

Looking After Health: A Joint Working Approach to Improving the Health Outcomes of Looked After and Accommodated Children and Young People

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Introduction

Looked after and accommodated children and young people represent one of the most vulnerable groups within our society. Inequality and disadvantage impact upon every aspect of their lives, but the health inequalities which they suffer are particularly disturbing. If we are to improve the health outcomes of these young people, then all agencies must commit themselves to working together. Only if we foster a joint working approach can we hope to make a positive impact upon what are wholly unacceptable health outcomes.

This paper examines current factors contributing to these poor outcomes, and goes on to describe one project, the Residential Care Health Project (RCHP), which has been encouraging and developing a multi-agency approach to improving the situation for one group of children and young people. The RCHP has been working collaboratively with social work, health and other support agencies to address these issues as they affect local authority residential units for young people in Edinburgh, East Lothian and Midlothian.

Background

The health inequalities suffered by children and young people looked after by local authorities have been well evidenced and documented (Saunders and Broad, 1997; Polnay et al, 1997; Brodie et al, 1997; House of Commons Health Committee, 1998). With unacceptably high levels of long term illnesses, mental ill health, alcohol and drug misuse, teenage pregnancy and sexually transmitted infections being reported, it is essential that all agencies work together and take measures to address these issues. It is important to consider all the factors which combine to work against the positive health of these young people, including

factors relating to social background, upbringing, culture and education (Scottish Executive, 2001a). There is also a need to examine problems which are specific to the delivery of health care and health promotion to children who are looked after and accommodated, looking innovatively at current systems and whether they are capable of delivering satisfactory health supports to marginalised and hard to reach groups.

The recent Scottish Office white paper on health *Towards a Healthier Scotland* (Scottish Office Department of Health, 1999) highlights the profound effects of early childhood experiences on lifelong health outcomes, and emphasises that good health is “more than not being ill: we need to work on a broad front to improve physical, mental and social wellbeing, fitness and quality of life” (Scottish Office Department of Health, 1999, p. 2). The Scottish Executive set child health as a priority target, and made a firm commitment to driving forward change so as to improve child health and reduce inequalities. Poverty, disadvantage and inequality, however, continue to take their toll and remain commonplace. Scotland is currently reported as having some of the highest rates of relative child poverty in the developed world, with one third of Scottish families surviving in, or on the margins of, poverty (Scottish Executive, 2001a).

Examining the barriers to good health

The problems of delivering health services and promoting good health for populations who move around and lose attachments to their communities of origin are complex. For looked after and accommodated children and young people, lack of continuity of medical care and, frequently, multiple moves of care contribute to a lack of information regarding past health history, an essential component of caring for any child. New patients can arrive at a GP surgery with obvious, complex needs but very little, or no, background information. Young people may resent what they feel are irrelevant and inappropriate medical assessments. The gathering of background information and communication between the health services and those caring for them are frequently absent, although this is very important to the care of the young person. Tracking health records is difficult and time consuming. Social work colleagues have long been left unsupported in trying to find their way around the many complex networks which contain our health information; networks which can be hard enough for health professionals to navigate.

Preventive health care and health promotion are two areas which are, in general, strongly supported by parents and schools. We may take for granted that this shared responsibility will ensure that all young people reaching adulthood will have had access to all preventive health programmes available, and will have experienced a wide range of health promotion and advice both in the home

and at school. Looked after and accommodated children tend therefore to be doubly disadvantaged, as they may start from a background of poor adult role modelling, frequently having experienced abuse, neglect and domestic violence. Looked after children are also known to have poor attendance rates and levels of achievement at school (Scottish Executive, 2001b). It is accepted that low educational attainment is one of the most significant factors perpetuating the cycle of deprivation, and therefore also the problems of health attendant upon disadvantage.

Ultimately, carers, no matter how dedicated, are not parents. Many children experience repeated moves of care (Department of Health, 2000) with the attendant problems of ensuring that information is passed from carer to carer, often at times of crisis. Children in residential care suffer particular difficulties which arise from, for example, shift systems. These may be a necessary fact of life for these units but, unless very reliable hand-over procedures are in place, they can lead to obstacles in all areas of children's lives, from arranging social activities to attending appointments. It takes time for a child or young person to trust an adult to the degree that they can seek help with their very personal health problems and anxieties. Frequent changes of carers can extend this period unacceptably for them. The often chaotic lifestyles of the young people themselves and, in the case of residential care, crises involving other young people in units, further add to the lack of security and continuity.

The Residential Care Health Project - fostering a joint approach

The Residential Care Health Project (RCHP), a two year innovation project, funded largely by the Scottish Executive, was established to address the health inequalities faced by children and young people accommodated in residential units in Edinburgh, East Lothian and Midlothian. The project has aimed to work with social work and education colleagues in order to establish a holistic approach to the provision of health care and health promotion for these young people. As a team, the RCHP aimed to raise health as a priority issue within social work and to examine and develop health care services which were so clearly not meeting the needs of this excluded group.

A core health team has been set up, with nurses who have a specific remit for each of the units. A part-time community paediatrician, mental health worker and GP researcher make up the rest of the team, supported by a clerical coordinator. This team approach has enabled us to examine thoroughly the current state of health provision for the young people; to identify the gaps and challenges; and to look at ways of addressing these issues. We have looked at the health profiles and needs of this population of young people and we have been able to guide staff towards more effective use of services. We have also acted as a link between units and health service providers in a way which will be sustainable at the end of the project.

A multi-disciplinary advisory group was set up at the outset, including representatives from social work (from both management and practice backgrounds), education, primary care, community child health, voluntary agencies, health promotion agencies and one of our children's rights officers. This group has been invaluable in steering the team so that they can carry out their work in what is both the children's home, but also another agency's workplace, and respecting both of these factors.

Working alongside social work colleagues has enabled us to gain an understanding of the day-to-day realities of residential care, and then to develop services which reflect this reality, for the benefit of the young people. We have come to realise how much health services lack flexibility, and therefore exclude this group of young people. We hope that, as a result of the findings of the project, we can highlight to health colleagues the inescapable fact that to access such populations the systems of service delivery need to be developed and improved.

From a very early stage, we have realised the value of working with these young people through trusted carers. We have been aware of the need to equip carers with the necessary knowledge and training to be able to care for and guide the young people they look after to improve their prospects for a healthy adult life. We had no knowledge of staff confidence in dealing with health issues, and so carried out an extensive audit of the training needs of care staff near the beginning of the project. This was very well supported by the staff, and the results will be published in the final report of the project. From this, it was clearly seen that staff had an interest in developing their knowledge base, and the health team delivered a week of comprehensive training for staff covering a wide range of health areas, including: understanding the NHS and building professional relationships; hidden disabilities; child and adolescent development; mental health and mental illness; specific medical conditions; sexual health; child sexual abuse; healthy eating; and the 'health promoting unit'.

As far as the young people and their carers are concerned, it has been rewarding to develop a close working relationship from which new methods of supporting and helping them with their understanding of health issues could be approached. Various methods of health promotion have been explored including drama, group work, individual work and work involving specialist agencies. There is a need to tailor the work to the particular group or individuals in the unit at any one time, no model being adopted as the only possibility. An open-minded approach seems to be the answer for most activities. In addition, we shall be asking young care leavers for their experiences of health care while looked after and accommodated, another crucial piece of the jigsaw in delivering appropriate services for young people.

We are now looking at the roles and responsibilities of the various agencies in terms of sustainability at the end of the project. Clearly, some aspects of the work will be addressed as part of an ongoing development of health supports for all looked after children, in line with the adoption of the new 'Looking After Children' materials. Other aspects cry out for new developments, for example, in the area of mental health supports and advice for the young people. To a large degree, we have simply 'connected' young people and the units they live in more effectively with existing local services. However, we have also uncovered a huge area of unmet need, which calls for innovative approaches. We hope that we have raised health as a priority in the residential units, and with our social work colleagues who have the responsibility of managing them, in a way which will ensure ongoing improvements for the children and young people.

The way forward

In conclusion, the Residential Care Health Project has made a number of recommendations which we aspire to maintain and develop for the improved health of young people in residential care in the future, in partnership with colleagues in the other agencies. These fall into three main categories: those dealing with staff and young people; management; and policy.

Staff and young people

Every young person should have an accurate, up-to-date health record at unit level, which is regularly reviewed and maintained. This health record has to be transferred **with the child** between placements – this action alone would bring an end to the problem frequently encountered by unit staff who take a young person into their care with no knowledge of any health problems.

It is important that confidentiality is sensitively managed, with secure storage being available for essential health information. Health records need to be respected, and acknowledgement given to the fact that the information belongs ultimately to the young person. Just as we would like to be consulted on the sharing of our private health information, so we should be discussing any need to share information and listening to young people's views.

Much of the work of the project has involved building sustainable links with other helping agencies in the mainstream and voluntary sectors, for example, primary care, mental health services, dental services, school health, sexual health services and drug and alcohol counselling services. The units currently have a system where they are allied to a specific local GP practice and we recommend that staff be encouraged to use the range of available services most appropriately.

Staff and young people need to develop a good knowledge of local health services, and care staff can help young people by being proactive in linking them with these services, not only for their benefit whilst accommodated, but also for the day when they will leave the care system.

Lastly, the value of positive role modelling cannot be underestimated; this can be used to develop the idea of the 'health promoting unit', where staff and young people pull together to make their lifestyles as healthy and enjoyable as possible.

Management (Social Work, Health and Education)

All agencies need to be proactive at all levels in encouraging interagency links, for example, between units, primary care, school health, education and voluntary agencies. We need to encourage reflective practice among staff of all agencies, casting a critical eye on established practice, with a questioning approach to better ways of working and developing services. Good managerial and clerical support is needed for all staff, to free them up to work constructively with young people.

Health services need to provide opportunities for more meaningful health assessments, moving away from the 'freedom from infection' type of model. We need to ensure that young people are appropriately registered with a GP when it is clear that they are going to stay in a placement beyond three months. We need to tailor the services to the needs of the young people, and not to the needs of the services.

Education is paramount not only to the delivery of health education programmes, but particularly with consideration to the ability to cut through the cycle of deprivation and disadvantage in which many of these young people find themselves. The relationship between poor educational achievement and poor health outcomes must not be underestimated.

It is essential, therefore, that health is firmly on the social work and education agenda at management level as well as at practice level. To deliver health care, **all** agencies must take ownership.

Policy

To tackle the difficult issues raised above on all levels, joint planning is essential, with funding from all agencies working together to address health in its widest sense. Vulnerable groups have to be specifically targeted, listening to the voices of children and young people, and to those who care for them.

The Residential Care Health Project has addressed one particular area of child health provision: that of caring for the health of children and young people in residential care. The lessons we have learned, however, go much wider. The problems around delivery of good health packages to excluded and hard to reach young people are very complex, and involve the entire fabric of health service delivery. As such, the problems will not be solved overnight. However, we feel that we have had a valuable opportunity to examine and realign services to the benefit of young people, and we have had the chance to support residential staff in their care of young people. In so doing, we hope that we have helped the various agencies to adapt and develop an element of flexibility and innovation, bringing about a truly integrated approach to ensure universal access for children and young people to all health services.

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