline’ SDQ score. To simplify the analyses each member of the cohort was given a mean SDQ score (each of their SDQ score were added together and divided by the total number of years that were available). Mean SDQ scores ranged from .00 to 37. As Figure 24 shows, less than half (48%) of the cohort had a ‘normal’ mean SDQ, 13% had a ‘borderline’ mean SDQ score, and 39% had an ‘abnormal’ mean SDQ score.

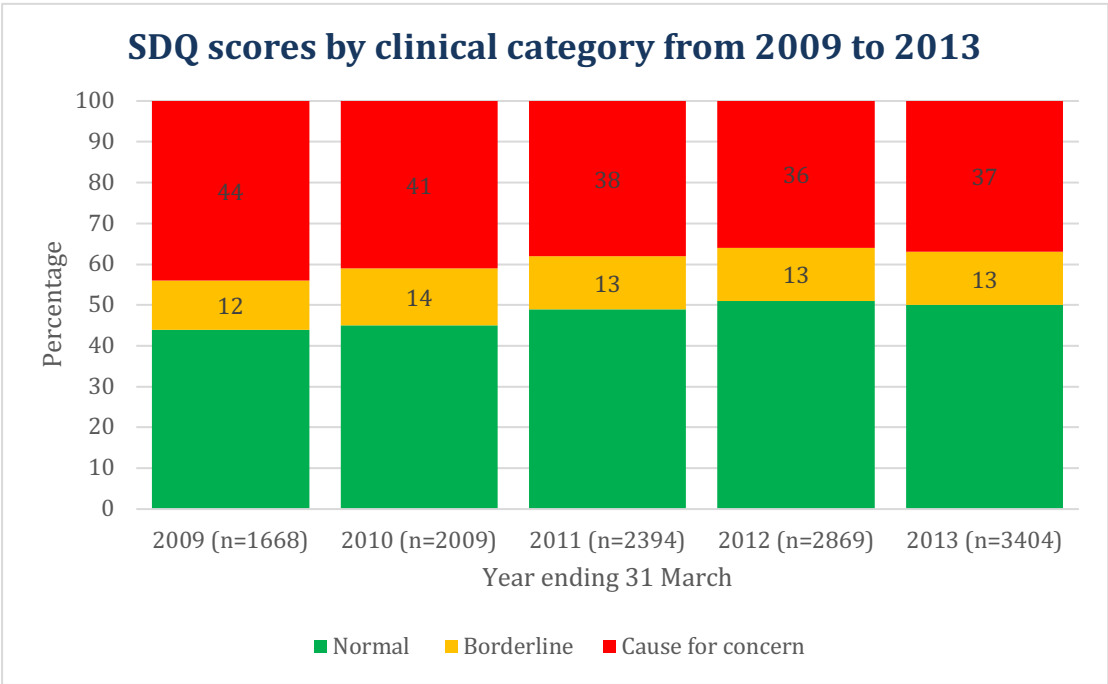


Figure 24: SDQ scores by clinical category for the 2013 cohort from 2009 to 2013

Building the regression model

In order to build a regression model, bivariate analyses were conducted to explore which factors were significantly associated with mean SDQ scores (these can be found in Appendix Two). Before running the regression analyses it was necessary to significantly reduce the number of variables and to choose which factors would be entered into the model. Variables were divided into categories which were adapted from Bronfenbrenner's Bioecological model starting from the individual level and expanding to their different environments within the microsystem as they journey through the care system. These are:

- Individual characteristics
- Pre-care experiences
- Experiences in the care system
- Experiences in education
- Special educational needs
- Risk-taking behaviour

Appendix Two shows which factors were significantly associated with mean SDQ scores when not taking into account other factors. Factors that were not significantly associated with mean SDQ scores were not entered into the regression model.

Characteristics significantly associated with mean SDQ scores

In order to explore whether certain characteristics and care or educational experiences were associated with a higher mean SDQ score, a stepwise multiple regression was conducted using SPSS. Table 6 shows the final model (block 27) of the regression analyses (the full analysis is included in Appendix Three). The variables in the final regression model (block 27) of this analysis account for 23 per cent of the variance in mean SDQ scores ($F(27) = 38.464$, $p < .001$). This suggests that there may be factors not captured in the current administrative data that may be better associated with mean SDQ scores among young people in care. Nevertheless, the chapter will now explore the significant characteristics and care or educational experiences that were included in the model.

	<i>B</i>	<i>SE B</i>	<i>β</i>
Block 27			
Constant	13.536	1.281	
Ethnicity: Black African (Reference group: White British or Irish)	-2.254	.704	-.053**
Ethnicity: Asian (Reference group: White British or Irish)	-.616	.699	-.017
Gender (1=Female, 2=Male)	.121	.219	.009
Ethnicity: Other (Reference group= White British or Irish)	-.063	.590	-.002
Ethnicity: Not known (Reference group: White British or Irish)	.542	.428	.020
Ethnicity: Black Caribbean and mixed White Black Caribbean (Reference group: White British or Irish)	-1.510	.457	-.050**
Reason for entry into care: Unaccompanied asylum-seeking young people (Reference group: Abuse or neglect)	-2.554	.726	-.068***
Reason for entry into care: Child's disability (Reference group: Abuse or neglect)	-.121	.486	-.004
Total number of years spent in care	.054	.034	.031
Placement types: Ever residential care (Reference group: Always foster or kinship care)	.862	.268	.058**
Mean placement length in years	-.583	.090	-.132***
Number of placements excluding short breaks	.058	.026	.041*
Ever placed with an independent or voluntary provider (1=No, 2=Yes)	.494	.244	.036*
Ever placed in another local authority provision (1=Yes, 2=No)	1.037	.549	.029
Placement location at KS4 (1=In local authority boundary, 2=Outside local authority boundary)	.305	.226	.022
Key stage 2 points scored	-.954	.159	-.120***
Proportion of fixed-term exclusions	9.696	3.911	.040*
KS4 school type: Special school (Reference group: Mainstream school)	.886	.346	.054*
KS4 school type: Alternative provision (Reference group: Mainstream school)	2.307	.500	.078***
KS4 school type: Pupil referral unit (Reference group: Mainstream school)	1.180	.451	.043**

Ever permanently excluded (.00=No, 1=Yes)	-1.730	.592	-.045**
Changed school in year 8-9 or 10-11 (1=No, 2=Yes)	.430	.263	.025
Primary special educational need: Behavioural, emotional or social difficulties (Reference group: No special educational need)	2.355	.288	.168***
Highest level of special educational need provision: Statement (Reference group: No special educational need)	1.820	.326	.123***
Primary special educational need: Other disabilities (Reference group: No special educational need)	1.184	.308	.083***
First language in 2013 (1=English, 2=Other language)	-1.372	.622	-.054*
Ever convicted (1=No, 2=Yes)	.665	.321	.035*

Table 5: Final regression model for mean SDQ scores¹

* $p < .05$, ** $p < .01$, *** $p < .001$

¹ The role of each variable in the model is shown by the significance level (p level) of its standardised beta (β). The p level shows whether each variable is significantly associated with the outcome, after controlling for all of the other variables in the model. The unstandardized beta (B) shows the nature of the relationship between each independent variable and the mean SDQ score by displaying the change in mean SDQ score if the independent variable was to increase by one unit. Positive values show that an increase of one in the independent variable increases the mean SDQ score. Whereas negative values show that an increase of one in the independent variable decreases the mean SDQ score. The R^2 statistic represents the percentage of variance in mean SDQ scores that can be explained by the model.

Individual characteristics

The results of the regression analyses show that Black African and Black Caribbean and mixed White Black Caribbean young people had a lower mean SDQ score than White British or Irish young people (by -2.254 and -1.510 points, retrospectively). Conversely, research looking at the mental health outcomes of adolescents who are not in the care system suggests that adolescents from ethnic minorities are at greater risk of bullying at school resulting in greater mental health difficulties (Vervoort, Scholte, & Overbeek, 2010).

Pre-care experiences

The results of the regression analyses show that unaccompanied asylum-seeking young people had a lower mean SDQ score than young people who had entered care due to abuse or neglect (by -2.554 points). Unaccompanied asylum-seeking young people are likely to have experienced significant trauma before entering the care system. For example, they may have experienced or witnessed others being beaten, tortured, raped or killed and they may have been put at significant risk of harm by human traffickers (Barrie & Mendes, 2011). Moreover, when young people arrive in the UK, they are met with a very different culture in which they are not familiar with the language, food, routines, religions, health service or education. One plausible explanation for this finding is that foster carers are not as aware of any difficulties the young person in their care is facing due to the language barrier, leaving young people to seek support from elsewhere. One of the young people interviewed for this study was an

unaccompanied asylum-seeking young person and he described how challenging the language barrier had been for him:

“[A]t the time you can’t have communication with them ‘cos you don’t know English and I was struggling anyway so I was trying to get used to the English language.”

[Buzz, aged 18]

This young man also described how he did not have a sense of belonging due to the complete change in culture, and how this negatively affected his mental health:

“[Y]ou miss your culture and stuff like that, and that’s what I miss the most. Literally like, even here, it’s not really where I belong... [H]opefully in the future I can move on somewhere different ‘cos culture to me is everything. It’s like the food, the atmosphere and everything, it’s like, so brilliant... it’s like family, my mum used to cook a hell of a food. She used to cook such a good food and that’s the thing like you miss it so much. Like I miss it every day... when you’re not with your family you’re thinking about things too much and you start getting worried and start getting anxious.”

[Buzz, aged 18]

In addition to carers’ limited understanding of young people’s mental health needs due to the language barrier, O’Higgins (2019) suggests a number of other explanations for this unexpected finding. These include cultural differences, carers limited understanding of young people’s mental health needs due to the language barrier, young people being overly compliant, and young people focusing on school which can promote their resilience and provide a distraction to past trauma. There is also some suggestion that

unaccompanied asylum-seeking young people come from loving homes with nurturing parents, and this is thought to go some way in promoting their resilience.

Experiences in the care system

In order to overcome childhood trauma and prevent young people from being re-traumatised it is essential that they are given the opportunity to lead a stable home life and to feel safe (Bada et al., 2008; Howe, 2005). Table 7 shows the number of placement changes young people in the 2013 cohort had experienced. The results of the regression analyses in this study also showed that instability in the care system was significantly associated with mental health difficulties. For example, each time that a child had moved to a new placement their mean SDQ score was higher (by .058 points). Although this may seem like a small increase, 10 per cent of the cohort had lived in 10 or more placements, with one young person living in 92 placements.

Number of placements changes	Number of young people	Percentage of young people
0	19	<1
1	819	17
2	948	20
3	763	16
4	543	11
5-9	1261	26
10-92	494	10

Table 6: Number of placement changes for the 2013 cohort

On the other hand, stability in the care system was shown to act as a protective factor for mental health difficulties. For example, for each year that a young

person remained in the same placement, their mean SDQ score was lower (by -.583 points). However, 29% of the current cohort had lived in their latest placement for less than one year, and 23% had only lived in their latest placement for one year, suggesting that there is some way to go to ensure young people experience stability in the care system.

Where young people are placed is also linked to instability in the care system. The local authority will always try to place their young people with local authority foster carers first. However, if they cannot find a placement (due to the young person's age or level of behavioural difficulties) they then reach out to independent/voluntary fostering agencies to place their young people with. Independent/voluntary fostering agencies often provide their foster carers with more training and support around behavioural difficulties as they tend to provide placements for children who have been deemed to be too challenging for the local authority foster carers.

Table 8 shows the number of young people that had only ever been placed with carers in their own local authority, those had ever been placed with another local authority, and those who had ever been placed with an independent or voluntary agency. In the current study, young people who had been placed with an independent or voluntary fostering agency had a higher mean SDQ score than those who had always been placed in their own local authority provision (by .494 points). However, the results do not reveal whether young people's SDQ scores were higher prior to being placed with an independent or voluntary fostering agency or as a result of their placement.

	No	Yes
Only ever placed with own local authority	3416 (70.5%)	1431 (29.5%)
Ever placed with an independent/voluntary agency	1984 (41%)	2863 (59%)
Ever placed with another local authority	4668 (96%)	179 (4%)

Table 7: Placement providers for the 2013 cohort

When young people are not able to be placed in foster or kinship placements (for example, their placements keep breaking down or they have a complex risk assessment) the local authority will then look to place them in residential care (this is usually considered a last resort). Table 9 shows the placement histories of young people in the 2013 cohort.

	No	Yes
Ever placed in residential care	3355 (69%)	1492 (31%)
Always placed in foster or kinship care	2939 (61%)	1908 (39%)
Placed in other types of care	3400 (70%)	1447 (30%)

Table 8: Placement history for the 2013 cohort

The regression analysis showed a significant association between residential care and mental health difficulties. Young people who had been placed in residential care had a higher mean SDQ score than those who had always been placed in foster or kinship care (by .862 points). Again, the results do not reveal whether young people's SDQ scores were higher prior to being placed in

residential care or as a result of being placed there. However, it is plausible that young people who need to be placed in residential care already have a higher level of mental health difficulties which is then further exacerbated as a result of being placed with a group of other young people experiencing a higher level of mental health difficulties (González-García et al., 2017).

Experiences in education

As well as supporting young people to lead stable home lives, it is essential that they are given the opportunity to experience stability in education in which they can learn to trust their teachers and build friendships with peers. Sixty seven per cent of the cohort had not missed any school sessions due to fixed term exclusions, 25% had missed less than five per cent of school sessions, and 8% had missed between five and 63 per cent of school sessions.

In the current study, the proportion of school sessions missed due to fixed-term exclusions was significantly associated with mean SDQ scores. Three thousand, two hundred and fifty (67%) young people had never received a fixed term exclusion. Young people who had missed a higher proportion of school sessions due to fixed-term exclusions also had a higher mean SDQ score than young people who had not received any fixed-term exclusions. This means that for every five per cent of possible school sessions missed for fixed-term exclusions, a young person's mean SDQ score increased by .484% points.

Only three per cent of the 2013 cohort had been permanently excluded from school. However, young people who had been permanently excluded from

school had a lower mean SDQ score than young people who had never been excluded from school (by -1.730 points). The unexpected direction of this relationship suggests that there is an interaction between permanent exclusions and another variable in the regression model, possibly the variable that represents young people who have a behavioural, social or emotional difficulty. On their own, both variables are linked to higher SDQ scores, but they are also likely to relate to each other (someone with a behavioural, emotional or social difficulty is more likely to be excluded from school). Children with behavioural, emotional or social difficulties may be less susceptible to the 'exclusion effect' because they already have high SDQ scores and being permanently excluded is not going to be linked to such a large difference in their scores.

In recent years, some research has begun to look at the impact of internal exclusions on young people's mental health (Children's Commissioner for England, 2019). Internal exclusions often involve isolating a pupil away from their peers. However, due to the complexities around reporting internal exclusions (such as what constitutes an internal exclusion) it is not yet clear how often children and young people are given internal exclusions (Department for Education, 2019). However, one of the young people interviewed for the current study described how he had been excluded both internally and externally. His foster carer had persuaded the headteacher to reduce the number of days he was excluded:

“Literally, one day I was in my class and I was doing my work and one of the students came in and he started swearing. I don’t like it when I’m concentrating on something and someone random comes and says something like that. At that time, I didn’t have a good temper either ‘cos I was feeling a lot of stress and I had other problems, like worrying about other things. So, then I just lost it. I got excluded – they wanted me to be excluded for the whole week, but I got away with one day exclusion and the next two days in internal – just being in an isolation room.”

[Buzz, aged 18]

In the current study, the analyses show that higher attainment at Key Stage 2 is associated with a lower SDQ score (a lower level of difficulties). Again, it is difficult to know the direction of the effect between this and mental health.

Additional needs

Some additional needs were also associated with a higher mean SDQ score. For example, young people who had been diagnosed with a behavioural, emotional, or social difficulty and young people who had been diagnosed with other types of disabilities had a significantly higher mean SDQ score than young people who did not have any special educational needs (by 2.355 and 1.184 points retrospectively). In the current cohort, 26 per cent of young people did not have a special educational need, 39 per cent had a behavioural, emotional or social difficulty, and 35 per cent had another disability. Young people who had a statement of special educational needs (now known as EHCP) also had a higher mean SDQ score (by 1.820 points) than young people who did not have any special educational needs. One thousand, four hundred and eighty six (30%) of the 2013 cohort had a statement of special educational needs.

Yet, young people whose first language was not English at Key Stage 4 had a lower mean SDQ score (by -1.372 points) than young people whose first language was English at Key Stage 4. 90 per cent of young people who did not speak English as a first language at Key Stage 4 were unaccompanied asylum-seeking young people; potential explanations for this finding have been covered above.

Young people with significant additional needs are more likely to attend a different educational provision from mainstream school as they should better meet their needs. Table 10 shows the type of school young people in the 2013 cohort attending in Key Stage 4. The type of school that young people attended in Key Stage four was also associated with mean SDQ scores. In comparison to those who had attended a mainstream school, young people who had attended a special school, alternative provision, or a pupil referral unit had a significantly higher mean SDQ score (by .886, 2.307, and 1.180 points retrospectively). Again, the results do not reveal whether young people had a higher mean SDQ score prior to their school placement or as a result of their school placement. But it is plausible that these young people had a higher level of mental health difficulties before attending a non-mainstream educational provision.

Type of School	Number of young people (%)
Mainstream	2966 (61%)
Special	1061 (22%)
Pupil referral unit	323 (7%)
Alternative provision	272 (6%)
Other	220 (4%)

Table 9: Types of school young people in the 2013 cohort attended

Risk-taking behaviour

Seven hundred and thirty four (15%) of young people in the 2013 cohort had a criminal conviction. Young people who had a criminal conviction had a higher mean SDQ score (by .035 points). This small increase suggests that the association between SDQ scores and criminal convictions is mediated by some of the other factors in the regression model. For example, number of placement changes, being placed in residential care, proportion of school sessions missed due to fixed-term exclusions, attending a PRU, alternative provision or special school, and having a behavioural, emotional or social difficulty were significantly associated both with having a higher SDQ score and having a criminal conviction.

These results suggest that there may be a group of young people who enter the care system with significant mental health difficulties which result in them experiencing a journey of instability through the care and education systems, which further exacerbate their mental health difficulties. For example, young people who had a higher level of difficulty also had more placements, and shorter lengths of stay in their placement, $r = -.302$, $p < .001$. The number of placements a young person had, and the length of their last placement were both significantly associated with being placed in residential care. Young

people who had ever been placed in residential care had, on average, seven placements, compared with young people who had always been placed in foster or kinship care who had, on average, three placements, $F(2) = 435.258$, $p < .001$. Moreover, young people who had ever been placed in residential care had only been in their last placement for around one year compared with young people who had always been placed in foster or kinship care who had been in their last placement for around three years, $F(2) = 295.888$, $p < .001$. This suggests that young people who enter care with a high level of mental health difficulties experience significant instability in the care system, which often results in them being placed in residential care along with other young people who also have mental health difficulties.

Instability in the care system was also significantly associated with the type of school young people attended at Key Stage 4. Young people who attended mainstream school had approximately four placements, compared with young people who attended a pupil referral unit who had approximately eight placements and young people who attended alternative provision who had approximately six placements, $F(4) = 64.608$, $p < .001$. So, not only is this group of young people likely to experience instability in the care system, they are also likely to experience instability in their education, both of which may further exacerbate their mental health difficulties. Moreover, only 16 per cent of young people who attended a mainstream school had been placed in residential care, compared with 60 per cent of young people attending a pupil referral unit, and 70 per cent of young people attending alternative provision, $X^2(8) = 932.676$, $p < .001$, further indicating that young people with mental health difficulties are

likely to be placed with peers with similar needs, both in residential care and in educational settings.

Sleep and mental health difficulties

Research suggests that there is a significant association between mental health difficulties and sleep problems such as difficulty falling asleep, difficulty staying asleep, difficulty waking up in the morning, and long-term fatigue (Freeman et al., 2017). Currently, no information about sleep is collected as part of the administrative data. However, all of the young people who participated in interviews completed a sleep diary and were asked about their sleep hygiene and were asked to rate their own quality of sleep from one to five. Table 11 shows that some young people slept very well while others experienced difficulties falling or staying asleep.

	Bedtime	Wake up time	Number of times awake during the night	Quality rating (1= very poor, 5= very good)
Baymax	19:30	06:00	0	5
Nemo	21:00	06:30	2	4
Bart	20:30	05:30	4	3
Heather	20:00	07:00	0	5
Elsa	22:00	07:00	3	3
Jimmy	22:00	07:00	0	5
Buzz	02:00	05:30	0	1
Mulan	02:00	06:00	1	2

Table 10: Young people's self-recorded sleep diary

None of the young people who were interviewed knew how much sleep was recommended for someone their age. One young person felt that she had to stay awake during the night just to keep on top of her schoolwork:

“It’s like for uni and college, sometimes you’ve got to just stay up ‘til two just to finish a piece of homework and finish coursework and meet your coursework deadlines. You know, you get into trouble if you don’t.”

[Mulan, aged 18]

Although she felt that she had difficulties with her sleep, one young person would drink coffee at bedtime, suggesting that some young people may need more education around sleep hygiene:

“Some nights I wake up a few times. It depends what’s going on really, you know, if I’m worried about school I won’t sleep. I come downstairs to give my phone to my foster mum and then I make a coffee and I go upstairs and do a bit of reading.”

[Elsa, aged 14]

Gaming and technology

In recent years, greater emphasis has been placed on the link between blue light and sleep difficulties (West et al., 2010). During the interviews, it became apparent that foster carers were taking additional steps to ensure that the young people in their care received sufficient support to limit their screen time. Most young people said that their foster carer would make them keep their phone downstairs at night:

“Most foster carers say that you can’t keep your phone upstairs ‘cos you’ll be on it all night. But I think I agree ‘cos if I have my internet, I would be on my phone all night.”

[Elsa, aged 14]

When describing unhealthy behaviours, one young person referred to gaming addictions. He felt that his foster carer had prevented him from developing a gaming addiction by placing restrictions on when he could access his devices:

“I’ve thought of something unhealthy, which is gaming addictions... I like gaming. I mostly play Minecraft. I’m only allowed to play until ten o’clock and after four o’clock. So, for those six hours I can’t play or have any technology, apart from my phone if I’m out... I’m not allowed my phone, PlayStation, computer, or iPad – unless I’m doing homework and then I’m allowed my iPad but that’s it.”

[Bart, aged 13]

When discussing gaming addictions Bart decided to draw a control for a games console on his collage and commented on the role of his foster mother in limiting the time he spent playing games:



[Bart, aged 14]

Self-harm

During their interviews, some young people disclosed that they self-harmed by cutting themselves. They linked their self-harm to feelings of anger and frustration, and they explained that this was the only way they could release their emotions:

“There’s a reason people self-harm and either it’s their past or things that have happened, and they need someone to talk to and they need another way of getting their anger and frustration out. From my personal experience, once you’ve done it, it relieves all your stress and all your anger... For me, there just isn’t another way except for hitting a wall. But obviously I don’t really wanna go around hitting walls and hitting people. I think there’s just not many ways that you can get your anger out, especially if you can’t talk to people, that’s a huge thing ‘cos you’ve got to find another way of getting it out.”

[Elsa, aged 14]

One young man described how he had sought help from his General Practitioner when he realised that his self-harm had become a significant issue:

“Well I used to have anger problems and – I feel ashamed – but like, cutting myself. I didn’t do it as much as like I’ve seen my friends doing it. But that was what I was doing and that’s when it started getting serious, and I went to the doctors. She said, ‘you’ve got depression’... My mind is not 100% fixed. But how I look at it is like I’m already hurt, so there’s no point solving it.”

[Buzz, aged 18]

Although she stated that she did not self-harm and did not understand why others may self-harm, one young person felt that it was an important topic because she had witnessed others self-harm:

“I would never self-harm. I have seen someone do it before though. I know people who have done it... I just don’t understand why you would want to do that because you have scars and it just makes you feel horrible.”

[Heather, aged 13]

This young person also wanted to represent the topic of self-harm on her collage:

“A knife – that could present self-harming; I might put that on the arm because people self-harm on their arm.”

[Heather, aged 13]



[Heather, aged 13]

One of the young people who disclosed that they self-harmed also described how professionals had suggested using other strategies when she felt the urge to self-harm. But she did not find these strategies effective:

“I’ve been told to put an elastic band around my wrist and pull that whenever I feel stressed. But it doesn’t leave a permanent mark. I do regret doing it. But sometimes I feel like I still need to do it, and I do – it leaves a mark.”

[Elsa, aged 14]

Although no data are collected, at a national level, on young people who internalise their emotions and behaviours (for example, those who self-harm). It would appear from the interviews conducted with young people in care that a large proportion of young people (both in and out of the care system) need support in order to learn how to deal with their emotions. It is plausible that those in the care system are at greater risk of self-harming due to trauma related to their experiences of living in suboptimal environments.

Experiences of mental health services

All of the young people who participated in an interview had received support from mental health services at some point during their care experience. Those who entered care during early childhood were aware that they had received play therapy but could not really remember their experience of therapy. However, one young person did recall:

“Oh CAMHS, it was ‘cos I was young so, it was just doing some art or something... it helped quite a bit actually.”

[Nemo, aged 13]

Another young person had chosen to see her school counsellor instead of the Child and Adolescent Mental Health Service (CAMHS) because she felt that this made her more ‘normal’ in the eyes of her peers (see Chapter Seven for

more on the concept of normality for young people in care). A couple of the other young people described their more recent experiences of CAMHS. Some young people felt the therapy sessions they had received were not helpful. One young person who was uncomfortable with eye contact during the interviews described how he disliked counselling in which he was expected to sit down and talk:

“I was referred to CAMHS. That was because I was having trouble at school. But I didn’t like CAMHS because it’s just sitting down and talking all the time, and I didn’t want to do it, so I stopped... I don’t like therapy.”

[Baymax, aged 12]

However, this young person attended a programme with his foster carer that focused on building up his independence skills and within this programme he was taught therapeutic strategies to better understand himself. He described some of these experiences very positively, perhaps because they were not labelled as being ‘therapy’:

“There’s this system they use; if you have a blank bit of paper and you choose a button that represents you, and [the paper] is your life, and you have to take buttons out of a jar that represent different people. So, if there’s a black button that would be for me, and then I’d have to place whereabouts people are in my life, on the bit of paper, and we do that regularly. We see if people change, if they get closer to my world or further away. So that really helps.”

[Baymax, aged 12]

Another young man had reached out for support from his doctor after he began self-harming and he was referred for counselling. However, his experience of

the counsellor choosing to focus on his past trauma meant that he stopped attending his sessions altogether. Instead this young person decided to keep all his past trauma to himself because he wanted to ensure that he did not upset others with his experiences, and he felt that he would be wasting resources:

“It was basically just about my background and stuff like that, and I like to keep things to myself. The therapy people tried so much and I went, ‘not being funny but I don’t wanna waste your time’... it was like the background of me and I didn’t feel comfortable about it. It was looking back – where I’m from and stuff like that, and the journey I’ve been through, and I didn’t find it easy. So I just said, ‘I can’t do it’.”

[Buzz, aged 18]

Another young person had seen multiple therapists and counsellors and described how their approach to the sessions had been different with some just sitting and listening and others offering advice. Her description about what was most beneficial for her suggests that CAMHS could be better tailored to meet each young person’s needs:

“I’ve been to a few counsellors and therapists. I’ve hated going. But I got told that it would help me and support me and make me feel better. The last counsellor I had, she helped me, and made me choose like the right decisions and things. But with my friendship problems I used to ask for her advice, and she’d help me and give me a few options, and I could pick one. The last counsellor I had, she was more of a sit and listen one. So, she’d ask how your week was and then she’d listen to you. At the end of the half an hour she’d say, ‘right, I’ll see you next week.’ So, you’d think, ‘well, what was the point in that?’”

[Elsa, aged 14]

Living with trauma

All of the young people described how their experiences of trauma impacted on their everyday lives in some way. For example, one young woman described how she had found it difficult to trust adults when she first entered care. But over time her current foster parents had proved to her that they were reliable and that she could trust them:

“With my carers, I didn’t trust them for a while and I didn’t think I could talk to them. But now there are certain things I can just go up to them and say, ‘I’m having a problem with this.’ Sometimes we have arguments and disagreements because their advice doesn’t help me in any way and I don’t know what to do still. But yeah, at least I now feel like I can talk to them and ask for their opinion and things.”

[Elsa, aged 14]

Another young person described how he had struggled to manage his emotions in the care system, often running away from his placement when he felt overwhelmed. Over time, his foster carers had taught him how he could better express himself and had even converted their garage into a soundproof music studio for him:

“If I feel I need to zone out or whatever, I just set up the mic I bought that I’ve got in the studio, and then I just get on my drum kit and just go off on one, and just have my own little moment. I mainly base it all on my past ‘cos I was brought up with like my step-dad who’s an alcoholic and drug addict – all that gets reflected in my music. But it’s a way to escape really.”

[Jimmy, aged 15]

Substance misuse problems among young people in care

Research suggests that people with mental health difficulties are at greater risk of developing addictions such as substance misuse problems (Crawford, Crome, & Clancy, 2003). The Department for Education (2019) adopts the definition of substance misuse put forward by the National Institute for Health and Care Excellence (2012):

“[I]ntoxication by, dependence on, or regular, excessive consumption of psychoactive substance leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs (including alcohol when used in combination with other substances).”

(Department for Education, 2021, p. 101)

All of the young people who took part in an interview felt that substance misuse problems were linked to mental health difficulties. When considering the reasons why some people may smoke, drink alcohol, or use drugs, they often explained how people did it because it made them happy:

“[People may take drugs, drink alcohol, or smoke] because it makes them feel happy. Like it gives them dopamine in their brain... It gets them addicted and it makes them feel happy, it gives their life a purpose.”

[Bart, aged 14]

They also felt that people turned to smoking in order to relieve any stress that they were experiencing, or even as a weight management strategy:

“A lot of people [start smoking], well, their excuse is that it relieves stress, which I don’t believe. But the other excuse is, apparently it makes you lose weight – I’ve heard that a lot.”

[Buzz, aged 18]

The young people interviewed also felt that peer pressure or negative family influences also played a role in other young people deciding to start smoking, drinking alcohol, or using drugs:

“It’s probably the people around you, the sort of people you’re hanging around with, like peer pressure. If they were doing drugs and alcohol then they would probably pressure you into doing that as well, and your family – if they’re a bad influence.”

[Elsa, aged 14]

Most of the young people felt that peer-pressure also played a huge role in young people turning to unhealthy substances:

“Like peer pressure from friends or maybe they’re influenced by their parents – not foster parents – but before they came into care. Or if they just don’t like their care placement. It’s so they can be popular and like they think they’re cool and they can say, ‘I’ve tried it.’”

[Heather, aged 13]

The regression model for substance misuse problems and criminal convictions

The database included up to five years of data that recorded whether a young person had a substance misuse problem or criminal conviction. To simplify this a new variable was created to capture whether each young person in the cohort

had ever had a substance misuse problem recorded (0=No, 1=Yes). A total of 583 (12%) young people were identified as having a substance abuse problem at some point during the years of 2009 to 2013. In order to build the regression model, bivariate analyses were conducted to explore which factors were significantly associated with having a substance misuse problem (see Appendix Two). Several significant variables also had to be excluded from the regression model due to the large number of missing data. This was because logistic regression automatically excludes cases (members of the cohort) from the regression analyses if they have any missing data. For example, one variable was whether the young person was placed in or out of their local authority boundary at KS2 – approximately half of the cohort had not entered the care system at that point and so they would all be excluded from the analyses. Due to the large number of variables in the regression model it was vital that the sample size remained relatively large. This meant that variables with a large proportion of missing data needed to be excluded. However, this meant that some key factors could not be explored within this study and so it is not possible to know if they were associated with young people having a substance misuse problem or criminal conviction.

Groups of young people in care most likely to have a substance misuse problem

Logistic regression was used to explore whether any characteristics or experiences were significantly associated with having a substance misuse problem recorded. The Nagelkerke's R^2 indicates that the final model can account for 25 per cent of the variability, suggesting that there are factors not

captured in the current data that may be better associated with young people who have a substance misuse problem recorded. However, the chi-square statistic indicates that the model is statistically significant $\chi^2(13) = 537.352, p < .001$. Table 12 shows Block 8 of the final regression model for substance misuse problems.

	B	SE B	Exp (B)
Step 2b			
Reason for entering care: UASC (Reference category: Abuse or neglect)	-.788	.601	.455
Reason for entering care: Child's disability (Reference category: Abuse or neglect)	-.973	.608	.378
Number of placements excluding respite	.055	.010	1.057***
Ever placed in residential care (1=No, 2=Yes)	.610	.127	1.840***
Ever placed with parents (1=No, 2=Yes)	.042	.177	1.043
Mean number of respite placements	-1.682	1.020	.186
Proportion of school sessions missed due to unauthorised absences	1.997	.695	7.367**
Proportion of school sessions missed due to fixed-term exclusions	4.810	1.774	122.683**
Type of school at KS4: Pupil referral unit (Reference category: Mainstream school)	.283	.181	1.328
Type of school at KS4: Alternative provision (Reference category: Mainstream school)	.725	.238	2.064**
Highest level of SEN provision: Statement (Reference category: No SEN)	-.612	.140	.542***
Primary SEN: Behavioural, emotional, or social difficulty (Reference category: No SEN)	.144	.121	1.155
Mean SDQ score	.017	.009	1.018*
Ever convicted (1=No, 2=Yes)	1.432	.128	4.188***
Constant	-3.182	.150	.042***

Table 11: Final regression model for substance misuse problems²

* $p < .05$, ** $p < .01$, *** $p < .001$

² The role of each independent variable in the model is shown by the significance value (p value) of its associated beta (B). The Exp(B) value shows the type of relationship between each independent variable and substance misuse problems. It provides an odds ratio for the likelihood of a group of young people having a substance misuse problem recorded when there is a change of one unit in the independent variable. Values below 1 suggest that when the independent variable increases by one the odds of having a substance misuse problem recorded decrease. Whereas predictor variables with a value over 1 suggest that when the independent variable increases by one, the odds of having a substance misuse problem recorded increase.

Pre-care experiences

As Table 12 shows, none of the variables within pre-care experiences were significantly associated with substance misuse problems. This suggests that young people's care and educational experiences are better associated with substance misuse problems.

Experiences in the care system

The regression analyses showed that every time a young person moves placement, the odds of having a substance misuse problem recorded increase by 1.057. The analyses also showed that the odds of having a substance misuse problem recorded if young people are placed in residential care are 1.840 times the odds of having a substance misuse problem recorded if young people are always placed in foster or kinship care.

Experiences in education

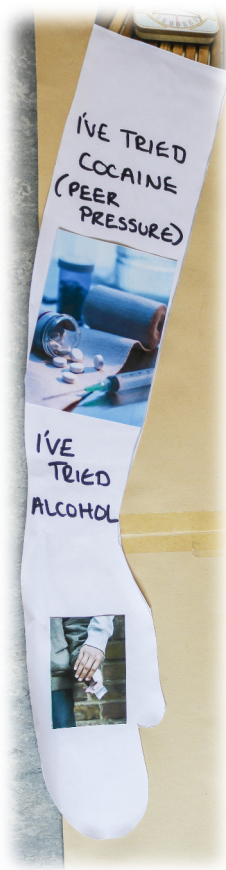
The results also showed that the odds of having a substance misuse problem recorded if young people had missed all possible school sessions (100 per cent) due to fixed-term exclusions were 122.683 times the odds of having a substance misuse problem recorded if young people had not missed any school sessions due to fixed-term exclusions. This means children missing 5 per cent of possible school sessions due to fixed-term exclusions are around 6 times as likely to have a substance misuse problem recorded as those with no exclusions. The odds of having a substance misuse problem if young people missed all possible school sessions due to unauthorised absences were 7.367

times the odds of having a substance misuse problem if young people had not missed any school sessions due to unauthorised absences. This means that for five per cent of possible school sessions missed due to unauthorised absences, the odds of having a substance misuse problem recorded increase by 1.368. One of the young people who participated in an interview demonstrated the link between fixed-term exclusions and substance misuse problems and how easy it can be for young people to be influenced by those around them:

“I smoke. I’m a regular smoker – 10 a day sort of thing. Alcohol, I’ve tried it and I got excluded from school for it and I haven’t touched it since. I’ve tried cocaine. I’m not gonna do that again. I’ve told everyone that, and I was offered some Mandy and I’m not gonna try that... It’s peer pressure. I wasn’t gonna touch them, but...”

[Baymax, aged 12]

Mandy is the club name for Ecstasy and is usually taken in the form of pills, although some people may crush them into a powder and snort them. This young man also represented his unhealthy behaviours in his collage:



[Baymax, aged 12]

Additional needs

The regression analyses showed that the odds of having a substance misuse problem recorded if young people were placed in alternative educational provision at Key Stage 4 are 2.064 times the odds of having a substance misuse problem recorded if young people are placed in mainstream school at Key Stage 4. The regression analyses show that young people who have not received any special education needs provision are half as likely to have a substance misuse problem recorded than young people who have a statement of special educational needs (now known as EHCP).

Risk-taking behaviours

There was only a small association between high SDQ scores and substance misuse problems, with every SDQ point increasing the odds of a substance misuse problem by 1.018. This suggests that the relationship between SDQ scores and substance misuse problems is mediated by some of the other factors in the model. For example, the number of placements, the proportion of school sessions missed due to fixed-term exclusion, attending alternative educational facilities, or having a criminal conviction were all associated with mean SDQ scores and substance misuse problems. However, there was a strong association between substance misuse problems and having a criminal conviction, with those who were recorded as having a criminal conviction being four times as likely to have a substance misuse problem compared to those without a criminal conviction.

Groups of young people in care most likely to have a criminal conviction

While having a criminal conviction may not be considered to be health-related, evidence suggests a strong association between the two (Walters, 2014). This is of some concern as it suggests that the most vulnerable young people in care not only have mental health difficulties and substance misuse problems but may also have a criminal record which will affect their future outcomes, such as employment. Seven hundred and thirty four (15%) of the 2013 cohort had a criminal conviction. Logistic regression was also used to explore whether any characteristics and experiences can significantly predict which groups of young people have a criminal conviction recorded. The Nagelkerke's R^2 indicates that

the final model can account for 38 per cent of the variability, suggesting that there are still factors not captured in the current data that may better predict which groups of young people are more likely to have a criminal conviction. However, the chi-square statistic indicates that the model is statistically significant $X^2(20) = 888.574$, $p < .001$. Table 13 shows Block 11 of the final regression model for criminal convictions.

	B	SE B	Exp (B)
Step 1a			
Gender	.716	.126	2.046***
Reason for entry into care: Anti-social behaviour (Reference category: Abuse or neglect)	.247	.339	1.281
Reason for entry into care: Reduced parenting capacity (Reference category: Abuse of neglect)	.061	.120	1.063
Reason for entry into care: UASC (Reference category: Abuse or neglect)	-.785	.612	.456
Reason for entry into care: Child's disability (Reference category: Abuse or neglect)	-2.444	.730	.087**
Number of placements excluding respite	.047	.011	1.048***
Ever placed in residential care (Reference category: Always placed in foster or kinship care)	.903	.124	2.467***
Ever placed with parents (1=No, 2=Yes)	.725	.172	2.066***
Ever placed in another local authority provision (1=No, 2=Yes)	.635	.256	1.887*
Changed school in year 8-9 or 10-11 (1=No, 2=Yes)	.336	.132	1.399*
Proportion of school sessions missed due to unauthorised absences	2.922	.734	18.577***
Proportion of school sessions missed due to fixed-term exclusions	8.190	1.866	3603.676***
Type of school at KS4: Special school (Reference category: Mainstream school)	.795	.176	2.214***
Type of school at KS4: Pupil referral unit (Reference category: Mainstream school)	1.276	.182	3.584***
Type of school at KS4: Alternative provision (Reference category: Mainstream school)	.760	.256	2.137**
Type of school at KS4: Other provision (Reference category: Mainstream school)	.918	.241	2.503***
Highest level of SEN provision: Statement (Reference category: No SEN)	-.256	.158	.774
Primary SEN: Behavioural, emotional, or social difficulty (Reference category: No SEN)	.464	.122	1.590***
Ever had a substance misuse problem (1=No, 2=Yes)	1.401	.131	4.061***
Constant	-5.543	.219	.004***

Table 12: Final regression model for criminal convictions

* $p < .05$, ** $p < .01$, *** $p < .001$

Individual characteristics

The regression analyses show that boys were almost twice as likely to have a criminal conviction as girls.

Pre-care experiences

The regression analyses show that the odds of having a criminal conviction if young people enter care due to abuse and/or neglect are 18.519 times the odds of having a criminal conviction if young people enter care due to their disability.

Experiences in the care system

The regression analyses show that every time young people move placements, the odds of having a criminal conviction increase by 1.034. The results also show that young people who had ever been placed in residential care were two and a half times more likely to have a criminal conviction compared to young people who were always placed in foster or kinships care. This fits with other research which has found that young people in residential care are over criminalised – often convicted for things like criminal damage which foster, or kinship carers are less likely to involve the police for (Gerard, McGrath, Colvin, & McFarlane, 2018). Young people who had ever been placed with their parents were nearly twice as likely to have a criminal conviction than those who had not. Those who had ever been placed in another local authority provision were also nearly twice as likely to have a criminal conviction.

Experiences in education

The regression analyses show that the odds of having a criminal conviction if young people change school in years 8 to 9 or 10 to 11 are .399 times the odds

of having a criminal conviction if young people do not change school during these years. The results also show that the odds of having a criminal conviction if young people miss all possible school sessions (100 per cent) due to fixed-term exclusions are 3603.676 times the odds of having a criminal conviction if young people do not miss any school sessions due to fixed-term exclusions. This means that for every five per cent of possible school sessions missed due to fixed-term exclusions, the odds of having a criminal conviction increase by 180.183. Young people who missed all possible school sessions due to unauthorised absences were 18.577 times the odds of young people having a criminal conviction if they did not miss any school due to unauthorised absences. This means that for every five per cent of possible school sessions missed due to unauthorised absences the odds of having a criminal conviction increase by .929.

Additional needs

Compared to young people who attended a mainstream school at Key Stage 4, young people who attended a special school or alternative provision were twice as likely to have a criminal conviction, young people who attended other educational facilities were two and a half times more likely to have a criminal conviction, and young people who attended a pupil referral unit were three and a half times more likely to have a criminal conviction. The regression analyses also showed that the odds of having a criminal conviction if young people are diagnosed with behavioural, emotional, or social difficulties are 1.590 times the odds of having a criminal conviction if young people do not have any special educational needs.

Risk-taking behaviour

Young people who had ever been recorded as having a substance misuse problem were four times as likely to have a criminal conviction compared to young people who had never had a substance misuse problem.

Conclusion

Young people in care are likely to have had a number of adverse childhood experiences while living with their birth families, and sometimes after entry into care; as a group, they have greater mental health needs than their peers in the general population. When defining good mental health, the young people interviewed for this study felt that good mental health could not be achieved without good physical health, and vice versa. Their definitions of good mental health reflected those of subjective well-being: feeling happy, feeling settled and safe in their placements, and feeling positive about their futures. They felt that in order to achieve good mental health it was important to have time to relax, to have hobbies and interests, to have supportive family and friends, and to have a trusted adult whom they could confide in.

The statistical analyses of the Children Looked After Dataset and National Pupil Database showed that more than half of the 2013 cohort had an 'abnormal' or 'borderline' mean SDQ score, indicating a high level of mental health difficulties among the care population. Risk-taking behaviour was also linked to mental health difficulties. Twelve per cent of young people in the 2013 cohort had a substance misuse problem recorded, and this was a significant predictor of

young people having a criminal conviction. Fifteen per cent of young people had a criminal conviction. Indicators of instability in the care system and in education were significantly associated with all three of these adverse outcomes. Multiple placement changes, being placed in residential care, having a higher proportion of fixed-term exclusions and unauthorised absences, attending alternative educational facilities, and having additional needs were all associated with having mental health difficulties, substance misuse problems and criminal convictions.

Young people's earlier adverse experiences meant that they had often not experienced the nurturing proximal processes that Bronfenbrenner and Morris suggest are necessary for children and young people's ongoing development. This meant that young people had often not had the interactions needed to understand and regulate their emotions. This may result in children and young people adopting certain behaviours as a means to survive their often hostile worlds (for example, they may withdraw and emotionally shut down to protect themselves from perceived harm). Such difficulties were described by most of the young people interviewed for this study. Around half of these young people had turned to self-harm behaviours as a means of dealing with their anger and frustration and recognised that they did not know how else to deal with it. Currently, administrative data only collects the difficulties score of the SDQ as a whole and not the individual subscales. Therefore, any distinctions between the subscales (such as internalising versus externalising emotions) cannot be seen.

Young people's earlier adverse experiences mean that young people may have a skewed view of the world, in which they do not trust adults to meet their needs, keep them safe and protect them from harm. In order to meet the mental health needs of children and young people in care, and to give them the best possible future, it is crucial that their primary caregivers (foster carers, kinship carers, and residential workers) receive adequate training on the impact of childhood trauma. It is also necessary for mental health support to be provided to children and young people at a time that is right for them, and to be offered more than once if they do not feel ready to engage with mental health services.

Currently no information is collected as part of the administrative data on young people's difficulties with sleep. However, sleep diaries completed by the young people who participated in interviews revealed that some young people in care were experiencing difficulties with their sleep (particularly falling or staying asleep). Young people felt that these difficulties were also linked to their earlier adverse experiences and commented on how bedtime was a time when they could not avoid thinking about their pasts or current worries.

The interviews conducted with young people in care also suggest that mental health services need to better personalise the support that they provide to children and young people in care. Although those who entered the care system during early childhood had positive memories of playing and doing art during their therapy sessions, those who entered care later struggled with the setup of counselling. They described how they disliked having to sit facing their therapist, and they also wanted to receive more advice and feedback rather

than being the only one to talk during their sessions. Other young people preferred to access what they perceived as being more normative mental health support, such as having sessions with the school counsellor. Despite the SDQ being used as a tool to identify young people in need of mental health support, currently no information is collected as part of the administrative data on which young people have been offered or accessed mental health support.

Chapter Seven has shown that the care system may be meeting the mental health needs of some children and young people in care. However, it has some way to go to meet the mental health needs of a vulnerable group of young people in care who experience instability and adopt risk-taking behaviour. The next chapter will explore the government policy has attempted to meet the health needs of children and young people and identify any characteristics and care or educational experiences that may be associated with health assessments, dental checks and immunisations being up to date.

Chapter Eight: How has the English government attempted to meet the health needs of children and young people in care?

Chapter Eight considers factors at the exo (the complex nature of having multiple professionals involved in the lives of children in care) and macro levels (how the government has attempted to meet the health needs of young people in care) of Bronfenbrenner's ecological systems theory and how these may impact the health development of young people in care.

Introduction

Following on from the previous chapter in which we begin to understand the complexity of the health needs of children and young people entering care, this chapter looks at how the government has tried to meet the exceptional health needs of children and young people in care and monitor their access to health services. It evaluates the latest national guidance on promoting the health of children and young people in care (2015) and explores how this guidance is implemented in practice. It then explores the relevance of the data that is collected at a government level to monitor health and assesses the extent to which it helps us understand the health status of children and young people in care. The chapter then explores data which show how far, at Bronfenbrenner's exo-level, the care system might be ensuring that the health needs of children and young people in care are adequately met. A regression analysis of administrative data submitted for annual statistical returns is presented. The data presented in this chapter can help us understand how far the care system

as a whole attempts to meet the health needs of children and young people in care, and the structural problems which prevent it from doing so.

The Exosystem

The next level in the current framework, adapted from Bronfenbrenner and Morris's (2006) ecological systems theory, is the exosystem. The exosystem refers to settings in which children are not directly involved but that still have an impact on the immediate environments in which they develop health behaviour. A common example of an exosystem is a parent's workplace. The child may not go to work with their parent but the workplace may still affect the child's development in terms of the family's income, the number of hours the parent needs to work, and the emotional impact that work may have on the parent (for example, how stressful they find their work). For children and young people in care, the exosystem becomes far more complex because there is a whole range of professionals and systems working behind the scenes of their everyday lives with their primary carers (see Chapter One for a full list of professionals that may be working with children and young people in care). The current thesis proposes that within the Exosystem there are different levels that exist. These levels are based on how closely they co-exist with the child's microsystem. These levels may include:

- 1) The primary caregiver level: any training attended on the mental and physical health of children and young people in care, their own perceptions of health and health behaviours, and the number of different caregivers the child has been placed with.

- 2) The child's social worker level: their own perceptions of health and health behaviours, their workload and how much time they can give to the child or young person, as well as the number of different social workers that children and young people have had.
- 3) The supervising social worker level: their own perceptions of health and health behaviours, the level of support they give to the primary caregiver, and their awareness of training events taking place for caregivers on the health of children and young people in care.
- 4) The local authority level: their corporate parenting ethos, policies relating to the physical and mental health of children and young people in care, submitting data to the annual statistical return, Ofsted inspections, and inter-agency communication and availability of specialist services and resources.
- 5) The specialist health services level: training and supervision of named and designated health professionals, Care Quality Commission inspections, type of paperwork completed during health assessments, and inter-agency communication.

All of these factors will impact on the quality of care that children and young people receive in the care system and may either help or hinder their health development. Furthermore, the complex network of professionals who are involved in each child's life can often, unintentionally, turn the care system into an impersonal one leaving children to feel different from their peers in the general population.

Approving foster and kinship carers who can promote children's health development

The assessing social worker plays a key role in promoting the health of children and young people in care. They assess each carer's ability to meet the needs of any children or young people placed in their care. However, the role of prospective carers' health perceptions and health behaviours in promoting the health development of children and young people placed in their care during day-to-day life can often be overlooked during the assessment. During the fostering assessment, prospective carers explore and reflect on their childhoods, past relationships, employment history, health, family and personal interests, and their support networks. The assessment has a focus on attachment styles and any unresolved childhood trauma. They also undergo a number of other checks including a medical check with their GP, checks with the Disclosure and Barring service, a health and safety check of the home, an assessment of any pets in the home, and references are sought from friends and family. Specifically, GPs (who assess the health of prospective carers) will look into any historical illnesses as well as assessing the prospective carer's current state of health (mental health, BMI, blood pressure, smoking status (including e-cigarettes) and alcohol consumption). All of the information gathered is written up into a report and submitted to the fostering panel. However, some social workers do not always explore how the carer's health behaviours will affect the child's health development (based on the researcher's own experience as an independent member of a local authority fostering panel). For example, they do not ask carers whether they have the ability to promote a healthy diet (what is their understanding of a healthy diet for children), whether

they understand the importance of sleep hygiene (what they consider to be appropriate bedtimes), and whether the children will be exposed to any negative health behaviours (binge eating, smoking or use of e-cigarettes, or higher levels of alcohol consumption).

This process can often differ for kinship carers. Since the introduction of The Children Act 1989, more emphasis has been placed on keeping children within the family. This has been further emphasised by legislation such as the Children and Young Persons Act 2008, and the implementation of statutory guidance on Family and Friends Care in 2011. In recent years, research has begun to explore the outcomes of children placed with kinship carers in comparison to children placed with 'stranger' foster carers. For example, in a systematic review, Winokur, Holtan, and Batchelder (2014) concluded that children in kinship care experience fewer behavioural or mental health problems, greater well-being, and greater placement stability. Little attention has been given to the health outcomes of children in kinship care. The assessment process is often different for kinship carers as children and young people are usually placed with them before they have been fully assessed. This is due to the children and young people needing to be placed with them in an emergency. Hence, kinship carers are often temporarily approved by the service manager while they undergo the full assessment (in accordance with Regulation 24 of the Care Planning, Placement, and Case Review (England) Regulations 2010). Due to the nature of emergency situations, young children can often end up living within a smoking environment, despite policies recommending that children under five or children with disabilities or health conditions should not

be placed within a smoking household. This can be problematic for fostering panels who then have to consider whether the potential impact of smoke on a young child's lungs should outweigh the impact of removing them from their kinship carer and placing them with carers that they do not know (from the researchers experience as an independent fostering panel member).

After reading the reports submitted by the assessing social worker, the fostering panel make a recommendation to the agency decision maker about whether the prospective carers should be approved or not. Carers are invited to attend panel to answer any further questions and to express why they wish to care for children and/or young people. In order to fulfil its role, the fostering panel should have access to medical expertise and legal advice. Having a designated or named health professional sit on the fostering panel can ensure that any unmet health needs of children and young people are dealt with promptly. The health professional can also explain complex medical jargon to other panel members, and they are likely to already know the children and young people that kinship carers are looking after. However, it is not a legal requirement to have a health professional sit on the fostering panel and so health services are often reluctant to allow these professionals to attend panel during work hours.

The role of the primary caregiver in promoting the health of children and young people in care

Primary caregivers were identified by the young people interviewed for the current study as playing a key role in promoting their health and changing any negative health behaviours (see Chapter Nine). Yet, the statutory guidance on

promoting the health and well-being of children and young people in care (2015) does not recognise the importance of this role or outline the responsibilities that carers have in promoting their health development in their day-to-lives. Although it does state that carers require regular training on the emotional and mental health needs of the children and young people they look after, no attention is given to the importance of training on physical health. However, the guidance does require that carers are provided with information on each child and young person's health needs.

As seen in Chapters Five and Six, the most vulnerable children and young people in the care system often end up in residential care. They are more likely to have mental health needs and to adopt risk-taking behaviours. Yet, residential carers are not required to go through the same extensive assessment as foster or kinship carers nor are they required to hold any relevant qualification. The Guide to the Children's Homes Regulations including the Quality Standards (2015) states:

"The registered person must ensure that staff have the relevant skills and knowledge to be able to: respond to the health needs of children; administer basic first aid and minor illness treatment; help children to manage long-term conditions and where necessary meet specific individual health needs arising from a disability, chronic condition or other complex needs."

(Department for Education, 2015b, p. 34)

However, apart from having at least one staff member with a first aid qualification on site at all times, the training recommendations for residential workers remain vague. Yet, residential workers have a duty to help the children

in their care understand their health behaviour and to support them to make changes where necessary (for example, healthy eating, sexual health, and substance misuse). More attention needs to be given to the training needs of residential workers.

The role of social workers in promoting the health of children and young people in care

The role of children's social workers

According to the statutory guidance on promoting the health and well-being of children and young people in care (2015), children's social workers have a duty to ensure that the children and young people they are responsible for have their physical, emotional and mental health needs assessed and have a health plan drawn up outlining how any identified health needs will be addressed. They should also ensure that young people's health plans are reviewed annually in line with the care planning requirements. Children's social workers are also required to work with the young person, foster or kinship carers, residential workers, birth parents (only if appropriate) and health professionals to ensure that all relevant information can be formulated into the health plan. They must also gain the necessary consent forms and delegated authority permission forms so that delays in treatment can be avoided. However, in practice, children's social workers often find themselves with an extremely large workload and are constantly having to prioritise those children in immediate need. This can mean that less consideration is given to the physical health of the children and young people that they are responsible for. Moreover, the large workload means that children's social workers often burn out or move onto

other roles, leaving children to experience another form of instability within the care system. This is of particular concern for the most vulnerable children and young people in the care system who may already be experiencing placement instability, and therefore may not have a stable adult in their life. Clarke (2019) found that 27 per cent of children in care had experienced two or more changes in social worker during a one-year period.

The role of Supervising Social Workers

Supervising social workers work primarily with foster and kinship carers, providing them with emotional and practical support to promote the physical, emotional and mental health of children and young people on a day-to-day basis. Supervising social workers should make sure that the carers are clear about what health care decisions have been delegated to them, and what decisions need to be made by the local authority. They should also provide contact details for the designated and named health professionals, and the 'looked-after children' team (including out-of-hours for urgent matters). The statutory guidance on promoting the health of children and young people in care (2015) also states that supervising social workers should make sure that carers understand that it is the carer's responsibility to ensure that a young person attends their health assessment and any other health checks or treatment needed. Supervising social workers also play a role in recommending training for carers and monitoring the carer's ability to meet the needs (including health needs) of the children and young people that they are caring for.

The role of local authorities in promoting the health of children and young people in care

The corporate parenting ethos behind local authority services

At the heart of services provided by local authorities to children and young people in care should be their corporate parenting ethos. Corporate parents are professionals within the council including elected members, employees and partner agencies, who all have a collective responsibility to provide the best possible outcomes for the children and young people in their care. Staff are encouraged to consider whether the care that their children and young people are receiving would be good enough for their own children:

“A strong ethos of corporate parenting means that sense of vision and responsibility towards the children they look after and their care leavers is a priority for everyone. They recognise that looked-after children have the same needs – to be loved, cared for and feel safe - as other children. But also that there are unique challenges that looked-after children and care leavers face... Local authorities that have a strong corporate parenting ethos recognise that the care system is not just about keeping children safe, but also to promote recovery, resilience and well-being.”

(Department for Education, 2018, p. 6)

The concept of corporate parenting first came from the Children Act 1989 but was later emphasised within the Quality Protects programme (1998). The Quality Protects programme was a five-year policy initiative, accompanied by a programme of research, designed to transform the management and delivery of local authority services, with a view to improving the quality of care provided to children and young people looked after in the care system.

In 2018 the Department for Education released statutory guidance on applying corporate parenting principles to children and young people in care; this sets out seven principles that local authorities must consider when exercising their duties:

- 1) *“to act in the best interests, and promote the physical and mental health and wellbeing, of those children and young people;*
- 2) *to encourage those children and young people to express their views, wishes and feelings;*
- 3) *to take into account the views, wishes and feelings of those children and young people;*
- 4) *to help those children and young people gain access to, and make the best use of, services provided by the local authority and its relevant partners;*
- 5) *to promote high aspirations, and seek to secure the best outcomes, for those children and young people;*
- 6) *for those children and young people to be safe, and for stability in their home lives, relationships and education or work;*
- 7) *to prepare those children and young people for adulthood and independent living.”*

(Department for Education, 2018, p. 8)

Specific guidance has been developed around promoting the health of children and young people in care. The latest guidance (2015) mainly focuses on mental health and wellbeing. It advises local authorities to work in partnership with health services to ensure that children and young people have their health needs met and that they are able to access health services. However, it does not define physical health or provide best practice examples of how local authorities can promote the physical health of children and young people in their care. In order to help young people develop a sense of identity, local authorities are encouraged to provide their children and young people access

to sport, leisure and cultural activities. Such activities could also promote their physical health.

As corporate parents, local authorities should ensure that the children and young people in their care receive the care and support they need in order to thrive. They also have a duty to safeguard and promote the health and welfare of their children and young people. In order to do this they need to ensure that they have effective systems and policies in place. This includes the process in which care plans are developed and reviewed (care plans must also include individual health plans). Before children and young people enter the care system or change placement the local authority should (whenever possible) notify the child or young person's GP and notify the responsible CCG (and receiving local authority and CCG if the child or young person is moving outside of the local authority boundary) that they are now a looked after child or young person. If young people enter care or need to move placements in emergency situations, local authorities are encouraged to inform the relevant partners within five days.

Once young people enter the care system, local authorities are responsible for making arrangements for them to have their physical, emotional and mental health needs assessed to ensure that they have a health plan drawn up before their first statutory 'looked-after child' review. The initial review for children and young people in care must take place within 20 working days of the child or young person entering local authority care, and Independent Reviewing Officers should be sent the health plan at least three days before the review.

So, young people should attend their initial health assessment within 17 working days from when they entered the care system.

As outlined in Chapter Seven, in accordance with the statutory guidance on promoting the health and well-being of children and young people in care, local authorities have a responsibility to ensure that each child or young person's carer completes a two-page version of the Strengths and Difficulties Questionnaire before they attend their health assessment (and this difficulties score is submitted as part of the administrative data). The local authority is also responsible for discussing any concerns raised by the IRO with the designated nurse, to ensure that issues are addressed in a timely manner.

The Macrosystem

The Macrosystem refers to wider society as a whole. It includes factors such as socioeconomic status and poverty. For children in care in England this is largely impacted by the government including policy initiatives on promoting the health and well-being of children and young people in care, how often policy initiatives are updated, and what data they collect at a national level sit at the macro-level in this thesis.

How has the government tried to meet the exceptional health needs of children in care?

Chapters Six and Seven have shown the complexity of the health needs of the children and young people who enter the care system. These exceptional health needs have long been documented (Chambers et al., 2010; Hill &

Thompson, 2003; Lewis, 2000). Children and young people entering the care system may be malnourished, obese, have dental cavities, physical injuries, mental health difficulties, and outstanding vaccinations. They may have experienced abuse, neglect, poverty, parental ill health, parental death, domestic violence, and/or been exposed to toxic substances (both before and after birth). There is an ever-growing literature on the negative long-term health outcomes of adverse childhood experiences (Almuneef, 2014; Annerbäck, Sahlqvist, Svedin, Wingren, & Gustafsson, 2012; Chapman et al., 2011; Clark, Thatcher, & Martin, 2010). In response, policy makers have had to consider how corporate parents can best meet the exceptional health needs of the children and young people in their care. The Care Planning, Placement and Case Review (England) Regulations (2010) set out a legal requirement for the responsible authority to arrange for the children and young people in their care to have their health needs assessed and regularly reviewed by a registered medical professional (these are known as health assessments).

Assessing the health needs of looked after children

One of the major policy initiatives developed to promote the health and well-being of children and young people in local authority care, was the development of specialist health teams who are required to assess and regularly view the health needs of children and young people in care.

Initial health assessments

In accordance with the 2015 statutory guidance on promoting the health and well-being of children and young people in care, the initial health assessment

must be conducted within 20 working days of a child or young person entering the care system and must be conducted by a paediatrician. The initial health assessment is designed to identify any unmet or ongoing health needs and to ensure that a health plan is drawn up identifying who is responsible for taking action. For example, the child or young person may need to be referred to Child and Adolescent Mental Health Services, and the health plan will list who needs to make that referral and by when. As shown in Chapter Two the health assessment should address the health topics that are specified in Section 1 of Schedule 1 of the Care Planning, Placement and Case Review (England) Regulations 2010. These include, but are not limited to:

- The child's physical, emotional, and mental state;
- The child's health history as well as any known family history;
- Ensuring routine checks have or will take place:
 - Dental checks
 - Immunisations

Review health assessments

After their initial health assessment, children and young people aged five and over are required to attend a review health assessment annually. Children under five are required to attend a bi-annual review health assessment that incorporates a developmental element. Unlike initial health assessments, review health assessments can be conducted by the named or designated nurse for children and young people in care. In the latest statutory guidance,

professionals are offered guidance about areas that need to be addressed. This includes recording information about:

- The child's current state of health – physical and emotional health and well-being.
- The child's medical history (including any family history).
- The effect of the child's health on their development.
- Any existing arrangements for the child's health, dental care, and immunisation status, and any planned changes to these arrangements.
- The responsibilities of each professional in promoting the child's health and well-being.

However, this statutory guidance simply recommends general areas that need to be addressed during health assessments and does not offer a standardised format for information to be recorded. This means that health assessments undertaken may vary enormously between local authorities and may unnecessarily promote health inequalities (Brown et al., 2005).

Research demonstrates that comprehensive health assessments can improve the likelihood of children and young people in care being referred to suitable services (Croft, 2009; Eichler, 2011; Elertson, 2017; Everson-Hock et al., 2012; Hill & Watkins, 2003). However, they do not always have an advocate (birth parent or foster parent) who will request assessments and follow up treatments on their behalf. It is therefore essential health and social care services work together holistically to ensure that the children and young people in their care

can access the services they need (Glisson, 1994). Furthermore, due to their traumatic pasts, children and young people in care can often present unusual and challenging behaviour, and placement breakdowns are common in the social care system (only 17% of the 2013 cohort had remained in the same placement or had one placement change, and one young person was recorded as having 92 placement changes). These changes in placement can result in lost or incomplete health information and treatment because children and young people will usually need to transfer to a new GP (Kools et al., 2013b; Ward, 2009).

Although Government policy and legislation is designed to have indirect effects on young people via the professionals around them (such as foster carers and social workers), this may be limited in effectiveness due to the lack of explicit guidance for foster carers and social workers on promoting young people's health and the lack of provision of best practice examples on promoting physical health.

How is the government attempting to monitor the health of children in care?

Each year ending 31 March, local authorities are required to submit data to the Department for Education for the annual statistical return. Data relating to health includes whether the child or young person:

- Attended a health assessment in the last 12 months
- Attended a dental check in the last 12 months

- Is up to date with their immunisations
- Has a substance misuse problem
- Has received a substance misuse intervention
- Was offered a substance misuse intervention
- Received a criminal conviction
- Is a young mother
- The child's Strengths and Difficulties Questionnaire score

Although these data do not allow us to understand the health status of children and young people in the care system, they do allow us to see what access they have to routine and specialist health services, the prevalence of mental health difficulties among the care population, and the rate of risk-taking behaviour among the care population. One might also assume that being up to date with health assessments, dental checks, and immunisations would result in the child having their health needs met. These data give some indication as to who might need specialist mental health support, but they do not show who actually receives this support. These data also do not show who might need specialist physical health support or who receives it. However, these data allow the government to evaluate policies and monitor objectives for children and young people in care.

Analyses of administrative data collected by local authorities

The rest of this chapter analyses national data collected for this purpose. It specifically focuses on the data available for health assessments, dental checks, and immunisations for one cohort of 4847 young people who were aged

16 on the 31 March 2013 and who had been looked after continuously for at least 12 months from 1 April 2012 to the 31 March 2013.

Health Assessments

Figure 25 shows the proportion of health assessments that were up to date over a five-year period for the cohort analysed for this research: these figures are based on the proportion of health assessments that were up to date for the young people who had been in care for at least 12 months on the 31 March each year. It does not include the young people who had not yet entered care or young people who had been in care less than 12 months. For example, of the 2924 young people who were in care (and had been for at least 12 months) on the 31st March 2009, 2174 young people were up to date with their health assessment (89%) and 271 young people were not up to date with their health assessment (11%) (479 young people had missing data). The exclusion of young people who had not yet entered care or had not been in care for at least 12 months also apply to the analyses for dental checks and immunisations.

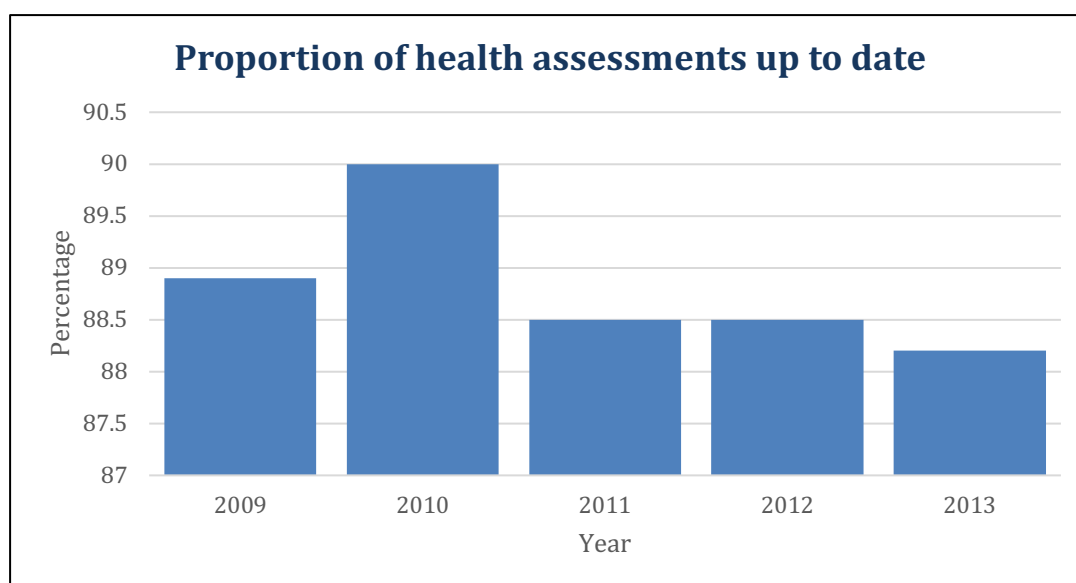


Figure 25: Proportion of health assessments up to date for the 2013 cohort from 2009 to 2013

The data shown in Figure 25 indicate that over the five years of data collected, the proportion of health assessments that were up to date never exceeded 90 per cent. The sudden spike in the year ending 31 March 2010 is likely to reflect the implementation of the new statutory regulations. However, the other years show a steady decline in the proportion of health assessments that were up to date, from nearly 89 per cent in 2009, to 88.5 per cent in 2011, to 88.2 per cent in 2013. At first glance it would appear that young people start to disengage with health assessments as they become older.

Dental Checks

Figure 26 shows the proportion of dental checks that were up to date over a five-year period for the cohort analysed for this research. Again, these figures are based on the proportion of dental checks that were up to date for the young people who had been in care for at least 12 months each year. Of the 2809

young people who had been in care for at least 12 months on the 31 March 2010, 2456 were up to date with their dental checks (87.4%).

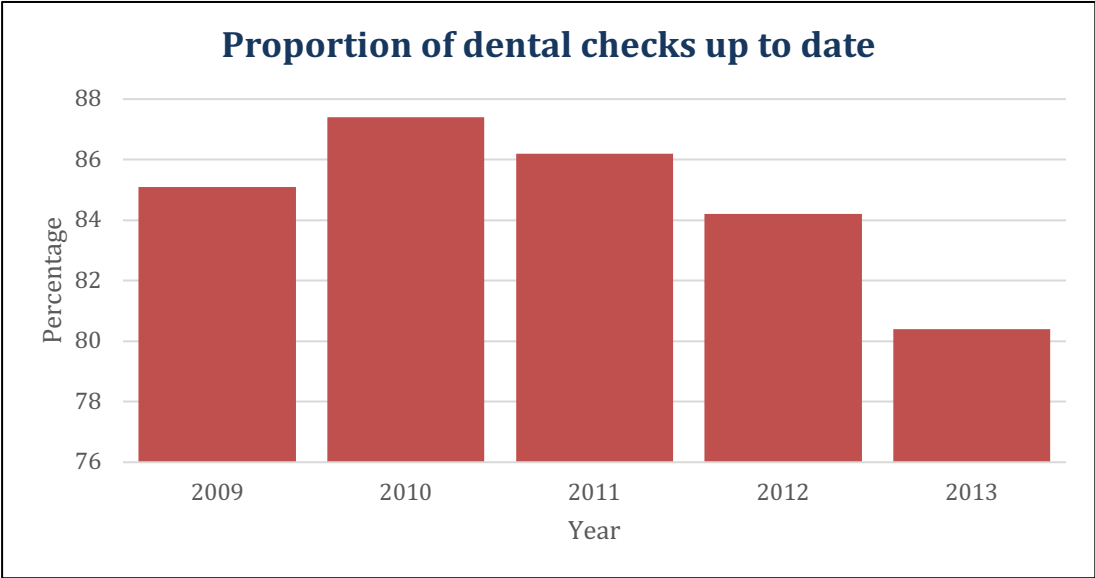


Figure 26: Proportion of dental checks up to date for the 2013 cohort from 2009 to 2013

The data shown in Figure 26 show that over the five-year period, the proportion of dental checks that were up to date never exceeded 87 per cent. As with health assessments, the proportion of dental checks that were up to date increased from 85 per cent in 2009 to 87 per cent in 2010. This too is likely to reflect the implementation of the new statutory regulations. After this, there was a steady decline in the proportion of dental checks that were up to date, from 86 per cent in 2011, to 84 per cent in 2012, and 80 per cent in 2013. It would appear that young people's engagement with dental health services also declines with age.

Immunisations

Figure 27 shows the proportion of immunisations that were up to date over a five-year period for the cohort analysed for this research. Again, these figures are based on the proportion of immunisations that were up to date each year (in accordance with the governmental immunisation schedule) for the young people who had been in care for a minimum of 12 months. For example, of the 3300 young people who had been in care for at least 12 months on the 31 March 2011, 2659 were up to date their immunisations (80.6%).

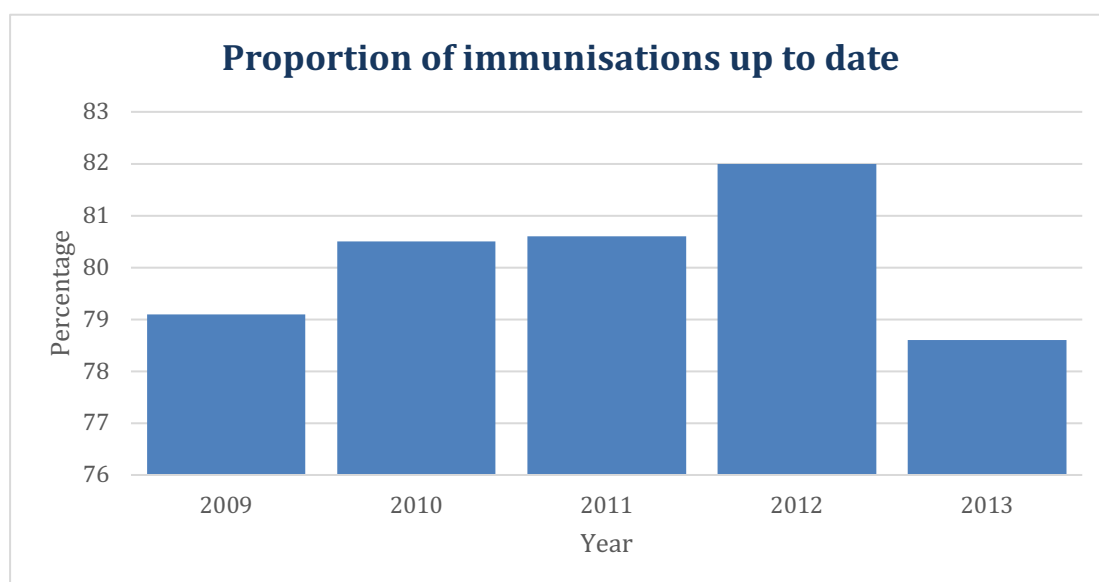


Figure 27: Proportion of immunisations up to date for the 2013 cohort from 2009 to 2013

The data shown in Figure 27 show a steady increase in the proportion of immunisations that were up to date from 79 per cent in 2009, to 80 per cent in 2010, 80 per cent in 2011, and 82 per cent in 2012. However, there is a significant decline in 2013 with only 78 per cent of young people up to date with immunisations. Being up to date with immunisations is more complex than health assessments or dental checks; if young people entering care have not

previously received any vaccinations then these would likely need to be given over several months. This requires young people to have access to and engage with the relevant service multiple times rather than just once for a health assessment, or twice for dental checks. It could be that young people have received some vaccinations since entering care but not everything listed on the immunisation schedule produced by the Department of Health.

Experiences of the care system

Of the 4847 young people in the cohort selected from the national database, 391 (8%) had been placed with their parent/s at some point over the five years covered. Young people who had ever been placed with parents had a significantly lower proportion of dental checks up to date (74%) than those who had not (84%, $t(462.953) = 6.624$, $p < .001$). However, there was no significant difference in the proportion of health assessments or immunisations that were up to date between those who had been placed with parents and those who had not. It is plausible that young people had caught up with any outstanding immunisations during their previous period in care.

Placement history	N	Proportion of health assessments up to date	Proportion of dental checks up to date	Proportion of immunisations up to date
Ever residential care	1490	86% (a**, b**)	79% (a***, b***)	74% (a***)
Always foster or kinship care	1905	89% (a**)	85% (a***, c*)	77% (b**)
Other	1447	89% (b**)	83% (b***, c*)	80% (a***, b**)

Table 13: The effect of placement history on the proportion of health assessments, dental checks and immunisations up to date³

* $p < .05$, ** $p < .01$, *** $p < .001$

Placement history also had a significant effect on the proportion of health assessments ($F(2, 4839) = 8.070, p < .001$) dental checks ($F(2, 4839) = 21.535, p < .001$) and immunisations ($F(2, 4839) = 11.125, p < .001$) that were up to date. As shown in Table 14 post hoc comparisons using the Games-Howell test indicated that young people who had ever been placed in residential care were significantly less likely to be up to date with health checks and dental checks than those who had always lived in foster or kinship care or those who had lived in other types of care. Young people who had always been in foster or kinship care were significantly *more* likely to be up to date with dental checks than those in other types of care. It could be that foster parents take on the role of ensuring their young people are up to date and advocate for them:

“I have [health assessments] at home, in my lounge. That way [foster] mum can keep track directly in her diary, she keeps track of everything.”

[Bart, aged 14]

³ The superscript (raised) letters in the table show which groups were significantly different from one another for each outcome. For example, for the proportion of health assessments that were up to date ever being placed in residential care (a**) was significantly different to those always placed in foster or kinship care (a**).

However, young people who had always been in foster or kinship care were significantly less likely to be up to date with immunisations than those in other types of care. Table 14 shows that foster and kinship care appear to be somewhat of a protective factor while residential care seems to be somewhat a risk when it comes to young people's access to specialist health services. However, by looking at Table 15 we can see that young people who have always been in foster or kinship care have experienced a significantly more stable journey through care, whereas young people who have ever been in residential care have had a significantly more unstable journey through care. Both the young people who had ever been in residential care and the young people who had always been in foster or kinship care had spent a similar number of years in care but there was still a significant difference between young people's placements and their access to health services ($F(2,4844) = 247.503, p < .001$). However, young people in residential care had entered care an average of three times compared to young people in foster or kinship care who only entered care once ($F(2,4844) = 19.316, p < .001$). Young people in residential care had also experienced an average of seven placements compared to young people who had always been in foster or kinship care who had only experienced an average of three ($F(2,4844) = 435.540, p < .001$). Similarly, young people who had ever been in residential care had spent around five per cent of their time in care in respite placements, compared to young people who had always been in foster kinship care who had only spent an average of two per cent of their time in care in respite placements ($F(2,4844) = 55.719, p < .001$).

	N	Mean number of years in care	Mean number of entries in care	Mean number of placements	Mean number of respite placements
Ever residential care	1492	4.57(a**,b***)	2.90(a***,b***)	7.13(a***,b***)	.05(a***,b***)
Always foster or kinship care	1908	4.96(a**,c***)	1.29(a***)	2.59(a***,c***)	.02(a***)
Other	1447	7.39(b***,c***)	1.41(b***)	5.04(b***,c***)	.02(b***)

Table 14: Indicators of stability based on placement type

* $p < .05$, ** $p < .01$, *** $p < .0014$

Further analyses showed that the more times young people had entered care, the lower the proportion of health assessments up to date ($r = -.040$, $p < .01$). Although the proportion of dental checks and immunisations up to date was not likely to be any less. Similarly, more placement changes while in care was linked to a lower proportion of health assessments ($r = -.066$, $p < .001$) and dental checks ($r = -.053$, $p < .001$) being up to date. But, the number of placements young people had experienced were not related to the proportion of immunisations that were up to date. In addition, young people whose latest placement had lasted longer also had a higher proportion of health assessments ($r = .062$, $p < .001$) dental checks ($r = .100$, $p < .001$) and immunisations ($r = .134$, $p < .001$) up to date. In summary, the preceding few paragraphs show the importance of stability, which was also shown for mental health and risky behaviours in Chapter Seven. This also resonated with the young people who participated in the interviews. Young people who had been

⁴ The superscript (raised) letters in the table show which groups were significantly different from one another for each outcome. For example, for the mean number of years in care, ever being placed in residential care (a**) was significantly different to those always placed in foster or kinship care (a**).

in care the longest and also either remained in one placement or had been in their placement for a significant amount of time, described feeling part of the family and trusting their foster parents which may explain why they are more likely to be up to date with their checks. The young people who had developed secure attachment styles with their foster parents described them as having a key role in teaching them to be healthy:

“[C]arers can recommend what you, what you do and what you don’t do, and like I think if you’re going out and, you know, there are some foster kids that go out and get drunk every day, you know, it’s the foster carers job to recommend that they don’t do that and try and help them stop. So that, you know, that’s an influence and even if people still do it at least they know what they’re doing is wrong. Like even if it’s on a more subconscious level and they don’t realise at first that what they’re doing is wrong. At least now they know that actually they’re causing themselves harm.”

[Mulan, aged 18]

There was also a significant and positive association between the number of years a young person had spent in care and the proportion of health checks ($r = .034, p < .05$), dental checks ($r = .085, p < .001$), and immunisations ($r = .194, p < .001$) that were up to date. Time in care was also linked to reasons for entering care; the amount of time that young people had been in care was significantly different depending on the reason they entered care ($F(4, 4840) = 126.625, p < .001$). Bart gives an example of how entering care at a young age (and spending more years in care) can impact on health behaviours, which illustrates (as covered in Chapter Six) the role of proximal processes:

“[We learn health behaviour from] our birth parents or from your foster parents – it depends who you’ve lived with the most. Like ‘cos children in care, some people are taken in from like the age of five, some people are taken in from the age of ten. So, they will learn a) from their birth parents if they are taken during older years or b) from their foster carers if they are taken during younger years. So, that way they learn more information from their foster parents or their real parents because my sister is, my younger sister, she came into care four years ago and she was about eight when she came into care. So, she is still very picky, like doesn’t like many foods, like her parents from what I understand. But, her younger brother came into care when he was two and a half (at the same time) but he’s not picky anymore, he likes everything and anything, and he just, everything that [foster mother] likes he likes because he’s been brought up with that background and just knowing that food. And he isn’t as picky as [foster sister]. So, it’s like you can see like from young to old the amount of change that’s happened.”

[Bart, aged 14]

Table 16 shows the mean number of years young people had been in care, based on the reason they entered care. Young people who entered care due to abuse and/or neglect had also been in care for a longer period of time. So, they may be more likely to have a higher proportion of health assessments up to date due to professionals and foster carers targeting their health over a longer period of time. However, young people who entered care due to anti-social behaviour had also been in care for a much shorter period of time and were most likely to have a lower proportion of health assessments up to date. It is plausible that their challenging behaviour makes it more difficult for professionals to engage with them, and as professionals have not had as long to work with them, they are less likely to change their health behaviour.

Reason for entry into care	Mean number of years spent in care	Proportion of health assessments up to date	Proportion of dental checks up to date	Proportion of Immunisations up to date
Abuse and/or neglect	6.5(a ^{***} ,b ^{***} ,c ^{***})	89%(a ^{**})	84%(a [*])	80%(a [*] ,b ^{***} ,c ^{***})
Anti-social behaviour	2.5(a ^{***} ,d ^{***} ,e ^{***})	85%	79%	67%(a [*])
Parenting capacity	4.5(b ^{***} ,d ^{***})	87%(a ^{**})	82%(a [*])	75%(b ^{***})
Other reasons	4.5(c ^{***} ,e ^{***})	88%	82%	69%(c ^{***})

Table 15: Proportion of health assessments, dental checks, and immunisations based on reason for entry into care and mean number of years spent in care

* $p < .05$, ** $p < .01$, *** $p < .0015$

Young people who entered care due to anti-social behaviour were also more likely to have a criminal conviction. So, a number of these young people may have been detained in custody. Young people in care who go on to become young offenders and young people placed in secure settings are deregulated from the health arrangements for children in care. Instead, those responsible for the care of young people in secure settings are responsible for carrying out a Comprehensive Health Assessment Tool (CHAT) and creating a CHAT care plan outlining their health needs for those directly involved in their care. However, communication and the sharing of health information between the specialist health service for children in care and secure units has been historically poor. Communication between different parts of the exosystem is essential to child development, yet the number of professionals at the exo-level for young people in care is far greater than for those outside of the care system.

⁵ The superscript (raised) letters in the table show which groups were significantly different from one another for each outcome. For example, for the proportion of health assessments that were up to date entering care due to abuse or neglect (a^{**}) was significantly different to those who entered care due to reduced parenting capacity (a^{**}).

Young people who had ever received a conviction had a significantly lower proportion of health assessments ($t(951.372) = 3.742, p < .001$) and dental checks ($t(4840) = 3.650, p < .001$) up to date. It is not clear whether young people in secure settings are still included in the health data collected by local authorities and so it is not clear if this difference is because young people have not been able to attend a health assessment or dental check.

One difficulty that authorities face in providing their young people with specialist services, is ensuring that those placed out of area receive specialist services that they consider to be of high standard and in a timely manner. When a young person is placed out of area the originating CCG is still responsible for ensuring that specialist services are provided to them. Depending on distance, some specialist health professionals will travel to undertake the assessment themselves. When this is not possible, the national guidance on promoting the health and well-being of looked after children states:

“CCGs, NHS England and NHS service providers have a duty to comply with requests from local authorities in support of their statutory requirements. Where a looked after child is placed out of area, the receiving CCG is expected to cooperate with requests to undertake health assessments on behalf of the originating CCG.”

(Department for Education & Department of Health, 2015, p. 16)

In practice this may not always be as clearly defined because the originating CCG is expected to pay a fee to the receiving CCG for their service, and as Chapter One showed, there is not a standardised health assessment form and different CCGs have different expectations. If the local authority responsible for

the young person does not have the resources available to place them, they may call upon an independent or voluntary fostering agency or another local authority for a placement. Narey and Owers (2018) found that although at a national level there was not a shortage of foster carers in England, at a local level there were areas without sufficient numbers of carers, or insufficient numbers of carers equipped to look after children and young people with complex needs, and other areas with carers without a child or young person in placement. When there is not a placement available a young person may be placed away from their local authority area. The further away a young person lives from home, the harder it is for direct support from their 'home' services (such as education and health professionals) to be implemented and sustained. There may also be serious delays in securing support locally to promote education and emotional wellbeing. Issues have been identified in securing Child and Adolescent Mental Health Services for young people living out of area. This is normally due to lengthy disputes regarding funding. While the originating local authority is responsible for funding such services, there can be varying costs across the country, meaning lengthy negotiations (Ofsted, 2014).

Looked after children's nurses have raised concerns about the difficulties in completing health assessments for their young people who are placed out of area. Some designated nurses will liaise with the team where the young person is placed to see if they are able to complete it for them. However, due to services being stretched they are not always able to do so, even when payment has been offered. Some nurses have had to travel hundreds of miles to conduct health assessments with young people placed out of their area. However, there

is not always the capacity to do so meaning some young people do not have an up-to-date health assessment (Royal College of Nursing & Royal College of Paediatrics and Child Health, 2015).

In order to try and reduce delays and conflicts between CCGs NHS England and NHS Improvement devised and mandated a payment schedule (for many services not just children and young people in care) and also created a health assessment checklist tool for receiving CCGs in order that they are undertaken to a certain standard.

	N	Proportion of health assessments up to date	Proportion of dental checks up to date	Proportion of immunisations up to date
In local authority boundary at KS4	2736	89%*	82%**	78%**
Outside of local authority boundary at KS4	2106	87%*	84%**	75%**

Table 16: Proportion of health assessments, dental checks and immunisations up to date based on placement location at key stage 4

* $p < .05$, ** $p < .01$, *** $p < .001$

As shown in Table 17 young people who were placed out of area at key stage four had a significantly lower proportion of health assessments ($t(4414.829)=2.469$, $p < .05$) and immunisations ($t(4425.080) = 3.098$, $p < .01$) up to date than young people placed within their local authority are. However, young people placed out of their local authority area at key stage four had a

significantly higher proportion of dental checks up to date ($t(4654.483) = -3.091$, $p < .01$) than young people placed within their local authority area. All of the young people who participated in interviews were living within their local authority area at the time.

	N	Proportion of health assessments up to date	Proportion of dental checks up to date	Proportion of immunisations up to date
Never placed with an independent fostering provider	1981	90%***	84%**	79%**
Has been placed with an independent fostering agency	2861	87%***	82%**	76%**
Has been placed outside of own LA	3414	88%***	82%***	77%
Only ever placed with own LA	1428	90%***	85%***	77%
Never placed in another LA provision	4663	88%*	83%*	77%**
Has been placed in another LA provision	179	83%*	77%*	69%**

Table 17: Proportion of health assessments, dental checks, and immunisations up to date based on placements with an independent fostering agency

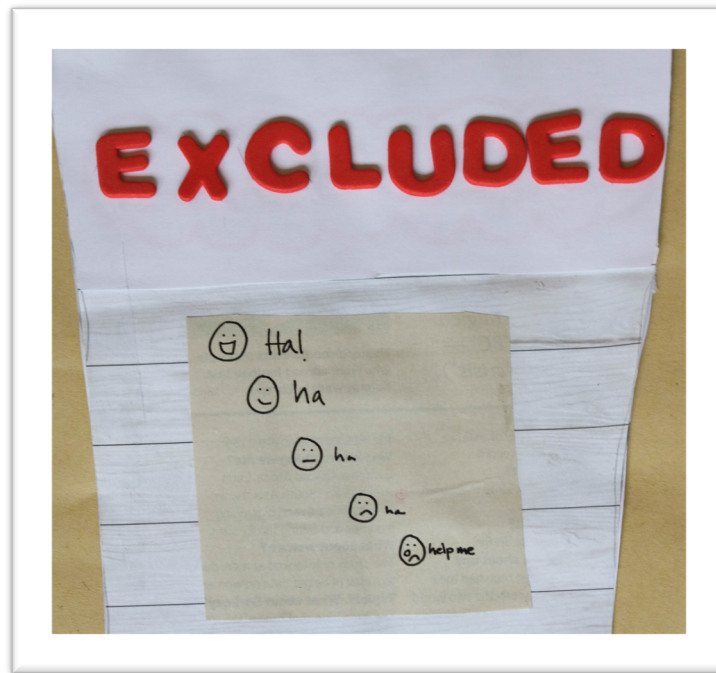
* $p < .05$, ** $p < .01$, *** $p < .001$

Table 18 shows that young people who had ever been placed with an independent or voluntary fostering provider had a significantly lower proportion

of up to date health assessments ($t(4577.916) = 4.119, p < .001$), dental checks ($t(4499.475) = 2.705, p < .01$) and immunisations ($t(4447.609) = 3.481, p < .01$). Young people who had been placed in another local authority provision also had a significantly lower proportion of health assessments ($t(187.005) = 2.464, p < .05$) dental checks ($t(187.806) = 2.568, p < .05$) and immunisations ($t(187.925) = 2.680, p < .01$) up to date. Moreover, young people who had only ever been placed in their own local authority provision had a significantly higher proportion of health assessments ($t(2798.343) = -3.498, p < .001$) and dental checks ($t(2794.613) = -3.778, p < .001$) up to date.

Experiences of education

There were also several educational factors that were associated with the proportion of health assessments that were up to date. As shown in Table 19, young people who had experienced a change of school between years 8 and 11 had a significantly lower proportion of health assessments ($t(1142.997) = 2.540, p < .05$) and immunisations ($t(1203.573) = 2.068, p < .05$) up to date than those who had not changed schools. One young man who participated in the study had experienced a high level of instability at home and in education, leading to him finally being excluded from mainstream education. He felt that it was important to include this in his collage:



[Baymax, aged 12]

	Proportion of health assessments up to date	Proportion of dental checks up to date	Proportion of immunisations up to date
Changed school in year 8-9 and/or 10-11	87%*	83%	76%*
Did not change school in year 8-9 and/or 10-11	89%*	83%	78%*

Table 18: Proportion of health assessments, dental checks, and immunisations up to date based on school changes

* $p < .05$, ** $p < .01$, *** $p < .001$

Moreover, young people with a higher number of fixed term exclusions had a significantly lower proportion of health assessments ($r = -.040$, $p < .01$), dental checks ($r = -.052$, $p < .001$), and immunisations ($r = -.028$, $p = .05$) up to date. Young people who had a higher number of unauthorised absences were also significantly more likely to have a lower proportion of health assessments ($r = -$

.050, $p < .01$), dental checks ($r = -.077$, $p < .001$) and immunisations ($r = -.081$, $p < .001$) up to date. It is worth noting that young people who had ever been placed in residential care had a higher proportion of unauthorised school absences than young people who had not ($t(1789.925) = -12.647$, $p < .001$) and those who had ever been placed in residential care were also more likely to be in other educational provisions as opposed to mainstream or special school ($t(1083.861) = -18.133$, $p < .001$). It would appear that residential care links many of the factors that indicate which young people may have a lower proportion of health assessments up to date, and so interventions to promote the engagement of young people in specialist health services could begin by focusing on the young people placed in residential care.

Young people in mainstream or special schools at Key Stage 4 had a significantly higher proportion of health assessments up to date (89%) than those placed in other educational provisions (85%), $t(1027.611) = 3.531$, $p < .001$. Moreover, young people whose first language was not English in 2004 had a significantly higher proportion of health assessments up to date (92%) than those whose first language was English (88%), $t(240.015) = -3.463$, $p = .001$.

Special educational needs occur on a spectrum and so it is difficult to link health behaviours to young people with special educational needs as a whole. However, we know that young people with complex or multiple disabilities simply do not have the opportunity to misuse substances. Young people with special educational needs are thought to be at greater risk of physical health

disorders and conditions, but also to have worse access to healthcare than their peers (Department for Education, 1999). Young people with learning disabilities have been found to be more likely to experiment with potentially harmful levels of alcohol and to be easily influenced by peer-pressure (Public Health England, 2016).

Young immigrants who have moved to a new country are thought to go through a process of acculturation – whereby they may be influenced by and incorporate the values and customs of their new country. Research suggests that as young people's English language proficiency increases, they are at increased risk of misusing substances (Myers et al., 2009). Young people whose first language is not English may also not understand how the healthcare system works or be aware that they can request an interpreter and so may not access healthcare services until prompted.

There was also a significant effect of primary special educational need on the proportion of health checks that were up to date, $F(2, 4805) = 6.902, p < .001$. Post hoc comparisons using the Games-Howell test indicated that those with behavioural, emotional and social difficulties had a significantly lower proportion of health assessments up to date (87%) than those without any special educational needs (89%, $p < .01$), and those with other types of special educational needs (89%, $p < .01$).

Regression analysis

Further analyses were conducted to explore whether any characteristics or experiences were associated with a higher proportion of health assessments, dental checks or immunisations being up to date. As young people had a range of available years of data available for a maximum of five years (as they had been in care for different amounts of time), a variable was created to capture the proportion of health assessments, dental checks, and immunisations that had been up to date during their time in care. On average, children and young people had up-to-date health assessments for 88 per cent of the possible 100 per cent of occasions during their time in care that these could have been up to date. However, children and young people had between one and five possible occasions recorded (i.e. one a year for up to five years). By way of illustration, if all the young people in the sample had five possible occasions for their health assessment to be up to date, then the figure of 88 per cent suggests that, on average, their health assessments were up to date on more than four out of the five possible occasions. For dental checks, the equivalent figure was 83 per cent and for immunisations it was 77 per cent.

Characteristics significantly associated with health assessments being up to date

In order to explore whether certain characteristics and care or educational experiences were associated with a higher proportion of health assessments being up to date, a stepwise multiple regression was conducted using SPSS. Table 20 shows the final model (block 6) of the regression analyses. The final regression model (block 6) of this analysis only accounts for 3 per cent of the

variance in the proportion of health assessments that were up to date ($F(6) = 11.960, p < .001$). This suggests that there are other factors not captured in the administrative data that may be better associated with the proportion of health assessments that are up to date. For example, this may include the reasons why some young people do not wish to engage with specialist health services (see chapter Nine). Nevertheless, the chapter will now explore the significant characteristics and experiences that were include in the model. The full regression model is included in Appendix Three.

	<i>B</i>	<i>SE B</i>	β
Block 6			
Constant	.912	.017	
Ofsted LA rating 2011	.013	.004	.078***
Age at first entry into care: 10+ (Reference group = Under five)	-.005	.011	-.017
Reason for first entry into care: UASC (Reference group = Abuse or neglect)	-.070	.018	-.083***
Local deprivation affecting children index 2004	.037	.017	.047*
Number of placements (excluding respite)	-.003	.001	-.079***
Total number of years spent in care	-.005	.001	-.120**

Table 19: Final regression model for the proportion of health assessments up to date

* $p < .05$, ** $p < .01$, *** $p < .001$

Pre-care experiences

The results of the regression analyses show that some pre-care experiences were associated with the proportion of health assessments that were up to date. For example, unaccompanied asylum-seeking children and young people had a lower proportion of health assessments up to date when compared to children and young people who had entered care due to abuse or neglect (by 7 per cent). This may be accounted for by the delays that unaccompanied asylum-

seeking young people face in accessing services when they first arrive in the country. For example, due to needing an interpreter present or due to placement moves caused by them arriving in an emergency. If a child is only going to be placed with a foster carer temporarily (less than four weeks) then they are likely to be informed that they do not need to register them with a GP. But until the young person is registered with a GP, they will not be given an NHS number and this can delay other treatments such as Tuberculosis screening. Health assessments can be conducted without an NHS number, but this may increase the risk of information not being passed on to the GP practice, as this will need to be done at a later date (based on Researcher's own experience as a foster carer).

Another pre-care experience associated with the proportion of health assessments that were up to date is the level of neighbourhood deprivation in 2004. Most of the children had not entered the care system at this point (only 1258 out of 4847 were in care). So, for most children this is based on their birth family's neighbourhood. Children who had scored higher on the Local Deprivation Affecting Children Index (indicating a higher level of deprivation) had a higher proportion of health assessments up to date. Research suggests that there is a strong link between poverty and health outcomes, for example, obesity, malnourishment, and dental neglect. This may indicate that professionals are able to target the children most in need of health treatment and ensure that they attend their health assessments.

Experiences of the care system

The results of the regression analyses show that experiences of the care system are associated with the proportion of health assessments that were up to date. For example, Ofsted ratings for local authority children services were significantly associated with the proportion of health assessments that were up to date, with local authorities that had received a rating of 'outstanding' being more likely to have children and young people with a higher proportion of health assessments up to date (by three per cent) when compared to local authorities who were deemed to be 'inadequate' in 2011.

The number of placement changes that young people had experienced was also associated with the proportion of health assessments that were up to date. For example, for each placement change a young person had, the proportion of health assessments that were up to date decreased (by -0.3 per cent per year). In the current cohort, young people had been in the care system between one and 16 years (with those in care for 16 years being associated with an eight per cent decrease in the proportion of health assessments that were up to date compared to those who had been in care for one year). So not being up to date with health assessments may not necessarily indicate a poor outcome for an individual young person. It is plausible that those in care for a longer period of time have experienced placement stability and may not wish to be treated differently from their peers (this concept of normality is explored further in Chapter Seven). Thus, young people who have experienced stability in the care system and developed secure attachments to their foster carer may be better placed to exercise choice in relation to potential stigma.

Characteristics significantly associated with dental checks being up to date

A stepwise multiple regression was also run using SPSS to explore whether any characteristics and care or educational experiences were associated with the proportion of dental checks that were up to date. Table 21 shows the final model (block 6) of the regression analyses. The variables in the regression model (block 6) of this analysis account for 3 per cent of the variance in the proportion of dental checks that were up to date ($F(6) = 11.141, p < .001$). This suggests that there are factors not captured in the current administrative data that may be better associated with attendance at dental checks. For example, being fearful of the dentist may result in disengagement or non-attendance. Nevertheless, the chapter will now explore the significant characteristics and experiences that were included in the model. The full regression model is included in Appendix Three.

	<i>B</i>	<i>SE B</i>	β
Block 6			
Constant	.891	.034	
Age at first entry into care: 10+ (Reference group = Under five)	-.024	.013	-.044
Length of last placement in years	.003	.002	.040
Whether child ever placed with parents (1 = No, 2 = Yes)	-.080	.021	-.081***
Whether child ever placed in residential care (1 = No, 2 = Yes)	-.034	.013	-.060**
Child's placement location at KS2 (1 = In LA boundary, 2 = Out of LA boundary)	.028	.012	.050*
School type at KS4: Pupil Referral Unit (Reference group = Mainstream school)	-.072	.023	-.068**

Table 20: Final regression model for the proportion of dental checks up to date

* $p < .05$, ** $p < .01$, *** $p < .001$

Experiences of the care system

The results of the regression analyses show that the types of placements used in care were associated with the proportion of dental checks that were up to date. For example, young people who had been placed with their parents had a lower proportion of dental checks that were up to date (by eight per cent). Chapter Four showed how most of the young people interviewed had developed a similar fear of the dentist to their parents, and that they had not previously attended dentist appointments regularly. This may explain why children who have been placed with their parents are associated with having a lower proportion of dental checks up to date.

The analyses also show that young people who had been placed in residential care had a lower proportion of dental checks that were up to date (by three per cent). These young people are likely to have experienced greater instability in the care system and may also have mental health needs. This may mean that dental appointments are not the priority, or that these young people are less willing to attend dental checks.

Conversely, children who had been placed out of their local authority area at Key Stage 2 had a significantly higher proportion of dental checks that were up to date (by three per cent). It is plausible that these children are in specialist types of care due to their disability as 62 per cent of children who were placed outside of their local authority boundary were diagnosed with a disability. This

may mean that these children are not given a choice about attending their dental appointments.

Experiences of education

Young people who had attended a pupil referral unit at key stage 4 also had a lower proportion of dental checks that were up to date (by seven per cent). As with young people who were placed in residential care, young people who attended a pupil referral unit were more likely to have experienced instability in the care system and to adopt risk-taking behaviours. Thus, attending dental checks may not be the priority.

Characteristics significantly associated with immunisations being up to date

As with the health assessments and dental checks, a stepwise multiple regression was conducted using SPSS to explore whether certain characteristics and care or educational experiences were associated with immunisations being up to date. Table 22 shows the final model (block 11) of the regression analyses. The variables in the final regression model (block 11) of this analysis account for seven per cent of the variance in the mean proportion of immunisations that were up to date ($F(11) = 15.796, p < .001$). This suggests that there are factors not captured in the current administrative data that may be better associated with the mean proportion of immunisations that are up to date. Nevertheless, the chapter will now explore the significant characteristics and experiences that were included in the model. The full regression model is included in Appendix Three.

	<i>B</i>	<i>SE B</i>	<i>β</i>
Block 11			
Constant	.802	.051	
Ethnicity: Black African (Reference group = White British or Irish)	-.163	.047	-.079**
Ethnicity: Other (Reference group = White British or Irish)	-.047	.037	-.028
Ethnicity: Not known (Reference group = White British or Irish)	-.042	.027	-.032
Age at first entry into care: 10+ (Reference group = Under five)	-.033	.023	-.049
Reason for first entry into care: UASC (Reference group = Abuse or neglect)	.009	.055	.005
Reason for first entry into care: Child's disability (Reference group = Abuse or neglect)	-.093	.029	-.068**
Total number of years spent in care	.009	.003	.109**
Placement location at KS4 (1 = In LA boundary, 2 = Outside of LA boundary)	-.029	.014	-.043*
Proportion of unauthorised absences (from 2009 to 2013)	-.317	.107	-.063**
First language at KS4 (1 = English, 2 = Any other language)	-.219	.047	-.176***
First language at KS1 (1 = English, 2 = Any other language)	.224	.050	.142***

Table 21: Final regression model for the proportion of immunisations up to date

* $p < .05$, ** $p < .01$, *** $p < .001$

Individual characteristics

Young people of Black African ethnicity had a lower proportion of immunisations that were up to date compared to young people of White British or Irish ethnicity (by 16 per cent). One possible explanation may be that Black African young people are at risk of having latent or active TB, therefore T-spot tests to test for TB need to be conducted before immunisations begin. This is because the T-spot test requires a 4-week period in which no vaccinations are given in order for the test to be accurate. In some cases, the test is inconclusive,

and the young person is required to have another blood test which can delay immunisations further.

Pre-care experiences

Young people who had first entered care due to their disability had a lower proportion of immunisations that were up to date compared to young people who had entered care due to abuse or neglect (by nine per cent). However, 52 per cent of young people with a disability were diagnosed with behavioural, emotional, and social difficulties. This may make it more difficult to administer vaccinations and may explain why children and young people who entered care due to their disability are less likely to be up to date with immunisations.

Experiences of the care system

Experiences of the care system were also significantly associated with the proportion of immunisations that were up to date. For example, for each additional year a young person had been in care, the proportion of immunisations that were up to date increased by one per cent (up to 16 per cent). Conversely, young people who had been placed outside of their local authority boundary at key stage 4 had a lower proportion of immunisations that were up to date (by 3 per cent).

Experiences of education

Unauthorised absences were significantly associated with immunisations not being up to date. For example, young people who had missed 100 per cent of possible school sessions due to unauthorised absences were associated with

a lower proportion of immunisations being up to date (by 32 per cent). 50 per cent of the cohort had not missed any school sessions due to unauthorised absences. However, for every five per cent of school sessions missed the proportion of immunisations that were up to date decreased by two per cent. This could mean that some young people were absent when immunisations were given at school.

Additional needs

First language was significantly associated with the proportion of immunisations that were up to date. For example, young people whose first language was not English at Key Stage 1 had a higher proportion of immunisations that were up to date (by 22 per cent). Conversely, young people whose first language was not English at Key Stage 4 had a lower proportion of immunisations that were up to date (also by 22 per cent). 42% of the young people whose first language was not English were also unaccompanied asylum-seeking young people and so may have delays in receiving their immunisations due to needing other tests first (such as TB screening).

The importance of stability in the care system

The secondary data analyses identified several factors relating to instability that were associated with young people's health assessments, dental checks and immunisations being up to date. It is well documented that instability in the care system can negatively impact on young people's education, health and wellbeing, and poor outcomes in adulthood (Bederian-Gardner et al., 2018; Munro, 2006; Rubin, 2007; Schormans, Coniega, & Renwick, 2006). Instability

can include having multiple placements, moving through different types of care, being moved out of the local authority area, re-entry into care after returning to live with family, moving schools, and changes in social worker. Young people who experience high levels of placement instability have been found to experience difficulties in other areas too, such as: employment, social relationships, money management, and housing (Biehal, Clayden, Stein, & Wade, 1995). Changes in placement may also result in a young person being separated from siblings, having to change schools, and losing contact with friends. Furthermore, young people who are relocated to a new geographical area will need to change GPs and may need to be seen by a LAC nurse from another local authority.

However, there is research which has found that the longer a child has been in care the better they do educationally (Sebba et al., 2015). Given some children and young people may come from unhealthy environments where there is domestic violence, smoking, or substance misuse problems, it could be assumed that entering care at a younger age would allow a longer amount of time for any learned unhealthy behaviours to be addressed. Despite an emergency entry into care, one young person interviewed was able to remain with the same carers for his whole time in care:

“Eleven years is it? I’m trying to think. Was it just after I was five or just after I was four? I’m trying to think of when I came into care like either ten or eleven years ago... I’ve been stuck with them for the whole time... My mum was in a court case and I was just at home and then I was taken by, I was taken from home in the car straight to [foster mum] and [foster dad] and like that was, I don’t really remember details as such. But I only just remember being taken and my parents turning off all the lights and pretending they weren’t in.”

[Bart, aged 14]

Bart attended his health assessments and regularly visited the dentist. However, he was not sure whether he had any outstanding immunisations.

Attachments and relationships

Stability in the care system may allow children and young people to build up a relationship with those caring for them. Attachment theory suggests that children and young people need to form secure attachments with their caregiver so that they feel protected and safe when exploring their worlds. In time they begin to make sense of their own and others psychological nature (Fonagy et al., 2002). Secure attachments also allow children and young people to develop their affect regulation – the ability to regulate their emotions in order to maintain a state of wellbeing (Fonagy 2002). Children who have experienced insecure attachments may struggle to understand their own and other peoples’ emotions which can later contribute to social, emotional and behavioural difficulties (Howe, 2005). When children and young people are faced with changes in caregiver they may start to perceive them as being unreliable and incapable of providing protection. This will result in them developing defensive behavioural techniques to protect themselves. This includes becoming self-reliant,

misbehaving in order to end the placement sooner, and not allowing others to look after them (Howe, 2005). Research suggests that when children experience high levels of arousal and do not have strategies in which to deal with them, they will also begin to experience problems with eating and sleeping (McNamara, Belsky, & Fearon, 2003).

The young people who were interviewed all spoke positively about their relationships with their current foster parents. Elsa had only been living with her current foster parents for about a year, but it seemed that she was already developing a secure attachment to them:

“Just like, they’re there for me and they support me. They make me feel safe. Just the fact that they’re there for me and that they support me through anything, and they say that I can come and talk to them when I need to.”

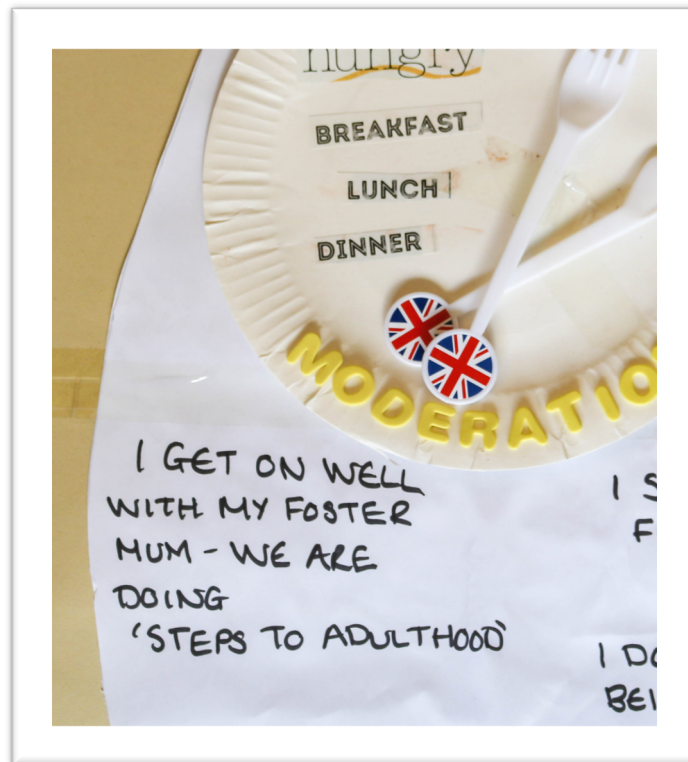
[Elsa, aged 14]

One young person described how his foster parents had built up his trust in them by being honest and reliable:

“I think it’s just like reassuring me saying, ‘this is gonna happen, this might not happen, but definitely this is gonna happen’ and just saying, ‘yes, no, yes, no’ sort of thing, and just keeping me on track and stuff like that. So yeah. But they’ve supported me a lot where they can. So yeah, which I’m quite grateful of to be fair.”

[Jimmy, aged 15]

Having a positive relationship with his foster mum was also reflected in one young man’s collage:



[Baymax, aged 12]

By allowing children and young people in care to live in stable placements the care system can provide them with the opportunity to develop secure attachments with their foster carers. This development of secure attachment styles is critical for positive outcomes later in life.

Conclusion:

Chapter Eight has shown that children and young people in care have complex exosystems due to the number of professionals involved in their care. The government has tried to meet the physical and mental health needs of children and young people in care by producing guidance outlining professionals' responsibilities and collecting annual data on some health-related outcomes. These include whether young people are up to date with health assessments,

dental checks and immunisations, their SDQ score and whether they have a substance misuse problem, criminal conviction or are a young mother. Health assessments are one of the major policy initiatives that have been implemented nationwide. There are conducted by specialists and are designed to assess and review the health needs of children and young people in care. However, currently no information is collected on the health issues that children and young people in care are dealing with or whether they receive specialist care for these issues.

Results of the regression analyses showed that young people in the 2013 cohort were more likely to be up to date with their health assessments if their local authority had an outstanding rating from Ofsted. They were less likely to be up to date with their health assessments if they had multiple placement changes, had been in care for a greater number of years, or entered care as an unaccompanied asylum-seeking young person. Different sets of predictors emerged for the other two health outcomes. The results showed that young people in the 2013 cohort were less likely to be up to date with dental checks if they had been placed with parents, had been placed in residential care or were attending a pupil referral unit. Finally, the results showed that young people in the 2013 cohort were more likely to be up to date with immunisations if they had been in care for a number of years or their first language was not English at Key Stage 2. However, they were less likely to be up to date with immunisations if they entered care due to their disability, had been placed outside of the local authority boundary, had a higher proportion of unauthorised absences or if English was not their first language at Key Stage 4.

The chapter has also shown how promoting the physical health of children and young people in care during their day-to-day care is often overlooked. Foster and kinship carers, and residential workers have not been recognised as key professionals in promoting the health of children and young people in the care system. Moreover, despite residential workers caring for some of the most vulnerable children and young people in care, they are not required to undertake mandatory training like foster and kinship carers. Training on promoting the physical and mental health of children and young people in care should become mandatory for all primary caregivers. More attention also needs to be given to the health behaviours of carers prior to approval. Furthermore, clear guidance needs to be offered on placing children under five with kinship carers who smoke, due to the detrimental impact passive smoking can have on the long-term health of children.

Currently, no information is collected as part of the administrative data on the number of social workers children and young people in care have had and this is an important part of young people's complex exosystems. Children and young people are likely to have multiple social workers due to the high turnover of staff. More attention needs to be paid to the impact this instability has on children and young people, particularly for the most vulnerable children and young people who may already be experiencing placement instability and instability in education.

The data presented in this chapter suggest that, at least to some extent, the care system is providing compensatory health care for those children with the greatest needs. However, the data also reflect a number of well-known problems within the care system. Children and young people who experienced greater levels of instability in the care system accessed health care significantly less; this provides one more strand of evidence concerning the negative impact of instability within the care system. However, the data collected at a national level to monitor the health of children and young people in local authority are not able to indicate whether children and young people are in good health. Nor do the data allow us to understand why some young people are not up to date with their health assessments, dental checks and immunisations due to the small amount of variance explained. It is only at the microlevel that we can understand how children's and professionals' perceptions and actions around health help or hinder their adequate access to health care services. This will be explored in the next chapter.

Chapter Nine: How do young people in care in England experience policy initiatives designed to promote their health?

Chapter Nine considers factors at the microlevel (experiences of specialist health services) of Bronfenbrenner's ecological systems theory in young people's health development.

Introduction

Having looked at the individual and exo- levels of the ecological systems theory in Chapters Six, Seven and Eight, this chapter now focuses on the microsystem and young people's experiences of the impact of national guidance on the health of young people in care. It attempts to identify those factors within their experiences and perceptions that make it more or less likely that their health care needs will be met. Key findings from the analysis of the quantitative data collected at a national level showed that the proportion of health assessments that were up to date remained at 88 per cent even as the size of the cohort grew each year; and that certain characteristics or care and educational experiences are associated with which young people in care are more or less likely to have a higher proportion of health assessments, dental checks and immunisations up to date. Data collected through interviews with young people in care can help us to understand the reasons for these findings, and also shed some light on some of the variance that could not be explained by the regression analyses. A theme that runs throughout this chapter is the tension

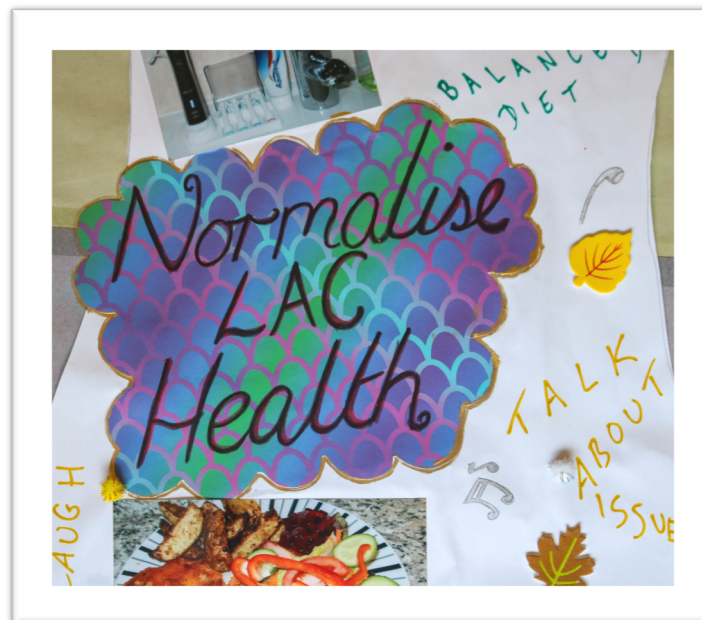
between the exceptional health needs of this population of young people and their desire for normality. The chapter explores young people's understandings of why health assessments are undertaken and considers their experiences of them, including their understanding of informed consent. These qualitative data, collected from interviews with young people in care, show how increased perceptions of the stigma of being in care make it less likely that young people will want to access the specialist services designed specifically to meet their needs. The chapter also outlines how research participants believe they learn health behaviour, their experiences of and access to universal and specialist health services, and their understandings about why they might access these services.

Exceptional health needs versus normality

As shown in Chapter Six, the young people who participated in this research initially struggled to identify any exceptional health needs that children or young people in care may have. Throughout their interviews all of the young people stressed a need and desire to feel normal and to be treated normally, and this was also reflected in their artwork:



[Nemo, aged 12]



[Mulan, aged 18]

It is possible that they were reluctant to identify any exceptional health needs as they wanted to be viewed as normal. Through the telling of their stories it

became apparent that their label as a 'looked after' young person meant that none of the young people saw themselves as 'normal':

"I'm not saying that we have more, well we sort of do have more problems than normal people. So, we're probably more likely to need to get our anger out and [self-harm]. But then people in general have their own problems, don't they? Like friends and school and like the only thing that's different for us to normal people is that we're in care and that's it really."

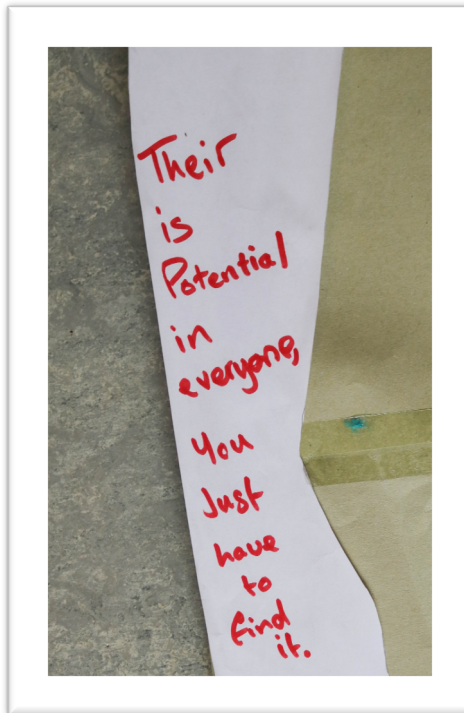
[Elsa, aged 14]

Interviewees' perceptions of how the general population viewed children and young people in care led them to feel ashamed about being in care. One young person described how he felt that the general population viewed young people in care:

"Someone that's, straight out of my mind is, that they're completely different to others. Reason being, some people might think because of their background they might be a bit mentally aggressive, physically aggressive. But I'm not physically aggressive. I'm not mentally aggressive. I'm just casual. I'm just like others. Exactly the same."

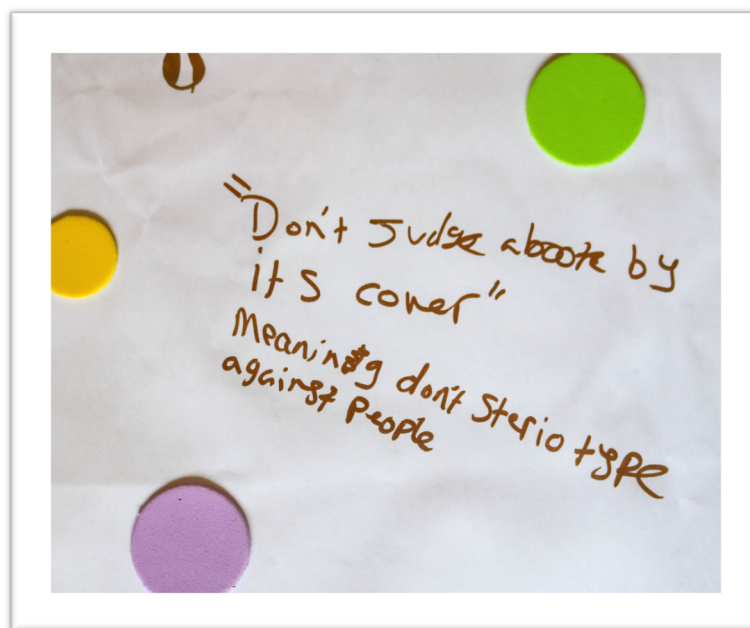
[Nemo, aged 12]

He also wanted to send a more positive message through his collage:



[Nemo, aged 12]

Similarly, another young man felt the need to include a key message relating to stigma as well:



[Jimmy, aged 15]

They were not alone in feeling this way. All of the young people spoke about experiences in which someone had assumed that they were in care due to anti-social behaviour or made comments that their birth parents did not love them:

“I’ve mentioned that I was in care before and someone turned around to me and said, ‘what did you do?’ And I was like ‘well nothing you twat!’ I’m not very nice to people when they make judgements... I was like ‘I didn’t do anything!’ and they were like ‘well you must have done something’ and I was like ‘obviously fucking not!’”

[Mulan, aged 18]

One young man spoke about how hurtful some comments were:

“Most of them are like, ‘oh your mum never loved you!’ and stuff like that and, ‘that’s why she put you in care.’ I’m just like, ‘why?’ Like of everything to say, why that?”

[Jimmy, aged 15]

Young people seemed to become more aware of stigma as they grew older, but they also felt that the public perception of why children and young people were in care became more negative as they became older too; they felt that the public moved the responsibility for the reason why someone was looked after by the local authority from the parents to the young person themselves, particularly as they entered the teenage years. This meant that young people were less likely to inform others of their care status as they became older:

“You know in primary I didn’t really have a problem with telling them that I was in care but now secondary, there’s more people, there’s more different types of background people. So, some people might think ‘oh my god he’s in care – get away from him!’”

[Bart, aged 13]

This need to become secretive and cautious about who they tell about their care status reflects previous research (Crumbley & Little, 1997). Young people’s experiences and perceptions of stigma meant that they were also less willing to engage with specialist health services as they grew older. They felt that the most important thing in their lives at that moment was not to fit in and not to feel different from their peers. The young people all spoke about the sheer number of professionals that they had to see due to their care status and how this alone set them apart from their peers. One young person suggested:

“I think just rather than having loads of different people for social worker, dentist, orthodontist, doctor, nurse... that there should just be one person to come and see you for everything. That’s probably the best way of doing it, just dialling it down really!”

[Elsa, aged 14]

In reality this suggestion would not be possible due to the specialist training required for each role. Hence, the concept of normality for young people in care is somewhat complex for the professionals responsible for promoting their health and well-being. As Chapter Six has shown, young people in care are required to have an annual health assessment in order to ensure that adequate attention is given to any health care needs which may have previously been neglected. These assessments also allow professionals to ensure that young people are accessing routine healthcare by checking whether they are up to

date with their immunisations and dental checks. However, health assessments can also set young people in care apart from their peers and become a focus of stigma and embarrassment, particularly for those young people who have their health assessments undertaken at school:

“[T]hey did it at the most ridiculous times, like they were pulling me out of lessons to do it. It’s just like I’m not learning just so you can write some stuff on a clipboard, that’s actually never gonna be used... It does make you stand out from your mates whether, you know, social care mean to or not, and even if it is necessary it still does that and there’s no way to stop it from doing that. Like, you know, ‘oh how come you weren’t in school for this period?’ ‘Well I had a LAC review or health assessment’ and it’s like, ‘what?’ know what I mean. You’ve got to have an excuse, ‘cos like they couldn’t just take time off school for some form of meeting.”

[Mulan, aged 18]

Even the young people who had their health assessments undertaken at ‘home’ spoke about the negative consequences of being taken out of school lessons for other meetings relating to their care status such as for their Personal Education Plan (PEP) meeting or their LAC review (see Glossary of terms for more about what these involve). Not only were young people worried about being questioned about their absence by their peers, but as they reached their GCSE years, they also worried about missing vital information for their exams:

“Definitely don’t want to be pulled out of class now, I’m in year 11. It’s like year 11’s the most important year as they say ‘cos you’ve got all your GCSE’s and stuff like that to worry about.”

[Jimmy, aged 15]

It appeared that it was any additional service relating to their care status that made young people feel different to their peers. During a meeting with a group of young people in care, one young person had suggested implementing a specialist dental service for children and young people in care (this young person later decided not to participate in an interview). Children and young people often enter care with a significant level of dental neglect, resulting in tooth decay and tooth loss. They also may not have visited a dentist before entering the care system which can lead to a level of anxiety. All of the young people interviewed had experienced some level of anxiety around visiting the dentist when they first entered care. As one young person explained:

“Oh god! I used to be so scared to go to the dentist, when I hadn’t got my braces, I was like ‘oh god I’m gonna die! They’re gonna pull my teeth out!’ and all that, and I was so worried. I’d get wound up and I really didn’t wanna go... It’s the noises of the tools. It’s just the fact, I’m very, I’m sort of like, I worry a lot, really I do – about everything. I’m not so bad now but I just think you know ‘what if this happens? What if that happens? I’m gonna die! They’re gonna rip my teeth out!’... ‘Cos you’re sitting and waiting in the hall in the dentist and all you can hear is all the tools going off, and they’re not nice. And then just watching videos and Mr Bean at the dentist. Plus with my mum, she wouldn’t go, she hated it!”

[Elsa, aged 14]

Despite their anxiety, all of the young people interviewed rejected the idea of having a specialist dentist for children and young people in local authority care. Young people made it clear that a specialist dentist would distance them further from their sense of normality:

“Nah, that wouldn’t be normal. I don’t think so, you’d say ‘oh I’m off to my LAC dentist’ and people would be like ‘what are you on about LAC dentist? It’s called a dentist.’ I mean, I don’t think, well as I said like normalising – they should have like the same for like what other people have.”

[Nemo, aged 12]

One young woman felt like she had enough appointments related to her care status, and felt that they made her stand out as being different to her peers in the general population:

“I don’t know it just, ‘cos when you’re in care you try and, you want to be normal, and having all these extra people like in school as well, ‘cos you get taken out of classes to see the counsellor and some of the check-ups you get and things like that. And people start asking questions, so if it was in school then you’ve been missing out and people just start asking questions and that can cause problems, and you want to feel normal!”

[Elsa, aged 14]

Instead, they felt it would be more beneficial for dentists to receive specific training on the dental needs and experiences of children and young people in care:

“I think it's good for them to understand us simply because they, they might understand that actually the kid isn't just not cleaning their teeth. But, I think also just as human beings learning that we don't all get taught that and actually there are going to be some people who don't do that simply because they don't know how because they've never been taught. And I think that's just becoming better at like accepting people for who they are more... So, I think it's just about teaching dentists not to judge and that sort of ‘well if you can try and do this’ as opposed to ‘look, you need to be doing this; you are doing it wrong!’ sort of attitude which can be quite negative, and I don't think that inspires the best results.”

[Mulan, aged 18]

This did not just apply to dental services. Young people spoke about a range of professionals who should receive specific training on the needs and experiences of children and young people in care, such as: General practitioners, school nurses, teachers, school counsellors, and police officers. In doing so, professionals would understand their exceptional health needs and young people would be able to access the same services as their peers, giving them a better sense of normality.

Confidentiality

In spite of young people's experience of stigma and wanting to fit in with their peers, they recognised the benefit in professionals knowing about their care status. However, they felt that it should be down to the young people themselves to decide who should and should not know about their care status. Furthermore, they expressed the need for professionals to keep such information confidential. Some young people had not wanted anyone to know about their care status when they first entered care but had changed their minds after a negative experience:

“Yes, they should definitely know that you’re in care. Like most teachers if you want them to. Like an example of what a teacher said, ‘cos we had PSHE and a teacher was like, we were doing NSPCC stuff and after an advert the teacher said, ‘at least none of you have been through that trauma!’... So, I went up to her at the end of the lesson and I said, ‘I am in care and I have been through that trauma!’ and she was like ‘oh’... Since then I’ve told most teachers that I’m in care. So, now everyone knows, and I don’t mind.”

[Bart, aged 13]

Normality in foster care

When exploring the concept of normality further, most of the young people felt that being in care had been a positive experience as their needs were better met and they were provided with better opportunities in life. It was apparent that feeling part of their foster family allowed young people in care to have a sense of normality. During interviews, young people would refer to their foster parents as ‘mum’ and ‘dad’, sometimes only realising they had done so when the researcher sought clarification about who they were referring to. It was apparent that all of the young people interviewed had developed or were developing secure attachments with their foster carers and this reduced their sensitivity to stigmatisation by offering them some normality. Young people would also lose the ‘foster’ when talking about their brothers and/or sisters (whether they were other children in care or their foster parents’ biological children). Young people further emphasised the need to be treated the same as other children and not to be treated differently within the family:

“[I]f I wanted to be treated normally I would want to be treated like with the same amount of respect that my foster parents’ daughters get. I want to be treated exactly the same as them. Maybe not

expense-wise as in I'm going to get all their money spent on me but, you know, I want to be treated exactly the same."

[Nemo, aged 12]

One young woman felt that it was important for foster parents to take their foster children on holiday with them, to show them that they are part of the family:

"I know there are loads of foster carers who, they foster but, when they go on holiday they don't take their foster kids with them, they only take their family! I think actually, you know, if you're gonna foster you have got to at least include them as part of that and be prepared to take them, I think. You know, I understand the cost and all that and, you know, I know it's a bit of an ask but, I think well actually if you're trying to make that kid part of your family, well they're not going to feel a part of your family if your family goes on holiday and you go to respite, do you know what I mean?"

[Mulan, aged 18]

As detailed in Chapter Four, when exploring how they learn health behaviour, young people placed a huge emphasis on the role that their foster parents played in promoting their health. Young people believed it was the normative behaviours that came with being part of the family that taught them to be healthy. This included being given a routine, having access to healthy meals and snacks, being encouraged to brush their teeth and shower, having mobile phones taken away at night to ensure that they sleep, and being encouraged to take part in fun activities.

"I give my phone to, I have to take it downstairs half an hour before I go to bed. That way, 'cos then it, I think it helps you get to sleep quicker 'cos a) I don't have the blue light and b) I can read and actually do something productive in the evening."

[Bart, aged 13]

“Well they obviously, like I say, they moderate what I eat I could scoff loads down, but they stop me from doing that.”

[Baymax, aged 12]

However, no matter how far young people in care felt part of their foster family issues still arose for young people when they needed medical treatment. When medical treatment is needed, the local authority need to provide consent on the young person's behalf (depending on the young person's age and seriousness of the treatment needed). One young person spoke about a health problem she had and having to wait for children's services to provide consent:

“I used to have really heavy periods so they, I had to go to the hospital about that. I had to have that, and I was thinking of having, what's it called? Implant – that's the word. Yeah, I was thinking of having the implant... I was pretty young when I started, it was a lot to deal with and when it's really heavy and you go through like a whole packet of pads a week. So, I want to stop having really heavy ones and it stops your periods for like three to five years and as I do so much sport I find it really difficult. So, I asked my social worker and she's agreed I'm allowed to have it. But, she needs to write a letter to say I'm allowed it and I've been waiting ages. You have to have permission, or I don't know, stupid stuff like that.”

[Heather, aged 13]

Heather had been living with her foster family for approximately ten or eleven years and considered them to be her 'real' family. She calls her foster parents 'mum' and 'dad' and felt that they should be able to provide consent on her behalf. This would certainly reduce any delay in receiving treatment for something that is not considered to be an emergency and would reduce the sense of stigma.

Perceived value of health assessments

All but one of the young people who took part in the interviews had entered care as a result of abuse or neglect and they had been in care between 4 and 11 years. Two of the young people were no longer engaging in health assessments; they were the eldest two and had been in care for a shorter period of time than the other young people interviewed. Buzz had been in care for four years and was about to move to independent living. His memory of health assessments was somewhat hazy. He had entered care as an unaccompanied asylum-seeking young person, and at that time did not speak any English. Unaccompanied asylum-seeking young people have been identified as having experienced different trauma to other young people in care. They may have experienced conflict, violence, trafficking, female genital mutilation, sexual exploitation, discrimination, and they may have had limited access to healthcare in their home country. They have been identified as a group needing screening for infectious disease and many immunisations. They are also recognised as being unlikely to speak English and in need of an interpreter for their initial and review health assessments (Dansokho, 2018). When asked how he had found the health assessments, he responded:

“It was strange... I’ve had a translator before in other meetings but not, I don’t think in health checks and stuff like that. I did, had a health assessment, when I was in the care like, the permanent one... I think it was like they ask you a few questions and like they do your height and weight, and I can’t remember the rest of it. I think that’s all I remember ‘cos it’s been a while from when I had one.”

[Buzz, aged 18]

Although Mulan had recognised that she entered care with exceptional health needs, she did not feel that these needs were addressed through health assessments:

“[W]hen I realised I could, I refused to do them because at the end of the day, you know, if I’ve got a problem I’ll go to the doctor, I don’t care what some, you know, worker thinks of how healthy I am... When I came into care I was taught to brush my teeth and all that and like, I went to the dentist for my teeth. You know, I went to the doctor if I was feeling unwell, went to opticians for my eyes. I didn’t see the use for a health assessment and like, them coming in and constantly like weighing me and doing my height, it’s just like, that doesn’t go onto anybody’s records but yours. I was like ‘none of what you’re doing right now actually benefits me’. I was like ‘you can tell that I’m obviously not underweight. You can tell that I’m not obviously overweight’. I was like ‘you can tell that I’ve not stunted my growth’. I was like ‘you know, if there was an issue my carer would report it’. She would say ‘actually, there’s an issue here’.”

[Mulan, aged 18]

Mulan believed that health assessments had no benefit, and that the information gathered was not used elsewhere. Her attendance at the health assessment is what Bronfenbrenner would refer to as an ‘act’. He defines an act as being an immediate and spontaneous behaviour such as smiling, opening a door, or answering a single question; it generally lacks meaning for the individual performing it. In contrast to acts, Bronfenbrenner suggests that individuals need to undertake a number of molar activities within different settings for their psychological growth and development. For Bronfenbrenner, molar activities are ongoing and have some sort of meaning to the individual. Individuals would only be considered to be learning about health if the activities that they participated in were ongoing and meaningful to them. For Mulan, there

was no benefit in attending health assessments and so she was less willing to engage. There was also evidence that Jimmy's attendance at his health assessments was just an act as his attitude towards them was that he did not have a choice and so he might as well get it over with:

"They're annoying but you have to do them at the end of the day. It's like, I have one every summer holiday and they basically come in and just be like, 'right let me take your height, your weight, ask you a few questions and we'll be done.' So, it's that, that, and that, and you're done. So, it takes me like half an hour, maybe even fifteen minutes 'cos I'm so used to it."

[Jimmy, aged 15]

The young people who felt that they benefited from having health assessments were much more positive and enthusiastic about them. They believed that the purpose of health assessments was to monitor their health and to make sure that they had no unmet health needs, which also offered them reassurance that they were healthy:

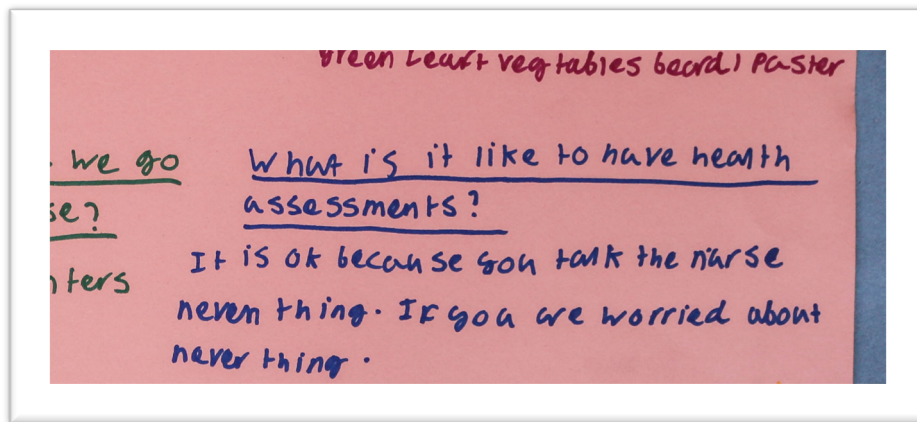
"[T]hey're there for me, they're not there for, you know, my foster carer. They're there for me and my health."

[Nemo, aged 12]

"[T]hey're not too bad because they don't go on for a long time and I'm not shy about the way I am 'cos I'm quite happy with how healthy I am. I get told that I look healthy, so yeah, I don't really mind health assessments."

[Elsa, aged 14]

One young woman identified a positive aspect of health assessments through her artwork, stating that she could talk to the nurse about 'anything':



[Heather, aged 13]

It could be that young people with negative perceptions of health assessments consider their attendance to be an act; they deem it to be a task that they have to do, a tick box exercise that does not hold any meaning and that does not benefit them in any way:

"So social services do it just so they can have an official document of how your health is, not just what people think, not their interpretation, but an official document of how your health is."

[Bart, aged 13]

"[I]t just felt a bit like it was being done just so that they could have results. Do you know what I mean, just for their own stuff and like their statistics because it didn't feel like they were doing it just for me at all."

[Mulan, aged 18]

This may also link in with young people's experiences of the care system as a whole. The fact that they have a large number of professionals involved in their

lives may mean that young people feel that any information about them is used for the benefit of social care rather than for them themselves. One young person felt that everything done in care is over the top and felt that professionals needed to:



[Elsa, aged 14]

Young people may also not want to accept that health assessments have any benefits because to do so may mean accepting that they are different to peers. However, this explanation may only offer a possible reason why young people become less willing to engage in health assessments and does not account for other reasons why health assessments may not be up to date. One young person reflected the lack of control over his life through his artwork. Refusing to attend health assessments may be a means for young people to feel in control of some aspects of their lives. In the following photograph the young person was referring to social services:



[Jimmy, aged 15]

Young people's experiences of and willingness to engage with health assessments in terms of acts versus molar activities, suggests that they are more likely to engage with health services when they are seen to have meaning.

Informed consent

During interviews with the young people it emerged that there appears to be a conflict between what professionals consider to be consent and what the young people themselves understand to be consent. Although local authorities are

legally required to arrange for their young people to have their health needs assessed every twelve months, the guidance also states that young people do not have to have a health assessment if the young person:

“[R]efuses consent to the assessment, being of sufficient age and understanding to do so.”

[The Care, Planning, Placement and Case Review (England) Regulations 2010, Number 959, Part 2, Regulation 7, Paragraph 4]

Moreover, the statutory guidance on promoting the health and well-being of looked-after children (Department for Education & Department of Health, 2015) recommends that once children are competent to provide consent then health assessments should be undertaken with their informed consent. As with any medical treatment in England young people aged over sixteen are allowed to consent to their own treatment. However, those under sixteen years of age can also provide consent if they are believed to be Gillick competent:

- *“The ability to understand that there is a choice and that choices have consequences*
 - *The ability to weigh the information and arrive at a decision*
 - *A willingness to make a choice (including the choice that someone else should make the decision)*
 - *An understanding of the nature and purpose of the proposed intervention*
 - *An understanding of the proposed intervention’s risks and side effects*
 - *An understanding of the alternatives to the proposed intervention, and the risks attached to them*
 - *Freedom from undue pressure.”*
- (British Medical Association, 2019, pp. 7-8)

Young people in care are asked to sign their health assessment form to indicate that they are providing their consent. However, when speaking to young people it seemed that they did not believe that they were ever asked whether they wanted a health assessment, and so did not believe that they gave their consent. Some young people remembered being asked for their permission to have their height and weight measured. But even so, they did not believe that they had ever been asked for their consent. One young person felt that her social worker had been deceptive by not informing her that health assessments were optional. She instead overheard her social worker talking to another professional about health assessments in which it was revealed that they are not compulsory:

“I don’t think that’s very well like, told. Like no one told me that, it just so happened that, you know, someone mentioned it just like off-the-cuff. They weren’t even like talking to me and I was like, ‘wait, you don’t have to do them?’ and they were like, ‘well no. But, I don’t think you’re really meant to know that’ know what I mean. Like they try not to tell people that they can refuse them. I think that’s out of order as well because like if you don’t have an issue you should be well within your rights to say, ‘yeah, I don’t want to do this’ instead of being controlled and being practically lied to.”

[Mulan, aged 18]

This led Mulan to feel angry and resentful towards her social worker, and she immediately stopped attending her health assessments. However, given that there is a lack of clear guidance around attendance and consent it may be that social workers themselves are unclear about when young people are allowed to give their own consent to health assessments. If it is made clear to young people that health assessments are not compulsory, and the benefits of them

highlighted then perhaps young people will be less likely to refuse to attend.

Other young people felt that consent was assumed rather than asked:

“No. It’s kind of, you have no choice because they call a LAC nurse – well, I don’t know what they call it now if ‘LAC’s changed. But, we basically have to have the nurses come in, do the assessments, and just go again – write it all down in the document, send it through and then they send it to schools, carers, social worker, IROs, and then done.”

[Jimmy, aged 15]

This young man also used his collage to illustrate that he felt like he did not have a voice:



[Jimmy, aged 15]

One young woman explained how the nurse called her foster carer to arrange an appointment rather than talking to her directly:

“Well usually with my foster carer, she just says ‘the lady phoned up and said she wants to come for a health assessment’ and she asks me what days I’m free.”

[Elsa, aged 14]

It was apparent that young people did not feel they had control over the things that were happening in their lives, and that by empowering them to feel more in control over their health assessments (for example, by being able to say when they would like to attend their assessment) they would be more likely to engage in them.

The role of the General Practitioner

During their interviews, young people were asked what the role of the General Practitioner is, and when they might seek help from them. However, it quickly became apparent that young people were not seeing their GP's due to them having a 'Looked After Children's' nurse. Young people were not able to describe the role of a GP or why they might go to see them:

“I don’t know, I don’t see my GP that often. I don’t know, I seriously do not know. I don’t see my GP that often, so I don’t know what they do as such.”

[Bart, aged 13]

Other young people felt that they would only go to see the GP if they had a very serious health issue. One young man described how he had only seen the GP when he had a serious health issue:

"I've never really been. I only went when I had a really serious earache."

[Baymax, aged 12]

Another young man felt that the role of the GP was to prescribe medication and as he did not like taking medication, he would avoid appointments with the GP:

"I haven't been to my doctor for over two or three years now. I only go if it's like very serious. I don't go 'cos I know like, what they're gonna say... 'here have a paracetamol, that'll do, or antibiotics."

[Buzz, aged 18]

However, one young woman suggested that instead of having health assessments, young people in care should be given the option of having a check-up with their GP, as this was considered to be a normative health appointment and meant they could avoid feeling stigmatised:

"It should be exactly the same as a doctor check-up. Instead of having a health assessment just book a check-up for the kids. Just say they've got to have a check-up twice a year instead or something, 'cos that's quite normal. It's like 'oh I've got a doctors appointment,' 'oh, how come?' 'Just a check-up.' That's quite a normal thing."

[Mulan, aged 18]

This suggestion could mean that young people who are disengaging with health assessments still have their health needs reviewed. But at the same time can help young people to learn how to navigate the healthcare system before leaving local authority care.

All of the young people also spoke positively about the 'Looked After Children's' nurse suggesting that it was not the relationship with them that was the issue with health assessments. But some young people did refer to the 'Looked After Children's' nurse as being a stranger as they only saw them once a year and felt that it was not possible to build up a relationship with them:

"Like it's a random stranger coming into our home, taking all my personal details, and then I don't know if they're gonna share it or not because they haven't really told me."

[Baymax, aged 12]

Some young people had also seen a different nurse for each health assessment and so had not been able to build up a relationship. The young people who had been able to build a positive relationship with their 'Looked After Children's' nurse felt that they could contact them whenever they had a concern about their health. However, some young people felt that the 'Looked After Children's' nurse was just 'another professional' among the many they had to see and felt that they were interested in the health of children and young people in local authority care as a whole rather than them as an individual:

"The LAC nurse is nice but she's, she sees so many people. That's the thing, she goes around so many houses so she can't keep on a continuous track 'cos she doesn't have documents of you since, well she does but it's like she's with so many people and she's just like looking at children as a whole, like looked after children."

[Bart, aged 14]

This suggests that health professionals building up a relationship with children and young people may go a long way in promoting children's and young people's engagement with services.

Conclusion

Chapter Nine has shown that young people in care find it difficult to accept that they may have exceptional health needs that are far substandard to their peers in the general population. In a world that is taken over by numerous professionals, young people are striving for normality, not wanting to be treated differently to their peers. Moreover, as they become older, they are exposed to the stigma around being a young person in care, in which they are subjected to comments about being anti-social, unloved and unwanted. They begin to feel shame about being in care, which leads young people disengaging with specialist health services. Although young people felt that it was useful for some professionals to know about their care status, they also felt that they should have control over who is told, and that confidentiality should be enforced. One aspect of their lives that offered young people a sense of normality was their foster families. Young people referred to their foster parents as 'mum' and 'dad' and foster siblings as 'brothers' and 'sisters'. Furthermore, young people identified their foster parents as key in teaching them to be healthy, often through routines and boundaries. However, it seems that foster parents still have limited authority when it comes to consenting for their foster children's treatment, and young people are left waiting for social care to consent instead. Another theme that came through in this chapter was the role of molar activities in young people's engagement with health services. It seems that if young

people do not feel in control or do not see any benefit in attending health services then they are more likely to begin to disengage with them. One area that seems to need some improvement is the role of informed consent in health assessments. Young people felt that they did not provide consent and that consent was often assumed, despite acknowledging that they signed their consent on the health assessment form.

Chapter Ten: Conclusions

Introduction

There is considerable evidence that children and young people in care have exceptional physical and mental health needs in comparison to their peers in the general population. A large proportion of children and young people in care will have experienced childhood poverty, childhood abuse or neglect and other adverse childhood experiences, all of which have been linked to adverse health outcomes during childhood and adulthood. The English government has responded to this by implementing specialist health services for children and young people in care. These services provide health assessments in which the health needs of children and young people in care are assessed and regularly reviewed. However, little is known about how children and young people in care engage with or experience these specialist health assessments, or whether their identified health needs are adequately addressed.

The aim of this thesis was to explore the factors associated with the ability of the care system to meet the physical and mental health needs of children and young people in care. The specific objectives were to explore:

- How pre-care experiences and experiences of entering the care system affect the health development of young people in care.
- What health related information is collected for the Children Looked After Dataset and what this information can tell us about young people's access to routine and specialist health services.

- Whether any characteristics or care and educational experiences were associated with young people's access to routine and specialist health services.
- Whether any characteristics or care and educational experiences were associated with young people in care having mental health difficulties, substance misuse problems or criminal convictions.
- The health perceptions of young people in care and how these perceptions relate to their engagement with health services.
- Whether young people understand why health assessments are undertaken and how they experience them.

A convergent mixed-methods design was used in which a pragmatic philosophical approach to Bronfenbrenner's ecological systems theory was adopted as the conceptual framework for the thesis, combined with relevant theory relating to attachment and stigmatisation. The research involved exploring the physical and mental health of young people in care as part of their journey into and through the care system. The researcher undertook a secondary data analyses of administrative data (in which the Children Looked After Database was linked to the National Pupil Database) of one cohort of 4847 young people in care who were aged 15-16 on the 31 March 2013. The researcher also undertook in-depth qualitative interviews incorporating visual and creative research methods with eight young people in care aged 12 to 18. Specifically, young people were given the opportunity to take photographs and collect other images (for example, magazine cut outs) of things that they felt represented their health and health experiences which they later included in

their life-size human collages. Notwithstanding the limitations of the study design as outlined in Chapter Four, this thesis has presented important findings across five chapters.

Chapter Five presented a vignette for each of the young people interviewed to allow the reader to better understand each young person's individual experiences. The chapter also displayed each young person's collage. Chapter Six explored how pre-care experiences can affect the health development of children and young people in care. It looked at the role of proximal processes (the interactions that children have with the people, objects, and symbols in their environment) and how the development of insecure attachments may have influenced young people's health behaviour. Chapter Six also considered how young people's experiences of entering the care system might affect their health development. Chapter Seven focused on the mental health needs of young people in care. This chapter explored the role of childhood trauma in the development of mental health difficulties and substance misuse problems and identified factors within young people's care and educational experiences and perceptions that are associated with mental health difficulties and risk-taking behaviour. Chapter Eight looked at how the government has tried to meet the exceptional health needs of children and young people in care and explored whether certain characteristics and care or educational experiences were associated with health assessments, dental checks and immunisations not being up to date. Finally, Chapter Nine focused on young people's experiences of the impact of national guidance on their health behaviour. This chapter reflected on the theory of stigma to explore the tension between the exceptional

health needs of young people in care and their desire for normality. Chapter Nine also considered young people's understanding about why health assessments are undertaken and explored their experiences of them as well as their understanding about informed consent.

Key findings

The sections below summarise key findings from the research in relation to each of the study objectives.

How can pre-care experiences and experiences of entering the care system affect the health development of young people in care?

The secondary analyses of the Children Looked After Database revealed that the majority of young people had experienced some level of childhood adversity. Fifty five per cent had experienced childhood poverty; 56 per cent were in care due to abuse or neglect, and 32 per cent were in care due to reduced parenting capacity. Chapter Six showed that young people in care had not experienced nurturing parenting or environments prior to entering the care system. While Bronfenbrenner suggests that children's development is learned through proximal processes (the interactions that they have with the people, objects and symbols in their immediate environments) and attachment theory suggests that children's development may be shaped by their feelings of safety and security, the young people interviewed described living in environments where their basic needs had not always been met. Young people described environments where there was an absence of routine. Their memories of living with their biological parents included fear and anxiety, instability, violence, and

being unable to rely on their biological parents to meet their needs and keep them safe.

These pre-care experiences impacted on young people's health development in a number of ways. Most young people had entered the care system with significant dental neglect, many had trouble sleeping, some found themselves overeating or hiding food, and most did not trust adults. Living in suboptimal environments also meant that young people had not experienced the nurturing relationships that are required to understand and regulate their emotions, and this had led to them experiencing poor mental health, which resulted in young people self-harming and misusing substances as a means to cope with their emotions. Moreover, the young people interviewed were not used to attending routine health appointments which later led to fear and anxiety around them.

As well as their pre-care experiences, young people's experiences of entering the care system and their understandings about the reason they needed to become looked after impacted on their health development and health behaviour. Some young people found entering the care system stressful, while others were angry and frustrated, and this impacted on their willingness to engage with professionals and services. The statistical analyses showed that the age that young people entered the care system was a factor in their health development, and the interviews with young people showed this also affected their health behaviour. Those who entered care at a younger age were able to quickly adapt to new routines and boundaries. However, young people who had lived in suboptimal environments for a longer period of time found it difficult to

adapt to living in a new environment with routine and boundaries. Since entering care young people had access to nutritious foods and ate regular meals, although some still described impulsive eating behaviours. All of the young people interviewed spoke about previous or ongoing health needs but described how these had been addressed through their health assessments, and where needed, they had been referred to other services.

What health-related information is collected for the CLAD and what can this information tell us about young people's access to routine and specialist health services?

As shown in Chapter Six, the CLAD collects data on nine factors relating to health. These are:

- Whether the young person has had a health assessment within 12 months of the 31 March each year.
- Whether the young person has had a dental check within 12 months of the 31 March each year.
- Whether the young person is up to date with their immunisations according to the immunisation schedule on the 31 March each year.
- Young people's SDQ score for the year ending 31 March.
- Whether the young person has had a substance misuse problem within the year ending 31 March.
- Whether the young person received a criminal conviction within the year ending 31 March.
- Whether young people with a substance misuse problem were offered a substance misuse intervention within the year ending 31 March.

- Whether young people with a substance misuse problem refused a substance misuse intervention within the year ending 31 March.
- Whether the young person is or is due to be a young mother.

The study found that these variables tell us too little about the health needs of children and young people in care and the extent to which they are met. They do not tell us about the actual health status of young people in care or their engagement with health professionals if attending routine and specialist health services. They also do not capture the reasons why young people may not be up to date with health assessments, dental checks or immunisations. For example, if the young person refused to attend or whether there are other reasons why the young person did not attend their appointments. There is also no information collected on whether young men are, or are due to be, young fathers. Moreover, whilst young people's SDQ scores are recorded as part of the CLAD no information is collected on whether young people with mental health difficulties have accessed support this.

Are any characteristics or care and educational experiences collected for the CLAD and NPD associated with young people's access to routine and specialist health services?

Chapter Eight showed that overall a large proportion of young people in the 2013 cohort accessed routine and specialist health services. For example, between the years ending 31 March 2009-2013 between 88-90% of young people were up to date with their health assessments, between 80-87% were

up to date with their dental checks and between 79-82% were up to date with their immunisations.

Statistical analyses revealed a number of factors that were associated with these outcomes. However, there were no factors that were associated with all three outcomes. The proportion of up-to-date health assessments was associated with individual characteristics (being an unaccompanied asylum-seeking young person or experiencing early childhood poverty), care experiences (age at entry into care and number of placement changes) and context (local authority Ofsted rating). The proportion of up-to-date immunisations was associated with a different set of individual characteristics (ethnicity, first language and disability), care experiences (being placed out of their local authority area) and educational factors (unauthorised absences). In contrast, the proportion of up-to-date dental checks was only associated with placements (ever placed with parents, in residential care or out of their local authority area) and school contexts (attending a pupil referral unit).

These factors only accounted for 3% of the variance for health assessments, 3% of the variance for dental checks, and 7% of the variance for immunisations, suggesting that there are factors not captured in the CLAD or NPD that may be better associated with health assessments, dental checks and immunisations being up to date.

Are any characteristics or care and educational experiences collected for the CLAD and NPD associated with young people having mental health difficulties, substance misuse problems or criminal convictions?

Research has shown that there is greater prevalence of mental health difficulties among the care population compared to their peers in the general population (Meltzer et al., 2002). Chapter Seven revealed that approximately half of the looked after cohort had an SDQ score that indicated they required support from mental health services. Mean SDQ scores were associated with individual characteristics (ethnicity and being an unaccompanied asylum-seeking young person), care experiences (placement stability, being placed in residential care, multiple placement changes, and being placed with an independent or voluntary fostering agency), and educational experiences (key stage 2 points achieved, proportion of fixed term exclusions, attending non-mainstream educational facilities, and disability).

Research suggests a strong link between mental health difficulties and risk-taking behaviours (such as substance misuse and criminal activity) (Ahrens, McCarty, Simoni, Dworsky, & Courtney, 2013; Braciszewski & Stout, 2012; Brook & et, 2015). The results of the quantitative analyses revealed a direct link between SDQ scores and substance misuse problems. Other factors associated with substance misuse problems were care experiences (placement instability and being placed in residential care) and educational experiences (missing school due to unauthorised absences or fixed term exclusions, and attending non-mainstream educational facilities). These factors accounted for 25% of the variance for substance misuse problems. Substance misuse

problems were also associated with having a criminal conviction. Similarly, criminal convictions were associated with care experiences (placement instability) educational experiences (missing school due to unauthorised absences or fixed-term exclusions and attending non-mainstream educational), but also individual characteristics (disability). These factors accounted for 38% of the variance for criminal convictions. The amount of variance explained within mental health difficulties, substance misuse problems and criminal convictions was much higher than for health assessments, dental checks and immunisations being up to date. This may be because professionals around the young person have less 'control' over issues like mental health and substance misuse than they do over ensuring young people attend appointments. There is a body of literature already linking some of these factors to mental health difficulties, substance misuse problems and criminal convictions (Jacobs & Slabbert, 2019; Mitchell, Betts, & Epling, 2002; Osher, 2008).

What are the health perceptions of young people in care and how do these perceptions relate to their engagement with health services?

As shown above, there are a number of ways in which the health development of children in care is affected by pre-care experiences and experiences of entering care. Analysis of national datasets identified a range of factors (individual characteristics, care and educational factors) that were associated with engagement with health services, but these only accounted for a small proportion of the variance in these outcomes. The interview findings presented in Chapter Six revealed details about the health perceptions of young people in care, and Chapter Nine explored the implications of these for their engagement

with health services. The interviewees all felt that health included being both physically and mentally healthy and felt that they were intertwined. When describing good mental health, young people's definitions mirrored definitions of subjective well-being. They felt that good mental health was about feeling happy, settled and safe in their placements and feeling positive about their futures. Young people also placed emphasis on the role of family in promoting good mental health. However, young people felt that family need not only include people who were genetically related to them and instead felt that their foster family and friends were part of their family, and one young person felt that his social worker was part of his family.

Young people also described good mental health as something that is achieved through secure attachments. However, they also noted that these secure attachments did not necessarily have to be with the primary caregiver. As shown in Chapter Six and Eight, proximal processes with caregivers mean young people learn about healthy behaviours from their primary caregivers and seem to learn more about health behaviours once they have entered care. However, the young people in this study appeared to retain factual health information without actual understanding.

From the interviews with young people in care it was clear that they find it difficult to accept that they may have exceptional health needs that are more extensive than those of their peers in the general population. This may, in part, impact on their willingness to engage with health services. In the care system, young people can find themselves dealing with a large number of professionals,

when all they want in life is some normality, and not to feel different from their peers. Young people described being exposed to stigma related to their care status as they became older and this had a clear implication for engagement with health services. As shown in Chapter Nine, these experiences of feeling stigmatised led young people to disengage with specialist health services. Furthermore, young people wanted to feel more in control of the decisions made about their lives. One aspect of the care system that offered young people a sense of normality was their foster families. All of the young people felt that their foster parents played a key role in promoting their health and felt that this was the most normal way to learn positive health behaviours. However, foster carers have limited authority relating to medical treatment, and having to wait for social workers to consent to treatment can make young people feel different from their peers.

All interviewees had been offered mental health services once they were in the care system. For teenagers, it was apparent that they preferred sessions where their therapist was able to offer insight and advice, rather than the typical counselling session. Some young people also preferred to access sessions through their school counsellor rather than through Child and Adolescent Mental Health services, as they did not want to be seen as different by their peers.

Foster carers play an important role in supporting young people to attend their appointments, preparing them for what to expect, and teaching them how to navigate the health service. The young people interviewed described how they

had become more comfortable attending the dentist when supported by their foster carers. However, when asked about their experiences of seeing the General Practitioner, young people stated that they did not go to see their GP and therefore did not know what their role was. All of the young people felt that they would only go and see the GP for something more extreme such as the flu or for a serious injury. They were also unable to distinguish between the role of the GP and the role of an Accident and Emergency department. Only one young person had experienced appointments in a hospital setting and this was due to her abnormal menstrual cycles. Although she thought that the appointments had been useful her treatment had been delayed due to her social worker needing to sign their consent for her to have the treatment. This young woman could not understand why her foster mother (who she saw as a mother) could not give her consent despite having looked after her for a number of years and being approved as her long-term carer.

When considering how they learn health behaviour, all of the young people felt that their foster carers played a significant role in teaching and encouraging them how to be healthy – both physically and mentally. Yet, the national guidance on promoting the health and well-being of children and young people in care fails to recognise primary caregivers as having a key role in promoting their health. Moreover, despite being the key adult/s in young people's lives who provide them with routines and boundaries, teach them to eat healthily, teach them sleep hygiene, and teach them when to seek help for health concerns, primary caregivers are not required to attend any training on the health needs of the children and young people that they look after.

Do young people understand why health assessments are undertaken and how do they experience them?

Chapter Nine showed that there were mixed experiences of young people attending their health assessments. Around half the young people liked using their health assessments to find out how much they had grown in height and weight. However, other young people could not see what the point of health assessments were and instead felt like it was a tick box exercise. Disengagement with services appeared to be due to feeling stigmatised and not wanting to feel different to their peers rather than negative experiences with health professionals. All of the young people spoke positively about specialist looked after children nurses.

Young people felt that they were not asked for their consent to have a health assessment although they stated that they had signed a form. Further investigation revealed that this was to allow health professionals to share health related information about the young person with other professionals, rather than to gain consent. Consent appears to be assumed by way of attendance. Moreover, young people did not feel in control over what happened because their health assessments were being organised with their foster carer rather than with them. They also did not recall being told that having a health assessment was their decision, but rather assumed that it was obligatory as their carers would tell them when it was and not inform them that they did not have to do it if they did not want to.

According to Bronfenbrenner, young people are most likely to engage with health assessments if they are seen as molar activities (something they will benefit from) and not just an act (a tick box exercise). Research suggests that patient empowerment is key to sustaining patient engagement (Khuntia, Yim, Tanniru, & Lim, 2017). Moreover, there is a direct link between young people feeling included in the decisions made about their lives and their well-being (Zhang & Selwyn, 2019).

What the key findings add to existing knowledge

This study makes a number of contributions to existing knowledge on the health needs of young people in care. Firstly, this study is the first to use national statistics for the purpose of identifying any characteristics and care or educational experiences that are associated with young peoples' health assessments, dental checks, and immunisations being up to date, as well as adverse outcomes such as having a substance misuse problem or criminal conviction. National datasets have only recently become accessible to researchers and this study shows their potential as a means of understanding children's experiences and assessing the strengths and weaknesses of the care system. The analyses presented in this thesis go beyond the descriptive statistics that are produced by the Department for Education (2019). But more importantly, by controlling for other factors in a regression model, the researcher has been able to look at the unique role of individual factors. Although only a small amount of variance was explained for health assessments, dental checks and immunisations, the analyses identified a number of factors that were associated with engagement with health services.

Factors associated with mental health difficulties and risky behaviours were also identified, and for these outcomes explained more of the variance. The analyses therefore suggest a number of factors that might be used to better target support, services and resources; in particular, there were a number of indicators of instability in the Children Looked After Dataset. These included number of placement changes, being placed in residential care, being placed out of area, and length of latest placement. One or more of these indicators of instability in the care system were significantly associated with the proportion of health assessments, dental checks, and immunisations that were up to date, SDQ scores, having a substance misuse problem and having a criminal conviction. The results suggest that while children and young people may enter the care system with exceptional physical and mental health needs, these are likely to be exacerbated if they experience instability in the care system.

From a methodological perspective, this study has shown the value of a mixed methods approach to complex issues in children's health and social care. In conjunction with the secondary analysis of the national data, a major contribution of the interviews with young people in care was their ability to show how young people experience some of the factors identified in the databases (such as maltreatment) and how these factors affect their health behaviours and experiences. The interviews also revealed a number of factors relating to their engagement with health services, which are not currently recorded in the databases. These included young people's awareness of stigmatisation relating to their care status and their desire for normality, the significant role of foster carers in teaching and supporting young people to lead healthy lives, and young

people wanting to have more control over the things that happen to them (such as giving consent to have a health assessment).

This study has also shown the important role of user-led research in better understanding experiences of the care system. The researcher's own experience of growing up in care meant she quickly built-up rapport with the young people interviewed as well as the youth advisory panel. This rapport was essential and meant young people were able to openly discuss sensitive issues such as mental health difficulties and self-harm behaviours. By working with a young advisory panel, this study was also able to adopt creative research methods which allowed young people to feel in control, have fun and also reduce the need for eye contact. This sense of control and ownership meant that all of the young people prepared for their interview by doing their own research and capturing photographs of things that they felt were important to their health and experiences. Moreover, because young people saw the researcher as 'one of us' and not as a professional they were able to discuss issues with the care system without fear of repercussions or judgement. As young people were given the opportunity to ask the researcher questions at the end of their interview key issues relating to stigma and normality were identified as being really important issues to interviewees, and these were further endorsed by the youth advisory panel and the researcher herself. Moreover, young people completed sleep diaries and by discussing these in their interviews, the researcher found that some young people have significant struggles with their sleep, including poor sleep routines.

Finally, this study has shown the benefits of using Bronfenbrenner's approach to child development to identify key factors at different levels of his ecological systems theory, and looked at whether the exosystem (e.g., policy) is reflected at the microlevel level (e.g., young people's experiences). This mixed-methods study has provided an in-depth understanding of what is happening at a national level as well as how young people experience policy initiatives aimed at promoting their health and has gained a better understanding of why some young people may not be up to date with health assessments, dental checks and immunisations or why they may experience mental health difficulties or adopt risky behaviours.

Recommendations

Having summarised key findings and what this adds to existing knowledge, the sections below now set out recommendations for decision makers, young people and those involved in supporting them.

Recommendations for policymakers

This study has identified a number of weaknesses and in particular, gaps in data collection that need to be addressed. The findings of this study suggest that the Children Looked After Dataset could better facilitate the understanding of some key issues relating to the health of children and young people in care. The researcher appreciates that it is difficult to identify data that is considered feasible for collection, given that local authorities already have to collect a lot of information. In considering what is feasible, the findings from this study imply that the following changes to the national dataset would be helpful:

- a. The dataset already includes information on whether children and young people in care with a substance misuse problem have been offered or received an intervention (which means researchers can also identify young people who were not offered an intervention). It would be useful for further research and national policy to collect similar data for health assessments, dental checks and immunisations. In doing so, research and policy can better explore why young people may not be up to date and consider whether the current timescales are feasible in practice.
- b. Very little is known about the physical health of children and young people in care. Health assessments are designed to identify the health needs of children and young people in care. In doing so a health plan is drawn up that outlines how these needs will be met, by who, and by when. While it is not feasible to record all the health conditions that children and young people in care are dealing with, it would be useful for research and policy to know which young people have an up-to-date health plan, and whether they have accessed appropriate treatment or support for these needs. It would also be useful to collect data on whether a young person has unmet health needs or ongoing health conditions.
- c. The total difficulties score from the SDQ (reference) is already submitted as part of the administrative data. Ensuring that every child and young person in care in England has an SDQ completed each year was implemented in order that services could identify

those in need of mental health support. However, the current data collection does not show whether these young people were offered or received support for their mental health difficulties. The findings of this study suggest that mental health services need to better personalise the support given to young people in care. It would be useful for research and policy, as a starting point, to explore how many young people in care are disengaging with mental health services.

- d. While it may not be as accurate as recording mothers and mothers to be, it would be useful to identify those who are young fathers.

Study findings also suggest ways in which national policy might shape young people's engagement with health services. Specialist health services play a vital role in identifying and addressing any unmet health needs that children and young people in care may have. However, the specialist health teams have a number of other essential roles such as educating those caring for the child and ensuring referrals are made to other services where needed. Some young people also enjoy having the safe space that these professionals provide in which they can ask questions about their health. However, a small minority of young people in care begin to disengage with specialist health services as they become older. Future statutory guidance should be mindful of young people's need to have some control over what is happening to them and therefore should place emphasis on young people being able to have choices around who assesses their health needs (for example, the specialist nurse or a GP) and

when these assessments happen (for example, outside of school hours) in order to encourage their engagement with health services. Data on where young people choose to have their health needs assessed should also be collected as part of the administrative data. To support this, GP's would need to receive commissioning resources to allow them to undertake a comprehensive assessment of young people's needs, and this commissioning should not be withdrawn from the specialist services. The specialist nurse should continue to liaise with the foster carer and social worker annually to offer advice and ensure that the young person's health needs are still met, and young people should still be provided with contact details for the specialist team should they need them. Furthermore, greater attention needs to be given to young people's transitions from specialist health services to primary care services to ensure that young people leaving care are confident about how to access these universal services. Such work may require specialist health services to work with young people outside of their annual health assessment.

The statistical analyses showed that young people who had multiple placement changes, were placed in residential care, attended non-mainstream education, or who had a high proportion of fixed-term exclusions and unauthorised absences were less likely to be up to date with their health assessments, dental checks and immunisations, and more likely to have a substance misuse problem or criminal conviction. Moreover, research suggests that due to frequent placement breakdowns, these children and young people are less likely to be registered with a GP. By reducing the number of young people the specialist health team for looked after children are responsible for, the more

time they will have to promote the health of the most vulnerable children and young people in care.

Recommendations for local decision makers

The findings of this study also have implications for local decision makers in specialist and general healthcare services, and in children's social care. The key findings of this study showed that children and young people enter care with a poor understanding of normative health care (such as dental care, primary care, health eating, and sleep and exercise routines). Once they are in the care system, young people rely solely on specialist services for looked after children (health assessments and contact with looked after children's nurses). This means that they do not access primary care services such as appointments with the General Practitioner, and so they do not know what the role of the GP is or why they might seek help from them.

The young people in this study identified their foster carers as being the key person in their lives to teach them how to lead healthy lives, and this may also suggest an avenue for education about specialist and general healthcare services. Young people felt that this was a more normative approach to learning how to be healthy. Yet, foster and kinship carers, and residential workers, do not receive training on promoting the physical health of the children and young people in their care. The researcher suggests that training on promoting the physical and mental health of children and young people in care should become mandatory for all carers. Moreover, residential workers are looking after the most vulnerable children and young people in care but do not have to complete

any mandatory training. The researcher suggests that training for residential workers becomes mandatory and that they receive further mandatory training on promoting the health of children and young people who adopt risk-taking behaviours: smoking, substance misuse, criminal activity, child sexual exploitation and risky sexual behaviour. In order to give the most vulnerable children and young people in care a positive future it is essential that those caring for them are equipped with the knowledge and skills they need to best deal with risk-taking behaviour. In all health-related training, thought needs to be given to the impact of trauma on how young people learn to lead healthy lives.

When young people leave care at the age of 18, they no longer have access to the specialist services for young people in care and do not have experience of navigating the National Health Service. Leaving care teams need to take an active role in ensuring that young people leaving care understand how to navigate the health care system and should receive adequate training in order to do so.

Another issue that arose during interviews with young people was delays in young people's treatment due to their social workers having insufficient time to write a letter. The researcher suggests that when children and young people are in long-term stable placements (and only with the young person's permission), foster or kinship carers should be able to sign consent for the young person's treatment to reduce delays. Rather than waiting for social workers to write a letter giving consent, it should be sufficient for social workers

to email carers giving permission for them to sign consent for treatment. By working together, the delays experienced by the young people in this study could be avoided, and young people are not reminded that they are different to their peers in the general population.

Recommendations for professionals

A key finding in this study was that the young people did not feel that they gave their consent to have a health assessment, even though they acknowledged signing a health assessment form. The researcher suggests that professionals need to better inform young people about their rights, and rather than referring to health assessments as something that is compulsory, professionals should focus more on what the benefits of having a health assessment are.

There are some things that designated and named nurses for looked after children can do in order to make young people feel more in control of their lives. For example, as young people reach adolescence, they can speak directly to the young person about having a health assessment and once the young person has agreed, they can get the young person's permission to contact their carer to arrange a time to visit at home. Young people were also concerned about how the information collected during their health assessments would be used (for example, embarrassing health information being raised during their looked after child review). Nurses should explore with young people what information they feel comfortable with being shared in future meetings and to inform them about what happens with any information they have collected. Any health information that may be considered embarrassing for the young person

should be communicated outside of meetings and with the permission of the young person.

This study found that young people experienced significant stigma related to their care status as they reached adolescence. Their experiences of stigma meant that young people often began to disengage with specialist services as they were striving for normality and did not want to be treated differently to their peers in the general population. The social worker and Independent Reviewing Officer should work with each young person to discuss who they feel comfortable with knowing about their care status. Young people should also be reassured that those who are informed about their care status will keep information confidential and will keep their care status discreet (i.e. will not announce that they are in care).

Recommendations for researchers

There is a long way to go before there is sufficient understanding of the health needs of children and young people in care. A key area of research that is needed is to fully explore the health needs of children and young people at the point of entry into care, including the health issues they are dealing with and how they differ to their peers in the general population. Until this starting point is found it is difficult for research and policy to explore how well the care system is able to meet the health needs of children and young people in care. Another key area of research that could be explored is how health care plans are used in practice – how do they ensure that the health needs of children and young people in care are met, and over what time frame?

The young people in this study rarely saw their GPs and did not know what their role was or when to seek help from them. Research needs to consider whether GPs have the capacity to review the health of children and young people in long-term stable placements and consider how this service can be commissioned to allow young people in care access to normative healthcare services.

Another key area of research is to fully explore the health needs of the most vulnerable group of children and young people in the care system – those experiencing multiple placement changes and those placed in residential care. If the extent of their risk-taking behaviours can be better understood, then professionals will be better placed to target interventions to promote their health behaviours.

As the young people in this study identified their foster carers as the key people to teach them how to live a healthy life, research is needed to explore the health perceptions and health behaviours of foster and kinship carers and residential workers. The health perceptions and behaviours of carers will influence the health perceptions and behaviours of the young people in their care. Furthermore, research could consider carers understandings of the exceptional health needs of the children and young people in care.

Finally, research is also needed to design a standardised health assessment form that is free to use by all local authorities. In doing so, it would be hoped

that any health inequalities are avoided. Young people placed out of area may also face delays while the two CCGs negotiate the standard of the health assessment that will be offered. By implementing a standardised health assessment form in which all local authorities address the same areas, these delays can be avoided.

Recommendations for young people

Young people in care (such as children in care councils) should be involved in producing crib sheets for other young people that outlines who different professionals are, what different services do, and why attending their health assessment might be useful. These groups of young people can play a key role in educating other young people in care as well as professionals. For example, by liaising with health professionals to discuss what consent looks like to them.

Closing remarks

This study has shown that, at least to some extent, the care system is providing compensatory health care for those children and young people with the greatest needs. However, the care system needs to do more to reduce instability in the care system as this can further exacerbate the health needs of young people in care and can lead to mental health difficulties and risk-taking behaviours. This study has also shown that the Children Looked After Dataset (SSDA903) does not fully facilitate the understanding of some key issues relating to the health needs of children and young people in care, such as the health issues they may have or their access to specialist services. Young people in care are striving for normality and yet do not understand how to navigate the National

Health Service. This will become problematic when young people turn 18 and no longer have access to specialist health services for looked after children. These findings may inform future policy and interventions to promote the health and well-being of children and young people in care.

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Appendix One: Preliminary analyses

		Health Checks		Dental Checks		Immunisations	
Variable	Categories	Mean	SD	Mean	SD	Mean	SD
Gender	1 – Female	.8849	.22652	.8313	.27456	.7619	.34459
	2 – Male	.8806	.21741	.8255	.26078	.7764	.32320
UASC	1 – No	.8831	.21985	.8282	.26588	.7782	.32511
	2 – Yes	.8636	.26282	.8234	.29608	.5419	.44812
Age at first entry into care	1 – 0 to 9 years	.8897	.17236	.8486	.19943	.8303	.24649
	2 – 10+	.8756	.25948	.8085	.31685	.7128	.38937
Age at last entry into care	1 – 0 to 9 years	.8919	.16111	.8507	.18962	.8382	.23419
	2 – 10+	.8754	.25788	.8107	.31219	.7181	.38370
Ever placed with parents	1 – No	.8836	.22301	.8355	.26602	.7674	.33676
	2 – Yes	.8692	.20284	.7427	.26295	.7994	.28349
Placement location at KS2	1 – In own LA	.8950	.16246	.8445	.19541	.8299	.24508
	2 – In another LA	.8863	.16480	.8649	.17898	.8185	.24847
Placement location at KS4	1 – In own LA	.8894	.21660	.8177	.27386	.7831	.32606
	2 – In another LA	.8734	.22738	.8414	.25714	.7530	.34084
Only ever placed in own LA	1 – No	.8754	.22433	.8188	.27024	.7699	.33047
	2 – Yes	.8993	.21361	.8500	.25768	.7703	.33863

Ever placed by an independent agency	1 – No 2 – Yes	.8978 .8718	.20392 .23229	.8403 .8195	.25170 .27674	.7897 .7564	.31803 .34214
Ever placed by another LA	1 – No 2 – Yes	.8843 .8337	.21914 .27157	.8303 .7691	.26473 .31456	.7729 .6938	.33017 .38999
Placement provider	1 – Own LA 2 – Another provider	.8927 .8717	.21228 .23057	.8408 .8148	.25082 .28257	.7911 .7470	.31741 .34754
Ever had a school change Y8-11	1 – No 2 – Yes	.8895 .8659	.20965 .25084	.8322 .8261	.26085 .27355	.7842 .7569	.32019 .35085
Unauthorised absences	1 – Less than 5% 2 – More than 5%	.8865 .8632	.20947 .27049	.8386 .7777	.25143 .32621	.7827 .7099	.31651 .39610
First language at KS1	1 – English 2 – Another language	.8807 .9245	.22062 .17586	.8272 .8446	.26441 .26068	.7865 .7782	.31718 .33966
Secondary SEN	1 – No 2 – Yes	.8818 .8847	.22183 .22033	.8251 .8376	.27252 .24753	.7714 .7654	.33640 .32103
Ever convicted	1 – No 2 – Yes	.8879 .8519	.21666 .24453	.8339 .7950	.26524 .27411	.7682 .7801	.33584 .31574
Ever had a substance misuse problem	1 – No 2 – Yes	.8842 .8695	.21947 .23529	.8316 .8017	.26511 .27879	.7710 .7631	.33326 .33018

t-tests		Health Checks		Dental Checks		Immunisations	
Variable	Categories	N	t	N	t	N	t
Gender	1 – Female 2 – Male	2140 2702	.673	2140 2702	.754	2140 2702	-1.500
UASC	1 – No 2 – Yes	4675 167	.950	4675 167	.230	4675 167	6.750***
Age at first entry into care	1 – 0 to 9 years 2 – 10+	2358 2484	2.243*	2358 2484	5.306***	2358 2484	12.618***
Age at last entry into care	1 – 0 to 9 years 2 – 10+	2089 2750	2.727**	2089 2750	5.517***	2089 2750	13.445***
Ever placed with parents	1 – No 2 – Yes	4451 391	1.233	4451 391	6.624***	4451 391	-2.104*
Placement location at KS2	1 – In own LA 2 – In another LA	1573 1011	1.311	1573 1011	-2.732**	1573 1011	1.154
Placement location at KS4	1 – In own LA 2 – In another LA	2736 2106	2.469*	2736 2106	-3.091**	2736 2106	3.098**
Only ever placed in own LA	1 – No 2 – Yes	3414 1428	-3.498***	3414 1428	-3.778***	3414 1428	-.035
Ever placed by an independent agency	1 – No 2 – Yes	1981 2861	4.119***	1981 2861	2.705**	1981 2861	3.481**
Ever placed by another LA	1 – No 2 – Yes	4663 179	2.464*	4663 179	2.568*	4663 179	2.680**
Placement provider	1 – Own LA 2 – Another provider	2440 2381	3.288**	2440 2381	3.370**	2440 2381	4.594***
Ever had a school change Y8-11	1 – No 2 – Yes	3521 845	2.540*	3521 845	.602	3521 845	2.068*
Unauthorised absences	1 – Less than 5% 2 – More than 5%	3998 844	2.359*	3998 844	5.112***	3998 844	5.010***
First language at KS1	1 – English	4254	-3.463**	4254	-.925	4254	.366

	2 – Another language	208		208		208	
Secondary SEN	1 – No	3716	-.394	3716	-1.448	3716	.530
	2 – Yes	1126		1126		1126	
Ever convicted	1 – No	4107	3.742***	4107	3.650***	4107	-.935
	2 – Yes	735		735		735	
Ever had a substance misuse problem	1 – No	4257	1.427	4257	2.547*	4257	.535
	2 – Yes	585		585		585	

Variable	Categories	Health Checks		Dental Checks		Immunisations	
		Mean	SD	Mean	SD	Mean	SD
Ethnicity	1 – White British or Irish	.8802	.22152	.8262	.26692	.7929	.31468
	2 – Other ethnicities	.8952	.21936	.8398	.26341	.7010	.37586
	3 – Ethnicity unknown	.8705	.22600	.8137	.27665	.7229	.35887
Category of need	1 – Abuse and/or neglect	.8933	.19520	.8386	.23915	.7974	.29966
	2 – Anti-social behaviour	.8495	.28939	.7860	.33561	.6737	.41784
	3 – Parenting capacity	.8673	.25056	.8157	.29562	.7465	.36457
	4 – Other reasons	.8833	.23589	.8166	.30056	.6925	.36708
All placement types	1 – Ever residential care	.8633	.25452	.7927	.30620	.7430	.35767
	2 – Always foster or kinship care	.8915	.21413	.8528	.24930	.7679	.33515
	3 – Other types of care	.8903	.19125	.8318	.24101	.8007	.29934
Last placement type	1 – Kinship care	.9002	.18295	.8376	.23700	.8094	.28803
	2 – Foster care	.8889	.20962	.8484	.24573	.7790	.32382
	3 – Residential or other types of care	.8660	.24905	.7881	.30469	.7435	.35730
School type at KS4	1 – Mainstream school	.8937	.20619	.8451	.24983	.7845	.32329

	2 – Special school	.8735	.22153	.8265	.26149	.7848	.31054
	3 – Other educational provisions	.8533	.26745	.7679	.32053	.6980	.38263
Highest level of SEN provision	1 – No SEN	.8902	.22764	.8273	.28706	.7374	.37129
	2 – School action/school action plus	.8800	.22916	.8236	.27371	.7758	.33357
	3 - Statement	.8826	.20299	.8391	.23865	.7794	.30569
Primary SEN	1 – No SEN	.8903	.22094	.8364	.27173	.7609	.34798
	2 – Behavioural, emotional & social difficulties	.8671	.23260	.8184	.26686	.7749	.33064
	3 – Other disabilities	.8922	.20861	.8342	.25968	.7755	.31908

ANOVA		Health Checks		Dental Checks		Immunisations	
Variable	Categories	N	F	N	F	N	F
Ethnicity	1 – White British or Irish	3556	2.246	3556	1.483	3556	32.592***
	2 – Other ethnicities	951		951		951	
	3 – Ethnicity unknown	335		335		335	
Category of need	1 – Abuse and/or neglect	2715	5.609**	2715	3.689*	2715	17.772***
	2 – Anti-social behaviour	105		105		105	
	3 – Parenting capacity	1705		1705		1705	
	4 – Other reasons	314		314		314	
All placement types	1 – Ever residential care	1490	8.070***	1490	21.535***	1490	11.125***
	2 – Always foster or kinship care	1905		1905		1905	
	3 – Other types of care	1447		1447		1447	

Last placement type	1 – Kinship care 2 – Foster care 3 – Residential or other types of care	395 2883 1564	6.817**	395 2883 1564	26.401***	395 2883 1564	8.813***
School type at KS4	1 – Mainstream school 2 – Special school 3 – Other educational provisions	2967 1060 815	11.815***	2967 1060 815	27.026***	2967 1060 815	23.145***
Highest level of SEN provision	1 – No SEN 2 – School action/school action plus 3 - Statement	650 2701 1454	.564	650 2701 1454	1.631	650 2701 1454	4.087*
Primary SEN	1 – No SEN 2 – Behavioural, emotional & social difficulties 3 – Other disabilities	1270 1857 1681	6.902	1270 1857 1681	2.287	1270 1857 1681	.862

Variable	Mean	SD
Eligible for free school meals at KS1	1.55	.498
Local deprivation index	.327269091	.197609361
Number of years in care	5.5674	3.94373
Number of periods in care	1.82	8.122
Number of placement changes	4.7192	4.86569
Length of last placement	3.6457	3.14138
Number of respite placements	.0300	.12506
Proportion of time spent at home	.0486	.13637
Number of fixed term exclusions	11.8440	22.08752
KS2 points	3.8767	.85356
Mean SDQ score	.2124	6.84434

Correlation	Health Checks		Dental Checks		Immunisations	
Variable	N	r	N	r	N	r
Eligible for free school meals at KS1	4464	.263*	4464	.002	4464	-.024
Local deprivation index	4436	.056***	4436	.004	4436	.001
Number of years in care	4842	.034*	4842	.085***	4842	.194***
Number of periods in care	4842	-.040**	4842	-.010	4842	-.016
Number of placement changes	4842	-.066***	4842	-.053***	4842	.023
Length of last placement	4833	.061***	4833	.100***	4833	.134***
Number of respite placements	4842	-.019	4842	-.003	4842	-.029*
Proportion of time spent at home	4842	-.016	4842	-.029*	4842	-.029*
Number of fixed term exclusions	4842	-.040**	4842	-.052***	4842	-.028*
KS2 points	4224	.017	4224	.008	4224	.022
Mean SDQ score	4310	-.040**	4310	-.037*	4310	-.015

Chi-square		Substance Misuse		Intervention received		Intervention offered	
Variable	Categories	N (%)	X²	N (%)	X²	N (%)	X²
Gender	1 – Female 2 – Male	227 (10.6%) ^a 303 (11.2%) ^a	.457	128 (56.4%) ^a 171 (56.4%) ^a	.000	73 (66.4%) ^a 118 (75.2%) ^a	2.457
Ethnicity	1 – White British or Irish 2 – Other ethnicities 3 – Ethnicity unknown	381 (10.7%) ^a 102 (10.7%) ^a 47 (14.0%) ^a	3.506	207 (54.3%) ^a 60 (58.8%) ^a 32 (68.1%) ^a	3.517	136 (68.0%) ^a 37 (78.7%) ^a 18 (90.0%) ^a	5.769
Age at first entry into care	1 – 0 to 9 2 – 10+	212 (9.0%) ^a 318 (12.8%) ^b	17.983***	115 (54.2%) ^a 184 (57.9%) ^a	.677	79 (66.4%) ^a 112 (75.7%) ^a	2.795
In care at KS1	1 – No 2 – Yes	419 (11.8%) ^a 111 (8.7%) ^b	9.313**	241 (57.5%) ^a 58 (52.3%) ^a	.990	149 (74.9%) ^a 42 (61.8%) ^b	4.278*
In care at KS2	1 – No 2 – Yes	291 (12.9%) ^a 239 (9.3%) ^b	16.326***	172 (59.1%) ^a 127 (53.1%) ^a	1.901	101 (75.4%) ^a 90 (67.7%) ^a	1.946
In care at KS3	1 – No 2 – Yes	95 (12.5%) ^a 435 (10.7%) ^a	2.271	61 (64.2%) ^a 238 (54.7%) ^a	2.861	29 (85.3%) ^a 162 (69.5%) ^a	3.622
Category of need	1 – Abuse and/or Neglect 2 – Anti-social behaviour 3 – Parenting capacity 4 – Other reason	306 (11.3%) ^a 18 (17.1%) ^a 202 (11.8%) ^a 4 (1.3%) ^b	35.839***	172 (56.2%) ^a 12 (66.7%) ^a 113 (55.9%) ^a 2 (50.0%) ^a	.860	115 (70.6%) ^a 6 (85.7%) ^a 69 (72.6%) ^a 1 (50.0%) ^a	1.280
Placement location at KS2	1 – In own LA	151 (9.6%) ^a 88 (8.7%) ^a	.595	77 (51.0%) ^a 50 (56.8%) ^a	.758	50 (58.1%) ^a 40 (85.1%) ^b	10.102**

	2 – In another LA						
Ever placed in residential care	1 – No 2 – Yes	375 (9.3%) ^a 155 (18.8%) ^b	62.965***	200 (53.3%) ^a 99 (63.9%) ^b	4.953*	139 (71.6%) ^a 52 (71.2%) ^a	.005
Always placed in foster care	1 – No 2 – Yes	519 (11.4%) ^a 11 (3.9%) ^b	15.137***	297 (56.6%) ^a 5 (45.5%) ^a	.549	187 (71.6%) ^a 4 (66.7%) ^a	.071
Always placed in kinship care	1 – No 2 – Yes	529 (11.0%) ^a 1 (3.7%) ^a	1.462	298 (56.3%) ^a 1 (100.0%) ^a	.774	N/A	N/A
Ever placed with parents	1 – No 2 – Yes	498 (10.7%) 32 (16.1%)	5.607*	283 (56.8%) ^a 16 (50.0%) ^a	.570	179 (72.2%) ^a 12 (63.2%) ^a	.705
Always placed by own LA	1 – No 2 – Yes	517 (11.3%) ^a 13 (5.0%) ^b	9.866**	291 (56.3%) ^a 8 (61.5%) ^a	.142	186 (71.3%) ^a 5 (83.3%) ^a	.420
Ever placed by own LA	1 – No 2 – Yes	140 (10.0%) ^a 390 (11.3%) ^a	1.758	85 (60.7%) ^a 214 (54.9%) ^a	1.430	46 (79.3%) ^a 145 (69.4%) ^a	2.200
Ever placed by another LA	1 – No 2 – Yes	512 (10.7%) ^a 18 (23.7%) ^b	12.846***	285 (55.7%) ^a 14 (77.8%) ^a	3.458	185 (71.2%) ^a 6 (85.7%) ^a	.710
Ever placed by an independent agency	1 – No 2 – Yes	281 (10.1%) ^a 249 (12.1%) ^b	5.002*	149 (53.0%) ^a 150 (60.2%) ^a	2.796	99 (67.3%) ^a 92 (76.7%) ^a	2.818
First language at KS1	1 – English 2 – Other language	490 (11.5%) ^a 23 (11.1%) ^b	.042	274 (55.9%) ^a 17 (73.9%) ^a	2.898	176 (70.4%) ^a 8 (100.0%) ^a	3.320
First language at KS2	1 – English 2 – Other language	479 (11.4%) ^a 21 (9.0%) ^a	1.277	269 (56.2%) ^a 16 (76.2%) ^a	3.294	171 (70.1%) ^a 6 (100.0%) ^a	2.535
Unaccompanied asylum-seeking child or young person	1 – No 2 – Yes	526 (11.3%) ^a 4 (2.4%) ^b	12.978***	298 (56.7%) ^a 1 (25.0%) ^a	1.618	188 (71.2%) ^a 3 (100.0%) ^a	1.207

Changed school in Y8 or Y9	1 – No 2 – Yes	391 (10.2%) ^a 79 (14.7%) ^b	9.927**	218 (55.8%) ^a 42 (53.2%) ^a	.178	140 (70.0%) ^a 30 (73.2%) ^a	.165
KS2 school type	1 – Mainstream school 2 – Special school 3 – Other provisions	471 (12.2%) ^a 24 (4.8%) ^b 5 (9.6%) ^{a,b}	23.763***	269 (57.1%) 10 (41.7%) 3 (60.0%)	2.242	167 (71.1%) ^a 12 (80.0%) ^a 2 (66.7%) ^a	.588
SEN Provision 3	1 – No provision 2 – School action/plus 3 – Statement	82 (11.4%) ^a 341 (13.0%) ^a 104 (7.5%) ^b	28.632***	43 (52.4%) ^a 193 (56.6%) ^a 61 (58.7%) ^a	.743	29 (70.7%) 125 (73.5%) 36 (65.5%)	1.339

Correlation	Substance Misuse		Intervention received		Intervention offered	
Variable	N	<i>r</i>	N	<i>r</i>	N	<i>r</i>
Number of years in care	4141	-.040**	530	.005	267	-.025
Number of periods in care	4841	-.017	530	.024	267	.014
Number of placements	4841	.096***	530	.039	267	.070
Number of respite placements	4841	-.060***	530	.053	267	-.077
Time at home	4841	-.033*	530	-.125**	267	-.094
Proportion of time spent at home	4082	-.005	444	-.050	235	-.146*
Time in 'other' residential placements	229	-.081	41	.070	15	-.132

Proportion of time spent in other residential placements	226	-.003	41	.022	15	-.436
KS2 points	4223	.075***	473	-.038	236	-.085
Eligible for free school meals in 2004	4463	.052**	513	.008	258	-.140*
Local deprivation index in 2004	4435	.075***	510	-.017	256	-.141*
Mean SDQ from 2009 to 2011	2880	.052**	287	.061	156	.032

Variable	Mean	SD
Number of years in care	3.1719	3.22872
Number of periods in care	1.6086	8.13372
Number of placements	2.9907	3.01299
Number of respite placements	.0284	.12197
Time at home	669.3165	1018.53859
Proportion of time spent at home	13.6914	103.51875
Time in 'other' residential placements	225.3755	393.79804
Proportion of time spent in other residential placements	.2380	.28076
KS2 points	3.8767	.85356
Eligible for free school meals in 2004	1.55	.498
Local deprivation index in 2004	.327269091	.197609361
Mean SDQ from 2009 to 2011	.0599	7.12007

Health

	N	Mean	SD
Health Checks	4842	.8825	.22147
Dental Checks	4842	.8280	.26695
Immunisations	4842	.7700	.33286
Mean SDQ	4305	14.369	6.813
Substance Misuse Problem	4842	.0627	.20129
Criminal conviction	4837	1.152	.35901

Gender

	Girls	Boys
Health Checks	.8849 (.22652) N = 2140	.8806 (.21741) N = 2702
Dental Checks	.8313 (.27456) N = 2140	.8255 (.26078) N = 2702
Immunisations	.7619 (.34459) N = 2140	.7764 (.32320) N = 2702
Substance Misuse Problem	.0638 (.20796) N = 2140	.0619 (.19588) N = 2702
Mean SDQ	13.652 (.15668) N = 1893	14.9316 (.13759) N = 2412
Criminal conviction	1.109 (.31279) N = 2139	1.185 (.38863) N = 2698

Ethnicity8Cats

	Health Checks	Dental Checks	Immunisations
White British or Irish	.8802 (.22152) N = 3556	.8262 (.26692) N = 3556	.7929 (.31468) N = 3556
Asian	.8913 (.24218) N = 183	.8485 (.26793) N = 183	.7164 (.37340) N = 183
Black African	.9155 (.21420) N = 130	.8505 (.27814) N = 130	.6141 (.43666) N = 130
Black Caribbean and Mixed White/Black Caribbean	.8957 (.20457) N = 260	.8246 (.25547) N = 260	.7372 (.32539) N = 260
Other Mixed	.8793 (.29151) N = 163	.8512 (.24484) N = 163	.7680 (.33037) N = 163
Traveller	.8939 (.23889) N = 11	.8015 (.20391) N = 11	.5242 (.40390) N = 11
Other	.8978 (.21975) N = 204	.8373 (.27823) N = 204	.6526 (.41272) N = 204
Ethnic Origin Not Known	.8705 (.22600) N = 335	.8137 (.27665) N = 335	.7229 (.35887) N = 335

	Substance Misuse Problem	Intervention Received	Intervention Offered
White British or Irish	.0613 (.19968) N = 3556	.2435 (.40858) N = 855	.2090 (.39580) N = 683
Asian	.0523 (.18764) N = 183	.3229 (.46747) N = 32	.2391 (.42291) N = 23
Black African	.0392 (.16728) N = 130	.2778 (.46089) N = 18	.3333 (.48795) N = 15
Black Caribbean and Mixed White/Black Caribbean	.0665 (.19127) N = 260	.2841 (.43467) N = 69	.3462 (.48038) N = 52
Other Mixed	.0575 (.17515) N = 163	.3750 (.47519) N = 35	.2174 (.42174) N = 23
Traveller	.0182 (.06030) N = 11	.1667 (.28868) N = 3	.0000 (.00000) N = 3
Other	.0643 (.21901) N = 204	.3750 (.47519) N = 32	.2857 (.43507) N = 21
Ethnic Origin Not Known	.0930 (.24308) N = 335	.4157 (.47258) N = 82	.3712 (.47952) N = 52

**Special Educational Needs
SEN provision**

	Health Checks	Dental Checks	Immunisations
No Special Need	.8902 (.22764) N = 650	.8273 (.28706) N = 650	.7374 (.37129) N = 650
School Action	.8864 (.22272) N = 718	.8279 (.27344) N = 718	.7727 (.33136) N = 718
School Action Plus	.8777 (.23146) N = 1983	.8220 (.27386) N = 1983	.7769 (.33444) N = 1983
Statemented	.8826 (.20299) N = 1454	.8391 (.23865) N = 1454	.7794 (.30569) N = 1454

Primary SEN

	Substance Misuse Problem	Intervention Received	Intervention Offered
No Special Need	.0726 (.22735) N = 650	.3199 (.45860) N = 136	.2623 (.42803) N = 95
School Action	.0686 (.21403) N = 718	.3026 (.44327) N = 168	.2699 (.43758) N = 124
School Action Plus	.0739 (.21509) N = 1983	.2839 (.43198) N = 516	.2538 (.42761) N = 392
Statemented	.0414 (.15917) N = 1454	.2040 (.37510) N = 304	.1647 (.35869) N = 259

SEN provision

	Health Checks	Dental Checks	Immunisations
No Special Need	.8898 (.22799) N = 678	.8191 (.29559) N = 678	.7347 (.37232) N = 678
School Action	.8913 (.21472) N = 645	.8453 (.25546) N = 645	.7791 (.32680) N = 645
School Action Plus	.8801 (.23000) N = 1968	.8215 (.27405) N = 1968	.7769 (.33458) N = 1968
Statemented	.8775 (.21088) N = 1531	.8336 (.24656) N = 1531	.7745 (.31118) N = 1531

SEN provision

	Substance Misuse Problem	Intervention Received	Intervention Offered
No Special Need	.0729 (.227513) N = 678	.3369 (.46139) N = 141	.2534 (.42045) N = 97
School Action	.0591 (.20010) N = 645	.2711 (.43330) N = 150	.2175 (.40729) N = 114
School Action Plus	.0728 (.21416) N = 1968	.2729 (.42755) N = 505	.2655 (.43330) N = 388
Statemented	.0475 (.17174) N = 1531	.2336 (.39421) N = 329	.1808 (.37488) N = 272

Primary special educational need

	Health Checks	Dental Checks	Immunisations
No Special Educational Need	.8890 (.22382) N = 1363	.8287 (.27846) N = 1363	.7564 (.35104) N = 1363
Behavioural, Emotional and Social	.8670 (.23081) N = 1735	.8224 (.26250) N = 1735	.7783 (.32733) N = 1735
Moderate Learning Disability	.8848 (.22593) N = 683	.8305 (.25591) N = 683	.7759 (.32328) N = 683
Specific Learning Disability	.8996 (.19712) N = 177	.8155 (.28307) N = 177	.7849 (.31841) N = 177
Speech, Language and Communication	.9294 (.16956) N = 131	.8527 (.26729) N = 131	.7580 (.32565) N = 131
Autistic Spectrum Disorder	.8914 (.19341) N = 185	.8668 (.22292) N = 185	.7650 (.31729) N = 185
Sensory Impairment	.9343 (.14917) N = 36	.8731 (.22898) N = 36	.7245 (.36344) N = 36
Severe or Multiple Learning Difficulties	.8816 (.22266) N = 223	.8126 (.28840) N = 223	.7599 (.31504) N = 223
Physical and Other Disabilities	.8905 (.18957) N = 272	.8439 (.23927) N = 272	.8135 (.29627) N = 272

Primary SEN

	Substance Misuse Problem	Intervention Received	Intervention Offered
No Special Educational Need	.0693 (.21787) N = 1363	.3074 (.44912) N = 302	.2632 (.43061) N = 218
Behavioural, Emotional and Social	.0807 (.22066) N = 1735	.2988 (.43117) N = 463	.2787 (.43638) N = 354
Moderate Learning Disability	.0576 (.19728) N = 683	.2093 (.36832) N = 172	.2042 (.39570) N = 142
Specific Learning Disability	.0344 (.13345) N = 177	.2250 (.40746) N = 40	.0606 (.24231) N = 33

Speech, Language and Communication	.0687 (.22900) N = 131	.3194 (.46604) N = 24	.2941 (.46967) N = 17
Autistic Spectrum Disorder	.0115 (.08231) N = 185	.0370 (.19245) N = 27	.0962 (.28352) N = 26
Sensory Impairment	.0472 (.18591) N = 36	.5000 (.54722) N = 6	.0000 (.00000) N = 3
Severe or Multiple Learning Difficulties	.0130 (.10162) N = 223	.0968 (.30054) N = 31	.0357 (.18898) N = 28
Physical and Other Disabilities	.0284 (.11238) N = 272	.2034 (.38415) N = 59	.1020 (.30584) N = 49

Primary SEN

	Health Checks	Dental Checks	Immunisations
No Special Educational Need	.8903 (.22094) N = 1270	.8364 (.27173) N = 1270	.7609 (.34798) N = 1270
Behavioural, Emotional and Social	.8671 (.23260) N = 1857	.8184 (.26686) N = 1857	.7749 (.33064) N = 1857
Moderate Learning Disability	.8858 (.22592) N = 668	.8281 (.26089) N = 668	.7720 (.32589) N = 668
Specific Learning Disability	.9013 (.19577) N = 175	.8134 (.28400) N = 175	.7853 (.31909) N = 175
Speech, Language and Communication	.9277 (.17120) N = 128	.8570 (.25893) N = 128	.7539 (.32803) N = 128
Autistic Spectrum Disorder	.8919 (.19305) N = 186	.8658 (.22280) N = 186	.7663 (.31690) N = 186
Severe or Multiple Learning Difficulties	.8816 (.22266) N = 223	.8126 (.28840) N = 223	.7599 (.31504) N = 223
Physical, Sensory and Other Disabilities	.8941 (.18751) N = 301	.8467 (.23937) N = 301	.8039 (.30453) N = 301

Primary SEN

	Substance Misuse Problem	Intervention Received	Intervention Offered
No Special Educational Need	.0602 (.20357) N = 1270	.2792 (.43855) N = 271	.2214 (.40518) N = 202
Behavioural, Emotional and Social	.0883 (.23175) N = 1857	.3198 (.43829) N = 505	.3073 (.44907) N = 377
Moderate Learning Disability	.0547 (.19349) N = 668	.2036 (.38478) N = 167	.1920 (.38835) N = 138
Specific Learning Disability	.0348 (.13417) N = 175	.2250 (.40746) N = 40	.0606 (.24231) N = 33
Speech, Language and Communication	.0609 (.21591) N = 128	.3030 (.45900) N = 22	.2500 (.44721) N = 16
Autistic Spectrum Disorder	.0115 (.08209) N = 186	.0370 (.19245) N = 27	.0962 (.28352) N = 26
Severe or Multiple Learning Difficulties	.0130 (.10162) N = 223	.0968 (.30054) N = 31	.0357 (.18898) N = 28
Physical, Sensory and Other Disabilities	.0243 (.10299) N = 301	.1967 (.39029) N = 61	.0800 (.27405) N = 50

Secondary SEN

	Health Checks	Dental Checks	Immunisations
No Special Educational Need	.8818 (.22183) N = 3716	.8251 (.27252) N = 3716	.7714 (.33640) N = 3716
Behavioural, Emotional and Social	.8880 (.20942) N = 324	.8255 (.26447) N = 324	.7533 (.33371) N = 324
Moderate Learning Disability	.8630 (.24349) N = 276	.8208 (.25083) N = 276	.7721 (.31628) N = 276
Specific Learning Disability	.9151 (.17406) N = 98	.8238 (.25623) N = 98	.8117 (.30120) N = 98

Speech, Language and Communication	.9003 (.21043) N = 121	.8562 (.21701) N = 121	.7621 (.32663) N = 121
Autistic Spectrum Disorder	.8461 (.27790) N = 77	.8346 (.26359) N = 77	.7292 (.33673) N = 77
Sensory Impairment	.9410 (.12078) N = 39	.8526 (.23646) N = 39	.8517 (.21727) N = 39
Severe or Multiple Learning Difficulties	.9133 (.18017) N = 50	.8877 (.21014) N = 50	.7370 (.32794) N = 50
Physical and Other Disabilities	.8809 (.22904) N = 141	.8716 (.22304) N = 141	.7567 (.32144) N = 141

Secondary SEN

	Substance Misuse Problem	Intervention Received	Intervention Offered
No Special Educational Need	.0668 (.20679) N = 3716	.2898 (.43445) N = 865	.2508 (.42265) N = 652
Behavioural, Emotional and Social	.0677 (.21067) N = 324	.2424 (.40425) N = 88	.1667 (.36579) N = 72
Moderate Learning Disability	.0480 (.17766) N = 276	.2206 (.39001) N = 68	.1339 (.33698) N = 56
Specific Learning Disability	.0869 (.24097) N = 98	.2133 (.40689) N = 25	.4762 (.51177) N = 21
Speech, Language and Communication	.0021 (.02273) N = 121	.0000 (.00000) N = 19	.0000 (.00000) N = 19
Autistic Spectrum Disorder	.0286 (.13941) N = 77	.2000 (.41404) N = 15	.0833 (.28868) N = 12
Sensory Impairments	.0410 (.12920) N = 39	.2222 (.44096) N = 9	.1429 (.37796) N = 7
Severe or Multiple Learning Difficulties	.0200 (.14142) N = 50	.2500 (.50000) N = 4	.0000 (.00000) N = 3
Physical and Other Disabilities	.0475 (.18179) N = 141	.1364 (.31307) N = 33	.2167 (.40860) N = 30

Last placement type

	Health Checks	Dental Checks	Immunisations
Kinship Care	.9002 (.18295) N = 395	.8376 (.23700) N = 395	.8094 (.28803) N = 395
Foster Care	.8889 (.20962) N = 2883	.8484 (.24573) N = 2883	.7790 (.32382) N = 2883
Residential or Other Care	.8660 (.24905) N = 1564	.7881 (.30469) N = 1564	.7435 (.35730) N = 1564

Last placement type

	Substance Misuse Problem	Intervention Received	Intervention Offered
Kinship Care	.0375 (.14007) N = 395	.1870 (.37462) N = 90	.1623 (.35764) N = 77
Foster Care	.0310 (.13883) N = 2883	.1712 (.36691) N = 557	.1390 (.34267) N = 473
Residential or Other Care	.1275 (.28069) N = 1564	.3981 (.45913) N = 479	.3829 (.46960) N = 322

All placement Types

	Health Checks	Dental Checks	Immunisations
Only ever Residential care	.8620 (.28934) N = 170	.7483 (.40940) N = 170	.6996 (.41659) N = 170
Only ever Foster care	.8906 (.21571) N = 1761	.8533 (.25047) N = 1761	.7645 (.33880) N = 1761
Only ever Kinship care	.9017 (.19424) N = 144	.8465 (.23521) N = 144	.8094 (.28455) N = 144
Mix of Foster and Residential care	.8650 (.24932) N = 973	.7978 (.29601) N = 973	.7477 (.34888) N = 973
Mix of Foster and Kinship care	.8946 (.19136) N = 478	.8240 (.24026) N = 478	.7849 (.30620) N = 478
Mix of Kinship and Residential care	.9096 (.17206) N = 26	.7846 (.28476) N = 26	.8551 (.28487) N = 26
Mix of Foster and other types of care	.8836 (.18578) N = 766	.8375 (.23304) N = 766	.8136 (.28634) N = 766
Mix of Kinship and other types of care	.9195 (.14755) N = 95	.8582 (.19995) N = 95	.8567 (.22510) N = 95
Mix of Residential and	.8466 (.30530) N = 138	.8181 (.31187) N = 138	.6716 (.40377) N = 138

other types of care			
Mix of all three types of care	.8616 (.21332) N = 183	.7890 (.23792) N = 183	.7962 (.30196) N = 183
None of these three types of care	.8929 (.25299) N = 108	.8031 (.31986) N = 108	.7289 (.38973) N = 108

All placement types

	Substance Misuse Problem	Intervention Received	Intervention Offered
Only ever Residential care	.1020 (.28621) N = 170	.7292 (.44181) N = 24	.4286 (.53452) N = 7
Only ever Foster care	.0219 (.11708) N = 1761	.1568 (.35819) N = 271	.1073 (.30666) N = 233
Only ever Kinship care	.0259 (.11690) N = 144	.0926 (.27863) N = 27	.1000 (.28868) N = 25
Mix of Foster and Residential care	.1256 (.27521) N = 973	.3727 (.45828) N = 311	.3783 (.46824) N = 214
Mix of Foster and Kinship care	.0441 (.15719) N = 478	.1802 (.36440) N = 123	.1478 (.34681) N = 106
Mix of Kinship and Residential care	.0885 (.23380) N = 26	.5000 (.40825) N = 4	1.0000 (.00000) N = 3
Mix of Foster and other types of care	.0491 (.17175) N = 766	.2029 (.38465) N = 207	.1788 (.37902) N = 172
Mix of Kinship and other types of care	.0274 (.10360) N = 95	.1322 (.30660) N = 29	.1667 (.36690) N = 27
Mix of Residential and other types of care	.1757 (.35651) N = 138	.5215 (.49205) N = 31	.6875 (.47871) N = 16
Mix of all three types of care	.1304 (.23751) N = 183	.4069 (.44801) N = 75	.3782 (.47038) N = 52
None of these three types of care	.0935 (.27036) N = 108	.3229 (.46904) N = 24	.3235 (.46574) N = 17

All placements 3 categories

	Health Checks	Dental Checks	Immunisations
Ever Residential	.8633 (.25452) N = 1490	.7927 (.30620) N = 1490	.7430 (.35767) N = 1490

Always Foster or Kinship	.8915 (.21413) N = 1905	.8528 (.24930) N = 1905	.7679 (.33515) N = 1905
Other	.8903 (.19125) N = 1447	.8318 (.24101) N = 1447	.8007 (.29934) N = 1447

All placements 3 categories

	Substance Misuse Problem	Intervention Received	Intervention Offered
Ever Residential	.1275 (.28029) N = 1490	.4092 (.46380) N = 445	.4029 (.47504) N = 292
Always Foster or Kinship	.0222 (.11704) N = 1905	.1510 (.35181) N = 298	.1066 (.30443) N = 258
Other	.0493 (.17335) N = 1447	.1978 (.37915) N = 383	.1752 (.37284) N = 322

Age at first entry into care

	Health Checks	Dental Checks	Immunisations
Under 5	.8866 (.17682) N = 748	.8442 (.19422) N = 748	.8508 (.23158) N = 748
5 to 9	.8911 (.17029) N = 1610	.8507 (.20184) N = 1610	.8208 (.25263) N = 1610
10 +	.8756 (.25948) N = 2484	.8085 (.31685) N = 2484	.7128 (.38937) N = 2484

Age at first entry into care

	Substance Misuse Problem	Intervention Received	Intervention Offered
Under 5	.0328 (.11231) N = 748	.1490 (.33175) N = 226	.1422 (.33691) N = 202
5 to 9	.0329 (.11449) N = 1610	.1554 (.33805) N = 490	.1266 (.32184) N = 437
10 +	.0911 (.25507) N = 2484	.4708 (.48223) N = 410	.5043 (.49128) N = 233

Age at last entry into care

	Health Checks	Dental Checks	Immunisations
Under 5	.8850 (.16940) N = 611	.8490 (.18490) N = 611	.8615 (.21884) N = 611
5 to 9	.8947 (.15753) N = 1478	.8514 (.19160) N = 1478	.8287 (.23966) N = 1478
10 +	.8754 (.25788) N = 2750	.8170 (.31219) N = 2750	.7181 (.38370) N = 2750

	Substance Misuse Problem	Intervention Received	Intervention Offered
Under 5	.0265 (.09027) N = 611	.1445 (.32377) N = 188	.1221 (.31744) N = 170
5 to 9	.0300 (.10127) N = 1478	.1358 (.31994) N = 475	.1190 (.31027) N = 431
10 +	.0884 (.25001) N = 2750	.4581 (.47988) N = 461	.4814 (.49213) N = 269

Reason for entering care

	Health Checks	Dental Checks	Immunisations
Abuse or Neglect	.8933 (.19520) N = 2715	.8386 (.23915) N = 2715	.7974 (.29966) N = 2715
Child Disability	.8824 (.23772) N = 308	.8150 (.30250) N = 308	.6939 (.36745) N = 308
Parent ill/disabled	.8675 (.24053) N = 198	.8537 (.21923) N = 198	.7876 (.31312) N = 198
Family Stress	.8739 (.23853) N = 517	.8190 (.29524) N = 517	.7711 (.34940) N = 517
Family Dysfunction	.8615 (.26447) N = 703	.7927 (.32120) N = 703	.7645 (.35681) N = 703
Child Behaviour	.8495 (.28939) N = 105	.7860 (.33561) N = 105	.6737 (.41784) N = 105
Low Income	.9333 (.10328) N = 6	.9000 (.16733) N = 6	.6167 (.37103) N = 6
Absent Parent	.8693 (.24436) N = 287	.8399 (.27235) N = 287	.6296 (.41812) N = 287

Reason for entering care

	Substance Misuse Problem	Intervention Received	Intervention Offered
Abuse or Neglect	.0584 (.18791) N = 2715	.2359 (.40038) N = 703	.2120 (.39750) N = 572
Child Disability	.0117 (.10013) N = 308	.0811 (.27672) N = 37	.0294 (.17150) N = 34
Parent ill/disabled	.0285 (.11876) N = 198	.1125 (.28840) N = 40	.1892 (.37917) N = 37
Family Stress	.0891 (.24582) N = 517	.4076 (.48241) N = 110	.3841 (.47855) N = 69
Family Dysfunction	.0888 (.24581) N = 703	.3507 (.46892) N = 168	.2566 (.43361) N = 113
Child Behaviour	.1359 (.31750) N = 105	.5478(.49806) N = 23	.5000 (.52223) N = 12
Low Income	.0000 (.00000) N = 6	.0000 (.00000) N = 3	.0000 (.00000) N = 3
Absent Parent	.0455 (.16489) N = 287	.3292 (.43443) N = 40	.3600 (.48252) N = 30

Number of periods in care since KS2

	Health Checks	Dental Checks	Immunisations
1 period	.8774 (.26134) N = 1856	.8089 (.31888) N = 1856	.7085 (.39406) N = 1856
2 periods	.8685 (.29404) N = 351	.7811 (.36319) N = 351	.7277 (.40851) N = 351
3 or more periods	.7995 (.34596) N = 138	.7723 (.36672) N = 138	.6516 (.43016) N = 138

Number of periods in care since KS2

	Substance Misuse Problem	Intervention Received	Intervention Offered
1 period	.0880 (.25335) N = 1856	.5813 (.47463) N = 1856	.7027 (.44913) N = 1856
2 periods	.1104 (.27921) N = 351	.5699 (.47799) N = 351	.7407 (.44658) N = 351
3 or more periods	.1812 (.35597) N = 138	.5000 (.50000) N = 138	.6875 (.47871) N = 138

Last placement provider

	Health Checks	Dental Checks	Immunisations
Parents	.8503 (.21960) N = 162	.7309 (.26075) N = 162	.7764 (.29955) N = 162
Own Local Authority	.8927 (.21228) N = 2440	.8408 (.25082) N = 2440	.7911 (.31741) N = 2440
Other Local Authority	.8323 (.27389) N = 67	.7595 (.32165) N = 67	.6674 (.39410) N = 67
Independent Fostering Agency	.8745 (.22983) N = 2152	.8229 (.28176) N = 2152	.7473 (.34914) N = 2152

Last placement provider

	Substance Misuse Problem	Intervention Received	Intervention Offered
Parents	.0699 (.18229) N = 162	.1800 (.33135) N = 50	.3222 (.45422) N = 45
Own Local Authority	.0503 (.17954) N = 2440	.2254 (.40480) N = 582	.1457 (.34210) N = 470
Other Local Authority	.1585 (.32381) N = 67	.5167 (.47419) N = 20	.4091 (.49082) N = 11
Independent Fostering Agency	.0735 (.21924) N = 2152	.3253 (.44534) N = 466	.3346 (.46420) N = 338

Career type

	Health Checks	Dental Checks	Immunisations
Entry 0 to 4	.8854 (.17883) N = 715	.8434 (.19473) N = 715	.8546 (.22676) N = 715
Entry 5 to 9	.8931 (.16338) N = 1463	.8529 (.19526) N = 1463	.8301 (.24354) N = 1463
Teenage Entrant	.8532 (.28800) N = 1028	.7896 (.34234) N = 1028	.7229 (.39690) N = 1028
Teenage abused	.8959 (.22792) N = 1161	.8253 (.28841) N = 1161	.7369 (.36193) N = 1161
UASC	.8636 (.26282) N = 167	.8234 (.29608) N = 167	.5419 (.44812) N = 167
Disabled	.8824 (.23772) N = 308	.8150 (.30250) N = 308	.6939 (.36745) N = 308

Career type

	Substance Misuse Problem	Intervention Received	Intervention Offered
Entry 0 to 4	.0341 (.11449) N = 715	.1512 (.33297) N = 216	.1488 (.34327) N = 193
Entry 5 to 9	.0359 (.11946) N = 1463	.1634 (.34477) N = 466	.1340 (.32958) N = 413
Teenage Entrant	.1130 (.28351) N = 1028	.5348 (.48567) N = 187	.5753 (.48871) N = 93
Teenage Abused	.0902 (.25003) N = 1161	.4225 (.47376) N = 213	.4436 (.48716) N = 133
UASC	.0142 (.09438) N = 167	.1429 (.37796) N = 7	.6667 (.51640) N = 6
Disabled	.0117 (.10013) N = 308	.0811 (.27672) N = 37	.0294 (.17150) N = 34

School Type at KS4

	Health Checks	Dental Checks	Immunisations
Mainstream	.8937 (.20619) N = 2967	.8451 (.24983) N = 2967	.7845 (.32329) N = 2967
Special School	.8735 (.22153) N = 1060	.8265 (.26149) N = 1060	.7848 (.31054) N = 1060
Pupil Referral Unit	.8656 (.25981) N = 323	.7339 (.34269) N = 323	.7169 (.38627) N = 323
Alternative Provision	.8288 (.28514) N = 272	.7850 (.30811) N = 272	.6896 (.37322) N = 272
Other	.8654 (.25476) N = 220	.7967 (.29806) N = 220	.6806 (.38923) N = 220

	Substance Misuse Problem	Intervention Received	Intervention Offered
Mainstream	.0394 (.15557) N = 2967	.1950 (.38192) N = 645	.1514 (.34909) N = 540
Special School	.0632 (.20038) N = 1060	.2961 (.44271) N = 242	.2165 (.40373) N = 180
Pupil Referral Unit	.1760 (.31606) N = 323	.4977 (.46032) N = 108	.6058 (.47642) N = 63
Alternative Provision	.1259 (.29001) N = 272	.4120 (.45423) N = 68	.5109 (.48864) N = 46
Other	.1311 (.29459) N = 220	.3757 (.45591) N = 63	.4457 (.49162) N = 43

School type at KS4

	Girls	Boys
Health Checks	.8849 (.22652) N = 2140	.8806 (.21741) N = 2702
Dental Checks	.8313 (.27456) N = 2140	.8255 (.26078) N = 2702
Immunisations	.7619 (.34459) N = 2140	.7764 (.32320) N = 2702
Substance Misuse Problem	.0638 (.20796) N = 2140	.0619 (.19588) N = 2702
Intervention Received	.2690 (.42990) N = 491	.2689 (.41930) N = 635
Intervention Offered	.2141 (.40520) N = 376	.2441 (.41673) N = 496

Always in residential care

	No	Yes
Health Checks	.8832 (.21861) N = 4672	.8620 (.28934) N = 170
Dental Checks	.8309 (.25990) N = 4672	.7483 (.40940) N = 170
Immunisations	.7726 (.32919) N = 4672	.6996 (.41659) N = 170
Substance Misuse Problem	.0613 (.19741) N = 4672	.1020 (.28621) N = 170
Intervention Received	.2589 (.41797) N = 1102	.7292 (.44181) N = 24
Intervention Offered	.2295 (.41071) N = 865	.4286 (.53452) N = 7

Ever in residential care

	No	Yes
Health Checks	.8910 (.20454) N = 3352	.8633 (.25452) N = 1490
Dental Checks	.8437 (.24594) N = 3352	.7927 (.30620) N = 1490
Immunisations	.7820 (.32055) N = 3352	.7430 (.35767) N = 1490
Substance Misuse Problem	.0339 (.14467) N = 3352	.1275 (.28029) N = 1490
Intervention Received	.1773 (.36791) N = 681	.4092 (.46380) N = 445
Intervention Offered	.1447 (.34550) N = 580	.4029 (.47504) N = 292

Always in foster care

	No	Yes
Health Checks	.8778 (.22459) N = 3081	.8906 (.21571) N = 1761
Dental Checks	.8136 (.27492) N = 3081	.8533 (.25047) N = 1761
Immunisations	.7732 (.32944) N = 3081	.7645 (.33880) N = 1761
Substance Misuse Problem	.0860 (.23315) N = 3801	.0219 (.11708) N = 1761
Intervention Received	.3045 (.43674) N = 855	.1568 (.35819) N = 271
Intervention Offered	.2763 (.43556) N = 639	.1073 (.30666) N = 233

Ever in foster care

	No	Yes
Health Checks	.8820 (.24974) N = 681	.8825 (.21652) N = 4161
Dental Checks	.8086 (.31479) N = 681	.8312 (.25818) N = 4161
Immunisations	.7496 (.36277) N = 681	.7733 (.32763) N = 4161
Substance Misuse Problem	.0886 (.25841) N = 681	.0585 (.19002) N = 4161
Intervention Received	.3579 (.46305) N = 139	.2564 (.41666) N = 987
Intervention Offered	.3105 (.45651) N = 95	.2214 (.40529) N = 777

Always in Kinship Care

	No	Yes
Health Checks	.8819 (.22224) N = 4698	.9017 (.19424) N = 144
Dental Checks	.8275 (.26786) N = 4698	.8465 (.23521) N = 144
Immunisations	.7688 (.33419) N = 4698	.8094 (.28455) N = 144
Substance Misuse Problem	.0638 (.20323) N = 4698	.0259 (.11690) N = 144
Intervention Received	.2733 (.42588) N = 1099	.0926 (.27863) N = 27
Intervention Offered	.2350 (.41441) N = 847	.1000 (.28868) N = 25

Ever in Kinship Care

	No	Yes
Health Checks	.8802 (.22779) N = 3916	.8922 (.19227) N = 926
Dental Checks	.8292 (.27355) N = 3916	.8230 (.23706) N = 926
Immunisations	.7629 (.34096) N = 3916	.8003 (.29444) N = 926
Substance Misuse Problem	.0639 (.20742) N = 3916	.0579 (.17303) N = 926
Intervention Received	.2786 (.43193) N = 868	.2365 (.39413) N = 258
Intervention Offered	.2371 (.41645) N = 659	.2128 (.39762) N = 213

Placement Location at KS2 (in/out LA)

	In	Out
Health Checks	.8950 (.16246) N = 1573	.8863 (.16480) N = 1011
Dental Checks	.8445 (.19541) N = 1573	.8649 (.17898) N = 1011
Immunisations	.8299 (.24508) N = 1573	.8185 (.24847) N = 1011
Substance Misuse Problem	.0335 (.11002) N = 1573	.0289 (.09828) N = 1011
Intervention Received	.1398 (.32278) N = 542	.1752 (.35706) N = 272
Intervention Offered	.1062 (.29717) N = 491	.1797 (.36834) N = 236

In care at KS1

	No	Yes
Health Checks	.8804 (.23748) N = 3560	.8882 (.16919) N = 1282
Dental Checks	.8200 (.28918) N = 3560	.8503 (.19051) N = 1282
Immunisations	.7443 (.35776) N = 3560	.8413 (.23705) N = 1282
Substance Misuse Problem	.0748 (.22570) N = 3560	.0291 (.10026) N = 1282
Intervention Received	.3328 (.45289) N = 741	.1461 (.32840) N = 385
Intervention Offered	.2997 (.44989) N = 526	.1269 (.31959) N = 346

In care at KS2

	No	Yes
Health Checks	.8720 (.27284) N = 2258	.8916 (.16340) N = 2584
Dental Checks	.8000 (.33217) N = 2258	.8525 (.18938) N = 2584
Immunisations	.7066 (.40075) N = 2258	.8255 (.24643) N = 2584
Substance Misuse Problem	.0982 (.26793) N = 2258	.0317 (.10559) N = 2584
Intervention Received	.5751 (.47593) N = 312	.1516 (.33482) N = 814
Intervention Offered	.7379 (.43334) N = 145	.1301 (.32358) N = 727

In care at KS3

	No	Yes
Health Checks	.8663 (.34010) N = 759	.8855 (.19139) N = 4083
Dental Checks	.7794 (.41306) N = 759	.8371 (.22871) N = 4083
Immunisations	.6478 (.47698) N = 759	.7927 (.29302) N = 4083
Substance Misuse Problem	.1252 (.33013) N = 759	.0511 (.16418) N = 4083
Intervention Received	.6289 (.48562) N = 97	.2350 (.40140) N = 1029
Intervention Offered	.8333 (.37796) N = 36	.2052 (.39322) N = 836

Ever had a substance misuse problem

	No	Yes
Health Checks	.8842 (.21947) N = 4257	.8695 (.23529) N = 585
Dental Checks	.8316 (.26511) N = 4257	.8017 (.27879) N = 585
Immunisations	.7710 (.33326) N = 4257	.7631 (.33018) N = 585
Substance Misuse Problem	.0000 (.00000) N = 4257	.5191 (.31400) N = 585
Intervention Received	.0000 (.00000) N = 541	.5177 (.46577) N = 585
Intervention Offered	.0000 (.00000) N = 541	.6089 (.46576) N = 331

Always up to date with health checks

	No	Yes
Health Checks	.6258 (.24519) N = 1521	1.0000 (.00000) N = 3321
Dental Checks	.7620 (.27270) N = 1521	.8583 (.25874) N = 3321
Immunisations	.7377 (.31539) N = 1521	.7848 (.33959) N = 3321
Substance Misuse Problem	.0584 (.18100) N = 1521	.0647 (.20993) N = 3321
Intervention Received	.2257 (.38750) N = 398	.2926 (.44080) N = 728
Intervention Offered	.2295 (.40808) N = 331	.2321 (.41449) N = 541

Always up to date with dental checks

	No	Yes
Health Checks	.8339 (.24400) N = 1967	.9157 (.19791) N = 2875
Dental Checks	.5767 (.26269) N = 1967	1.0000 (.00000) N = 2875
Immunisations	.7334 (.33409) N = 1967	.7951 (.32975) N = 2875
Substance Misuse Problem	.0641 (.19197) N = 1967	.0617 (.20746) N = 2875
Intervention Received	.2593 (.41273) N = 530	.2775 (.43351) N = 596
Intervention Offered	.2355 (.41249) N = 421	.2271 (.41163) N = 451

Always up to date with dental checks

	No	Yes
Health Checks	.8492 (.23977) N = 2089	.9077 (.20294) N = 2753
Dental Checks	.7877 (.28373) N = 2089	.8587 (.24920) N = 2753
Immunisations	.4669 (.30860) N = 2089	1.0000 (.00000) N = 2753
Substance Misuse Problem	.0606 (.19196) N = 2089	.0643 (.20812) N = 2753
Intervention Received	.2875 (.43028) N = 480	.2552 (.41866) N = 646
Intervention Offered	.2454 (.41977) N = 364	.2209 (.40616) N = 508

English not a first language in 2004

	No	Yes
Health Checks	.8807 (.22062) N = 4254	.9245 (.17586) N = 208
Dental Checks	.8272 (.26441) N = 4254	.8446 (.26068) N = 208
Immunisations	.7865 (.31718) N = 4254	.7782 (.33966) N = 208
Substance Misuse Problem	.0648 (.20338) N = 4254	.0829 (.23941) N = 208
Intervention Received	.2653 (.42060) N = 1040	.3572 (.47449) N = 53
Intervention Offered	.2291 (.41048) N = 810	.2432 (.43496) N = 37

Ever had an 'abnormal' SDQ score

	No	Yes
Health Checks	.8848 (.22099) N = 1944	.8875 (.19983) N = 2366
Dental Checks	.8403 (.25878) N = 1944	.8352 (.24008) N = 2366
Immunisations	.7670 (.33846) N = 1944	.7900 (.30126) N = 2366
Substance Misuse Problem	.0496 (.18373) N = 1944	.0689 (.19960) N = 2366
Intervention Received	.2447 (.41654) N = 377	.2677 (.41921) N = 679
Intervention Offered	.1866 (.37867) N = 297	.2239 (.40675) N = 532

Ever permanently excluded

	No	Yes
Health Checks	.8829 (.22004) N = 4681	.8693 (.26014) N = 161
Dental Checks	.8306 (.26354) N = 4681	.7542 (.34489) N = 161
Immunisations	.7721 (.33023) N = 4681	.7092 (.39849) N = 161
Substance Misuse Problem	.0582 (.19246) N = 4681	.1931 (.35323) N = 161
Intervention Received	.2576 (.41747) N = 1078	.5243 (.48499) N = 48
Intervention Offered	.2169 (.40257) N = 847	.7133 (.43970) N = 25

Placement Location at KS4 (In/out LA)

	In	Out
Health Checks	.8894 (.21660) N = 2736	.8734 (.22738) N = 2106
Dental Checks	.8177 (.27386) N = 2736	.8414 (.25714) N = 2106
Immunisations	.7831 (.32605) N = 2736	.7530 (.34084) N = 2106
Substance Misuse Problem	.0605 (.19867) N = 2736	.0656 (.20465) N = 2106
Intervention Received	.2407 (.40716) N = 670	.3105 (.44424) N = 456
Intervention Offered	.1986 (.38886) N = 538	.2836 (.44193) N = 334

English not a first language in 2013

	English	Other Language
Health Checks	.8901 (.20831) N = 3656	.8983 (.22264) N = 307
Dental Checks	.8328 (.25845) N = 3656	.8575 (.26617) N = 307
Immunisations	.7959 (.30980) N = 3656	.6285 (.41676) N = 307
Substance Misuse Problem	.0527 (.18238) N = 3656	.0255 (.12598) N = 307
Intervention Received	.2258 (.39888) N = 864	.3000 (.46609) N = 30
Intervention Offered	.1929 (.38459) N = 703	.2500 (.42956) N = 22

Ever been convicted

	No	Yes
Health Checks	.8879 (.21666) N = 4107	.8519 (.24453) N = 735
Dental Checks	.8339 (.26524) N = 4107	.7950 (.27411) N = 735
Immunisations	.7682 (.33584) N = 4107	.7801 (.31574) N = 735
Substance Misuse Problem	.0365 (.15651) N = 4107	.2093 (.32380) N = 735
Intervention Received	.1847 (.37751) N = 790	.4671 (.45967) N = 336
Intervention Offered	.1414 (.33963) N = 663	.5158 (.48583) N = 209

School Change Yr 8-11

	No	Yes
Health Checks	.8895 (.20965) N = 3521	.8659 (.25084) N = 845
Dental Checks	.8322 (.26085) N = 3521	.8261 (.27355) N = 845
Immunisations	.7842 (.32019) N = 3521	.7569 (.35085) N = 845
Substance Misuse Problem	.0563 (.19086) N = 3521	.0853 (.23580) N = 845
Intervention Received	.2401 (.40763) N = 846	.3531 (.45807) N = 181
Intervention Offered	.1938 (.38681) N = 680	.3840 (.47199) N = 125

Ever Excluded

	No	Yes
Health Checks	.8829 (.22004) N = 4681	.8693 (.26014) N = 161
Dental Checks	.8306 (.26354) N = 4681	.7542 (.34489) N = 161
Immunisations	.7721 (.33023) N = 4681	.7092 (.39849) N = 161
Substance Misuse Problem	.0582 (.19246) N = 4681	.1931 (.35323) N = 161
Intervention Received	.2576 (.41747) N = 1078	.5243 (.48499) N = 48
Intervention Offered	.2169 (.40257) N = 847	.7133 (.43970) N = 25

UASC

	No	Yes
Health Checks	.8831 (.21985) N = 4675	.8636 (.26282) N = 167
Dental Checks	.8282 (.26588) N = 4675	.8234 (.29608) N = 167
Immunisations	.7782 (.32511) N = 4675	.5419 (.44812) N = 167
Substance Misuse Problem	.0644 (.20387) N = 4675	.0142 (.09438) N = 167
Intervention Received	.2697 (.42407) N = 1119	.1429 (.37796) N = 7
Intervention Offered	.2281 (.40978) N = 866	.6667 (.51640) N = 6

Young Mother

	No	Yes
Health Checks	.8879 (.22101) N = 2052	.8131 (.32330) N = 2702
Dental Checks	.8349 (.27038) N = 2052	.7475 (.35015) N = 2702
Immunisations	.7640 (.34223) N = 2052	.7131 (.39460) N = 2702
Substance Misuse Problem	.0626 (.20774) N = 2052	.0913 (.21243) N = 2702
Intervention Received	.2676 (.42965) N = 468	.2971 (.44369) N = 635
Intervention Offered	.2033 (.39976) N = 359	.2033 (.46376) N = 496

Correlations:

	Mean (SD) Number
Health Checks	.8825 (.22147) N = 4842
Dental Checks	.8280 (.26695) N = 4842
Immunisations	.7700 (.33286) N = 4842
Substance Recorded	.0627 (.20129) N = 4842
Intervention Received	.2690 (.42376) N = 1126
Intervention offered	.2311 (.41183) N = 872
Number of new periods in care	1.61 (5.200) N = 2350

Mean value of number of respite changes	.0300 (.12506) N = 4847
Mean Substance Misuse problem	.06 (.204) N = 4847
KS4 Points	202.4233 (133.38723) N = 4847
KS2 Points	3.8767 (.85356) N = 4228
Local Deprivation 2004	.327269091 (.197609361) N = 4441
Total time in care	2209.7652 (1442.39620) N = 4847
Mean of standardised SDQ Scores	.212 (6.8443) N = 4310
Number of placement changes since KS2	3.0745 (4.42380) N = 4847
Unauthorised absences 2009 to 2013	.0323 (.06621) N = 4654
Total sessions missed fixed term exclusions 2009-2013	11.8440 (22.08752) N = 4847
Length of latest placement	1133.21 (1157.481) N = 4847
Merged IDACI 2012/2013	.2208 (.16189) N = 4130

Has the child ever been placed with their parents?

	No	Yes
Health Checks	.8836 (.22301) N = 4451	.8692 (.20284) N = 391
Dental Checks	.8355 (.26602) N = 4451	.7427(.26602) N = 391
Immunisations	.7674 (.33676) N = 4451	.7994 (.28394) N = 391
Substance Misuse Problem	.0615 (.20262) N = 4451	.0770 (.18509) N = 391
Intervention Received	.2774 (.43064) N = 988	.2083 (.36654) N = 138
Intervention Offered	.2278 (.41052) N = 753	.2521 (.42123) N = 119

Child has only ever been placed in their own local authority provision

	No	Yes
Health Checks	.8754 (.22433) N = 3414	.8993 (.21361) N = 1428
Dental Checks	.8188 (.27024) N = 3414	.8500 (.25768) N = 1428
Immunisations	.7699 (.33047)	.7703 (.33863)

	<i>N</i> = 3414	<i>N</i> = 1428
Substance Misuse Problem	.0706 (.20961) <i>N</i> = 3414	.0438 (.17851) <i>N</i> = 1428
Intervention Received	.2873 (.42977) <i>N</i> = 847	.2133 (.40061) <i>N</i> = 279
Intervention Offered	.2729 (.43418) <i>N</i> = 644	.1132 (.31287) <i>N</i> = 228

Has the child ever been placed in an other local authority provision?

	No	Yes
Health Checks	.8843 (.21914) <i>N</i> = 4663	.8337 (.27157) <i>N</i> = 179
Dental Checks	.8303 (.26473) <i>N</i> = 4663	.7691 (.31456) <i>N</i> = 179
Immunisations	.7729 (.33017) <i>N</i> = 4663	.6938 (.38999) <i>N</i> = 179
Substance Misuse Problem	.0592 (.19610) <i>N</i> = 4663	.1547 (.29310) <i>N</i> = 179
Intervention Received	.2563 (.41836) <i>N</i> = 1068	.5029 (.45749) <i>N</i> = 58
Intervention Offered	.2202 (.40556) <i>N</i> = 838	.5000 (.47673) <i>N</i> = 34

Has the child ever been placed with an independent fostering agency?

	No	Yes
Health Checks	.8978 (.20392) <i>N</i> = 1981	.8718 (.23229) <i>N</i> = 2861
Dental Checks	.8403 (.25170) <i>N</i> = 1981	.8195 (.27674) <i>N</i> = 2861
Immunisations	.7897 (.31803) <i>N</i> = 1981	.7564 (.34214) <i>N</i> = 2861
Substance Misuse Problem	.0405 (.16364) <i>N</i> = 1981	.0781 (.22241) <i>N</i> = 2861
Intervention Received	.1799 (.37163) <i>N</i> = 447	.3276 (.44548) <i>N</i> = 679
Intervention Offered	.1192 (.31451) <i>N</i> = 380	.3176 (.45534) <i>N</i> = 492

Appendix Two: Full regression models

Health assessments	<i>B</i>	<i>SE B</i>	β
Block 1			
Constant	.916	.003	
Reason for entry into care: UASC (Reference group = abuse or neglect)	-.053	.018	-.063**
Block 2			
Constant	.901	.007	
Reason for entry into care: UASC (Reference group = abuse or neglect)	-.052	.018	-.062**
Local deprivation index 2004	.045	.017	.057**
Block 3			
Constant	.930	.009	
Reason for entry into care: UASC (Reference group = abuse or neglect)	-.066	.018	-.078***
Local deprivation index 2004	.036	.017	.045*
Total number of years in care	-.004	.001	-.113***
Block 4			
Constant	.940	.009	
Reason for entry into care: UASC (Reference group = abuse or neglect)	-.071	.018	-.084***
Local deprivation index 2004	.038	.017	.049*
Total number of years in care	-.004	.001	-.106***
Number of placements (excluding respite)	-.003	.001	-.080***

Dental Checks	<i>B</i>	<i>SE B</i>	β
Block 1			
Constant	.849	.008	
Age at first entry into care: 10+ (Reference group = under 5)	-.041	.011	-.076***
Block 2			
Constant	.814	.013	
Age at first entry into care: 10+ (Reference group = under 5)	-.021	.013	-.040
Length of last placement in years	.007	.002	.082**
Block 3			
Constant	.917	.028	
Age at first entry into care: 10+ (Reference group = under 5)	-.027	.013	-.051*
Length of last placement in years	.006	.002	.067**
Whether child ever placed with parents (1 = No, 2 = Yes)	-.088	.021	-.090***
Block 4			

Constant	.938	.029	
Age at first entry into care: 10+ (Reference group = under 5)	-.029	.013	-.054*
Length of last placement in years	.004	.002	.043
Whether child ever placed with parents (1 = No, 2 = Yes)	-.089	.021	-.091***
Child has been placed in residential care (Reference group: always foster or kinship care)	-.039	.013	-.067**
Block 5			
Constant	.896	.034	
Age at first entry into care: 10+ (Reference group = under 5)	-.026	.013	-.049*
Length of last placement in years	.004	.002	.045
Whether child ever placed with parents (1 = No, 2 = Yes)	-.086	.021	-.087***
Child has been placed in residential care (Reference group: always foster or kinship care)	-.040	.013	-.069**
Child's placement location at KS2 (1 = In LA boundary, 2 = Out of LA boundary)	.026	.012	.048*
Block 6			
Constant	.891	.034	
Age at first entry into care: 10+ (Reference group = under 5)	-.024	.013	-.044
Length of last placement in years	.003	.002	.040
Whether child ever placed with parents (1 = No, 2 = Yes)	-.080	.021	-.081***
Child has been placed in residential care (Reference group: always foster or kinship care)	-.034	.013	-.060**
Child's placement location at KS2 (1 = In LA boundary, 2 = Out of LA boundary)	.028	.012	.050*
School type at KS4 = Pupil Referral Unit (Reference group = Mainstream school)	-.072	.023	-.068**

Immunisations	<i>B</i>	<i>SE B</i>	β
Block 1			
Constant	.774	.007	
Ethnicity: Black African (Reference group = White British or Irish)	-.160	.044	-.078***
Block 2			
Constant	.780	.007	
Ethnicity: Black African (Reference group = White British or Irish)	-.166	.044	-.080***
Ethnicity: Other (Reference group = White British or Irish)	-.127	.035	-.077***

Block 3			
Constant	.784	.008	
Ethnicity: Black African (Reference group = White British or Irish)	-.170	.044	-.083***
Ethnicity: Other (Reference group = White British or Irish)	-.132	.035	-.080***
Ethnicity: Not known (Reference group = White British or Irish)	-.061	.028	-.047*
Block 4			
Constant	.839	.010	
Ethnicity: Black African (Reference group = White British or Irish)	-.149	.043	-.073**
Ethnicity: Other (Reference group = White British or Irish)	-.108	.035	-.065**
Ethnicity: Not known (Reference group = White British or Irish)	-.055	.027	-.042*
Age at first entry into care: 10+ (Reference group = Under 5)	-.111	.014	-.166***
Block 5			
Constant	.838	.010	
Ethnicity: Black African (Reference group = White British or Irish)	-.124	.044	-.060**
Ethnicity: Other (Reference group = White British or Irish)	-.061	.037	-.037
Ethnicity: Not known (Reference group = White British or Irish)	-.051	.027	-.039
Age at first entry into care: 10+ (Reference group = Under 5)	-.104	.014	-.156***
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-.150	.042	-.082
Block 6			
Constant	.845	.010	
Ethnicity: Black African (Reference group = White British or Irish)	-.128	.044	-.062**
Ethnicity: Other (Reference group = White British or Irish)	-.061	.037	-.037
Ethnicity: Not known (Reference group = White British or Irish)	-.051	.027	-.039
Age at first entry into care: 10+ (Reference group = Under 5)	-.105	.014	-.158***
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-.156	.041	-.085***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	-.098	.028	-.072**
Block 7			
Constant	.750	.028	

Ethnicity: Black African (Reference group = White British or Irish)	-.125	.043	-.060**
Ethnicity: Other (Reference group = White British or Irish)	-.060	.037	-.036
Ethnicity: Not known (Reference group = White British or Irish)	-.052	.027	-.039
Age at first entry into care: 10+ (Reference group = Under 5)	-.039	.023	-.058
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-.153	.041	-.084***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	-.080	.029	-.059**
Total number of years spent in care	.011	.003	.126***
Block 8			
Constant	.790	.034	
Ethnicity: Black African (Reference group = White British or Irish)	-.122	.043	-.059**
Ethnicity: Other (Reference group = White British or Irish)	-.058	.037	-.035
Ethnicity: Not known (Reference group = White British or Irish)	-.045	.027	-.035
Age at first entry into care: 10+ (Reference group = Under 5)	-.039	.023	-.059
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-.153	.041	-.084***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	-.077	.029	-.057**
Total number of years spent in care	.011	.003	.128***
Location of placement at KS4 (1 = In LA boundary, 2 = Outside of LA boundary)	-.029	.014	-.043*
Block 9			
Constant	.803	.034	
Ethnicity: Black African (Reference group = White British or Irish)	-.129	.043	-.063**
Ethnicity: Other (Reference group = White British or Irish)	-.058	.037	-.035
Ethnicity: Not known (Reference group = White British or Irish)	-.041	.027	-.031
Age at first entry into care: 10+ (Reference group = Under 5)	-.037	.023	-.055
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-.161	.041	-.088***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	-.085	.029	-.063**
Total number of years spent in care	.010	.003	.117**

Location of placement at KS4 (1 = In LA boundary, 2 = Outside of LA boundary)	-.028	.014	-.041*
Proportion of unauthorised absences (from 2009 to 2013)	-.291	.108	-.058**
Block 10			
Constant	.876	.049	
Ethnicity: Black African (Reference group = White British or Irish)	-.101	.045	-.049*
Ethnicity: Other (Reference group = White British or Irish)	-.042	.038	-.025
Ethnicity: Not known (Reference group = White British or Irish)	-.041	.027	-.031
Age at first entry into care: 10+ (Reference group = Under 5)	-.035	.023	-.053
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-.110	.048	-.060*
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	-.086	.029	-.063**
Total number of years spent in care	.010	.003	.116**
Location of placement at KS4 (1 = In LA boundary, 2 = Outside of LA boundary)	-.027	.014	-.040
Proportion of unauthorised absences (from 2009 to 2013)	-.296	.108	-.059**
First language at KS4 (1 = English, 2 = Any other language)	-.072	.034	-.057*
Block 11			
Constant	.802	.051	
Ethnicity: Black African (Reference group = White British or Irish)	-.163	.047	-.079**
Ethnicity: Other (Reference group = White British or Irish)	-.047	.037	-.028
Ethnicity: Not known (Reference group = White British or Irish)	-.042	.027	-.032
Age at first entry into care: 10+ (Reference group = Under 5)	-.033	.023	-.049
Reason for entry into care: UASC (Reference group = Abuse or neglect)	.009	.055	.005
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	-.093	.029	-.068**
Total number of years spent in care	.009	.003	.109**
Location of placement at KS4 (1 = In LA boundary, 2 = Outside of LA boundary)	-.029	.014	-.043*
Proportion of unauthorised absences (from 2009 to 2013)	-.317	.107	-.063**
First language at KS4 (1 = English, 2 = Any other language)	-.219	.047	-.176***

First language at KS1 (1 = English, 2 = Any other language)	.224	.050	.142***
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Strengths and difficulties questionnaire	B	SE B	β
Block 1			
Constant	14.516	.116	
Ethnicity: Black African (Reference group = White British or Irish)	-4.654	.707	-.110***
Constant	14.660	.117	
Ethnicity: Black African (Reference group = White British or Irish)	-4.797	.704	-.113***
Ethnicity: Asian (Reference group = White British or Irish)	-3.690	.596	-.103***
Block 2			
Constant	12.643	.374	
Ethnicity: Black African (Reference group = White British or Irish)	-4.693	.701	-.111***
Ethnicity: Asian (Reference group = White British or Irish)	-3.775	.594	-.105***
Gender (1=Male, 2=Female)	1.295	.228	.094***
Block 3			
Constant	12.703	.373	
Ethnicity: Black African (Reference group = White British or Irish)	-4.794	.700	-.113***
Ethnicity: Asian (Reference group = White British or Irish)	-3.880	.593	-.108***
Gender (1=Male, 2=Female)	1.322	.227	.096***
Ethnicity: Other (Reference group = White British or Irish)	-2.303	.563	-.068***
Block 4			
(Constant)	12.825	.374	
Ethnicity: Black African (Reference group = White British or Irish)	-4.906	.699	-.116***
Ethnicity: Asian (Reference group = White British or Irish)	-3.991	.593	-.111***
Gender (1=Male, 2=Female)	1.316	.227	.096***
Ethnicity: Other (Reference group = White British or Irish)	-2.413	.563	-.071***
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.853	.502	-.061***

Block 5			
Constant	12.789	.374	
Ethnicity: Black African (Reference group = White British or Irish)	-4.787	.699	-.113***
Ethnicity: Asian (Reference group = White British or Irish)	-3.864	.593	-.108***
Gender (1=Male, 2=Female)	1.260	.227	.091***
Ethnicity: Other (Reference group = White British or Irish)	-2.286	.563	-.067***
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.731	.502	-.057***
Ethnicity: Not known (Reference group = White British or Irish)	1.494	.448	.055**
Block 6			
Constant	12.494	.373	
Ethnicity: Black African (Reference group = White British or Irish)	-3.739	.707	-.088***
Ethnicity: Asian (Reference group = White British or Irish)	-2.259	.625	-.063***
Gender (1=Male, 2=Female)	1.454	.227	.106***
Ethnicity: Other (Reference group = White British or Irish)	-.478	.607	-.014
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.734	.498	-.057**
Ethnicity: Not known (Reference group = White British or Irish)	1.703	.445	.063***
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-5.406	.709	-.144***
Block 7			
Constant	13.151	.400	
Ethnicity: Black African (Reference group = White British or Irish)	-3.525	.707	-.083***
Ethnicity: Asian (Reference group = White British or Irish)	-2.051	.625	-.057**
Gender (1=Male, 2=Female)	1.449	.226	.105***
Ethnicity: Other (Reference group = White British or Irish)	-.343	.606	-.010
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.471	.501	-.048**
Ethnicity: Not known (Reference group = White British or Irish)	1.742	.444	.065***

Reason for entry into care: UASC (Reference group = Abuse or neglect)	-5.375	.707	-.143***
Local Deprivation Index 2004	-3.106	.696	-.074***
Block 8			
Constant	13.153	.399	
Ethnicity: Black African (Reference group = White British or Irish)	-3.470	.705	-.082***
Ethnicity: Asian (Reference group = White British or Irish)	-2.085	.624	-.058**
Gender (1=Male, 2=Female)	1.344	.227	.098
Ethnicity: Other (Reference group = White British or Irish)	-.349	.605	-.010**
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.432	.499	-.047***
Ethnicity: Not known (Reference group = White British or Irish)	1.753	.443	.065***
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-5.213	.706	-.139***
Local Deprivation Index 2004	-2.974	.696	-.070***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	1.950	.458	.070***
Block 9			
Constant	13.482	.419	
Ethnicity: Black African (Reference group = White British or Irish)	-3.538	.705	-.084***
Ethnicity: Asian (Reference group = White British or Irish)	-2.121	.623	-.059**
Gender (1=Male, 2=Female)	1.404	.228	.102***
Ethnicity: Other (Reference group = White British or Irish)	-.394	.605	-.012
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.359	.500	-.045**
Ethnicity: Not known (Reference group = White British or Irish)	1.733	.443	.064***
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-5.413	.710	-.144***
Local Deprivation Index 2004	-2.963	.695	-.070***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	1.843	.460	.066***
Total number of years in care	-.073	.029	-.042*

Block 10			
Constant	12.589	.416	
Ethnicity: Black African (Reference group = White British or Irish)	-3.244	.691	-.077***
Ethnicity: Asian (Reference group = White British or Irish)	-1.877	.610	-.052**
Gender (1=Male, 2=Female)	1.173	.224	.085
Ethnicity: Other (Reference group = White British or Irish)	-.390	.592	-.011**
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.382	.489	-.046**
Ethnicity: Not known (Reference group = White British or Irish)	.826	.440	.031
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-4.874	.696	-.130***
Local Deprivation Index 2004	-2.845	.680	-.067***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	1.141	.454	.041*
Total number of years in care	-.010	.029	-.006
Ever placed in residential care (Reference group = Always foster or kinship care)	3.068	.247	.207***
Block 11			
Constant	13.096	.416	
Ethnicity: Black African (Reference group = White British or Irish)	-3.195	.683	-.075***
Ethnicity: Asian (Reference group = White British or Irish)	-1.845	.604	-.051**
Gender (1=Male, 2=Female)	1.236	.222	.090***
Ethnicity: Other (Reference group = White British or Irish)	-.481	.586	-.014
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.552	.484	-.051**
Ethnicity: Not known (Reference group = White British or Irish)	.700	.435	.026
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-4.477	.690	-.119***
Local Deprivation Index 2004	-2.816	.673	-.067***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	2.117	.462	.076***
Total number of years in care	.144	.033	.083***

Ever placed in residential care (Reference group = Always foster or kinship care)	2.413	.255	.163***
Mean length of all placements	-.002	.000	-.176***
Block 12			
Constant	12.634	.432	
Ethnicity: Black African (Reference group = White British or Irish)	-3.161	.682	-.075***
Ethnicity: Asian (Reference group = White British or Irish)	-1.860	.603	-.052**
Gender (1=Male, 2=Female)	1.283	.222	.093***
Ethnicity: Other (Reference group = White British or Irish)	-.512	.585	-.015
Ethnicity: Black Caribbean (Reference group = White British or Irish)	-1.602	.484	-.053**
Ethnicity: Not known (Reference group = White British or Irish)	.633	.435	.023
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-4.429	.689	-.118***
Local Deprivation Index 2004	-2.877	.672	-.068***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	2.249	.463	.080***
Total number of years in care	.094	.036	.054**
Ever placed in residential care (Reference group = Always foster or kinship care)	2.148	.264	.145***
Mean length of all placements	-.002	.000	-.139***
Number of placements excluding short breaks	.102	.027	.073***
Block 13			
Constant	11.163	.563	
Ethnicity: Black African (Reference group = White British or Irish)	-3.175	.680	-.075***
Ethnicity: Asian (Reference group = White British or Irish)	-1.945	.602	-.054**
Gender (1=Male, 2=Female)	1.257	.221	.091***
Ethnicity: Other (Reference group = White British or Irish)	-.593	.584	-.017
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.674	.483	-.055**
Ethnicity: Not known (Reference group = White British or Irish)	.497	.435	.018

Reason for entry into care: UASC (Reference group = Abuse or neglect)	-4.556	.688	-.122***
Local Deprivation Index 2004	-2.680	.672	-.063***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	2.083	.463	.074***
Total number of years in care	.086	.036	.050*
Ever placed in residential care (Reference group = Always foster or kinship care)	1.955	.267	.132***
Mean length of all placements	-.002	.000	-.124***
Number of placements excluding short breaks	.088	.027	.062**
Ever placed with independent/voluntary provider (Reference group = Always own Local Authority)	.980	.240	.070***
Block 14			
Constant	9.682	.809	
Ethnicity: Black African (Reference group = White British or Irish)	-3.181	.680	-.075***
Ethnicity: Asian (Reference group = White British or Irish)	-1.961	.601	-.055**
Gender (1=Male, 2=Female)	1.250	.221	.091***
Ethnicity: Other (Reference group = White British or Irish)	-.602	.583	-.018
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.679	.483	-.055**
Ethnicity: Not known (Reference group = White British or Irish)	.428	.435	.016
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-4.552	.688	-.121***
Local Deprivation Index 2004	-2.680	.672	-.063***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	2.095	.463	.075***
Total number of years in care	.090	.036	.052*
Ever placed in residential care (Reference group = Always foster or kinship care)	1.934	.267	.131***
Mean length of all placements	-.002	.000	-.124***
Number of placements excluding short breaks	.079	.027	.056**

Ever placed with independent/voluntary provider (Reference group = Always own Local Authority)	.978	.240	.070***
Ever placed with other Local Authority (Reference group = Always own Local Authority)	1.471	.578	.041*
Block 15			
Constant	17.023	.973	
Ethnicity: Black African (Reference group = White British or Irish)	-2.928	.665	-.069***
Ethnicity: Asian (Reference group = White British or Irish)	-1.750	.588	-.049**
Gender (1=Male, 2=Female)	.989	.217	.072***
Ethnicity: Other (Reference group = White British or Irish)	-.384	.570	-.011
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.233	.473	-.041**
Ethnicity: Not known (Reference group = White British or Irish)	.419	.425	.016
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-4.964	.673	-.132***
Local Deprivation Index 2004	-2.544	.657	-.060***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	.386	.471	.014
Total number of years in care	.075	.035	.043*
Ever placed in residential care (Reference group = Always foster or kinship care)	1.688	.262	.114***
Mean length of all placements	-.002	.000	-.129***
Number of placements excluding short breaks	.088	.027	.063**
Ever placed with independent/voluntary provider (Reference group = Always own Local Authority)	.941	.235	.068***
Ever placed with other Local Authority (Reference group = Always own Local Authority)	1.366	.564	.038*
KS2 points, 3 test average	-1.692	.131	-.211***
Block 16			
Constant	17.164	.971	
Ethnicity: Black African (Reference group = White British or Irish)	-2.934	.663	-.069***

Ethnicity: Asian (Reference group = White British or Irish)	-1.708	.586	-.048**
Gender (1=Male, 2=Female)	.893	.218	.065***
Ethnicity: Other (Reference group = White British or Irish)	-.421	.569	-.012
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.252	.471	-.041**
Ethnicity: Not known (Reference group = White British or Irish)	.376	.424	.014
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-4.740	.673	-.126***
Local Deprivation Index 2004	-2.663	.655	-.063***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	.595	.472	.021
Total number of years in care	.087	.035	.050*
Ever placed in residential care (Reference group = Always foster or kinship care)	1.525	.264	.103***
Mean length of all placements	-.002	.000	-.126***
Number of placements excluding short breaks	.084	.027	.060**
Ever placed with independent/voluntary provider (Reference group = Always own Local Authority)	.878	.235	.063***
Ever placed with other Local Authority (Reference group = Always own Local Authority)	1.326	.563	.037*
KS2 points, 3 test average	-1.711	.131	-.213***
Proportion of fixed-term exclusions	17.939	3.879	.074***
Block 17			
Constant	16.515	.986	
Ethnicity: Black African (Reference group = White British or Irish)	-2.892	.662	-.068***
Ethnicity: Asian (Reference group = White British or Irish)	-1.644	.586	-.046**
Gender (1=Male, 2=Female)	.825	.218	.060***
Ethnicity: Other (Reference group = White British or Irish)	-.384	.568	-.011
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.206	.471	-.040*
Ethnicity: Not known (Reference group = White British or Irish)	.027	.435	.001

Reason for entry into care: UASC (Reference group = Abuse or neglect)	-4.546	.674	-.121***
Local Deprivation Index 2004	-2.612	.654	-.062***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	.348	.476	.012
Total number of years in care	.078	.035	.045*
Ever placed in residential care (Reference group = Always foster or kinship care)	1.413	.265	.095***
Mean length of all placements	-.002	.000	-.126***
Number of placements excluding short breaks	.086	.027	.061**
Ever placed with independent/voluntary provider (Reference group = Always own Local Authority)	.836	.234	.060***
Ever placed with other Local Authority (Reference group = Always own Local Authority)	1.280	.562	.035*
KS2 points, 3 test average	-1.521	.141	-.190***
Proportion of fixed-term exclusions	16.494	3.893	.068***
School type: Special school (Reference group = Mainstream school)	1.095	.303	.066***
Block 18			
Constant	16.520	.983	
Ethnicity: Black African (Reference group = White British or Irish)	-2.877	.660	-.068***
Ethnicity: Asian (Reference group = White British or Irish)	-1.634	.584	-.046**
Gender (1=Male, 2=Female)	.724	.218	.053**
Ethnicity: Other (Reference group = White British or Irish)	-.412	.566	-.012
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.199	.469	-.039*
Ethnicity: Not known (Reference group = White British or Irish)	.035	.433	.001
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-4.340	.673	-.116***
Local Deprivation Index 2004	-2.627	.652	-.062***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	-.143	.486	-.005
Total number of years in care	.085	.035	.049*

Ever placed in residential care (Reference group = Always foster or kinship care)	1.217	.267	.082***
Mean length of all placements	-.002	.000	-.131***
Number of placements excluding short breaks	.080	.027	.057**
Ever placed with independent/voluntary provider (Reference group = Always own Local Authority)	.730	.235	.052**
Ever placed with other Local Authority (Reference group = Always own Local Authority)	1.111	.561	.031*
KS2 points, 3 test average	-1.421	.142	-.177***
Proportion of fixed-term exclusions	15.498	3.886	.064***
School type: Special school (Reference group = Mainstream school)	1.542	.316	.093***
School type: Alternative provision (Reference group = Mainstream school)	2.376	.497	.080***
Block 19			
Constant	16.503	.981	
Ethnicity: Black African (Reference group = White British or Irish)	-2.862	.658	-.068***
Ethnicity: Asian (Reference group = White British or Irish)	-1.626	.583	-.045**
Gender (1=Male, 2=Female)	.698	.218	.051**
Ethnicity: Other (Reference group = White British or Irish)	-.442	.565	-.013
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.255	.469	-.041**
Ethnicity: Not known (Reference group = White British or Irish)	.116	.433	.004
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-4.235	.672	-.113***
Local Deprivation Index 2004	-2.742	.651	-.065***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	-.182	.485	-.007
Total number of years in care	.095	.035	.055**
Ever placed in residential care (Reference group = Always foster or kinship care)	1.058	.270	.071***
Mean length of all placements	-.002	.000	-.132***
Number of placements excluding short breaks	.069	.027	.049*

Ever placed with independent/voluntary provider (Reference group = Always own Local Authority)	.685	.235	.049**
Ever placed with other Local Authority (Reference group = Always own Local Authority)	1.079	.560	.030
KS2 points, 3 test average	-1.404	.141	-.175***
Proportion of fixed-term exclusions	13.658	3.905	.056***
School type: Special school (Reference group = Mainstream school)	1.797	.322	.109***
School type: Alternative provision (Reference group = Mainstream school)	2.710	.503	.091***
School type: Pupil referral unit (Reference group = Mainstream school)	1.786	.444	.065***
Block 20			
Constant	16.417	.980	
Ethnicity: Black African (Reference group = White British or Irish)	-2.872	.658	-.068***
Ethnicity: Asian (Reference group = White British or Irish)	-1.651	.582	-.046**
Gender (1=Male, 2=Female)	.724	.218	.053*
Ethnicity: Other (Reference group = White British or Irish)	-.459	.564	-.013
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.202	.468	-.040*
Ethnicity: Not known (Reference group = White British or Irish)	.191	.433	.007
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-4.265	.671	-.114***
Local Deprivation Index 2004	-2.662	.651	-.063***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	-.244	.485	-.009
Total number of years in care	.088	.035	.051*
Ever placed in residential care (Reference group = Always foster or kinship care)	1.082	.270	.073***
Mean length of all placements	-.002	.000	-.130***
Number of placements excluding short breaks	.070	.027	.050**
Ever placed with independent/voluntary provider (Reference group = Always own Local Authority)	.689	.234	.050**

Ever placed with other Local Authority (Reference group = Always own Local Authority)	1.133	.560	.031*
KS2 points, 3 test average	-1.403	.141	-.175***
Proportion of fixed-term exclusions	15.296	3.939	.063***
School type: Special school (Reference group = Mainstream school)	1.812	.322	.110***
School type: Alternative provision (Reference group = Mainstream school)	2.755	.503	.093***
School type: Pupil referral unit (Reference group = Mainstream school)	2.000	.449	.073**
Ever permanently excluded	-1.795	.605	-.047**
Block 21			
Constant	15.716	1.027	
Ethnicity: Black African (Reference group = White British or Irish)	-2.888	.657	-.068***
Ethnicity: Asian (Reference group = White British or Irish)	-1.649	.582	-.046**
Gender (1=Male, 2=Female)	.722	.218	.052**
Ethnicity: Other (Reference group = White British or Irish)	-.469	.564	-.014
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.199	.468	-.039*
Ethnicity: Not known (Reference group = White British or Irish)	.244	.433	.009
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-4.317	.671	-.115***
Local Deprivation Index 2004	-2.636	.651	-.062***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	-.224	.485	-.008
Total number of years in care	.094	.035	.054**
Ever placed in residential care (Reference group = Always foster or kinship care)	1.065	.269	.072***
Mean length of all placements	-.002	.000	-.128***
Number of placements excluding short breaks	.067	.027	.048*
Ever placed with independent/voluntary provider (Reference group = Always own Local Authority)	.660	.234	.047**

Ever placed with other Local Authority (Reference group = Always own Local Authority)	1.134	.560	.031*
KS2 points, 3 test average	-1.410	.141	-.176***
Proportion of fixed-term exclusions	15.020	3.939	.062***
School type: Special school (Reference group = Mainstream school)	1.819	.321	.110***
School type: Alternative provision (Reference group = Mainstream school)	2.805	.503	.094***
School type: Pupil referral unit (Reference group = Mainstream school)	2.074	.450	.076***
Ever permanently excluded	-1.806	.604	-.047**
Changed school in Year 8-9 and Year 10-11	.609	.268	.035*
Block 22			
Constant	15.898	1.017	
Ethnicity: Black African (Reference group = White British or Irish)	-2.763	.651	-.065***
Ethnicity: Asian (Reference group = White British or Irish)	-1.523	.576	-.042**
Gender (1=Male, 2=Female)	.483	.217	.035*
Ethnicity: Other (Reference group = White British or Irish)	-.489	.558	-.014
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.355	.464	-.045**
Ethnicity: Not Known (Reference group = White British or Irish)	.229	.429	.008
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-3.869	.667	-.103***
Local Deprivation Index 2004	-2.673	.645	-.063***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	.301	.484	.011
Total number of years in care	.085	.035	.049*
Ever placed in residential care (Reference group = Always foster or kinship care)	.937	.267	.063***
Mean length of all placements	-.001	.000	-.120***
Number of placements excluding short breaks	.058	.026	.041*
Ever placed with independent/voluntary provider (Reference group = Always own Local Authority)	.585	.232	.042*

Ever placed with other Local Authority (Reference group = Always own Local Authority)	1.119	.554	.031*
KS2 points, 3 test average	-1.455	.140	-.182***
Proportion of fixed-term exclusions	10.941	3.930	.045**
School type: Special school (Reference group = Mainstream school)	1.741	.318	.105***
School type: Alternative provision (Reference group = Mainstream school)	2.809	.498	.095***
School type: Pupil referral unit (Reference group = Mainstream school)	1.423	.452	.052**
Ever permanently excluded	-1.638	.599	-.043**
Changed school in Year 8-9 and Year 10-11	.516	.266	.030
Primary special educational need: Behavioural, emotional or social difficulty (Reference group = No special educational need)	1.925	.227	.137***
Block 23			
Constant	14.785	1.029	
Ethnicity: Black African (Reference group = White British or Irish)	-2.672	.648	-.063***
Ethnicity: Asian (Reference group = White British or Irish)	-1.427	.573	-.040*
Gender (1=Male, 2=Female)	.264	.219	.019
Ethnicity: Other (Reference group = White British or Irish)	-.452	.556	-.013
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.305	.462	-.043**
Ethnicity: Not Known (Reference group = White British or Irish)	.520	.430	.019
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-3.603	.665	-.096***
Local Deprivation Index 2004	-2.571	.642	-.061***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	-.151	.487	-.005
Total number of years in care	.059	.035	.034
Ever placed in residential care (Reference group = Always foster or kinship care)	.952	.266	.064***
Mean length of all placements	-.001	.000	-.119***

Number of placements excluding short breaks	.066	.026	.047*
Ever placed with independent/voluntary provider (Reference group = Always own Local Authority)	.547	.231	.039*
Ever placed with other Local Authority (Reference group = Always own Local Authority)	1.097	.551	.030*
KS2 points, 3 test average	-1.105	.151	-.138***
Proportion of fixed-term exclusions	11.366	3.911	.047**
School type: Special school (Reference group = Mainstream school)	.901	.347	.054**
School type: Alternative provision (Reference group = Mainstream school)	2.405	.500	.081***
School type: Pupil referral unit (Reference group = Mainstream school)	1.472	.450	.054**
Ever permanently excluded	-1.504	.596	-.039*
Child changed school in Year 8-9 and Year 10-11	.460	.265	.027
Primary special educational need: Behavioural, emotional or social difficulty (Reference group = No special educational need)	1.719	.229	.122***
Special educational needs provision: Statement (Reference group: No special educational need)	1.943	.326	.131***
Block 24			
Constant	13.391	1.085	
Ethnicity: Black African (Reference group = White British or Irish)	-2.692	.647	-.064***
Ethnicity: Asian (Reference group = White British or Irish)	-1.355	.573	-.038*
Gender (1=Male, 2=Female)	.195	.220	.014
Ethnicity: Other (Reference group = White British or Irish)	-.420	.555	-.012
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.352	.461	-.045**
Ethnicity: Not Known (Reference group = White British or Irish)	.583	.429	.022
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-3.216	.671	-.086***
Local Deprivation Index 2004	-2.603	.640	-.062***

Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	-.252	.487	-.009
Total number of years in care	.058	.035	.034
Ever placed in residential care (Reference group = Always foster or kinship care)	.942	.265	.064***
Mean length of all placements	-.001	.000	-.121***
Number of placements excluding short breaks	.066	.026	.047**
Ever placed with independent/voluntary provider (Reference group = Always own Local Authority)	.540	.231	.039*
Ever placed with other Local Authority (Reference group = Always own Local Authority)	1.111	.550	.031*
KS2 points, 3 test average	-.893	.160	-.111***
Proportion of fixed-term exclusions	11.638	3.903	.048**
School type: Special school (Reference group = Mainstream school)	.939	.346	.057**
School type: Alternative provision (Reference group = Mainstream school)	2.441	.499	.082***
School type: Pupil referral unit (Reference group = Mainstream school)	1.393	.449	.051**
Ever permanently excluded	-1.485	.595	-.039*
'Count of whether child changed school in Year 8-9 and Year 10-11 (range 0-2)'	.488	.264	.028
Primary special educational need: Behavioural, emotional or social difficulty (Reference group = No special educational need)	2.427	.289	.173***
Special educational needs provision: Statement (Reference group: No special educational need)	1.782	.327	.120***
Primary special educational need: Other disability (Reference group = no special educational need)	1.237	.310	.086***
Block 25			
Constant	12.805	1.125	
Ethnicity: Black African (Reference group = White British or Irish)	-2.706	.646	-.064***
Ethnicity: Asian (Reference group = White British or Irish)	-1.309	.573	-.036*

Gender (1=Male, 2=Female)	.174	.220	.013
Ethnicity: Other (Reference group = White British or Irish)	-.393	.554	-.012
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.356	.461	-.045**
Ethnicity: Not Known (Reference group = White British or Irish)	.567	.429	.021
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-3.050	.676	-.081***
Local Deprivation Index 2004	-2.611	.640	-.062***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	-.248	.487	-.009
Total number of years in care	.057	.035	.033
Ever placed in residential care (Reference group = Always foster or kinship care)	.936	.265	.063***
Mean length of all placements	-.001	.000	-.121***
Number of placements excluding short breaks	.064	.026	.046*
Ever placed with independent/voluntary provider (Reference group = Always own Local Authority)	.549	.231	.039*
Ever placed with other Local Authority (Reference group = Always own Local Authority)	1.113	.550	.031*
KS2 points, 3 test average	-.840	.162	-.105***
Proportion of fixed-term exclusions	11.412	3.903	.047**
School type: Special school (Reference group = Mainstream school)	.960	.346	.058**
School type: Alternative provision (Reference group = Mainstream school)	2.444	.499	.082***
School type: Pupil referral unit (Reference group = Mainstream school)	1.287	.452	.047**
Ever permanently excluded	-1.533	.595	-.040*
Changed school in Year 8-9 and Year 10-11	.472	.264	.027
Primary special educational need: Behavioural, emotional or social difficulty (Reference group = No special educational need)	2.830	.355	.201***

Special educational needs provision: Statement (Reference group: No special educational need)	1.837	.328	.123***
Primary special educational need: Other disability (Reference group = no special educational need)	1.653	.375	.115***
Special educational needs provision: School action (Reference group = No special educational need)	.740	.377	.039
Block 26			
Constant	12.108	1.159	
Ethnicity: Black African (Reference group = White British or Irish)	-2.689	.646	-.064***
Ethnicity: Asian (Reference group = White British or Irish)	-1.316	.572	-.037*
Gender (1=Male, 2=Female)	.160	.220	.012
Ethnicity: Other (Reference group = White British or Irish)	-.388	.554	-.011
Ethnicity: Black Caribbean and MWBC (Reference group = White British or Irish)	-1.356	.460	-.045**
Ethnicity: Not Know (Reference group = White British or Irish)	.582	.429	.022
Reason for entry into care: UASC (Reference group = Abuse or neglect)	-2.995	.676	-.080***
Local Deprivation Index 2004	-2.684	.640	-.064***
Reason for entry into care: Child's disability (Reference group = Abuse or neglect)	-.195	.487	-.007
Total number of years in care	.058	.035	.033
Ever placed in residential care (Reference group = Always foster or kinship care)	.864	.267	.058**
Mean length of all placements	-.001	.000	-.121***
Number of placements excluding short breaks	.056	.026	.040*
Ever placed with independent/voluntary provider (Reference group = Always own Local Authority)	.553	.231	.040*
Ever placed with other Local Authority (Reference group = Always own Local Authority)	1.062	.550	.029
KS2 points, 3 test average	-.852	.162	-.106***
Proportion of fixed-term exclusions	10.931	3.906	.045**

School type: Special school (Reference group = Mainstream school)	.936	.346	.057**
School type: Alternative provision (Reference group = Mainstream school)	2.386	.499	.080***
School type: Pupil referral unit (Reference group = Mainstream school)	1.204	.453	.044**
Ever permanently excluded	-1.559	.595	-.041**
Changed school in Year 8-9 and Year 10-11	.454	.264	.026
Primary special educational need: Behavioural, emotional or social difficulty (Reference group = No special educational need)	2.819	.355	.201***
Special educational needs provision: Statement (Reference group: No special educational need)	1.880	.329	.126***
Primary special educational need: Other disability (Reference group = no special educational need)	1.660	.375	.116***
Special educational needs provision: School action (Reference group = No special educational need)	.756	.377	.039*
Ever had a substance misuse problem	.811	.331	.039*

Substance Misuse	B	SE B	Exp (B)
Step 1a			
Reason for entering care: UASC (Reference category: Abuse or neglect)	-.863	.600	.422
Reason for entering care: Reduced parenting capacity (Reference category: Abuse or neglect)	-.958	.608	.384
Number of placements excluding respite	.056	.011	1.058***
Ever placed in residential care (Reference categories: Always placed in foster or kinship care, other types of care)	.644	.126	1.903***
Ever placed with parents (1=No, 2=Yes)	.035	.177	1.036
Mean number of respite placements	-1.701	1.016	.183
Proportion of school sessions missed due to unauthorised absences	1.998	.695	7.378**
Proportion of school sessions missed due to fixed-term exclusions	4.968	1.777	143.714**
Type of school at KS4: Pupil referral unit (Reference categories: Mainstream school, special school)	.292	.181	1.338

Type of school at KS4: Alternative provision (Reference categories: Mainstream school, special school)	.769	.237	2.157**
Highest level of SEN provision: Statement (Reference category: No SEN)	-.561	.138	.571***
Primary SEN: Behavioural, emotional, or social difficulties (Reference categories: No SEN, other disabilities)	.173	.120	1.189
Ever convicted (1=No, 2=Yes)	1.436	.128	4.203***
Constant	-2.973	.103	.051***
Step 2b			
Reason for entering care: UASC (Reference category: Abuse or neglect)	-.788	.601	.455
Reason for entering care: Child's disability (Reference category: Abuse or neglect)	-.973	.608	.378
Number of placements excluding respite	.055	.010	1.057***
Ever placed in residential care (1=No, 2=Yes)	.610	.127	1.840***
Ever placed with parents (1=No, 2=Yes)	.042	.177	1.043
Mean number of respite placements	-1.682	1.020	.186
Proportion of school sessions missed due to unauthorised absences	1.997	.695	7.367**
Proportion of school sessions missed due to fixed-term exclusions	4.810	1.774	122.683**
Type of school at KS4: Pupil referral unit (Reference category: Mainstream school)	.283	.181	1.328
Type of school at KS4: Alternative provision (Reference category: Mainstream school)	.725	.238	2.064**
Highest level of SEN provision: Statement (Reference category: No SEN)	-.612	.140	.542***
Primary SEN: Behavioural, emotional, or social difficulty (Reference category: No SEN)	.144	.121	1.155
Mean SDQ score	.017	.009	1.018*
Ever convicted (1=No, 2=Yes)	1.432	.128	4.188***
Constant	-3.182	.150	.042***

Criminal Convictions	B	SE B	Exp (B)
Step 1a			
Gender	.716	.126	2.046***
Reason for entry into care: Anti-social behaviour (Reference category: Abuse or neglect)	.247	.339	1.281
Reason for entry into care: Reduced parenting capacity (Reference category: Abuse or neglect)	.061	.120	1.063
Reason for entry into care: UASC (Reference category: Abuse or neglect)	-.785	.612	.456
Reason for entry into care: Child's disability (Reference category: Abuse or neglect)	-2.444	.730	.087**

Number of placements excluding respite	.047	.011	1.048***
Ever placed in residential care (Reference category: Always placed in foster or kinship care)	.903	.124	2.467***
Ever placed with parents (1=No, 2=Yes)	.725	.172	2.066***
Ever placed in another local authority provision (1=No, 2=Yes)	.635	.256	1.887*
Changed school in year 8-9 or 10-11 (1=No, 2=Yes)	.336	.132	1.399*
Proportion of school sessions missed due to unauthorised absences	2.922	.734	18.577***
Proportion of school sessions missed due to fixed-term exclusions	8.190	1.866	3603.676***
Type of school at KS4: Special school (Reference category: Mainstream school)	.795	.176	2.214***
Type of school at KS4: Pupil referral unit (Reference category: Mainstream school)	1.276	.182	3.584***
Type of school at KS4: Alternative provision (Reference category: Mainstream school)	.760	.256	2.137**
Type of school at KS4: Other provision (Reference category: Mainstream school)	.918	.241	2.503***
Highest level of SEN provision: Statement (Reference category: No SEN)	-.256	.158	.774
Primary SEN: Behavioural, emotional, or social difficulty (Reference category: No SEN)	.464	.122	1.590***
Ever had a substance misuse problem (1=No, 2=Yes)	1.401	.131	4.061***
Constant	-5.543	.219	.004***

Appendix Three

Improving health outcomes for looked after children: a mixed-methods study
Funded by the Wellcome Trust October 2014 – September 2017

Confirmation and consent

	Please tick if you agree
The young people have read and understood the information sheet about the project and they have a copy each to keep.	
The young people have had an opportunity to ask questions, and they have received satisfactory answers to any questions they have asked.	
The young people understand that they do not have to take part if they don't want to and that they are free to withdraw from this study at any time or decide not to answer a question without giving a reason.	
The young people understand that everything they say will be confidential. The only exception to this is if they say something that makes the researcher concerned that a young person is at risk of serious harm. The young people understand that if this happens, the researcher will need to talk to them about who should be told.	
The young people understand that the information they give will be kept in a secure place in accordance with the Data Protection Act 1998, and they understand that the recordings will be destroyed at the end of the project.	
The young people understand that the results of this study may be published and that quotes may be used but neither their name nor any other identifying information will be included.	
The young people understand that this project has received ethical approval from the University of Oxford's Ethics Committee, and is supported by the Association of Directors of Children's Services.	
The young people understand how to raise a concern or make a complaint.	
I agree to the young people taking part in this study on Improving the health outcomes of looked after children by taking photographs, completing a food and sleep diary, and completing an interview with a researcher.	
I agree to the interviews being audio recorded and to their contents being used for the research purposes stated above.	

The University of Oxford takes ethical conduct of research seriously. We therefore ask you to read the information sheet thoroughly and take the opportunity to ask the researchers any questions you may have before signing this form.

We would be very grateful for your help in this study. Your signature confirms that you are happy to participate. You may stop being involved at any time, without giving a reason and decide what happens to any information you have already given. We will always help with a request to withdraw information, however, sometimes it is not possible, for example, if a report has already been published.

Names of the young people taking part: _____

Your signature: _____

Your name: _____

Today's date: _____

Name of researcher: _____

Signature of researcher: _____

Date: _____

If you would like to discuss any aspect of the research, or the details of this form, please contact Áine Kelly at the University of Oxford:

aine.kelly@education.ox.ac.uk

01865 611034 / 07785 708478

INFORMATION SHEET/CONSENT FORM FOR FOSTER
CARER/KEY/RESIDENTIAL WORKER

Improving Health Outcomes for Looked After Children and Young People: a mixed-methods study

Funded by the Wellcome Trust October 2014 – September 2017

What is the project about?

I am a care leaver and through my own experiences I am interested in the health experiences of children and young people in care. As a group, children and young people who are in care have worse health than their peers and they are more likely to experience a deterioration in their health when transitioning to independence. They are also more likely to have a substance misuse problem, smoke or get pregnant during adolescence. Our government has tried to tackle these issues by ensuring that children and young people are offered an annual health assessment where their health needs can be identified and an appropriate health plan drawn up. However, as children in care reach adolescence they are more likely to opt out of these health assessments and it is believed that they are less likely to be treated in the way that the statutory guidance recommends. It is thought that they also receive worse health care in comparison to their peers. These experiences are likely to impact their engagement with the health service when they later move to independence, and could explain why their health deteriorates. As researchers, we are interested in finding out more about their health experiences and health beliefs. By doing so, health and social care services will be better able to provide support appropriate to their needs.

In this project I am working with nine Local Authorities (one from each region of England) to identify children and young people with different experiences of the health care service who can share with me their health experiences and health beliefs.

What will happen?

In this project your Local Authority has identified children/young people who are on a full care order and have been offered an initial health assessment. We are asking the child or young person that you care for to conduct their own research to capture their health beliefs and health experiences, and then to talk about the items they have gathered with me.

I expect interviews to take one to two hours and you can choose whether I come to your home or go to another convenient location. With the child/young person's permission I will audio record the interview to make it easier to remember everything that was said.

What happens to the information?

The information will be used to find out the child/young person's thoughts about health and their health experiences. This will help me to understand how the health and welfare of children and young people in care can be improved, and how services can help them to adopt healthy behaviours. The results will be added to those of the other interviews I am conducting for this project, and written up in a report. The report might include quotes or visual items from some of the interviews but no individuals, agencies or services will be named or identifiable. The audio recordings will be kept securely and will only be accessible by members of the research team; recordings will be destroyed after the project is finished.

Risks and benefits

This project has been reviewed by, and received ethical clearance through, the University of Oxford's ethics committee and is supported by Association of Directors of Children's Services. There are no known risks involved if the young person takes part in this project, and I hope that the information they provide will help us to understand how policy makers and practitioners might best support the health of children and young people in care.

If you have any questions or concerns at any time before, during or after the project, you can contact me (Áine Kelly – pronounced Orn-ya), principle researcher from the Rees Centre, University of Oxford, at aine.kelly@education.ox.ac.uk or on 01865 611034/07785708478, or Professor Judy Sebba, the Director of the Rees Centre at the University of Oxford, at Judy.Sebba@education.ox.ac.uk or on 01865 274050. If you are not happy with mine or Judy's answers you can contact Dr Nigel Fancourt, Chair of the Departmental Research Ethics Committee, at Nigel.Fancourt@education.ox.ac.uk or on 01865 274035.

Thank you for your help!

Improving health outcomes for looked after children: a mixed-methods study
Funded by the Wellcome Trust October 2014 – September 2017
Confirmation and consent

	Please tick if you agree
The young person has read and understood the information sheet about the project and they have a copy to keep.	
The young person has had an opportunity to ask questions, and they have received satisfactory answers to any questions they have asked.	
The young person understands that they do not have to take part if they don't want to and that they are free to withdraw from this study at any time or decide not to answer a question without giving a reason.	
The young person understands that everything they say will be confidential. The only exception to this is if they say something that makes the researcher concerned that a young person is at risk of serious harm. The young person understands that if this happens, the researcher will need to talk to them about who should be told.	
The young person understands that the information they give will be kept in a secure place in accordance with the Data Protection Act 1998, and they understand that the recordings will be destroyed at the end of the project.	
The young person understands that the results of this study may be published and that quotes may be used but neither their name nor any other identifying information will be included.	
The young person understands that this project has received ethical approval from the University of Oxford's Ethics Committee, and is supported by the Association of Directors of Children's Services.	
The young person understands how to raise a concern or make a complaint.	
I agree to the young person taking part in this study on Improving the health outcomes of looked after children by taking photographs, completing a food and sleep diary, and completing an interview with a researcher.	
I agree to the interviews being audio recorded and to their contents being used for the research purposes stated above.	

The University of Oxford takes ethical conduct of research seriously. We therefore ask you to read the information sheet thoroughly and take the

opportunity to ask the researcher any questions you may have before signing this form.

We would be very grateful for your help in this study. Your signature confirms that you are happy for the young person to participate. They may stop being involved at any time, without giving a reason and can decide what happens to any information they have already given. We will always help with a request to withdraw information, however, sometimes it is not possible, for example, if a report has already been published.

Would you be happy for Áine to come to your house to interview the young person?

(yes/no) _____

Name of the young person taking part: _____

Your signature: _____

Your name: _____

Today's date: _____

Signature of researcher: _____

If you would like to discuss any aspect of the research, or the details of this form, please contact Áine Kelly at the University of Oxford:

aine.kelly@education.ox.ac.uk

01865 611034 / 07785 708478

Appendix Four: Information and consent for young people



Information sheet

This leaflet gives you information about the research project and should answer any questions you have. As a young person in care, your views are really important. By telling me what you think, you can help me to find out how we can make health services better for young people in care.

What is this research about?

This project is looking at the health experiences of young people in care. We want to find out what young people in care know about health and illness, and what they like and dislike about their health services. This may include their experiences of having health assessments, going to see the doctor or dentist, and going to special services such as the sexual health clinic or mental health services. We want to know how we can make these services better.

Who can take part in this research?

All young people aged 11 to 18 on a full care order, who have been in care for 12 months can take part in this research.

What will you be asked to do?

Before you start, I will come and talk to you about the research and you can ask me any questions that you have. I will give you a folder with a list of questions in, and lend you a camera or voice recorder (unless you would prefer to use your phone). You can use these to answer the questions or to make notes about what health means to you. You can also create drawings, paintings or collages to answer these questions. There are no right or wrong answers and you can be as creative as you like.

I would like you to collect images of things that you think represent you and your health experiences. I would then like to talk to you about the images you have found. If you would like, you can collage a lifesize human body to represent your experiences while we talk. But we can just talk if you would prefer not to do this. I will ask you what you would like to do when I visit you. I will record the things that you say on a voice recorder so that I can write up everything you have told me. Once we have finished I will take your work with me so that I can copy it, but I will post it back to you at the end of my research (if you would like it – otherwise I will use them to decorate my office).

What will happen to the information you give?

The information that you tell me will be used to find out how to make health services better for young people in care. The results will be written up in a report. This might include some of the words or pictures that you have used or created, but your name will not be included.

Why won't your name be used?

Your name won't be used so that no one can find out who you are or that you have taken part in the research. Instead, you can choose a different name for me to use (such as a Disney/cartoon character) and I will use that instead.



Will anyone know what you have said?

The information you give me is confidential. This means that I will not tell anyone what you have said, unless you tell me something that means you are being harmed or could be in danger of being harmed. If this happens I will talk to you about who I need to tell (for example, your social worker or carer). I will write up our conversation and delete any names or names of places that have been used. This is called a transcript. Once I have done this I may share the transcript with my advisory panel, who will help me to analyse the results.

What is an advisory panel?

I have found a group of young people in care and some care leavers who are helping me with my research. They tell me what they think I should find out or ask, and they let me know how I can make my research better. They will also help me when I do the results and they will help me to make a list of things that will make health services better for children and young people in care. We will then let important people know so that they can make their health services better.

What are the benefits of taking part in the research?

As a young person in care, your views are really important to me. This is a chance for you to have your say. By telling me what you think, you can help me tell people how to make health services better for other children and young people in care. Once we have finished having a chat and we have looked through the things you have done in your folder, I will give you a £20 voucher to thank you for your hard work.

Are there any difficulties or risks if you take part in the research?

The university of Oxford takes special care when doing research to make sure everyone who takes part feels happy and safe. Special teams of people at the university of Oxford have looked at the questions I want to ask you to make sure they will not hurt anyone.

Do you have to take part?

No! It is up to you whether you would like to help me with the research. But if you are under 16 I will also need to ask your social worker for permission.



If you start taking part, can you stop later?

Yes. I hope that you will enjoy taking part in the research, but you can stop at anytime without giving me a reason. You can also choose not to answer any of the questions I ask.

Will you find out the results?

If you would like to know the final results you can fill in your details on another sheet and I will send them to you when I have finished writing the results.

What can you do if you are unhappy about something or want to make a complaint?

If you have any questions or concerns at any time before, during or after the project you can contact me, Áine Kelly, from the Rees Centre, University of Oxford at aine.kelly@education.ox.ac.uk or on 07785

708478, or Professor Judy Sebba, the Director of the Rees Centre at the University of Oxford, at judy.sebba@education.ox.ac.uk or on 01865 274050.

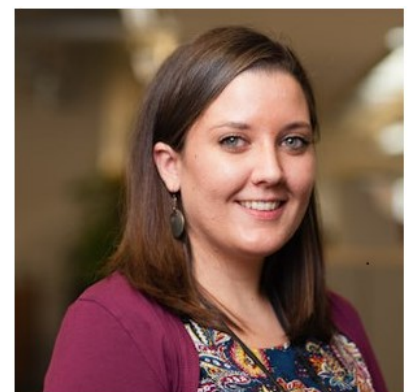
If you are not happy with mine or Judy's answers you can contact Dr Nigel Fancourt, Chair of the Departmental Research Ethics Committee, at nigel.fancourt@education.ox.ac.uk or on 01865 274035.

Who is doing the research?

My name is Áine Kelly (pronounced Orn-ya) and I grew up in foster care. I am now studying at the University of Oxford, and this research forms part of my doctoral training. If you have any questions then you can call, text or email me.

Email: aine.kelly@education.ox.ac.uk

Text/call: 07702181275



On these next pages you will find some questions. To answer these questions you can cut out and collect pictures, take photo's, draw or write down your answers. You can do whatever you feel like doing 😊
Áine

What does it mean to be healthy?

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What does it mean to be unhealthy or ill?

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What are symptoms?

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How do we learn to be healthy or unhealthy?

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What do you know about smoking, alcohol, and drugs?

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When should we go and see a doctor?

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When should we go and see a nurse?

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When should we go to the hospital?

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When should we see the dentist?

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What do you know about health assessments?

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What is a healthy diet?

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What is an unhealthy diet?

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Where can we find information about health?

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What do health services do well?

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(A health service is the doctor's, the dentist's, the hospital, the mental health service, sexual health clinics etc).

How could health services be better?

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(A health service is the doctor’s, the dentist’s, the hospital, the mental health service, sexual health clinics etc).

What does school teach us about health?

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What is it like to have health assessments?

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Is there anything else you want to say or do you have any questions?

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Improving Health Outcomes for Looked After Children and Young People
Young person's consent form

	Please tick if you agree
I have had the research explained to me.	
I understand what the study is about and what is involved in taking part.	
I know that the information I provide, including photos, collages, objects, sounds and music, will be used by the researcher to write reports about the research project.	
I know that no information which could identify me (e.g., names, place names, images of people) will be used in the reports for the study.	
I know that everything I tell you is confidential, unless the researcher thinks that I or someone else is at risk of harm.	
I understand that I do not have to take part in the research project.	
I know that I can change my mind and stop taking part at any point in the study.	
I know that I can decide not to answer any questions.	
I agree that the researcher can record our conversations and take notes and copy any of the creative work that I produce for the project.	

Please write your name:

 Your signature: _____
 Date: _____

Researcher:

 Your signature: _____
 Date: _____

If you would like to talk to someone about this study, or the details of this form, please contact Áine Kelly at Aine.kelly@education.ox.ac.uk or 01865 611034

Seven-day sleep diary

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
What time did you go to bed?							
How long did it take you to fall asleep after settling down?							
How many times did you wake up in the night?							
After going to sleep, how long were you were awake during the night?							
What time did you wake up?							
What time did you get out of bed?							
How long did you spend in bed in total?							
How would you rate the quality of your sleep? (1 = very poor, 5=very good)							

Seven-day food diary

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Snack							
Drinks							

Appendix Five: Interview Schedule

INDICATIVE INTERVIEW FRAMEWORK

Please note that full interview schedules will be drafted in consultation with the youth advisory panel.

Questions will be adapted according to the age and ability of each child/young person.

- **Health and Illness cognitions**
 - What does it mean to be healthy?
 - What does it mean to be ill?
 - What are symptoms?
 - What causes illness?
 - How long can illness last?
 - When should you go to the doctor?
 - When should you go to the dentist?
 - When should you go to the hospital?
 - How do you learn to be healthy?
 - What do you know about smoking/alcohol/drugs?
 - Who smokes/drinks/takes drugs?
 - What is a healthy diet?
 - How does diet affect your life?
 - What is exercise? And how often should you exercise?
 - How does exercise affect your life?
- **Health professionals**
 - Who are health professionals?
 - What makes a good health professional?
 - What makes a bad health professional?
 - Who would you prefer to talk to about health?
 - Who teaches you about health?
 - Who is responsible for your health?
 - How do you/they look after your health?
- **Health experiences**
 - What is it like to go to for health assessment?
 - i. Why do/don't you go for health assessments?
 - What is it like to go to the doctor?
 - What is it like to go to the dentist?
 - What is it like to go to hospital?
 - What is it like to go to the school nurse?