

DRAFT GUIDANCE

Front cover

Issue date: month/year

The physical and emotional health and wellbeing of looked-after children and young people

Introduction

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

The guidance is for all those who have a direct or indirect role in, and responsibility for, promoting the quality of life of looked-after children and young people. This includes policy makers, commissioners, managers, practitioners and carers in the NHS, local authorities, the criminal justice system, education, the private, voluntary and community sectors, and foster carers. It may also be of interest to looked-after children and young people, their families, prospective adopters and other members of the public. It contains draft recommendations (which start on page 26) for:

- **national organisations** (recommendations: 1, 11, 17, 41, 46, 50, 51, 52)
- **local organisations involved in strategic planning and commissioning** (recommendations: 2, 3, 4, 8, 12, 13, 23, 24, 25, 26, 27, 29, 37, 39, 40, 43, 44, 45, 46, 47, 48, 53)
- **organisations and practitioners delivering frontline services** (recommendations: 5, 6, 7, 9, 10, 12, 14, 15, 16, 18, 19, 20, 21, 22, 28, 30, 31, 32, 33, 34, 35, 36, 38, 42, 49).

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Please note that the final guidance will appear in short and long versions, with the possibility of different summary versions for different audiences.

Note that this document does not constitute formal final guidance from SCIE and NICE on looked-after children and young people. The recommendations made in section 4 are provisional and may change after consultation with stakeholders and fieldwork.

The final guidance should be read alongside:

- the revised guidance from the Department for Children, Schools and Families and Department of Health, 'Statutory guidance on promoting the health and wellbeing of looked-after children' (2009)
- the draft 'Care planning, placement and case review (England) regulations' (Department for Children, Schools and Families 2009a) and
- 'Putting care into practice: Draft statutory guidance for local authorities on care planning, placement and case review for looked after children' (Department for Children, Schools and Families 2009b).

The guidance complements but does not replace NICE guidance on young people's social and emotional wellbeing and child maltreatment (for further details, see section 8).

The Programme Development Group (PDG) has considered evidence reviews, cost effectiveness, commissioned reports and expert testimony.

This document sets out the PDG's preliminary recommendations. It does not include all sections that will appear in the final guidance. NICE and SCIE are now inviting comments from stakeholders (listed on the NICE website at: www.nice.org.uk).

The stages that will be followed after consultation (including fieldwork) are summarised below.

- The PDG will meet again to consider the stakeholder comments and fieldwork report. After that meeting, the PDG will produce a second draft of the guidance.

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- The guidance will be signed off by the NICE Guidance Executive and SCIE.

For further details, see 'The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)' available from www.nice.org.uk/phprocess

The key dates are:

Closing date for comments: 14 April 2010.

Next PDG meeting: 5–6 May 2010.

Members of the PDG are listed in appendix A and supporting documents used to prepare this document are listed in appendix E.

This guidance was developed using the NICE public health programme process. It has used a mixture of SCIE and NICE methods.

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1 Key priorities

This section will be completed in the final document.

2 Context

The term 'looked-after children and young people' is used in this guidance to mean those looked after by the State where the Children Act 1989 applies, including those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks or respite care. This guidance covers children and young people from birth to age 25, wherever they are looked after (including residential care, foster care, young offender or other secure institutions, boarding school, or those placed with birth parents, other family or carers).

About 60,900 children and young people were looked after by local authorities in England in 2009 (year end 31 March), 2% more than in 2008 but relatively unchanged since 2005 (Department for Children, Schools and Families 2009c). This report also states that:

- the number of boys who were looked after increased from 2005 to 2009, while the number of girls decreased
- the number of white children and young people who became looked after decreased from 2005 to 2009, while the number of Asian and children from other black and minority ethnic groups increased
- about 40% of the total in 2009 were children younger than 10, but in recent years there has been a decrease in the numbers aged 5–9 and a significant increase in the number of over-16s who are looked after
- most looked-after children (approximately 73% in 2009) were in foster care; about 13% were in residential settings and 10% were placed with parents or were living independently.

Early experiences may have long-term consequences for the health and social development of children and young people. A number have positive experiences in the care system and achieve good emotional and physical

health, do well in their education and have good jobs and careers. However, entering care is often strongly associated with poverty and deprivation (for example, low income, parental unemployment) and relationship breakdown (DH 2002).

For the first time, the Department for Children, Schools and Families presented data on the emotional and behavioural health of looked-after children and young people, finding that about 60% of those looked after in England were reported to have emotional and mental health problems. It also reported that a high proportion of looked-after children and young people experience poor health, educational and social outcomes after leaving care (Department for Children, Schools and Families 2009c). But the data does demonstrate improvements in providing settled accommodation and entering employment, education or training.

A government strategy for children and young people's health noted that a third of all children and young people in contact with the criminal justice system have been looked after (Department for Children, Schools and Families and DH 2009). However, a substantial majority of young people in care who commit offences have already started to offend before becoming looked after (Darker et al. 2008).

Consultation with looked-after children and young people indicates that they have clear expectations for their care and wellbeing (Children's Rights Director for England 2007). They expect to take part in decisions that affect their lives, be kept healthy and safe, be treated with respect, and be treated equally to other children and young people. However, local variations in service access and support can mean that these expectations are not always met.

National policy and guidance

There is a wide range of policies and guidance relevant to looked-after children and young people.

The overarching policy framework is 'Every child matters' (Department for Children, Schools and Families 2003), which aims to support all children to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing. The white paper 'Care matters: time for change' (Department for Education and Skills 2007) sets out how local authorities, strategic health authorities and primary care trusts have a shared responsibility in helping to achieve the aims of 'Every child matters' for looked-after children.

'Care matters: time to deliver for children in care' (Department for Children, Schools and Families 2008a), sets out a package of commitments aimed at improving the lives of looked-after children and young people.

Most recently, 'Healthy lives, brighter futures – the strategy for children and young people's health' (DH 2009a), reaffirms these commitments. In addition to setting out key principles and establishing what parents, carers and children in the general population can expect from services, the strategy draws attention to the poorer health outcomes of looked-after children and identifies the need for:

- children's trusts to develop robust joint plans with health, education and social care and be clear about overlapping responsibilities for services for looked-after children
- children and young people who are looked after to be given healthy opportunities; that is, they should live in healthy environments that encourage them to make healthy choices
- responsive services that provide looked-after children with the right services at the right time to meet their specific health needs and expectations
- targeted support for looked-after children.

Statutory guidance on promoting the health and wellbeing of looked-after children

In November 2009 the government published 'Statutory guidance on promoting the health and wellbeing of looked-after children' (Department for

Children, Schools and Families and DH 2009) for both healthcare bodies and local authorities to help remove inconsistencies and promote better-coordinated care. Local authorities, primary care trusts (PCTs) and strategic health authorities in England should implement it in accordance with sections 10 and 11 of the Children Act 2004. Local authorities must also comply under section 7 of the Local Authority Social Services Act 1970 in discharging their duties to promote the health of the children they look after.

Draft care planning regulations and statutory guidance for local authorities

In December 2009, the Department for Children, Schools and Families published draft 'Care planning, placement and case review (England) regulations' (2009a) and 'Putting care into practice: Draft statutory guidance for local authorities on care planning, placement and case review for looked after children' (2009b). These bring together the core duties of local authorities for ensuring more purposeful care planning. The draft regulations and guidance propose to strengthen the role of the social worker as 'frontline corporate parent' and the role of the independent reviewing officer (IRO) for monitoring the performance of the local authority in properly managing and implementing the care plan. The main underlying aim is to put the child at the heart of the care planning process.

Other policy and guidance

Several other policies have sought to promote joint working among different sectors at strategic and operational levels to improve outcomes for children and young people, and disadvantaged groups in particular. These include:

- 'Children and young people in mind: the final report of the national CAMHS review' (Child and Adolescent Mental Health Services 2008)
- 'Children's trusts: statutory guidance on inter-agency cooperation to improve well-being of children, young people and their families' (Department for Children, Schools and Families 2008b)

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- ‘Healthy children, safer communities – a strategy to promote the health and well-being of children and young people in contact with the youth justice system’ (DH et al. 2009)
- ‘The child health promotion programme: pregnancy and the first five years of life’(DH and Department for Children, Schools and Families 2008)
- ‘Healthy child programme: from 5–19 years old’ (DH and Department for Children, Schools and Families 2009)
- ‘High quality care for all: NHS next stage review’ (DH 2008)
- ‘National service framework for children, young people and maternity services (DH and Department for Education and Skills 2004)
- ‘The children’s plan – building brighter futures’ (Department for Children, Schools and Families 2007)
- ‘Transforming community services: enabling new patterns of provision’ (DH 2009b)
- ‘2020 children and young people’s workforce strategy’ (Department for Children, Schools and Families 2008c).

3 Considerations

The Programme Development Group (PDG) considered and took account of a number of factors and issues when developing the recommendations.

Needs of looked-after children and young people

- 3.1 The majority (80%) of children come into care because of abuse or neglect, or family dysfunction that causes acute stress among family members. Entry into care is usually a traumatic experience and brings with it a huge sense of loss from family and community that is insufficiently recognised in care planning. Older children in care may also experience significant problems at school. For those children and young people who remain in long-term care creating a sense of belonging and emotional security is vital to their health and wellbeing.

- 3.2 The number of looked-after children and young people has remained relatively unchanged since 2005 with a slight increase in 2009 (year end 31 March, Department for Children, Schools and Families 2009c). Of this total:
 - about 25% are in care for less than 1 year
 - about 50% are in care for between 1 to 5 years
 - just over 20% are in care for more than 5 years.

The main categories of looked-after children and young people in the care system are:

- those of all ages who entered care but left quickly and mainly returned home
- children aged under 5 who entered care and were adopted
- young people aged 16 and over who moved on to independent living
- children brought up in the care system.

The PDG acknowledged that children and young people who remain in long-term care are likely to have the most complex needs and may experience a greater lack of attachment and sense of loss.

3.3 There is a lack of information about the needs of particular groups in the care system including:

- children from birth to five years
- black and minority ethnic children
- children of multiple heritage
- unaccompanied asylum seekers
- children with disabilities
- teenage girls in foster care
- children placed in kinship care
- children with emotional or behavioural difficulties.

Quality of care and placement stability

3.4 Ensuring that children and young people feel attached to carers and experience a sense of 'permanence' has been a key issue for the PDG. Much of the evidence that the PDG received identified quality of care and stability of both the placement and education as critical to achieving permanence. The care system still faces major challenges in helping children and young people to:

- feel a sense of belonging
- feel they are supported
- have someone to talk to
- maintain contact with birth parents
- experience less stigma and prejudice about being in care
- do well at school
- prepare for leaving care.

It is also a major challenge to find stable placements for looked-after children and young people in need of permanence and a family to belong to that can provide a secure base through to adulthood.

- 3.5 The PDG considered that the length of time in a placement should not be the sole indicator of its success. Meeting national indicators (see section 3.10) for stability can divert attention from the actual experiences of children and young people. A placement may be long lasting but an unhappy experience and it is then more important to move than to stay. Placement length, it was agreed, does not guarantee that a child or young person feels secure.
- 3.6 Frequent placement changes can severely lessen the sense of identity and self-esteem of a child or young person, and can also adversely affect their experience of and access to education and health services. A system that allows multiple moves may be seen as harmful. The World Health Organization (WHO) definition of emotional abuse includes “the failure to provide a developmentally appropriate, supportive environment, including the availability of a primary attachment figure” (‘Report of the Consultation on Child Abuse Prevention’, WHO, Geneva, March 29–31 1999). Repeated separations or moves may therefore be regarded as indicators of emotional harm.
- 3.7 The impact of changing the placement of a child or young person can be less harmful if continuity is maintained in other areas of their life. For example, if they can stay at the same school, maintain contact with their siblings, family or past residential or foster carers, or keep social and community networks including friends and the same social worker or support team. In addition, unsettling effects can be lessened if information about the needs and preferences of the child or young person is passed on and used to inform future placements.

Inspection, monitoring and performance assessment

- 3.8 Local authorities have responsibility for the care and welfare of looked-after children and young people. The Care Quality Commission has reported a lack of clarity between local authorities and the NHS about payment for primary and secondary healthcare

for this group. The responsibility for commissioning an individual's care – who pays – is clearly identified in the guidance 'Who pays? Establishing the responsible commissioner' (DH 2007) and the recent 'Statutory guidance on promoting the health and wellbeing of looked after children' (Department for Children, Schools and Families and DH 2009).

- 3.9 Children's trusts have the lead responsibility for the strategic direction of children's services within local authority boundaries. The Audit Commission report (2008) on the effectiveness of children's trusts found little evidence they have improved outcomes for children and young people or delivered better value for money. Few children's trusts draw a sufficiently clear distinction between strategic and operational issues; most lack robust joint-commissioning agreements; few trusts have effective performance monitoring of the 'Every child matters' (Department for Children, Schools and Families 2003) agenda; and more needs to be done to ensure that children, young people and families are involved in designing services.

The new comprehensive area assessment (CAA) – which looks at how well local services are working together to improve the quality of life for local people – gives priority to looked-after children and young people.

The PDG heard from the Audit Commission about these issues and endorsed the recommendations in its report (2008) about improving the effectiveness of children's trusts and recognised its particular interest in looked-after children as a priority group.

- 3.10 The PDG noted that the national indicators for placement stability for children in long-term care are defined as a child or young person who has experienced three placement changes in the first year of care or been in care for 4 years or more and who has spent the last 2 years in one foster home. These indicators are a weak measure of placement stability. They indicate nothing about the quality of the

placement – whether the child’s emotional health is being supported, whether the child is happy in a placement and if those writing the care plan feel a placement will lead to permanence. The PDG believed that government and regulators should take a wider view of placement stability and develop indicators that reflect a more holistic understanding of stability that should include both foster and residential care.

- 3.11 The data on emotional health and wellbeing collected by the Department for Children, Schools and Families using the ‘Strengths and difficulties questionnaire’ (SDQ) could help to identify children and young people who may need additional specialist support at home or at school (Department for Children, Schools and Families 2009c). But it is only one measure and needs to be supported by other assessments and knowledge of the child or young person.

The PDG noted the need for comprehensive health assessments to ensure adequate provision of services for looked-after children and young people. It acknowledged that such assessments may inadvertently lead to further stigma by reinforcing the feeling among this group that they are ‘different’. The updated ‘Statutory guidance, on promoting the health and wellbeing of looked after children’ (Department for Children, Families and Schools and DH 2009), sets out key actions for local authorities, PCTs and strategic health authorities to improve the health of children and young people in care.

Residential care

- 3.12 Children and young people placed in residential care are some of the most vulnerable and traumatised individuals in the looked-after population. The PDG noted that stability of placement, quality of care, stability of education experience and planning for permanence are as applicable to children and young people in residential care as they are to those in foster care. Failure to address these issues risks

compounding existing health and social inequalities and increase their vulnerability to social exclusion as young adults.

- 3.13 There is less robust evidence on defining good residential care than foster care. However, the characteristics of good residential care are similar and include the manager having an authoritative parenting style that is child-centred with capacity for nurturing secure attachment. The approach should be warm but with the ability to set clear boundaries for behaviour and engage children and young people in education. It is equally important that other staff support and understand the manager's approach to ensure consistency.

Social pedagogy

- 3.14 Social pedagogy is an important development for all care provision in Europe, as the PDG heard in evidence from Denmark and the UK. Its central tenet is 'building relations' that are crucial to further healthy emotional development, based on the importance of attachment theory, having a 'secure base' and developing good social skills. Social pedagogy puts the child or young person at the centre and builds outwards, integrating care and education in its broadest sense to provide a holistic package of support. The PDG also heard about research in England – inspired by the approach in European children's homes – on a pilot programme that is introducing social pedagogic values in residential care homes here. The pilots are currently being evaluated and have potential for policy development in the 'Care matters: time to deliver for children in care – an implementation plan' (Department for Children, School and Families 2008a). The approach might also have value in foster care.

The outcomes from the pilots were not available at the time of completing this guidance. Some of the components of social pedagogy are likely to be present in high-quality residential homes and foster care where good practice is standard. The PDG heard evidence that some of the values underpinning the discussion on quality of care were similar to those of social pedagogy.

Kinship care

3.15 The PDG heard evidence that kinship placements last longer and score higher on a measure of wellbeing than other types of placements. The evidence also shows that:

- children and young people in kinship care have the same level of difficulties as those in other care settings
- placement stability appears to be good when children are placed with grandparents
- kin carers show high levels of commitment to children despite increasingly challenging behaviour.

3.16 There is little evidence to support concern about the quality of formal kinship care in more than a minority of cases. Despite the benefits of kinship care there is evidence that carers receive less support from children's services than foster carers, which puts greater strain on them. There is a need for practical help and access to specialist services to manage difficult behaviour, as well as financial help to cope with daily living.

Sibling care and contact

3.17 Up to 80% of looked-after children and young people in care are living separately from a brother or sister. Membership of a sibling group is a unique and important part of their identity and may help promote a sense of belonging and improve self-esteem. Good management of sibling placement and contact is therefore essential to their emotional health and wellbeing. This includes contact with siblings who are not looked after and 'sibling-like' relationships developed in a care setting. A decision on whether siblings should be placed together or apart may not be taken on the basis of the best interests and needs of a child or young person, but instead by poor planning and resource shortfalls.

3.18 Thorough assessment by highly experienced professionals is required if separation from siblings is to be considered. The PDG took the view that placements which enable siblings to live together or close by or which allow them to attend the same school are likely to be beneficial. However, it was noted that this is not always the case and there may be situations where it is preferable to separate siblings. For example, contact with the birth family ordered by a court while legal proceedings are underway can often be damaging for children and young people.

Foster care

3.19 Fostering is a complex task that requires a rehabilitative and therapeutic approach and an understanding of the challenges and rewards of caring for some children who have experienced abuse and neglect. This should be reflected in the recruitment of foster carers and in the training and support they receive. It should also be reflected in the training and supervision of professionals who work with foster carers.

3.20 In view of the complexity and challenge of fostering the PDG would like to promote the notion of 'supported foster care' to describe the type of care offered to looked-after children and young people. This reinforces the kind of care the PDG would like to endorse, as outlined in 3.23. A good foster carer has an authoritative parenting style, the qualities of which are described in more detail in the section 'High quality care and relationships'.

3.21 The PDG heard evidence that social workers and other professionals in frontline roles involved in placing children and young people in foster homes and supporting foster carers are good predictors of 'quality' foster homes. The PDG endorsed the draft revised national minimum standards for fostering against which Ofsted measures the quality of foster care placements (National Minimum Standards (NMS) for adoption, fostering and children's

homes, DCSF 2009). Poor quality foster care would then be identified and homes not used again.

Babies and children under 5

- 3.22 Decisive action is of key importance to the wellbeing of very young children who come into the care of local authorities. The majority of very young children who come into care are from families where parents are struggling with issues such as domestic violence, substance abuse, alcohol abuse and mental health problems, often in combinations. While some parents succeed in overcoming their difficulties during the child's formative years, not all are able to do so.
- 3.23 The psychological evidence suggests that separations within the first 6 months of life are likely to be less damaging than those that occur when a child is older. Interventions to help children overcome the consequences of abuse and neglect are less effective with older children. Leaving or returning children to abusive situations can increasingly damage their life chances. All this points to the need for clear and decisive permanence planning for very young children who come into care.
- 3.24 The absence of a permanent carer at such a young age can jeopardise children's chances of developing meaningful attachments and have adverse consequences for their long-term wellbeing. Carers can unwittingly contribute to the development of insecure attachment patterns. For example, they may withdraw when the child appears not to need them – rather than making it clear that they are always there to help, so ensuring the child feels secure. It is difficult for children to join nurseries and other early years settings if they have not experienced secure relationships with care givers.
- 3.25 Very young children can become closely attached to foster carers and can experience great distress if required to move on to a new

placement. For some children the need to establish stability may become so pressing as to override all other considerations.

Black and minority ethnic children and young people who are looked after and children and young people who are unaccompanied asylum seekers

3.26 Latest figures show that 27% of the care population are children and young people from black and minority ethnic backgrounds. The breakdown by different ethnic groups has remained similar since 2005. At 31 March 2009 there were 3700 unaccompanied children seeking asylum in care – an increase of 200 from 2008 (Department for Children, Schools and Families 2009c).

There is enormous diversity of ethnicity and cultural experience within and between these groups of children and young people and simply dividing them into broad categories such as white, black, mixed race, Asian or African is unhelpful and insufficient. Professionals need to take more care and time to understand the importance of cultural heritage for these children and young people when in the care system.

3.27 All looked-after children and young people need to develop a positive identity, emotional resilience and self-esteem. Achieving and maintaining a sense of security may be more difficult for children and young people from black and minority ethnic, multiple heritage backgrounds, or who are unaccompanied asylum seekers – they may also face racism and isolation. Care plans for these children need to capture the environmental circumstances for each child – where identity and cultural heritage is acknowledged and addressed.

3.28 Unaccompanied children and young people seeking asylum have other complex needs following their dislocation from family, community and home. They may also have experienced or witnessed extreme violence, abuse and rape. Their physical and emotional health needs will require specialist interventions. Care

planners need to be alert to these circumstances and ensure support is provided that is sensitive to their needs.

Health information

- 3.29 The PDG recognised the importance of recording information about looked-after children and young people in a factual and non-judgemental manner. Inaccurate record keeping can lead to wrong decisions by professionals and can adversely affect the child or young person.
- 3.30 Equally important is ensuring that health information held on looked-after babies, children and young people is accurate and kept up-to-date, and is transferred at the right time. Birth parents or relatives may not recall or be reluctant to share this information. The health history may not be incorporated into the initial healthcare assessment, plans may not be updated and recommendations may not be followed through. In addition, records may be misplaced when the child or young person is placed outside their local area, or when children are admitted to care, discharged and re-admitted again some time later.
- 3.31 The loss of personal health information has significant implications for the immediate and future health and wellbeing of looked-after children and young people. The birth family's health history may take on an additional importance when young adults begin to plan their own families. Recommendations in this guidance reflect these concerns.

Access to dedicated services to promote mental health and wellbeing

- 3.32 The role of child and adolescent mental health services (CAMHS) was considered. This included whether or not a more flexible and accessible service is needed to support the carers of children and young people to prevent the escalation of challenging behaviours

and to ensure that those with complex needs are identified and supported even when these difficulties are not displayed in ways that might traditionally lead to a CAMHS referral. Such interventions can prevent placements breaking down.

3.33 The PDG considered that CAMHS should be measured on the number and outcome of interventions for children and young people in their area.

Further, children and young people placed out of the local authority area are less likely to receive services from CAMHS in their new location. Looked-after children and young people should be regarded as a priority group for specialist mental health services, especially when moving from one area to another.

3.34 The PDG looked at the links between CAMHS and adult mental health services – in particular whether the remit for CAMHS could be extended to young people over 18 who were in care. Many young people receiving psychological support from CAMHS would not meet the criteria for accessing an adult mental health service, despite having significant complex needs requiring specialist intervention.

3.35 The PDG heard evidence from Ofsted about:

- a low uptake of formal counselling services by young people
- professionals not managing well the everyday handling of over-the-counter medication for looked-after children or young people.

Education

3.36 Evidence shows that educational attainment can influence the health, social and employment prospects of a child or young person. There is a strong relationship between employment and good mental health (see NICE public health guidance 19 on managing long-term sickness and incapacity to work). Schools have a duty to provide full-time education for looked-after children and young people. This includes students with complex needs who may exhibit the most

challenging behaviours and who are also the most vulnerable. An awareness and understanding of the complex issues these children face in an educational setting is essential.

- 3.37 Although schools have to give priority to admitting looked-after children and young people, under government regulation (The Education (Admission of Looked After Children) (England) Regulations 2006), the PDG was concerned that some schools may still be reluctant to admit them or, when they do, may be quick to exclude them when there is a problem. The PDG considered that concern about league tables and fear of behavioural problems may be behind this. The PDG also acknowledged that the education system does not pay sufficient attention to facilities for looked-after children and young people who are particularly gifted.
- 3.38 The PDG recognised the important role of the designated teacher and designated governor in each school and the virtual head teacher with responsibility for a cluster of schools. They could be more assertive in helping schools to manage tensions that might arise in relation to the attainment and behaviour of looked-after children and young people.
- 3.39 All looked-after children and young people would benefit from new educational opportunities. The Department for Children, Schools and Families is ideally placed to encourage such innovation. The PDG acknowledged that any schemes would need to be monitored and good practice shared. It believed longitudinal research into the effectiveness of such schemes would encourage professionals to adopt the best approaches.
- 3.40 In summary, the evidence presented to the PDG showed that educational stability is pivotal to the emotional health and wellbeing of looked-after children and young people.

Leaving care

- 3.41 For most young people leaving home and starting the journey into adulthood represents a landmark step. For young people who have been in care the journey is more arduous. They are more disadvantaged and face more difficulties than other young people in achieving independence. They become independent at a younger age, and have to cope with major changes in their lives in a much shorter time and with less support than their peers. Physical and mental health problems can increase after they leave care. Outcomes can be worse for some looked-after young people who have very damaging pre-care experiences or multiple placements, or who leave care early.
- 3.42 Health and wellbeing is closely connected to other aspects of young people's lives such as access to housing, employment and education, as well as personal and social support. Without adequate support many young care leavers feel marginalised within the wider community and experience the stigma of having been in care. Without an adequate knowledge of their rights and entitlements they are ill-equipped to cope with their move into the outside world.
- 3.43 Foster carers have an important role in helping looked-after young people make the transition to adulthood, in the way that many do for their own children. Equally, good residential care will prepare young people properly for leaving care. Young people with complex needs face particular problems in the transition from care to independence. The culture and organisation of many residential homes and the regulations that govern them often do not help staff to equip young people with the skills to support their move into adulthood. The PDG welcomes the pilot initiatives under the 'Care matters' (Department for Children, Schools and Families 2008a) agenda to improve support for care leavers.
- 3.44 Employment opportunities and access to accommodation are crucial for the successful transition into adulthood of young people leaving

care. Good mental health is strongly associated with employment (NICE public health guidance 19 on the management of long-term sickness and incapacity for work). Poor health and crime are associated with unemployment and lack of adequate housing. In the current economic climate it is important that agencies are mindful of the additional pressures that young people leaving care are likely to experience. Agencies will need to sustain support to reduce the impact of these extra pressures, which are likely to be felt by many young people leaving care for some time to come.

Training

3.45 High-quality training is important for all professionals involved in working with looked-after children and young people. Above all they need to understand attachment theory and the dynamics and theory of interpersonal relationships in the context of family, group living and care environments. Effective multi-agency training can reinforce a shared understanding of the challenges that looked-after children and young people experience growing up in the care system. A number of recommendations in this guidance address these training priorities.

Evidence

3.46 There is a lack of evidence on the effectiveness of interventions that improve the physical and emotional health and wellbeing of looked-after children and young people. The PDG drew on evidence from a qualitative review and a practice survey as well as a large number of expert testimonies from within and outside the PDG (see the appendices).

Cost-effectiveness evidence

3.47 A cost-effectiveness modelling exercise was conducted for the effectiveness review of support services for looked-after young people who were making the transition to independent living at the age of 18 (review 1 – see appendix B). For the other effectiveness

reviews undertaken ('Training and support' and 'Access to health and mental health services', see appendix B), a lack of data meant that no meaningful modelling could be undertaken.

3.48 The PDG considered the appropriateness of a cost-consequences framework, which is recognised in the scope for this topic as an appropriate method of analysis where there is a lack of meaningful data for cost-effectiveness analysis. This required the PDG to consider the best available evidence on the costs and effectiveness of services of relevance to the recommendations under consideration and to draw on their expertise to make an appropriate recommendation, where gaps in the evidence existed. This approach benefits from greater flexibility to draw on the multiple sources of evidence available to the PDG (including expert testimony, evidence from qualitative and quantitative reviews and the findings of a practice survey). For further details, see appendices B and C.

Despite limitations in the cost-effectiveness evidence, the PDG judged that each of the recommendations would do more good than harm compared with current practice, based on the evidence it was presented with. In addition, the PDG judged that many of the recommendations were likely to have low or no additional cost, and so were very likely to be cost effective.

However, the PDG expected that some of the recommendations would be costly. For these recommendations, the PDG did not have enough evidence on the magnitude of either the costs and/or the effects to reach an informed conclusion about their cost-effectiveness. This does not mean that these recommendations are not cost-effective, just that their cost effectiveness is not known.

4 Recommendations

When writing the recommendations, the Programme Development Group (PDG) (see appendix A) considered evidence reviews, cost effectiveness, commissioned reports and expert testimony. Note: this document does not constitute SCIE and NICE's formal final guidance. The recommendations are preliminary and may change after consultation.

The evidence statements underpinning the recommendations are listed in appendix C.

The evidence reviews, commissioned reports, supporting evidence statements and economic analysis are available at

<http://guidance.nice.org.uk/PHG/Wave17/24>

Role of the care system

This guidance focuses on the role of the care system in promoting the physical and emotional health and wellbeing of looked-after children and young people. Improved outcomes will depend on how organisations and professionals work together to ensure each child and young person experiences high-quality care, stable placements and nurturing relationships. These are essential for building the emotional resilience that children and young people need to cope with their challenging circumstances.

It is now recognised that different parts of the care system must work together to improve outcomes for looked-after children and young people.

Multidisciplinary assessments and interventions form a core part of the care planning process at the operational level. At a strategic level the role of children's trusts in securing effective partnership arrangements is critical. This guidance aims to impact on the care system as a whole.

High-quality care and relationships

Many of the recommendations are about the quality of care provided by the carer to the child or young person within the placement. The quality of this relationship is fundamental to the healthy development and wellbeing of looked-after children and young people. The foundation is good parenting that

promotes a sense of security and trust. An authoritative approach – combining emotional warmth, nurturing, good physical care, consistency, a strong sense of belonging with clear guidance and boundary setting – is most likely to contribute to the ability of children and young people to develop healthy attachments and build resilience.

Placement stability

High-quality care has a significant effect on the stability of placements, which is associated with a range of better outcomes for looked-after children and young people. Stable placements allow continuous access to key services that support healthy emotional development and educational achievement – placement instability is associated with poorer outcomes.

Length of placement on its own is a poor quality indicator as a child or young person may be placed in an unhappy and uncaring environment that does little to reinforce their healthy emotional development and resilience.

Effective corporate parenting

The responsibility of a corporate parent is to provide high-quality placements.

Well-planned and well-supported long-term foster care placements, coupled with training that has a focus on therapeutic care-giving, can meet the needs of children and young people for permanence. If foster carers feel supported by their social worker and have ready access to support services – in particular specialist child and adolescent mental health advice – they provide a more secure base and reduce the risk of placement breakdown.

Good residential homes have authoritative managers who are warm and place value on relationships that both nurture and provide clear boundaries. They have clear and effective strategies for managing challenging behaviour and transitional resident populations. In addition, they will have good capacity to provide effective educational strategies, and staff turnover will be low.

Residential homes who display these qualities will be best placed to manage institutional turbulence and low morale,

Care planning

Care planning is an ongoing multidisciplinary assessment of the needs of a child or young person, followed by careful identification of actions to meet these needs, with reviews at regular intervals to ensure that actions are implemented as agreed. Effective care planning is crucial for improving outcomes for looked-after children and young people.

Principles and values

The recommendations aim to help services follow the principles set out in the Department for Children, Schools and Families and Department of Health guidance¹ to:

- deliver services that are tailored to the individual and diverse needs of children and young people
- put the voices of children, young people and their families at the heart of service design and delivery
- address health inequalities and have an emphasis on prevention
- make sure that health needs are accurately assessed and met
- deliver excellent, world-class standards of care
- make sure all professionals working with looked-after children have a clear understanding of the roles and responsibilities of all relevant agencies
- be holistic, including consideration of physical health, sexual, emotional and mental health, wellbeing and health promotion
- use integrated working and joint commissioning based on effective partnerships at both strategic and individual case level to improve service delivery, information sharing, confidentiality and consent.

In addition, the PDG endorsed the six entitlements of the National Children's Bureau's 'National healthy care standard'² – a child or young person will:

- feel safe, protected and valued in a strong, sustained and committed relationship with at least one carer

¹ Department for Children, Schools and Families; Department of Health (2009) Statutory guidance on promoting the health and wellbeing of looked-after children. London: Department for Children, Schools and Families.

² Visit www.ncb.org.uk/healthycare

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- live in a caring, healthy and learning environment
- feel respected and supported in his/her cultural beliefs and personal identity
- have access to effective healthcare, assessment, treatment and support
- have opportunities to develop social skills, talents and abilities and to spend time in freely chosen play, cultural and leisure activities
- be prepared for leaving care by being supported to care and provide for him/herself in the future.

The PDG also developed the following principles, for all in the care system to:

- ensure practitioners reflect on their practice and apply both theoretical understanding and self-knowledge to the challenges they are confronted with
- value residential and foster carers as skilled, committed and loving 'professional' carers
- ensure processes for matching a child or young person with a carer focus on the quality of the relationship between them
- encourage warm and caring relationships that nurture attachment and create a sense of belonging for the child or young person.
- ensure each child or young person has a close relationship with at least one adult, who can act as their advocate if needed
- support the child or young person to integrate with a wider network of school and social activities and community groups to help them build resilience
- ensure children and young people have a stable school/education experience and encourage motivation and self-reliance
- protect children and young people from peer violence and bullying that might result from stigma and prejudice.

Performance management and inspection

Recommendation 1: regulating and auditing services

Who is the target population?

Looked-after children and young people.

Who should take action?

Statutory regulators and inspectors (including the Audit Commission and Ofsted).

What action should they take?

- Use the comprehensive area assessment (CAA) and the 'Framework for inspection and guidance for local authorities and partners³' to ensure that all children's trusts provide services for looked-after children and young people that:
 - meet the full range of their needs (including their physical and emotional health and wellbeing needs)
 - promote and support healthy lifestyles
 - deliver quality care, and placement and education stability
 - all looked-after children in the area can access equally.

- Audit children's trusts to:
 - ensure the 'Children and young people's plan' prioritises the needs of looked-after children and young people
 - ensure mainstream budgets are pooled or aligned to meet those needs
 - ensure effective joint commissioning of services is in place and show how costs are shared between agencies.

³ Ofsted (2009) Framework for inspection and guidance for local authorities and partners. London: Ofsted.

Strategic leadership

Recommendation 2: prioritising the needs of looked-after children and young people

Who is the target population?

Looked-after children and young people.

Who should take action?

- Children's trusts.
- Directors of children's services.
- Chief executives of PCTs and NHS trusts.

What action should they take?

- Create strong leadership and strategic partnerships under the arrangements for children's trusts to develop a vision and a corporate parenting strategy that:
 - focuses on partnership work
 - addresses health and educational inequalities for looked-after children in their area.
- Ensure that strategic plans adhere to national and local guidance, for example 'Statutory guidance on promoting the health of looked-after children⁴'.
- Ensure the 'Children and young people's plan' reflects fully the needs of looked-after children and young people, and care leavers, and sets out how these needs will be met. It should describe how to:
 - meet the changing needs of looked-after populations and provide high-quality care
 - provide services that meet the emotional health and wellbeing needs of children and their carers, including child and

⁴ Department for Children, Schools and Families (2009) Statutory guidance on promoting the health of looked-after children. London: Department for Children, Schools and Families.

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adolescent mental health services (CAMHS), core health services (for example, paediatrics) and enhanced services (for example, immunisation)

- promote healthy lifestyles
 - provide access to extra-curricular activities
 - improve the stability of placements and education.
- Ensure senior managers in partner agencies provide strong, visible leadership to raise aspirations and attainment, and promote joint working to meet the needs of looked-after children and young people.
- Ensure effective corporate parenting by complying with Department for Children, Schools and Families guidance on the role of directors of children's services and the lead member for children's services in helping looked-after children and young people improve their aspirations and outcomes.
- Ensure services are developed in line with the views of looked-after children and young people. These views should be channelled through the corporate parenting board or children-in-care council.
- Report annually to their children-in-care council, overview and scrutiny committee, primary care trust board and the leader of the council on the effectiveness of services for looked-after children and young people when evaluated against the 'Children and young people's plan', the local pledge to children in care, national indicators and local targets.
- Build communication networks with key partner organisations and publish and publicise a map identifying all agencies that are involved with looked-after children and young people.
- Publish a directory of resources for looked-after children and young people to aid social workers, and a resource guide for looked-after children and young people and care leavers.

Recommendation 3: commissioning services for looked-after children and young people

Who is the target population?

Looked-after children and young people.

Who should take action?

Commissioners in PCTs and local authority children's services.

What action should they take?

- Ensure that service commissioning for looked-after children and young people is informed by:
 - national evidence, guidance and datasets
 - the corporate parenting strategy
 - local knowledge and experts (for example, the director of public health)
 - local audits
 - the joint strategic needs assessment.

- Commission services dedicated to looked-after children and young people that are integrated, preferably on the same site, and have expert resources to address physical and emotional health needs. These services should include:
 - health promotion (see recommendation 33)
 - early identification and prevention of physical and emotional health problems (see recommendation 20, 33 and 39)
 - access to specialist child and adolescent mental health services (see recommendations 29, 39 and 40)
 - access to professional consultancy for the looked-after children and young people's care team (see recommendation 4).

- Encourage authorities to work in regional partnerships when commissioning services to offer greater choice and quality of services.

Multi-agency working

Recommendation 4: consultancy services

Who is the target population?

All practitioners, frontline staff and carers, including child and adolescent mental health services (CAMHS) teams.

Who should take action?

- Directors of children's services.
- Chief executives of PCTs.

What action should they take?

Ensure the multi-agency 'team around the child' (including carers) has access to a consultancy service to help consider and work collaboratively on complex cases and situations. The approach should be based on the concept of reflective practice, and should include how to manage:

- conflicting views in the team about the best interests and needs of a looked-after child or young person
- risks to or disruptions of long-term placements
- patterns of repeated placement breakdown or exclusion from education
- uncertainty or delays in care planning
- communication with colleagues decision making, information sharing, lead responsibilities, ensuring that the needs of the child continue to be priorities.

Such a service could be designed and delivered by in-house experts, an external consultancy or by child and adolescent mental health services, and should participate in regional support networks.

Recommendation 5: coordinating services between and within agencies

Who is the target population?

All frontline practitioners and carers including child and adolescent mental health services teams.

Who should take action?

Senior managers, local authorities and health services.

What action should they take

- Ensure that social workers undertake the key worker and coordinating role and fulfil their responsibility for managing the multidisciplinary care plan.
- Ensure that any professional who considers that the needs of the child or young person are not being addressed, or interventions are being avoidably delayed, can request through their line manager that a childcare review is reconvened before the date of the next statutory review.
- Ensure that independent reviewing officers have routine access to managers at all levels to deal with any problems in implementing agreed actions.

Recommendation 6: sharing health information

Who is the target population?

Professionals and carers.

Who should take action?

- Local authorities.
- Independent and voluntary sector providers.
- Primary and secondary healthcare providers.

What action should they take?

- Ensure that health information follows the child or young person. This may include deciding with partner agencies how 'hand-held records' can stay with the child or young person.
- Ensure that parental or delegated consent for medical and surgical intervention is available for all looked-after children and young people.

- Ensure that social workers obtain information on parental health and obstetric, neonatal and early health information of all children and young people entering care. This information should be incorporated into any assessments and shared with healthcare professionals, as appropriate.
- Ensure that healthcare professionals share health information with social workers, as appropriate.

Care planning, placements and case review

Recommendation 7: implementing care planning, placement and case review regulations and guidance

Who is the target population?

Social workers and independent reviewing officers (IROs).

Who should take action?

Local authority children's services.

What action should they take?

- Implement the Department for Children, Schools and Families draft 'Care planning, placement and case review (England) regulations'⁵ and 'Putting care into practice: draft statutory guidance on care planning, placement and case review for looked after children'⁶.
- Ensure the pivotal role of the social worker as 'local corporate parent' with overall responsibility for the coordination and implementation of the care plan is supported by:
 - regular high-quality supervision with a particular focus on the management of the care plan and remedial action to ensure that interventions are acted on as agreed – helping to prevent 'drift' in the care system

⁵ Department for Children Schools and Families (2009) Care planning, placement and case review (England) regulations consultation . London: Department for Children Schools and Families.

⁶ Department for Children, Schools and Families (2009) Putting care into practice: draft statutory guidance on care planning, placement and case review for looked after children. London: Department for Children Schools and Families.

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- continuing professional development for social workers to better understand and manage the difficult role of a local corporate parent.
- Implement in full the strengthened function of the independent reviewing officer as outlined in Department for Children, Schools and Families 'Putting care into practice: draft statutory guidance on care planning, placement and case review for looked after children'⁷ and the draft 'IRO handbook'⁸.
- Ensure the expanded and strengthened role of independent reviewing officers is supported by high-quality supervision.
- Ensure that prompt and decisive action is taken when planning permanence for very young children and babies who come into care, to safeguard and promote the wellbeing of the child. For example, where there is any uncertainty concerning reunification with birth parents 'concurrent planning' should be in place to ensure other permanence arrangements are available.
- When deciding whether rehabilitation with birth parents is an option for a very young child or baby who comes into care, give particular attention to the reasons why any siblings have been placed for adoption, and evidence of the willingness and ability of parents to change and sustain their behaviour after concerns were raised about this particular child.
- Ensure the voice of the child or young person is heard at every stage in the care planning process, with particular concern for the choice, quality and continuity of the placement.

⁷ Department for Children, Schools and Families (2009) Putting care into practice: draft statutory guidance on care planning, placement and case review for looked after children. London: Publisher.

⁸ Department for Children, Schools and Families (2009) Draft IRO handbook. London: Department for Children Schools and Families.

Residential, foster and kinship placements for children and young people

Recommendation 8: planning and commissioning placements

Who is the target population?

Looked-after children and young people.

Who should take action?

- Children's trusts.
- Local authority children's services.

What action should they take?

Develop a strategy to identify suitable placements and treatment interventions for looked-after children and young people. Such a strategy should:

- Clearly set out how to meet the 'sufficiency' duty under the Children and Young Persons Act 2008 to provide suitable placements to meet the needs of the looked-after population with a statement of the role of various forms of care, to include:
 - foster care, residential care and kinship care
 - use of secure accommodation
 - shared care/twin-track placement planning
 - how placements will be made if unavailable within the local authority area/region
 - consideration of sibling co-placement and contact (see recommendation 18).
- Use current DH guidance on complex care funding and ensure there are pooled budgets for looked-after children and young people who are likely to require highly specialised care placements for a significant period of time, and there is a multi-agency process for placement decisions that is informed by a comprehensive assessment of the social care, health and educational needs of the child or young person.

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- Include a robust protocol for sharing payment for placements that have a healthcare component. This is especially applicable to a 'best placement' decision where an integrated package of care and therapeutic, psychological or psychiatric input is purchased, and there is not an expectation that these services will be sourced from teams.
- Use a clear and open process for determining the type of placement best able to meet the assessed social care, health and educational needs of the child or young person, including where appropriate consideration of residential care as a positive choice.
- Ensure placements are sought in catchment areas of high-performing schools.
- Monitor the services for children and young people who have been placed out of the trust's area, including how to support care leavers if they choose to remain out of the area and how these services are sourced from local CAMHS teams.
- Encourage authorities to work in regional partnerships when commissioning services to offer greater choice and quality of services.

Recommendation 9: making decisions about placement changes

Who is the target population?

Looked-after children and young people.

Who should take action?

- Social workers.
- Placement teams.
- Commissioners.
- Independent reviewing officers.

What action should they take?

- Ensure decisions on changing placements are taken on a current assessment of the needs of the child or young person, or when their care plan clearly indicates that it is in their best interests to move and not on the basis of poor planning and resource shortfalls.
- Ensure that the number of emergency admissions are monitored with the aim of reducing their frequency, as these tend to lead to instability in the early stages of a care episode.
- Ensure placement plans and contracts state whether the placement is intended to meet the child or young person's long-term needs and further ensure that the provider has a specific and robust policy to minimise exclusions and terminations.
- When making decisions about moving children or young people from existing placements:
 - fully take into account the wishes and feelings of a child or young person
 - record the reasons for decisions taken that are not in accord with the wishes and feelings of the child or young person
 - ensure children and young people are made fully aware of their right to access advocacy services when a review decision is likely to overrule their wishes and feelings
 - ensure sibling co-placement and contact are considered (see recommendation 18).
- Ensure the child or young person has enough notice of any planned change to arrange for an advocate to support them in their review meeting.
- Monitor and audit the number of decisions where placement moves are made against the wishes of a child or young person, including the reasons for such moves.

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- After any placement move ensure appropriate measures are put in place for continued contact with adults identified by the child or young person as important, where this is desirable and practical.
- Ensure moves are planned and that for transitional arrangements the child or young person gets to know their new placement through prior visits and, wherever possible, overnight stays, and make 'good' endings to the previous placement.
- Ensure that placement decisions, including decisions about making and breaking placements, and planning for transition to leaving care:
 - take account of the developmental stage of the child or young person as well as their age
 - take into account fully all professional views about the progress and needs of the child or young person for any review, assessment and decision about changing placements
 - allow young people in residential care to remain in placement up to age 18 and beyond where it is in their best interests and appropriate to their continuing needs.
- Ensure kinship placement changes are recorded where the child or young person is moved from one family member to another.

Recommendation 10: providing care in secure and custodial settings

Who is the target population?

Looked-after children and young people.

Who should take action?

- Independent reviewing officers.
- Youth offending teams.
- Placement teams.
- Social workers.

- Leaving care teams.

What action should they take?

- Carry out an immediate review of the care or pathway plan when any looked-after child or care leaver enters a secure or custodial setting to reflect this change. The review should make provision for all of the health needs of the child or young person, including their emotional and psychological health and wellbeing, during their time in secure accommodation or custody.
- Ensure that children or young people living in secure accommodation have a move-on plan that is based on a comprehensive assessment of all their needs.
- Ensure a child or young person is not moved from a secure or custodial placement into independence or semi-independence any sooner than if they had not been in secure or custodial accommodation.

Kinship care

Recommendation 11: developing a national strategy for kinship care

Who is the target population?

Extended families and kinship carers of looked-after children and young people.

Who should take action?

Department for Children, Schools and Families.

What action should they take?

Consider developing a national policy to support kinship and family care and address the pressing need to provide adequate financial support.

Recommendation 12: promoting extended family and kinship care

Who is the target population?

Looked-after children and young people.

Who should take action?

- Children's services departments.
- Social work training bodies.
- Children's trusts.

What action should they take?

Endorse kinship care as a placement choice of equal status alongside adoption, foster care and residential care for looked-after children, by ensuring that:

- Social worker education and in-service training promotes kinship care as an equal and suitable placement option.
- After entry into care, agencies should immediately start concurrent planning to assess within 6 months all family members who could potentially provide kinship care for looked-after children and young people (that is, to match adoption processes that are not to exceed 6 months). For the assessment, agencies should:
 - consider the individual needs of the child or young person
 - identify placement support and services for kin carers.
- Agencies provide the necessary financial and emotional support to kin carers to support their care efforts, including:
 - information about what financial support is available
 - equitable access to services provided for all looked-after children and young people, including child mental health services and respite care, given the high levels of emotional and behavioural difficulty children and young people can present.

- All kinship placements are continuously reviewed and monitored so that unsatisfactory placements are brought to an end.

Sibling placements and contact

Recommendation 13: supporting sibling placements

Who is the target population?

Looked-after children and young people and their siblings.

Who should take action?

- Commissioners of children's placements.
- Strategic managers of looked-after children's teams.
- Managers of children's placement teams.
- Placement providers (fostering agencies and residential children's homes).

What action should they take?

- Ensure section 8 contact orders are followed and place siblings together unless assessments suggest otherwise.
- Ensure a placement strategy is in place that addresses any shortage of foster carers and/or suitable residential placements to meet the needs of sibling groups, for example through:
 - recruiting foster families specifically for sibling groups
 - commissioning homes for small family groups
 - meeting the additional financial and housing needs of foster carers to enable siblings to be placed together.
- Where a looked-after child or young person has a brother or sister in care, identify a placement that allows siblings to live together unless there is clear evidence that this would not be in their best interests.
- Ensure siblings have the same social worker, wherever possible.

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- Where siblings have different social workers establish a clear communication and liaison plan.
- Where decisions are made to separate sibling family groups, record clearly the reasons for separation, together with robust plans for ongoing sibling contact. Review a separation decision if the circumstances of a sibling changes.
- Where siblings are separated, assign practitioners to coordinate contact, arranging appropriate supervision where necessary and supporting foster or residential carers.
- Provide additional support and resources that help the co-placement of siblings to prevent disruption and possible end of a placement for any child or young person in a sibling family group.
- Where siblings live or are placed in different local authority areas ensure that arrangements are in place for their independent reviewing officers or social workers to liaise on their needs, ensuring ongoing contact and any possibility of future co-placement are regularly considered from the perspective of each sibling.

Foster care

Recommendation 14: assuring the quality of foster care

Who is the target population?

Foster carers.

Who should take action?

Local authority children's services.

What action should they take?

Ensure all foster carers meet and maintain statutory standards as set out in the draft 'Revising the national minimum standards (NMS) for adoption,

children's homes and fostering'⁹ and that mechanisms are in place to identify and remove those foster carers who repeatedly underperform or are unwilling to undertake additional training to meet these standards.

Recommendation 15: training foster carers

Who is the target population?

Foster carers.

Who should take action?

All responsible for providing training for foster carers, including: social work practices, managers, supervising social workers, social workers, CAMHS professionals and private and independent fostering agencies.

What action should they take?

- Deliver core training that covers the key components of parenting set out in the 'prerequisites and key principles' section of this guidance. Adapt this training to local needs.
- Deliver and assess a core training curriculum as set out in recommendation 7 of the training section in this guidance. It should include psychological theories of infant, child and adolescent development.
- For babies and young children, understand how to develop secure attachment (according to attachment theory¹⁰).
- Deliver training that provides or develops:
 - an understanding of the impact of transitions and stability on a child or young person, and how best to manage change and plan age-appropriate transitions, including preparation to leave care

⁹ Department for Children, Families and Schools (2009) Revising the national minimum standards (NMS) for adoption, children's homes and fostering. London: Department for Children, Families and Schools.

¹⁰ Department for Children, Families and Schools (2009) Promoting the health and wellbeing of looked after children. London: Department for Children, Families and Schools.

knowledge and awareness of how to safely meet the child or young person's needs for physical affection and intimacy within the context of the care relationship

- knowledge and understanding of the education system, educational stability and encouraging achievement
 - knowledge and awareness of how to promote, improve or maintain good health and healthy relationships
 - joint working practices with people from all agencies involved in the care of looked-after children and young people
 - understanding and awareness of the role of extra-curricular activities for looked-after children and young people.
- In addition, develop core training that provides a good understanding of how the absence of appropriate physical and emotional affection, or different forms of emotional and physical abuse, impact on a child or young person's psychological development and behaviour. Such core training should be delivered by trainers with specialist knowledge and expertise in these key areas.

Recommendation 16: supporting and supervising carers

Who is the target population?

Carers.

Who should take action?

- Social workers.
- Social work managers.
- CAMHS professionals.
- Private and independent fostering agencies.

What action should they take?

Ensure carers and their families (including kinship carers) receive high quality ongoing support packages that are based on the approach set out in the core

training recommendation above (recommendation 21). A support package should include:

- helping social workers to have reflective conversations with foster carers that include emotional support and parenting guidance
- providing consultancy from appropriately trained professionals to ‘the team around the child’, including foster carers, on the dynamics of the care relationship and the psychological and developmental needs of the child or young person
- ensuring that childcare arrangements are in place to enable foster carers to attend training
- ensuring that foster carers receive additional supervision, support and monitoring until foster care training is completed
- supporting the care of young people where age, gender or race may create additional challenges or stresses in the care relationship (e.g. foster mothers of teenage girls or young black boys) (see recommendations 23 to 30 on black and minority ethnic looked-after children and young people)
- ensuring children of foster carers are included when support is offered to foster care families
- making foster carers aware of stress (in its broadest sense, for example, everyday pressures on family life) within the foster care family to avoid placement breakdown
- providing out-of-hours emergency advice and help in calming emotions and handling challenging behaviours to support stability
- giving ongoing health promotion advice and help such as how to provide a healthy diet
- providing information about the role and availability of creative and leisure activities for looked-after children and young people.

Recommendation 17: training supervisors

Who is the target population?

All social workers and managers who undertake direct supervision of foster carers.

Who should take action?

- Children's Workforce Development Council (CWDC).
- General Social Care Council (GSCC).
- Local authorities.
- Independent foster agencies.

What action should they take?

- Ensure supervisors receive training that enables them to support carers and recognise the emotional impact of the role. Such training should include:
 - identifying support needs
 - how to support carers and develop their self-awareness and self-care skills
 - recognising signs of stress or secondary trauma
 - an understanding of when a child or young person needs to be referred for professional assessment or intervention (see recommendation on promoting mental health and wellbeing)
 - awareness of any additional support and information needed for carers of children and young people with particular vulnerabilities such as unaccompanied asylum seekers and those with special needs.
- Supporting cross-cultural placements (see recommendations 40 to 46 on black and minority ethnic looked-after children and young people, unaccompanied asylum seekers).
- Supporting sibling placements and contact between siblings and family members (see recommendation 18 on siblings).

Promoting the quality of life of the child and young person

Recommendation 18: meeting the individual needs and preferences of looked-after children and young people

Who is the target population?

Looked-after children and young people.

Who should take action?

All those with direct and indirect responsibility for looked-after children and young people, including corporate parents and children's rights representatives.

What action should they take?

- Promote continued contact with former carers, siblings or family members personally valued by the child or young person where this is felt to be in their best interests; and where this is not possible, acknowledge the significance of losing former attachment figures and relationships.
- Promote ongoing contact with friends, and personally valued mentors, professionals or advocates.
- Ensure access to creative arts, physical activities, and other hobbies and interests to support and encourage overall wellbeing.
- Ensure looked-after children and young people participate in policy decisions that affect their life.
- Allow contact with close family members to diminish when to maintain it is clearly not in the best interests of the child or young person and contrary to their wishes.
- Ensure local authorities reflect in their yearly 'pledge' to looked-after children and young people the needs and challenges raised by children-in-care councils of how services can be improved to achieve better outcomes.

Recommendation 19: exploring personal identity

Who is the target population?

Looked-after children and young people.

Who should take action?

All those with direct and indirect responsibility for looked-after children and young people, including corporate parents and children's rights representatives.

What action should they take?

- Ensure that policies and activities are in place to allow each child or young person to explore their life story. Such activities should be planned and supported using a sensitive approach that focuses on the needs of a child or young person.
- Ensure that in such activities looked-after children and young people have access to as much biographical information as possible, by promoting ongoing life-story work and conversations with carers and social workers that covers their:
 - personal journey before and through care
 - immediate and extended biological family
 - immediate and extended step-family members, if identified by the child or young person as significant
 - personal health history
 - family health history
 - cultural, faith and sexual identity.
- British Association of Fostering and Adoption forms that describe neonatal health and parents' general health should be completed at the point of the admission of the child or young person to public care.
- Extend existing good practice and policy on life-story work with children and young people during the adoption process and once adopted to all

children and young people who are looked after, including those leaving care.

- Deliver information in a realistic, respectful, sensitive and supportive manner by:
 - giving careful consideration to the timing and person who delivers life-story information and the extent of information given at any one time, according to the developmental stage and emotional needs of the child or young person
 - approaching life-story work as an ongoing process rather than a 'one-off', making sure it is reviewed and revisited as appropriate for each child or young person throughout their time in care
 - informing, authorising and supporting carers to answer questions about the personal history of the child or young person, including helping them to come to terms with sensitive or distressing information
 - ensuring the inclusion of written information, including:
 - ◇ 'later in life' letters (usually written by a social worker who knows the child or young person well, setting out his or her early history and sensitive explanations about becoming looked after)
 - ◇ letters from former carers
 - ◇ life-story books
 - ◇ visual records of celebrations, achievements and foster or residential family events (such as birthdays, religious and cultural events, and family and residential holidays).

Supporting babies and children from 0–5 years

Recommendation 20: accessing services for babies and young children

Who is the target population?

Looked-after children aged 0–5 years in foster care.

Who should take action?

- PCTs.
- Children's services.
- Social work managers.
- CAMHS.
- Independent training providers.

What action should they take?

- Ensure that services are in place to promote the emotional and physical wellbeing of babies and very young children in foster care by:
 - providing access to specialist services, including dedicated CAMHS teams, which offer early and preventive interventions for babies and young children to avoid placement breakdown and reduce the impact on a child's potential to develop meaningful relationships in the longer term
 - ensuring wherever possible that such interventions continue through transitional periods as babies or children move from one foster carer to another to reduce the distress of adjusting to a new placement
 - ensuring all babies and young children are assessed by a specialist child mental health worker to ensure the child does not exhibit signs of emotional distress (for example, children or babies who may exhibit passive, withdrawn or over-compliant behaviour).
- Where assessments identify emotional distress ensure a therapeutic treatment plan is put in place to support healthy development and secure attachment.

Recommendation 21: providing specialist training for foster carers and practitioners working with babies and young children

Who is the target population?

- Foster carers.
- Practitioners in early years settings.
- Social workers.

Who should take action?

- Social work managers (foster care).
- CAMHS.

What action should they take?

Ensure all carers and practitioners receive training from CAMHS or other specialist training providers on the:

- development of attachment in infancy and early childhood
- impact of broken attachments
- early identification of attachment difficulties.

Recommendation 22: reducing separation and loss for babies and young children aged 0–3 years

Who is the target population?

Looked-after babies and children aged 0–3 years.

Who should take action?

- Social workers.
- Foster care teams.
- Adoption teams.
- Independent reviewing officers.

What action should they take?

- Ensure an assessment of the emotional welfare of the child and their attachment to foster carers is taken into account in any decision to move a child to unknown adopters, and include consideration of the extent of previous placement instability.
- Ensure that the assessment of foster carers wishing to adopt a child already placed with them takes full account of their capacity to provide long-term stability and secure attachment.
- Ensure that pressure on resources does not influence decisions to move babies and very young children prematurely from stable foster care placements to unknown adopters.
- Ensure concurrent planning is in place to make alternative placements if assessments of birth parents or kinship carers are unsatisfactory.

Black and minority ethnic children and young people who are looked after and children and young people who are unaccompanied asylum seekers

Recommendation 23: understanding the issues

Who is the target population?

- Black and minority ethnic looked-after children and young people.
- Looked-after children and young people who are unaccompanied asylum seekers.
- Looked-after children and young people of multiple heritage.

Who should take action?

Children's trusts/directors of children's services at all agencies that have responsibility for looked-after children and young people.

What action should they take?

Provide all practitioners and managers with training, resources and access to experts and interpreters to:

- understand the complex issues for black and minority ethnic children in care, including racism and its effects, health, culture, identity and placement needs
- create links with community groups to reduce isolation and provide continuity of cultural experience
- ensure children-in-care councils include black and minority ethnic looked-after children and young people, unaccompanied asylum seekers and children and young people of multiple heritage as a standard agenda item.

Recommendation 24: sharing learning

Who is the target population?

- Black and minority ethnic looked-after children and young people.
- Children and young people who are unaccompanied asylum seekers.
- Looked-after children and young people of multiple heritage.

Who should take action?

Children's trusts and directors of services that have responsibility for looked-after children and young people.

What action should they take?

- Consider setting up a multi-agency specialist panel to discuss the needs and placement choices for black and minority ethnic children and young people, unaccompanied asylum seekers and children and young people of multiple heritage. Establishing such a panel may be a particular priority in areas with low numbers of these children and young people in care as there may be more need to increase local knowledge.
- Find opportunities for networking and sharing good practice with other local authorities with a similar profile of children and young people in care.

- Consider secondments of key staff to local authorities where good practice is recognised. Ensure there are mentoring and co-working opportunities to enhance expertise and understanding of how to meet the needs of black children and young people in care, unaccompanied asylum seekers and children and young people of multiple heritage.

Recommendation 25: appointing a children's champion

Who is the target population?

- Black and minority ethnic looked-after children and young people.
- Children and young people who are unaccompanied asylum seekers.
- Looked-after children and young people of multiple heritage.

Who should take action?

Local authorities.

What action should they take?

- Appoint a champion with leadership responsibilities to increase awareness of the particular needs of black and minority ethnic children and young people in care including unaccompanied asylum seekers and children and young people of multiple heritage.
- Ensure the leadership champion also reports and is accountable to the children-in-care council.

Recommendation 26: mapping and commissioning

Who is the target population?

- Black and minority ethnic looked-after children and young people.
- Children and young people who are unaccompanied asylum seekers.
- Looked-after children and young people of multiple heritage.

Who should take action?

Children's trusts and directors of services at all agencies that have responsibility for looked-after children and young people.

What action should they take?

- Produce a demographic profile of the local black and minority ethnic population in its widest interpretation, to include travellers, asylum seekers, European economic migrants and non-black minority ethnic groups.
- Create a community profile of black and minority ethnic children and young people to anticipate trends and plan for future needs, especially for areas where community support may exist.
- Use the information from the community profile to inform the commissioning of services for black and minority ethnic children and young people, and unaccompanied children and young people seeking asylum.
- Use the profile information to develop and train the workforce to meet existing and anticipated needs.

Recommendation 27: finding placements

Who is the target population?

- Black and minority ethnic looked-after children and young people.
- Children and young people who are unaccompanied asylum seekers.
- Looked-after children and young people of multiple heritage.

Who should take action?

Children's trusts and directors of services at all agencies that have responsibility for looked-after children.

What action should they take?

Ensure the placement strategy in the area includes a sufficient choice of culturally appropriate placements for black and minority ethnic children. The strategy should also:

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- ensure that sibling groups of different ethnicity are not separated inappropriately or unnecessarily
- in line with the community profile, increase the number of black and minority ethnic foster carers, or foster carers who can meet the needs of black children and young people who enter care at an older age and who stay longer in care
- pay particular attention to supporting the contact arrangements for white mothers with children and young people in care.

Recommendation 28: carrying out assessments

Who is the target population?

- Black and minority ethnic looked-after children and young people.
- Children and young people who are unaccompanied asylum seekers.
looked-after children and young people of multiple heritage.
- Looked-after children and young people of multiple heritage.

Who should take action?

Local authorities.

What action should they take?

Ensure that core assessments are completed and contain an accurate and comprehensive medical and cultural experience of the child or young person.
Pay particular attention to race, language, diet, faith and cultural identity.

Recommendation 29: accessing child and adolescent mental health services

Who is the target population?

- Black and minority ethnic looked-after children and young people.
- Children and young people who are unaccompanied asylum seekers.
- Looked-after children and young people of multiple heritage.

Who should take action?

- Children's trusts.
- PCT commissioners.

What action should they take?

- Ensure that child and adolescent mental health services (CAMHS) are sensitive to the needs of black and minority children and have sufficient expertise within the service to address issues of racism and cultural identity.
- Ensure that CAMHS have the necessary capacity, skills and expertise to address the particular and exceptional health needs of unaccompanied asylum-seeking children and young people, specifically in relation to:
 - post-traumatic stress syndrome
 - dislocation from country, family, culture, language and religion
 - risk of sexual exploitation
 - lack of parental support and advocacy in a foreign country
 - stress related to the immigration process
 - physical and emotional trauma from war and disruption at home related to torture, beatings, rape and death of family members
 - increased risk factors for suicide and serious mental illness.
- In addition, services for unaccompanied asylum-seeking children and young people who are looked after should have a keen understanding of differences in cultural attitudes and beliefs towards physical and mental health or wellbeing.

Recommendation 30: providing for unaccompanied asylum-seeking children who are looked after

Who is the target population?

Unaccompanied asylum-seeking children and young people who are looked after.

Who should take action?

Children's trusts and directors of services across all agencies with responsibility for looked-after children.

What action should they take?

- Provide support and training to foster parents and residential staff to ensure they have a better understanding of the particular issues affecting unaccompanied asylum-seeking children who are looked after (as identified in recommendation 29).
- Ensure that unaccompanied asylum-seeking children who are looked after have access to peer group support and religious and community groups to reduce their sense of isolation and disorientation in a foreign country.

Promoting the health of the child or young person

Recommendation 31: keeping the parent-held child health record (red book)

Who is the target population?

Looked-after children and young people.

Who should take action?

PCTs and provider services.

What action should they take?

- Ask social workers to ensure that the parent-held child health record book (red book) follows the child or young person (see recommendation 24 below).
- Ensure that if the original red book is lost or unavailable a replacement or equivalent is provided.
- Ensure there is a clear process to issue a red book to all new carers for children or young people in their care.

- Ensure that each PCT identifies a contact person to manage the administration of the red book.

Recommendation 32: providing the parent-held child health record book and early child health information

Who is the target population?

Looked-after children and young people.

Who should take action?

Social workers.

What action should they take?

- Ensure that the parent-held child health record book (red book) follows the child or young person.
- If the birth parent is unwilling to give up the red book work with them to:
 - ensure understanding that the health record is the property of the PCT
 - encourage them to temporarily relinquish it to enable information to be copied
 - obtain early health information, including obstetric and neonatal health information on all children or young people entering care
 - ensure this information is shared with health partners.
- Inform the contact person in the PCT if the red book is unavailable or lost so that it can be replaced.

Recommendation 33: producing a healthcare plan

Who is the target population?

Looked-after children and young people?

Who should take action?

- PCTs.

- Local authorities.
- Independent reviewing officers.

What action should they take?

- Thoroughly assess the health needs of each child or young person and highlight health risks that may lead to needs in future. This should be done in line with the statutory guidance¹¹, and should include:
 - completing a comprehensive healthcare plan (following assessment) for each child or young person as part of the initial (and review) health assessments within the designated time limits
 - clear actions, monitoring plans and milestones for follow-up including any referrals to other health professionals and their outcomes
 - a process (including contingency plans) to deal with requests made by the social worker to the designated nurse or doctor through the PCT to ensure that the health assessment is carried out in time to meet statutory requirements.
- In line with the Department for Children, Families and Schools and DH statutory guidance¹², healthcare plans should:
 - identify and follow up any immunisation requirements
 - make arrangements to complete dental checks
 - consider the safe management of any medication at a placement
 - consider any dietary requirements including healthy nutrition or special dietary requirements
 - consider appointments with other professionals.

¹¹ Department for Children, Families and Schools (2009) Promoting the health and wellbeing of looked after children. London: Department for Children, Families and Schools.

¹² Department for Children, Families and Schools and DH (2009) Statutory guidance on promoting the health and wellbeing of looked after children. London: Department for Children, Families and Schools.

Recommendation 34: providing health services for children and young people placed out of the area

Who is the target population?

Looked-after children and young people.

Who should take action?

Provider services in the original PCT.

What action should they take?

- Notify the receiving PCT and designated doctor or nurse of the health needs of children or young people placed out of area in a timely manner.
- Notify the receiving local authority and ensure statutory services are provided.
- Ensure health information, including a summary/record of health, is quickly and accurately transferred to the designated health professionals and GP, and monitor its delivery.

Recommendation 35: carrying out health reviews

Who is the target population?

Looked-after children and young people.

Who should take action?

PCTs and provider services.

What action should they take?

Ensure all health reviews are undertaken by an appropriately trained health professional and are in line with 'Statutory guidance on promoting the health and wellbeing of looked-after children'¹³, the draft 'Care planning, placement and case review (England) regulations'¹⁴ and 'Putting care into practice: Draft

¹³ Department for Children, Families and Schools (2009) Statutory guidance on promoting the health and wellbeing of looked after children. London: Department for Children, Families and Schools.

¹⁴ Department for Children, Families and Schools (2009) draft Care planning, placement and case review (England) regulations. London: Department for Children Schools and Families.

statutory guidance for local authorities on care planning, placement and case review for looked after children¹⁵.

Recommendation 36: providing a health summary update

Who is the target population?

Looked-after children and young people.

Who should take action?

PCTs and provider services.

What action should they take?

Ensure every looked-after child and young person has a robust summary of their health plan that is updated at every health assessment, so that all relevant health information about the child or young person can be easily accessed.

Recommendation 37: commissioning assessments for court processes

Who is the target population?

Looked-after children and young people.

Who should take action?

- Local authorities.
- Legal advisers.
- Courts.

What action should they take?

Ensure that when assessments are commissioned for court processes, leave of court is obtained to share this information (when legal proceedings are completed) with health professionals who carry out statutory assessments and/or advise on health needs.

15 Department for Children, Schools and Families and DH (2009) Putting care into practice: Draft statutory guidance for local authorities on care planning, placement and case review for looked after children. London: Department for Children Schools and Families

Recommendation 38: carrying out a leaving-care health consultation

Who is the target population?

Looked-after children and young people.

Who should take action?

- Children's trusts.
- Local authorities.
- PCTs.
- Provider services.

What action should they take?

Ensure that on leaving care, young people are given all details of their medical history. This should be as part of a consultation with the designated doctor or nurse but it could be solely in written form, including a letter from the designated doctor or nurse or other professional nominated by the health service. The young person's preference for a consultation or written material should be met if possible.

Access to dedicated services to promote the mental health and emotional wellbeing of children and young people in care

Recommendation 39 commissioning mental health services

Who is the target population?

All those with direct and indirect responsibility for looked-after children and young people.

Who should take action?

Local authority and PCT commissioners of mental health services.

What action should they take?

- Jointly commission services dedicated to promoting the mental health and emotional wellbeing of children and young people in care. These services

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should be integrated with looked-after children's services (ideally on the same site). They could be provided from a variety of sources including:

- NHS child and adolescent mental health services (CAMHS) teams
 - specialist clinicians from different agencies forming a team to work directly with looked-after children and young people.
- Ensure that the team includes practitioners who are trained and supported to work with multi-agency networks on the most complex cases.
 - Ensure that looked-after children and young people have access to these dedicated services in situations where their emotional wellbeing is at risk. For example children and young people who are:
 - unsettled as a result of inadequate implementation of care plans
 - in placements at risk of breakdown because of emotional or behavioural difficulties
 - in temporary foster care or residential placements for various reasons, such as during court proceedings
 - known to have experienced abuse or neglect prior to entry to care or in a previous placement.
 - Ensure that the services include:
 - training, support and clinical consultation for carers and other professionals to support and promote the mental health and emotional wellbeing of looked-after children and young people
 - training, support and consultation to carers, social workers and young people for early identification of those at risk of mental health problems, and to prevent problems from becoming worse
 - consultation and liaison with services and individuals who support all looked-after children and young people, such as specialist education teams, designated looked-after children nurses and paediatricians. This is to ensure the mental health

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- of all looked-after children and young people is considered, and not just those referred to CAMHS
- therapeutic services for children and young people including those in unstable and transitional placements
 - continuing with and completing a therapeutic intervention after the young person reaches the age of 18, when this is necessary.
- Include a clinical role in CAMHS teams for supporting young people leaving care at age 18 or older who may not meet the threshold for onward referral to adult mental health services. The clinician's role should be to:
 - support leaving-care teams in local authorities on the mental health and emotional wellbeing needs of the young person leaving care
 - provide information and advice to adult mental health services about the particular issues affecting young people's mental health while they are in care and the emotional and mental health needs of young people leaving care
 - provide clinical services to young people aged 18 and older when this is the best option to meet their mental health needs in the short to medium term.

Recommendation 40: providing access to specialist assessment services for young people entering secure accommodation or custody

Who is the target population?

Looked-after children and young people.

Who should take action?

PCT commissioners and provider services.

What action should they take?

Ensure that looked-after children and young people entering secure accommodation or custody have their physical and mental health assessed by a paediatrician, who could request support from CAMHS to carry out a

specialist mental health assessment (see recommendation 10 for additional information).

Supporting education for looked after children and young people

Recommendation 41: developing teacher training

Who is the target population?

Trainee teachers.

Who should take action?

Department for Children, Schools and Families.

What action should they take?

Ensure a core training module that looks at the needs of looked-after children and young people (as set out in recommendation 51) is included in all teacher training programmes and includes an understanding of:

- the impact of stable care and education on children and young people and how to help them have a stable education
- the impact of adversity and trauma on child development, attachment and cognitive functioning
- the value of engaging in activities outside the school curriculum and in the community.

Recommendation 42: involving designated teachers

Who is the target population?

Designated teachers.

Who should take action?

Local authorities

What action should they take?

Ensure designated teachers:

- are involved in preparing and monitoring the personal education plan (PEP), individual education plan (IEP) and pastoral support plan (PSP) for all looked-after children and young people that set out their education and training needs
- engage with the child's or young person's social worker to avoid school disruption and make every attempt to achieve educational stability.

Recommendation 43: role of virtual head teachers

Who is the target population?

Virtual head teachers.

Who should take action?

Local authorities.

What action should they take?

Appoint virtual head teachers and ensure they:

- hold head teachers and governors accountable for educating looked-after children, helping them to maximise their educational potential
- share good practice nationally to shape national and local policy
- maintain a record of all looked-after children educated out of the area and are aware of their educational needs and the adequacy of their educational provision
- maintain a register of all pupils on part-time timetables and monitor their appropriateness.

Recommendation 44: accessing further and higher education

Who is the target population?

Looked-after young people and care leavers continuing education.

Who should take action?

Local authorities.

What action should they take?

- Identify and provide personal support before and during the UCAS application process, and continue to support students throughout their time at university or higher education college.
- Ensure that looked-after children and care leavers have access to bursaries and other forms of financial and practical support.
- Publicise the £2000 bursary currently available for looked-after young people who go to university and ensure all eligible care leavers receive this entitlement.
- Ensure that accommodation is guaranteed for the duration of the course, including holidays, for students who have been in care.
- Continue to support care leavers after they have left higher education. This should include support with housing and other forms of practical and emotional support such as careers advice and coping with living alone until they gain employment and are ready to be independent.

Recommendation 45: entering higher education

Who is the target population?

Looked-after young people and care leavers who are continuing education.

Who should take action?

Universities and higher education colleges.

What action should they take?

- Ensure admissions procedures are transparent and accessible and that care leavers are given appropriate and easily accessible support and advice on accommodation, services, scholarships and any other support available to care leavers.

- Ensure that accommodation is guaranteed for the duration of the course, including holidays, for students who have been in care, regardless of where they live.
- Work to attain the Frank Buttle Trust quality mark¹⁶, which recognises higher education institutions that provide additional and targeted support to students who have been looked after.

Recommendation 46: funding education

Who is the target population?

Looked-after children and young people.

Who should take action?

Department of Children, Schools and Families.

What action should they take?

Consider taking the personal education allowance out of the area base grant and establish it as a separate fixed grant.

Preparing to leave care and leaving care

Recommendation 47: preparing to leave care

Who is the target population?

Looked-after children and young people leaving care.

Who should take action?

Local authorities.

What action should they take?

- Identify young people leaving care as a priority group for accessing adult services to support their transition into adulthood.

¹⁶ Visit www.buttletrust.org/quality_mark

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- Give care leavers the option to remain in a stable foster home or residential home beyond the age of 18 and allow care leavers in difficulty to return to the care of the local authority for support, including to the previous placement if available.
- Provide support to young people leaving kinship care, which should include:
 - financial help
 - access to CAMHS
 - respite care
 - high levels of support from the young person’s social worker or personal adviser.
- Ensure children and young people leaving care are encouraged and able to maintain contact with past carers they value.
- Ensure that residential homes equip young people with the skills to live independently before they leave care. This is particularly important for young people with complex needs, who might return unnecessarily to residential care otherwise.

Recommendation 48: providing leaving-care services

Who is the target population?

Looked-after children and young people leaving care.

Who should take action?

Children’s trusts.

What action should they take?

- Ensure there is an effective and responsive leaving-care service that includes support for preparing to leave care. It should be monitored by all service providers as part their statutory responsibility under the ‘Children’s and young person’s plan’. Such a service should include access to:
 - safe and settled accommodation

- further or higher education opportunities to increase access to employment, cultural, leisure and other community openings
 - skills training and employment opportunities
 - specialist mental health and other appropriate services to support emotional needs
 - training in life skills to manage everyday living with confidence.
- Ensure young people know their rights and entitlements to services, and how to access them.

Recommendation 49: transferring to adult mental health services

Who is the target population?

Looked-after children and young people preparing to leave or leaving care.

Who should take action?

Child and adolescent mental health services (CAMHS).

What action should they take?

Ensure that the continued case management and treatment of children receiving mental health services should remain with CAMHS until such time as a handover with an assessment and completed care plan has been developed with the relevant adult service (see recommendation 39 of this document).

Recommendation 50: inspecting services for care leavers

Who is the target population?

Looked-after young people preparing to leave or leaving care.

Who should take action?

- Ofsted.
- Care Quality Commission.

What action should they take?

Extend the inspection care frameworks to services for care leavers aged 18 and older to ensure adequate provision and support is in place.

Training professionals

Recommendation 51: developing a curriculum for core training

Who is the target population?

All professionals and primary carers who regularly work directly with looked-after children and young people, including teachers.

Who should take action?

Department for Children, Schools and Families.

What action should they take?

- Agree a core training module at national level to inform professionals and primary carers about the needs of looked-after children and young people. This module should include developing understanding and awareness of:
 - the reasons why children and young people enter care, including babies and children aged under 5
 - the impact of entering care on children and young people, including babies and children aged under 5
 - relationships with siblings (see recommendations 13, 17, 18 and 19 of this guidance)
 - how to meet children’s physical and emotional health and wellbeing needs, including their educational needs and development, and how to improve and maintain them
 - the impact of trauma and distress on the behaviour and development of looked-after children and young people and their ability to form meaningful relationships during childhood and as they move into adulthood
 - bereavement and loss

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- the impact of the carer’s own experiences on their parenting style and ability to care for and relate to children and young people
 - the roles of all professionals who work with looked-after children and young people
 - how to work in multi-agency settings
 - accountability within and across agencies
 - good practice in recording information about looked-after children and young people, such as ensuring records are factual and not biased by emotional judgements
 - how to encourage educational attainment, including higher education
 - how to encourage engagement in activities outside the school curriculum and in the community, including creative and leisure activities.
- Pay particular attention to developing reflective practice, including knowledge and skills to understand the dynamics of interpersonal relationships of:
 - looked-after children and young people
 - siblings
 - birth parents and members of the extended family
 - carers
 - professionals working in multidisciplinary teams.
 - Develop and update the training content for increasing levels of professional competence and continuous personal development.
 - Monitor the quality and impact of training.

Recommendation 52: training social workers to support looked-after children and young people in an educational setting

Who is the target population?

Trainee social workers.

Who should take action?

Department for Children, Schools and Families workforce unit.

What action should they take?

Work with education providers to include a module on looked-after children and young people in the educational setting in initial social worker training.

This should include:

- the importance of a stable and settled educational experience
- a basic understanding of the educational system including the structure and processes of the special needs system
- how to encourage educational attainment, including higher education
- how to support carers to get the best from the education system for the children and young people in their care
- awareness of the importance and impact of extra-curricular and enriching activities for looked-after children and young people.

Recommendation 53: training for independent reviewing officers

Who is the target population?

Independent reviewing officers (IROs).

Who should take action?

Local authorities.

What action should they take?

- Ensure all independent reviewing officers undertake a core training module that includes all issues identified in recommendation 6 and covers:
 - the educational system (including the special needs process) and its structure, the impact of moving schools and part-time timetables on confidence and attainment
 - the importance of a stable education and how to provide this
 - monitoring and evaluating the quality of health assessments, personal education plans (PEPs), personal education

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allowances (PEAs), individual education plans (IEPs) and pastoral support plans (PSPs)

- holding professionals accountable for decisions taken at a case conference and ensuring all relevant recording is of sufficient quality to describe the interventions required
 - understanding the implications of policy and legislation pertaining to looked-after children and young people
 - motivating and influencing others within the care and school settings to develop effective support for looked-after children and young people
 - understanding the importance and impact of extra-curricular creative and leisure activities for looked-after children and young people.
- Monitor the quality of training content and its delivery, and evaluate its impact on the quality of education and care of looked-after children and young people. Feed the outcomes into future planning and delivery of courses.
 - Ensure the IRO service is monitored for quality.

5 Implementation

SCIE and NICE guidance can help:

- NHS organisations, social care and children's services meet the requirements of the DH's 'Operating framework for 2008/09' and 'Operational plans 2008/09–2010/11'.
- NHS organisations, social care and children's services meet the requirements of the Department of Communities and Local Government's 'The new performance framework for local authorities and local authority partnerships'.
- National and local organisations within the public sector meet government indicators and targets to improve health and reduce health inequalities.
- Local authorities fulfil their remit to promote the economic, social and environmental wellbeing of communities.
- Local NHS organisations, local authorities and other local public sector partners benefit from any identified cost savings, disinvestment opportunities or opportunities for re-directing resources.
- Provide a focus for multi-sector partnerships for health, such as local strategic partnerships.

SCIE and NICE will develop tools to help organisations put this guidance into practice. Details will be available on the NICE website after the guidance has been issued (www.nice.org.uk/guidance/PHxx).

6 Recommendations for research

This section will be completed in the final document.

More detail on the gaps in the evidence identified during development of this guidance is provided in appendix D.

7 Updating the recommendations

This section will be completed in the final document.

8 Related SCIE and NICE publications and guidance

SCIE publications

Experiences of children and young people caring for a parent with a mental health problem. Research briefing (2008). Available from www.scie.org.uk/publications/briefings/briefing24/index.asp

Working with challenging and disruptive situations in residential child care. Knowledge review 22 (2008). Available from <http://www.scie.org.uk/publications/knowledgereviews/kr22.pdf>

Fostering. Practice guide 3 (2004). Available from www.scie.org.uk/publications/practiceguides/fostering/index.asp

Preventing teenage pregnancy in looked-after children. Research briefing (2004). Available from www.scie.org.uk/publications/briefings/briefing09/index.asp

Promoting resilience in fostered children and young people. Resource guide (2004). Available from www.scie.org.uk/publications/resourceguides/rg04/index.asp

Working with families with alcohol, drug and mental health problems (2003). Available from: www.scie.org.uk/publications/reports/report02.asp

NICE published guidance

Reducing differences in the uptake of immunisations. NICE public health guidance 21 (2009). Available from www.nice.org.uk/guidance/PH21

Social and emotional wellbeing in secondary education. NICE public health guidance 20 (2009). Available from www.nice.org.uk/guidance/PH20

When to suspect child maltreatment. NICE clinical guideline 89 (2009). Available from www.nice.org.uk/guidance/CG89

Social and emotional wellbeing in primary education. NICE public health guidance 12 (2008). Available from www.nice.org.uk/guidance/PH12

Interventions to reduce substance misuse among vulnerable young people. NICE public health guidance 4 (2007). Available from www.nice.org.uk/guidance/PH4

Prevention of sexually transmitted infections and under 18 conceptions. NICE public health guidance 3 (2007). Available from www.nice.org.uk/guidance/PH3

Depression in children and young people: identification and management in primary, community and secondary care. NICE clinical guideline 28 (2005). Available from www.nice.org.uk/guidance/CG28

NICE guidance in development

Contraceptive services for socially disadvantaged young people. NICE public health guidance (publication expected October 2010)

Personal, social and health education focusing on sex and relationships and alcohol education. NICE public health guidance (publication expected January 2011)

9 Glossary

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Appendix A Membership of the Programme Development Group (PDG), co-optees, expert witnesses, the NICE and SCIE project teams, and external contractors

Programme Development Group

PDG membership is multidisciplinary, comprising policy makers, commissioners, managers, public health and social care practitioners, clinicians and therapists, education professionals, young people who have been looked-after, and academics.

Jade Blake Community Member

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Valerie King Designated Nurse for Looked-After Children, Northamptonshire
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Susan Lane Associate Lecturer in Social Care, Open University

Jayne Ludlam Director of Children's Specialist Services, Sheffield City
Council

Helen Mason Independent Consultant and Community Member

Sue Revell General Manager, Cardiff and Vale NHS Trust

Janet Rich Children's Services Development Officer, National Care
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Douglas Simkiss Associate Professor of Child Health, Health Sciences
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Rhian Stone Independent Social Care Consultant

Colin Thompson Community Member, Ex-Care Leaver, VOICE Trustee

Harriet Ward Director, Centre for Child and Family Research, Loughborough
University

Sue Wressell Consultant Child and Adolescent Psychiatrist for Looked-after
children, Newcastle CAMHS, Northumberland Tyne and Wear NHS Trust

Expert co-optees to the PDG:

Claudia Phillips Foster Carer

Jane Thomson Foster Carer

Expert testimony to PDG:

The authors of the expert papers listed at the end of this appendix provided expert testimony to the PDG.

NICE project team

Mike Kelly

CPHE Director

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SCIE project team

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External contractors

Evidence reviews

Review 1: 'The effect of support services for transition to adulthood/leaving care on the adult outcomes of looked-after young people' was carried out by The University of Sheffield School of Health and Related Research (ScHARR). The principal authors were: Emma Everson, Roy Jones, Louise Guillaume, Diana Papaicannou and Alejandra Duenas.

Review 2: 'The effectiveness of training and support for carers, professionals and volunteers working with looked-after children and young people on the physical and emotional health and wellbeing of looked-after children and young people' was carried out by ScHARR. The principal authors were Emma Everson, Roy Jones, Louise Guillaume, Diana Papaicannou and Alejandra Duenas.

Review 3: 'The effectiveness of interventions aimed at improving access to health and mental health services for looked-after children and young people' was carried out by ScHARR. The principal authors were Emma Everson, Roy Jones, Louise Guillaume, Diana Papaicannou and Alejandra Duenas.

Review 4: 'A correlates review: factors associated with outcomes for looked-after children and young people: a review of the literature' was carried out by ScHARR. The principal authors were: Emma Everson, Roy Jones, Louise Guillaume and Diana Papaicannou.

Review 5: 'A qualitative review of the experiences, views and preferences of looked-after children and young people and their families and carers about the

care system' was carried out by the Evidence for Policy, Practice, Coordination and Information Centre, Social Science Research Unit, Institute of Education, University of London. The principal authors were Kelly Dickson, Katy Sutcliffe and David Gough.

Economic analysis

Cost-effectiveness review 1: 'The cost-effectiveness of support services for transition to adulthood/leaving care on the adult outcomes of looked-after young people' was carried out by SchARR. The principal authors were Alejandra Duenas, Emma Everson, Roy Jones, Louise Guillaume and Diana Papaicannou.

Primary research and commissioned reports

Report 1: 'Qualitative research to explore the priorities and experiences of practitioners working with looked-after children and young people' was carried out by Cragg Ross Dawson Associates. The principal author was Ben Toombs.

Report 2: 'The health and wellbeing of looked-after children and young people: a brief review of strengths and weaknesses in service provision from inspection and review data' was carried out by David Leah Associates. The principal author was Mary Ryan.

Report 3: 'Practice survey: the physical, emotional health and wellbeing of looked-after children and young people' was carried out by Action for Children. The principal authors were Juliet Ramage and Lisa Hewett-Craft.

Expert testimony

Expert paper 1: 'Patterns of instability in the care system' by Professor Harriet Ward, Centre for Child and Family Research, Loughborough University.

Expert paper 2: 'Stability and wellbeing in the care system' by Professor Ian Sinclair, University of York.

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Expert paper 3: 'Learning from Sheffield: services to meet the needs of the most challenging children' by Jayne Ludlam and Jon Banwell, Children and Young People's Directorate, Sheffield City Council.

Expert paper 4: 'The role of the Healthcare Commission in improving outcomes for looked-after children' by Sue Eardley, The Healthcare Commission.

Expert paper 5: 'Social pedagogy – an example of a European approach to working with looked-after children' by Karen Prins, University of Copenhagen, Denmark.

Expert paper 6: 'Improving outcomes for looked-after children and young people' by Kathy Turner, The Audit Commission.

Expert paper 7: 'Revised government guidance and policy developments on the health of looked-after children' by Sarah Lewis, Department for Children, Schools and Families.

Expert paper 8: 'The contribution of inspection to the health and wellbeing of looked-after children' by Anna Lis, Ofsted.

Expert paper 9: 'The physical and emotional health and wellbeing of children and young people growing up in foster care: support and training for carers' by Dr Gillian Schofield, Professor of Child and Family Social Work, University of East Anglia.

Expert paper 10: 'Making sense of performance problems in public organisations' by Professor Chris Skelcher, University of Birmingham.

Expert paper 11: 'Working with complex systems and networks around looked-after children and young people' by Jenny Sprince, Child and Adolescent Psychotherapist, Independent Child Care Consultant.

Expert paper 12: 'Care planning – the social work task for looked-after children' by Sue Lane, Independent Childcare Consultant.

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Expert paper 13: 'Multi-agency partnerships' by Dr Sue Wressell, Consultant Child and Adolescent Psychiatrist for Looked-after children, Newcastle upon Tyne.

Expert paper 14: 'Labels that disable – meeting the complex needs of children in residential care' by Janet Rich, Independent Childcare Consultant.

Expert paper 15: 'Siblings in care' by Delma Hughes, Independent Consultant on Siblings in Care, 'Siblings Together'.

Expert paper 16: 'Participatory approaches to involving looked-after children and young people in the design and delivery of services' by John Kemmis and Wendy Banks, VOICE.

Expert paper 17: 'Social pedagogy in children's residential care: DCSF pilot programme' by Professor Pat Petrie, Thomas Coram Research Unit, Institute of Education, University of London.

Expert paper 18: 'Pathways to permanence for black, Asian and mixed ethnicity children; dilemmas, decision-making and outcomes' by Dr Julie Selwyn, University of Bristol.

Expert paper 19: 'Kinship care' by Dr Julie Selwyn, University of Bristol.

Expert paper 20: 'Promoting the resilience and well-being of young people leaving care: messages from research' by Professor Mike Stein, University of York

Expert paper 21: 'Improving health and well-being outcomes of children under five years of age looked after in the care of local authorities' by Helen Chambers, Principal Officer, National Children's Bureau.

Expert paper 22: 'Mental health of looked-after children in the UK: summary' by Joe Sempik, Centre for Child and Family Research, Loughborough University.

Appendix B Summary of the methods used to develop this guidance

Introduction

The reviews, primary research and commissioned reports include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the PDG meetings provide further detail about the Group's interpretation of the evidence and development of the recommendations.

All supporting documents are listed in appendix E and are available at <http://guidance.nice.org.uk/PHG/Wave17/24>

Guidance development

The stages involved in developing public health programme guidance are outlined in the box below.

1. Draft scope released for consultation
2. Stakeholder meeting about the draft scope
3. Stakeholder comments used to revise the scope
4. Final scope and responses to comments published on website
5. Evidence reviews, economic analysis and practice survey undertaken
6. Evidence reviews, economic analysis and practice survey submitted to PDG
7. PDG produces draft recommendations
8. Draft guidance released for consultation and for field testing, evidence also released for comment
9. PDG amends recommendations
10. Final guidance published on website
11. Responses to comments published on website

Key questions

The key questions were established as part of the scope. They formed the starting point for the reviews of evidence and were used by the PDG to help develop the recommendations. The overarching question was:

What strategies, policies, systems, structures, interventions or services are effective and cost-effective in promoting the physical and emotional health and wellbeing of looked-after children and young people?

The subsidiary questions were:

- Can current systems, frameworks and processes used to identify and monitor health, emotional and social outcomes for looked-after children, young people and their families be improved?
- How does placement stability and breakdown affect key outcomes, and subsequent care placements?
- How do the structure, type, continuity and length of care that children and young people receive affect key outcomes for children, young people and their families?
- How effective, and cost effective, are interventions and activities (including participatory approaches) that are used to maintain, improve or promote key outcomes, in different settings and at different levels of intervention?
- Are there key points or transitions in the life-course or care pathways of looked-after children and young people at which intervention may be particularly beneficial (or harmful)?
- What physical, emotional and social outcomes are important to looked-after children and young people and their families?

These questions were made more specific for each review (see reviews for further details).

Effectiveness reviews

Reviews of effectiveness were conducted using NICE methods, on:

- support services for transition to adulthood/leaving care (review 1)
- training and support for carers/professionals/volunteers (review 2)
- improving access to health and mental health services (review 3).

Identifying the evidence

The strategy adopted for these reviews combined systematic review searching undertaken by SCIE with more targeted searches undertaken by SchARR. The following databases were searched for published literature (January 1990 – September 2008):

- Applied Social Sciences Index and Abstracts (ASSIA)
- Australian Family and Society Abstracts
- British Education Index (BEI)
- Campbell Collaboration C2 Library
- CERUK Plus
- ChildData
- Cochrane Library
- Cumulative Index to Nursing and Allied Health Literature (Cinahl Plus)
- EMBASE
- Health Management Information Consortium (HMIC)
- International Bibliography of the Social Sciences (IBSS)
- JSTOR
- MEDLINE
- PsycINFO
- Social Care Online
- Social Services Abstracts
- Zetoc (electronic tables of contents).

In addition, searches of reference lists and citation searches were conducted on all relevant papers included in the 'Correlates review' (review 4; see page 98). The reference lists of included papers were searched by hand, and

citation searching was undertaken on all included papers. The PDG was also consulted for relevant literature.

Further details of the databases, search terms and strategies are included in the review reports.

Selection criteria

Inclusion and exclusion criteria for each review varied and details can be found at <http://guidance.nice.org.uk/PHG/Wave17/24> However, in general:

- Population:
 - Review 1: looked-after children and young people and/or adults who were previously looked after as children and/or young people.
 - Review 2: carers (including foster and residential carers), professionals (such as teachers and social workers) and approved volunteers (such as independent visitors, mentors) involved in the care of or working with looked-after children and young people.
 - Review 3: looked-after children and young people, or adults who were looked after if relevant information on their childhood was collected.

- Intervention:
 - Review 1: support services to prepare looked-after young people for the transition from foster or residential care to independent living or community care.
 - Review 2: training and support to enhance the skills of carers, professionals or volunteers involved in the care of looked-after children and young people. This included training and support for birth families, but not treatment foster care (also described as therapeutic foster care).
 - Review 3: any intervention designed to improve access to any specialist or universal service for children and young people

during their time they were being looked after. Treatment foster care was not included.

- Comparison: usual or practice or no 'intervention'.
- Outcomes:
 - Review 1: all reported outcomes, including housing, alcohol or drug misuse, employment, educational attainment, employment, offending behaviour and physical, mental and sexual health.
 - Review 2: all outcomes relating to physical and emotional health and wellbeing of looked-after children and young people, including placement stability and long-term outcomes.
 - Review 3: access to the service in question.
- Study types: Decisions on the type of evidence to be included were informed by the searching process. Papers that did not present quantitative data were excluded.
- Other: English language papers.

Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in the NICE technical manual 'Methods for the development of NICE public health guidance' (see appendix E). Each study was graded (++, +, –) to reflect the risk of potential bias arising from its design and execution.

Study quality

- ++ All or most of the methodology checklist criteria have been fulfilled. Where they have not been fulfilled, the conclusions are thought very unlikely to alter.
- + Some of the methodology checklist criteria have been fulfilled. Those criteria that have not been fulfilled or not adequately described are thought unlikely to alter the conclusions.

- Few or no methodology checklist criteria have been fulfilled. The conclusions of the study are thought likely or very likely to alter.

Summarising the evidence and making evidence statements

The review data was summarised in evidence tables (see full reviews).

Within each review, the findings were synthesised and used as the basis for a number of evidence statements relating to each research question. The evidence statements were prepared by the public health collaborating centres (see appendix A). The statements reflect their judgement of the strength (quantity, type and quality) of evidence and its applicability to the populations and settings in the scope.

Other reviews

Two other reviews were conducted: a correlates review (review 4) and a qualitative review (review 5):

Correlates review

This review aimed to identify factors that are associated with outcomes for looked-after children and young people, and to present these as conceptual maps showing the strength of associations between factors, supported by evidence tables. It is not a full systematic review with exhaustive or comprehensive searches but it is a review of quantitative data, with inclusion and exclusion criteria, quality appraisal and a systematic and transparent methodology.

Identifying the evidence

Searches were done using free text and keywords/index terms, and several iterations were undertaken. Once an outcome or variable had been identified, further searches and sifting sought to identify new variables rather than to identify all the evidence for each relationship between variables. A thorough audit trail was maintained, to ensure that searches were transparent, systematic and replicable.

Selection criteria

Studies were included if the population was looked-after children and young people aged up to 25 years, or adults who had been looked-after children and young people. Explanatory factors were included if they could be defined as risk factors, protective factors or interventions (any intervention or activity that could affect these outcomes). Outcomes were as defined by individual studies.

Quality appraisal

Study quality was assessed using the checklists and guidance in 'Methods for development of NICE public health guidance (second edition, 2009)'.

Summarising the evidence

Relevant information was extracted and studies were classified according to both study type and the main variables analysed. The findings were then mapped using software that allows associations to be presented graphically.

Qualitative review

This review used SCIE methods and aimed to identify qualitative research on and synthesise the views, experiences and preferences of children and young people, their families and carers, about the care system.

Identifying the evidence

The following electronic health and social care databases were searched:

- ASSIA
- CINAHL
- EMBASE
- IBSS
- MEDLINE
- PsycINFO
- Social Care Online
- Social Science Citation Index
- Social Services Abstracts
- Sociological Abstracts

- Google (and Google Scholar)

Further details of the databases, search terms and strategies are included in the review.

Selection

Studies were included if they were performed in the UK and their methods for data collection and analysis enabled them to reflect what is important to looked-after children and young people and their families and carers.

Quality appraisal

Included studies were critically appraised and rated for:

- soundness (internal methodological coherence), using an adapted version of the NICE checklist for qualitative studies
- appropriateness of the research design and analysis used for answering the review
- relevance of the topic (from the sample, measures, scenario, or other indicator of the focus of the study) to the review question.

Each study was graded using the NICE system (++ , + , –).

Summarising the evidence

The pool of findings from all the studies was assessed for each of the three groups: looked-after children and young people; carers; and parents. Themes and subthemes were developed via a framework analysis approach. The detail of the findings was interrogated to answer, where possible, the research questions and evidence statements were developed.

Practice survey

This used SCIE's practice survey methodology to identify innovative and emerging practice in assessing, maintaining and improving the physical and emotional health and wellbeing of looked-after children and young people. The survey sought views about the acceptability, accessibility and effectiveness of targeted and specialist, as opposed to universal, interventions.

Sampling

The PDG identified sites that were of particular interest because of their specific areas of practice – for example, multi-disciplinary work, and specialist services for looked-after children. In addition, the Action for Children team who wrote the report identified a local authority that had ‘Beacon’ status for its engagement of young people and its targeted youth support initiatives.

Methods

Following initial approaches, all sites agreed to participate in the survey, and approval was gained from the Assistant Director of Children’s Services Research Team and ethical approval in each site. The first phase of the survey was to conduct a series of group and individual semi-structured interviews with managers, commissioners and practitioners from a range of social care, education and health organisations. These interviews took place between April and June 2009.

The second phase involved interviews with carers and looked-after children and young people.

The data collected from the survey was analysed, by reading and aggregation of data, measuring, identifying differences and similarities, identifying and acknowledging variables, contextualising, noting correlation, identifying themes and cross-cutting issues, comparing views within and across sample sectors and ordering and grouping findings to address topics and questions.

Summarising the evidence

The findings were structured around four topic areas: structure of care; delivery of care; interventions and activities; and the views of children, young people and their families. These were used as the basis for evidence statements.

Economic analysis

The economic analysis consisted of a review of economic evaluations and cost-effectiveness modelling.

Review of economic evaluations

A database supplied by SCIE was used to find papers containing evidence of cost effectiveness. This was supplemented by targeted searches of:

- Web of Science
- MEDLINE
- NHS EED
- EconLit.

Inclusion criteria followed the same criteria used for the effectiveness reviews, for which the economic reviews were an accompaniment. Quality was assessed using the 'Methods for development of NICE public health guidance' (2006).

Cost-effectiveness modelling

An economic model was constructed to accompany the three effectiveness and cost-effectiveness reviews (see appendix E). A satisfactory model was constructed for review 1. A model was attempted for review 2 but was rejected by the PDG because of data limitations. For review 3, a model was not attempted because of lack of relevant data.

The results of the model to accompany effectiveness review 1 are reported in: 'Review 1: The cost-effectiveness of support services for transition to adulthood/leaving care on the adult outcomes of looked after young people'. Following the inability to produce a meaningful modelling analysis for reviews 2 and 3, the PDG was asked to use a cost-consequences framework to consider the cost effectiveness of the recommendations. This required members to consider the best available evidence on the costs and effectiveness of services of relevance to the recommendations under consideration and to draw on their expertise to make an appropriate recommendation where evidence gaps existed.

The PDG examined the recommendations to see whether any were:

- on the balance of probabilities, likely to do more good than harm
- likely to be cost saving or have a very low additional cost.

This was successful for recommendations where the available evidence and the opinions of experts and PDG members strongly suggested that their implementation would do more good than harm, would be of relatively low cost to implement and would probably produce cost savings in the long run.

What prevented this method being used more widely to determine whether a recommendation was likely to be cost effective was that many of the recommendations focus on system-level changes, multi-agency working, information sharing and training. For these recommendations, the lack of data and the resulting level of uncertainty were too great to support even a cost-consequences approach.

Fieldwork

This section will be completed in the final document.

How the PDG formulated the recommendations

At its meetings in 2008 and 2009, the PDG considered the evidence reviews, commissioned reports, expert testimony and cost effectiveness to determine:

- whether there was sufficient evidence (in terms of strength and applicability) to form a judgement
- where relevant, whether (on balance) the evidence demonstrates that the intervention or programme can be effective or is inconclusive
- where relevant, the typical size of effect (where there is one).
- whether the evidence is applicable to the target groups and context covered by the guidance.

The PDG developed draft recommendations through informal consensus, based on the following criteria:

- Strength (type, quality, quantity and consistency) of evidence of effectiveness.
- The applicability of the evidence to the populations/settings referred to in the scope.

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- Effect size and potential impact on the target population's health.
- Impact on inequalities in health between different groups of the population.
- Ethical issues and social value judgements.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of risks and benefits.
- Ease of implementation and any anticipated changes in practice.

Where possible, recommendations were linked to an evidence statement(s), report or expert testimony (see appendix C for details).

Appendix C The evidence

This appendix lists the evidence statements from five evidence reviews and four commissioned reports provided by external contractors and the public health collaborating centre (see appendix A). It links them to the relevant recommendations. (See appendix B for the key to quality assessments.) The evidence statements are presented here without references – these can be found in the full reviews (see appendix E for details). It also lists 22 expert papers and their links to the recommendations (see additional evidence). This appendix also sets out a brief summary of the cost effectiveness evidence.

The five evidence reviews are:

- Review E1: 'The effectiveness of support services for transition to adulthood/leaving care on the adult outcomes of looked after young people'
- Review E2: 'The effectiveness of training and support for carers/professionals/volunteers working with looked-after children and young people on the physical and emotional health and wellbeing of looked-after children and young people'
- Review E3: 'The effectiveness of interventions aimed at improving access to health and mental health services for looked-after children and young people'
- Review E4: 'A correlates review: factors associated with outcomes for looked-after children and young people: a review of the literature'
- Review E5: 'A qualitative review of the experiences, views and preferences of looked-after children and young people and their families and carers about the care system'.

The three commissioned reports are:

- Report C1: 'Qualitative research to explore the priorities and experiences of practitioners working with looked-after children and young people'
- Report C2: 'The health and wellbeing of looked-after children and young people: a brief review of strengths and weaknesses in service provision from inspection and review data'

- Report C3: 'Practice survey: the physical, emotional health and wellbeing of looked-after children and young people'.

Evidence statement E1.5 indicates that the linked statement is numbered 5 in review 1. **E2.7** indicates that the linked statement is numbered 7 in review 2. **Evidence statement C3.6** indicates that the linked statement is numbered 6 in commissioned report 4. **C1** indicates that the whole of commissioned report 1 is linked to the recommendation.

The reviews, commissioned reports, expert papers and economic analysis are available at www.nice.org.uk/guidance/PHG/Wave17/24

Where the PDG has considered other evidence, it is linked to the appropriate recommendation below. It is also listed in the additional evidence section of this appendix.

Recommendation 1: evidence statements C3.1, C3.2; C2, EP1, EP2, EP6, EP8

Recommendation 2: evidence statements C3.1, C3.2; C1, C2, EP6, EP10, EP11, EP13, EP16

Recommendation 3: evidence statements C3.1; C2, EP4, EP6, EP11, EP13

Recommendation 4: EP11, C1, C2, C3

Recommendation 5: evidence statements C3.1; C1, C2, EP6, EP12, EP13, EP15

Recommendation 6: evidence statements C3.2; C1, EP6, EP19

Recommendation 7: evidence statements E4.2.11, C3.4; C1, C2, EP12

Recommendation 8: evidence statements E4.2.6, C3.5, C3.19; EP2, EP6, EP14, EP16, EP19

Recommendation 9: evidence statements E4.2.6, E5.2, E5.9, C3.5, C3.19; EP2, EP6, EP14, EP16, EP19

Recommendation 10: EP3, EP14

Recommendation 11: evidence statements E4.2.6, E5.17; EP18, EP19

Recommendation 12: evidence statements E4.2.6; EP18, EP19

Recommendation 13: evidence statements E4.2.5; EP2, EP11, EP16, EP18, EP19

Recommendation 14: evidence statements E5.12; C1, EP2, EP9, EP13

Recommendation 15: evidence statements E2.1, E4.2.12, E5.1, E5.2, E5.3, C3.17; C2, EP6, EP9, EP11, EP13

Recommendation 16: evidence statements C3.8, E2.1, E4.2.12, E5.8, E5.11; C1, C2, EP6, EP9, EP11, EP21

Recommendation 17: evidence statements E5.10, E5.13; EP1, EP3, EP6, EP9, EP11, EP21

Recommendation 18: evidence statements E5.5, E5.18; EP15, EP16

Recommendation 19: evidence statements C3.13, E5.2; EP11

Recommendation 20: C1, EP11, EP21, EP22

Recommendation 21: C1, EP11, EP21, EP22

Recommendation 22: C1, EP11, EP21, EP22

Recommendation 23: evidence statement E5.2; C1, EP11, EP18

Recommendation 24: evidence statements C3.4, E5.2; EP10, EP18

Recommendation 25: EP18

Recommendation 26: evidence statements C3.16; EP18

Recommendation 27: evidence statements C3.5, E5.2; EP18

Recommendation 28: evidence statement E5.2; EP18

Recommendation 29: evidence statement E5.16

Recommendation 30: evidence statements E5.12, C3.16; C1, EP8

Recommendation 31: evidence statements E3.3, E5.12, C3.2; C1, C2, EP8, EP18

Recommendation 32: evidence statements E3.3, C3.2; C1, C2, EP8, EP18

Recommendation 33: evidence statements E3.1, E3.2, E3.3, E4.2.13, C3.2, C3.8; C1, C2, EP8, EP12, EP18, EP21

Recommendation 34: evidence statements C3.14, C3.15

Recommendation 35: C2, C3, EP8, EP4

Recommendation 36: C2, C3, EP8, EP4

Recommendation 37: evidence statement C3.2; C1, EP6, EP19

Recommendation 38: evidence statement C3.6; C1, EP20

Recommendation 39: evidence statements E5.3, E5.4, E5.16, C3.3, C3.10, C3.11; C1, C2, EP6, EP9, EP11, EP22

Recommendation 40: EP3

Recommendation 41: evidence statements E5.1, E5.3, E5.6; C1

Recommendation 42: evidence statements E5.7, E5.8; C1

Recommendation 43: evidence statement E5.7; C1

Recommendation 44: evidence statements E1.1, E5.9, C3.6; C1, EP20

Recommendation 45: evidence statements E1.1, E5.9, C3.6; C1, EP20

Recommendation 46: evidence statements E1.1, E5.8, E5.16, E5.18, C3.6

Recommendation 47: evidence statements E1.1, E1.2, E1.3, E1.4, E1.5, E1.6, E1.7, E1.8, E1.9; C1, EP6, EP14, EP20

Recommendation 48: evidence statements E1.1, E1.2, E1.3, E1.4, E1.5, E1.6, E1.7, E1.8, E1.9, E5.9; C1, C2, EP6, EP14, EP20

Recommendation 49: evidence statement C3.11

Recommendation 50: EP6

Recommendation 51: evidence statements E2.1, E4.2.4, E4.2.12, E5.7, E5.8, C3.1, C3.2; EP1, EP3, EP6, EP9, EP11, EP21

Recommendation 52: evidence statements E5.3, E5.7; EP1, EP3, EP6, EP9, EP11, EP21

Recommendation 53: evidence statements E5.3, E5.7; EP1, EP3, EP6, EP9, EP11, EP21

Evidence statements

Please note that the wording of some evidence statements has been altered slightly from those in the review team's report to make them more consistent with each other and NICE's standard house style.

Evidence statement E1.1

There is moderate evidence of mixed quality from four retrospective US cohort studies (one [++], one [+], two [-]) to suggest that looked-after children and young people who received transition support services (TSSs) were more likely to complete compulsory education with formal qualifications than those who had not received this TSSs; whereas one prospective US cohort study (+) reported a non-significant finding in favour of the comparison group.

Evidence statement E1.2

There is moderate evidence of a positive effect of TSSs on current employment from one prospective (+) and two retrospective US cohort studies (one [+], one [-]) although one retrospective US cohort study reported no difference between those who had and had not received TSSs on current employment (++).

Evidence statement E1.3

There is moderate evidence of a mixed effect with regard to the effect of TSSs on employment history. Two retrospective US cohort studies (one [++], one [-]) reported that those who had received TSSs were more likely to have a better employment history than those who had not received TSSs, whereas one prospective UK cohort study (-) reported that those who had received TSSs were less likely to have taken an employment/academic career path than those who had not.

Evidence statement E1.4

There is moderate evidence of a mixed effect with regard to the effect of TSSs on employment at case closing. Two US cohort studies, one prospective (+) and one retrospective (-) reported that those who had received TSSs were more likely to be employed at case closing than those who had not received TSSs, whereas one retrospective US cohort study (-) reported that those who had received TSSs were less likely to be employed at case closing than those who had not.

Evidence statement E1.5

There is moderate evidence of a mixed effect with regard to the effect of TSSs on crime/offending behaviour. One retrospective US cohort study (-) reported that those who had received TSSs were less likely to have a problem with the law and one retrospective cohort study (++) reported that those who had received TSSs were more likely to have a problem with the law than those who had not received TSSs. One retrospective US cohort study (+) found no difference between those who had and had not received TSSs on never being arrested, those who had received TSSs were less likely to have been arrested for serious crimes but more likely to be arrested for moderate crimes than those who had not received TSSs, however those who had received TSSs were less likely to receive short jail sentences and more likely to receive long jail sentences than those who had not received TSSs.

Evidence statement E1.6

There is moderate evidence for a positive effect of TSSs on parenthood from one prospective (+) and two retrospective US cohort studies (one [++] and one [+]), in that those who had received TSSs were less likely to be parents than those who had not.

Evidence statement E1.7

There is moderate evidence for a positive effect of TSSs on housing and independent living from six studies: one prospective UK cohort study and five retrospective US cohort studies. Those who had received TSSs were more likely to have a place to live (one [-] and one [++]) and were more likely to be living independently (two [+] and 2[-]) than those who had not received TSSs.

Evidence statement E1.8

There is moderate evidence of a mixed effect with regard to the effect of TSSs on homelessness. Two retrospective US cohort studies reported that those who had received TSSs were less likely to have had a homeless episode at discharge (one [++]) or to have ever been without a place to sleep (one [-]) than those who had not received TSSs. However two retrospective US cohort studies (one [+] and one [-]) reported no difference between those who had and had not received TSSs on homelessness.

Evidence statement E1.9

There is evidence of mixed quality to suggest no evidence of effect of TSSs on mental health outcomes. Three retrospective US cohort studies (one [++], one [-] and one [+]) reported no difference on general satisfaction, life satisfaction and depression. However one retrospective US cohort study (-) reported that those who had received TSSs were more likely to be hopeful about the future than those who had not.

Review 1: applicability of non-UK studies to UK care system and populations

The majority of studies included in this review were conducted in the US, with only one UK study and this will have implications for the applicability of the review findings to the UK context. The UK study reported very little

quantitative data with no statistical comparisons. The findings from this review are based on studies that are small and furthermore some of the studies have been outdated by current legislation (for example, the studies from the 1990s will not have considered the recommendations of the Children's [Leaving Care] Act 2001) so the study conclusions may not reflect current policy and practice. The small number of studies reviewed and their poor methodological quality and rigour are also of concern when considering the applicability of the findings of this review.

Evidence statement E2.1

There is evidence of mixed quality to suggest a mixed effect of training and support for foster carers on child problem behaviours. Three US RCTs reported that children looked after by carers who had received a training and support intervention had lower rates of problem behaviour at follow-up than children of carers who had not received an intervention, among the whole sample (one [+] and one [-]) and in older infants (one +). However, one UK RCT (-) and one UK prospective cohort study (-) reported no differences on child problem behaviours between children of carers who had and had not received a training and support intervention. One US RCT (+) reported that the younger infants looked after by carers who had received a training and support intervention had higher rates of problem behaviours than children of carers who had not received an intervention. The findings of this review are moderately applicable to the UK care system, given that half of the studies reviewed were conducted in the UK and all were conducted in recent years.

Review 2: applicability to the UK

Half of studies included in this review were conducted in the UK with the other half conducted in the US, which may have implications for the applicability of the review findings to the UK context. Many of the studies had small sample sizes, which is a concern; as is the poor methodological quality of some of the studies, despite the use of RCT methodology. However, all studies included were conducted in recent years, with many conducted in the last 4 years, which increases the applicability of the findings of this review.

Evidence statement E3.1

There is mixed evidence of reasonable quality from one US prospective cohort study (+) on the effectiveness of a comprehensive multidisciplinary assessment compared with usual assessment on access to services in general. This study also reported that looked-after children and young people who received a comprehensive multidisciplinary assessment and were referred to a service were more likely to have received a service at 6-month follow-up than those who received usual assessments and were referred to a service, however this difference was not apparent at 12-month follow-up. These findings may have limited applicability to the UK care system as this was a US study and was conducted 9 years ago.

Evidence statement E3.2

There is mixed evidence of reasonable quality from one US prospective cohort study (+) on the effectiveness of a comprehensive multidisciplinary assessment compared with usual assessment on access to services in general. This study reported that looked-after children and young people who received a comprehensive multidisciplinary assessment were more likely to be referred to a service than those who received usual assessments. Regarding referral to specific services, there is evidence from the same study to suggest no significant difference in referral rates to mental health services between looked-after children and young people who received a comprehensive multidisciplinary assessment with an identified need for the specific service and those who received usual assessments with an identified need for the specific service. These findings may have little applicability to the UK care system as this was a US study and was conducted 9 years ago.

There is evidence of reasonable quality from one US study (+) to suggest a mixed effect of a comprehensive medical case management programme. One US study reported that looked-after children and young people who received a comprehensive medical case management programme were more likely to receive psychiatric clinic services than those looked-after children and young people receiving usual service but slightly less likely to receive mental health

services. This finding may be of medium relevance to the UK care system as this was a US study published 5 years ago.

Evidence statement E3.3

There is mixed evidence of reasonable quality from one US prospective cohort study (+) on the effectiveness of a comprehensive multidisciplinary assessment compared with usual assessment on access to services in general. This study reported that looked-after children and young people who received a comprehensive multidisciplinary assessment were more likely to be referred to a service than those who received usual assessments. Regarding referral to specific services, there is evidence from the same study to suggest no significant difference in referral rates to medical services between looked-after children and young people who received a comprehensive multidisciplinary assessment with an identified need for the specific service and those who received usual assessments with an identified need for the specific service. These findings may have little applicability to the UK care system as this was a US study and was conducted 9 years ago.

There is evidence of reasonable quality from one US study (+) to suggest that looked-after children and young people who received a comprehensive medical case management programme were more likely to receive physician services, hearing examinations and eye examinations services than those looked-after children and young people receiving usual service. This finding may be of medium relevance to the UK care system as this was a US study published 5 years ago.

There is evidence of reasonable quality from one US study (+) to suggest that providing all reasonably available medical records to the professional undertaking initial health assessment at entry into care increases uptake within 14-day, 30-day and 1-year periods. This finding may be of medium relevance to the UK care system as this was a US study published 2 years ago.

There is evidence of poor quality from one UK non-comparative study (-) to suggest no significant difference in immunisation uptake rates among looked-

after children and young people before and 12 months after providing social services with information on immunisation status. This finding may be moderately applicable to the UK care system as this was a UK study and was published 6 years ago.

Review 3: applicability to the UK

One non-comparative study included in this review was conducted in the UK with four prospective cohort studies conducted in the US, which may have implications for the applicability of the review findings to the UK context, although there is likely to be much similarity in medical assessments for looked-after children and young people in the UK and US. Many of the studies had small sample sizes, which is a concern, as is the poor methodological quality of some of the studies. However, all studies included were conducted within the last 9 years.

Evidence statement E4.2.1

There is evidence of mixed quality (five cohort studies and two reviews [all -], four cohort studies [all +]) for an association between older age at first placement and placement breakdown or behavioural problems.

Evidence statement E4.2.4

There is evidence of mixed quality (one review [-] and two cohort studies [both +]) for an association between professional foster care and placement stability.

Evidence statement E4.2.5

There is evidence of mixed quality (two reviews and one cohort study [all -] and one cohort study [+]) for an association between sibling co-placement and placement stability and emotional and behavioural problems (). There is evidence of good quality (two cohort studies [both +] and one [++]) for an association between sibling co-placement and emotional and behavioural problems ().

Evidence statement E4.2.6

There is evidence of mixed quality (two cohort studies and one review [all -] and four cohort studies [all +]) for an association between kinship care and placement stability (There is evidence of mostly good quality (one cross-sectional study [-] and three cohort studies [all +]) for an association between kinship care and emotional and behavioural problems).

Evidence statement E4.2.7

There is evidence of weak quality (two cohort studies [both -]) for an association between concurrent planning and placement stability).

Evidence statement E4.2.8

There is very good quality evidence (one RCT [++]) for an association between a shared parenting programme and externalising problems.

Evidence statement E4.2.10

This review did not identify any evidence for an association between transitional planning (for example, independent living programmes) and placement stability or emotional and behavioural problems. There is evidence of good quality (one cohort study [+]) for an association between transitional planning and drug and alcohol misuse as an adult. There is evidence of mixed quality (two cohort studies [both -] and one review [+]) for an association between transitional planning and education and employment as an adult

Evidence statement E4.2.11

This review did not identify any evidence for an association between adult mentorship and placement stability or emotional and behavioural problems. There is evidence of good quality (one cohort study [+]) for a positive association between adult mentorship and self-esteem, level of good health and participation in higher education, and a negative association between adult mentorship and suicide ideation.

Evidence statement E4.2.12

There is evidence of mixed quality (two cohort studies and one RCT [all -], two RCTs [both +] and one systematic review [++]) for an association between

training for foster carers and emotional and behavioural problems. There is evidence of good quality (two RCTs [both +]) for an association between training for foster carers and permanent placement).

Evidence statement E4.2.13

This review did not identify any evidence for an association between a full physical and mental health assessment and emotional and behavioural problems. There is evidence of weak quality (one cohort study [-]) for an association between a full physical and mental health assessment and mental health service use.

Evidence statement E4.3

There is evidence of varying quality from 17 studies (eight cohort studies and one RCT [all +], and six cohort studies and two cross-sectional studies [all -]) to suggest that the number of placements is a risk factor associated with a reduced likelihood of a positive outcome, and that placement stability is a protective factor that is associated with fewer placement moves and fewer emotional and behavioural problems. However, it should be noted that this is not an exhaustive review and not all evidence on these factors and outcomes has been identified and assessed.

Evidence statement E5.1

There was evidence in seven studies (one [++] and six [+]) that looked-after children and young people had the view that:

- love and affection is desired but is often lacking in their lives
- love, or the lack of it, has a significant impact on their emotional wellbeing, in particular their self-esteem
- for some training and payment for foster carers undermines the sense that they are wanted or loved
- an unmet need for love and affection is perceived by some to have a profound and lasting impact on their future outcomes.

Evidence statement E5.2

Statements from looked-after children and young people in 13 studies (one [++] and 12 [+]) provide strong evidence that looked-after children and young people feel that:

- a sense of belonging is desirable, yet often lacking in their lives
- their sense of identity is compromised by the lack of sense of belonging
- frequent moves and lack of permanence are a characteristic of being looked after that undermines any sense of belonging and therefore has a negative emotional impact for them
- a potential barrier to achieving the desired state of belonging is the conflict that arises of being part of two families simultaneously, their birth family and their carers family
- achieving a sense of belonging and identity is compromised further when they are placed with carers from different ethnic and cultural backgrounds.

Evidence statement E5.3

Evidence that being supported is important to looked-after children and young people was reported in 10 studies (all +):

- they expressed a need to feel that there is someone to support them
- emotional support is an important type of support they felt they needed
- encouragement to achieve in education and other aspects of their life is also needed
- practical support, such as help with homework and provision of materials, was also seen as essential for achieving success in their lives.

Evidence statement E5.4

Evidence on the importance for looked-after children and young people of having someone to talk to in confidence was found in eight studies (all +).

Looked-after children and young people reported that:

- opportunities to talk to someone about their concerns were often not available, but they appreciated when they were

- they were often mistrustful of talking to professionals as they could not be sure what they said would be kept confidential.

Evidence statement E5.5

The significance for looked-after children and young people of contact with their birth families was revealed in 11 studies (one [++]; ten [+]). Studies reported that:

- many have a strong desire to maintain contact with their birth families
- maintaining contact with birth families is important for supporting their self-identity
- they felt that social workers and care providers can obstruct their efforts to maintain contact with their families, and were resentful of this
- a lack of contact causes significant emotional upset
- contact with birth families is a complex issue, though an overwhelming majority saw it as positive, not all felt the same.

Evidence statement E5.6

Looked-after children and young people identified stigma and prejudice as a significant problem in their lives in seven studies (one [++] and six [+]). They reported that:

- negative attitudes towards them are common
- curiosity and pity are also attitudes commonly experienced and disliked
- a common and unwelcome experience was being singled out and made to feel different because of their status when what they particularly wanted was to feel 'normal'.

Evidence statement E5.7

Evidence about important issues for looked-after children and young people in relation to education was reported in 11 studies (one [++] and ten [+]). This evidence revealed that:

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- encouragement to attend and do well at school is lacking for many yet those who have achieved success in education feel it is a key factor in their success
- the provision of practical support and resources is felt to be another key facilitator of success, yet is frequently lacking, particularly in residential care
- another source of support often felt to be pivotal was education-specific support, in the form of educational advice
- emotional support during education, particularly higher education was noted as a need
- stereotyping and stigma on the part of others, including teachers, was seen as a common barrier to educational success
- a lack of continuity in placements and schooling is a further barrier to educational success
- being placed in residential care was seen as particularly disadvantaging in terms of education
- looked-after children and young people who had achieved success in education cited their self-reliance as the key factor which helped them overcome the barriers mentioned above.

Evidence statement E5.8

There was evidence from seven studies (all [+]) about looked-after children and young people's relationship with professionals. They raised similar concerns to carers. These include:

- the issues of continuity in their relationships with professionals
- the negative impact of a lack of continuity
- a desire to form a personal relationship with professionals
- to have professionals who listen, who are accessible
- to have professionals who can be relied upon to be there and have the ability to get things done.

Evidence statement E5.9

Seven studies (one [++] and six [+]) provide evidence that preparation and support for leaving care is an important issue for looked-after children and young people. In order to improve the process of leaving care looked-after children and young people said they needed:

- improved and more timely preparation for independent living prior to leaving care to improve this transition
- a network of support to provide ongoing practical help and emotional support after leaving care
- greater and more appropriate information and advice about entitlements to help to make better use of services available to them on leaving care
- a higher level of financial support and more advice for managing finances to prevent serious financial problems for care leavers
- access to better quality and more appropriate housing.

Evidence statement E5.10

There was evidence in five studies (one [++] and four [+]) about carers relationship with social workers. Carers said they wanted:

- a reliable, supportive and communicative relationships with social workers based on mutual trust and respect
- continuity in their relationships with social workers
- social services to be honest about the background of looked-after children and young people before a placement commences.

Evidence statement E5.11

There was evidence from four studies (one [+] and three [-]) on carers views about whether they are 'being a parent' or 'doing a job'. Carers views across the four studies indicate that they:

- view their role as both professionally demanding and a personally rewarding. This impacts on whether they consider payment to be financial compensation or an incentive or both

- are more satisfied with their role when they are paid appropriately and on time
- did not agree with payment banding according to the age or behavioural assessment of individual children.

Evidence statement E5.12

There was evidence from four studies (two [+] and two [-]) on carers relationships with looked-after children and young people. Carers stated that they were:

- concerned with being able to support looked-after children and young people to make a difference in their lives and assist them in achieving better short and long-term outcomes
- dissatisfied with trying to build supportive relationships with them when there are high levels of placement instability.

Evidence statement E5.13

There was evidence from five studies (one [++], one [+] and three [-]) about carers use of a wider support network. The views of carers indicated that:

- they benefit from the support of others who share similar experiences which can impact on the quality of care they provide looked-after children and young people
- support can include their own professional networks, often bypassing the assigned link to services
- although looked-after children and young people may be fostered by individuals or couples in many cases the wider family are providing support to them to ensure they feel 'love', and provide them with a sense of belonging which can act as an additional resource for carers.

Evidence statement E5.14

There was evidence from four studies (two [+] and two [-]) about carers' views on training. Carers say they want:

- access to training on topics that are important to them

- to be trained to the same standard as social workers
- to be trained in particular areas as this provides them with greater confidence in their abilities as carers.

Evidence statement E5.15

There was evidence from three studies (one [+] and two [-]) on carers' views about birth parents. Carers held strong views and felt that:

- birth parents had a disruptive impact on the lives of looked-after children and young people
- often they were left with the responsibility of dealing with any negative effects of birth parent contact.

Evidence statement E5.16

There was evidence from four studies (three [+] and one [-]) about the accessibility and acceptability of services. Studies asked carers about services they wanted or would like to have access to. Three of the four studies included carers' views on the acceptability of services they had received or had been in contact with. By comparing the participants direct quotes and author analysis across the four studies it was possible to identify three barriers to accessing services:

- lack of information about services available to looked-after children and young people and carers
- difficulty navigating the mental health referral system
- stigma about mental health.

In terms of acceptability of services, all three studies included both positive and negative experiences of the services they received with no strong implications for the improvement of services being made by carers.

Evidence statement E5.17

There was evidence from two (++) studies on being a kinship carer. Participants described what it was like being a kinship carer which provided

insight into the uniqueness of their experiences. The following emerged from their views:

- they often have to manage both their relationship with the child in their care and biological parent of child(ren) in their care and may need additional support do this
- they may have additional support needs because they are often older (grandparents) and looking after a child may be an added burden.

Evidence statement E5.18

There was evidence in two (+) studies on parents views about maintaining contact with their children. Parents specifically stated that:

- they wanted to maintain continuity in contact with their children
- they wanted to be a source of support to their children
- they needed support from professionals while their children are in care in order to have useful contact with them.

Evidence statement C3.1

Communication between professionals and services is undoubtedly aided by co-location, integrated front-line working and effective communication structures including regular consultation meetings, joint strategic planning and pooled resources.

Evidence statement C3.2

Effective practice in improving the health and wellbeing of looked-after children and young people relies on effective information sharing, communication across organisational boundaries and a shared commitment to improving their health and wellbeing. In describing effective information sharing and communication activity, the sites talked about the importance of having a range of structured and forward planned, information sharing meetings that had clear agendas and purpose, some of which were topic led and related to specific or emerging issues. Other examples were given as regular email correspondence between professionals and regular telephone conversations to discuss individuals or issues.

Evidence statement C3.3

In sites where Children and Mental Health Services (CAMHS) workers are co-located for part of the week, or where they are fully integrated into looked-after children and young people teams, the result is better and speedier access to CAMHS for looked-after children and young people.

Evidence statement C3.4

Effective strategy and planning is crucial in promoting productive partnership working at all levels. Joined-up, corporate and strategic planning impacts upon all other planning activity within the services, and ultimately improves the direct services to looked-after children and young people and their families.

Evidence statement C3.5

The evidence gathered in all sites and across the professional groups strongly suggests that the most important factors in influencing looked-after children and young people's health and wellbeing outcomes are stability and consistency. The child or young person's placement is of paramount importance and the characteristics of a quality placement are good matching of carer and child at the point of placement. Good matching is characterised by the matcher having robust and detailed information about the child, their characteristics and preferences so that they can match these against the lifestyle and characteristics of the foster carers at the point of matching. The matching process is also aided by timely planning, with the child and carers experiencing introductory meetings and agreeing to the time frame for the planned move. Additional characteristics of a quality placement are thought to be the consistent approach that the carer brings to the relationship, having commitment, staying power and demonstrating unconditional positive regard for the child. In summary, the quality of the relationship between the carer and child is crucial. Alongside this, stability of school placement and consistency in key workers are also thought to be highly influential in promoting health and wellbeing in looked-after children and young people.

Evidence statement C3.6

Good transition management is characterised by timely planning to ensure that young people are fully supported through the transition process. Young people voiced concern at the stark contrast between the lifestyle and support they had experienced in foster or residential care and the situation they face when leaving care. The significant reduction in their financial means, coupled with the added responsibilities of independent living affect their diet, opportunities for exercise and adds to their stress.

Evidence statement C3.7

Looked-after children and young people do not want to be identified as different from other children and young people and therefore it is important to offer them the same interventions and support services as their counterparts in universal settings, wherever possible. Evidence suggests that this is even more important for disabled looked-after children and young people who generally, have a strong wish to access services alongside their able-bodied peers.

Evidence statement C3.8

Early interventions that focus on preventing adverse behaviours such as offending behaviour, substance misuse, smoking, obesity, and bullying are key to improving children and young people's health and wellbeing in the future. Evidence suggests that activities and interventions that positively promote health and wellbeing – such as diet, exercise, emotional health and forming friendships, are the most engaging and successful. Such interventions are delivered to varying degrees in schools and universal settings with all children, but often, looked-after children and young people miss out on sessions or do not benefit from the consistent approach to these issues from a school, due to their frequent moves during care or the periods of school absence they experienced prior to coming into the care system.

Evidence statement C3.9

Specialist services do play an important role in improving health and wellbeing outcomes for some young people. Respondents felt strongly that the needs of

every looked-after child or young person are different and that a range of universal and specialist services are needed to meet their bespoke needs.

Evidence statement C3.10

CAMHS support to the carers of looked-after children and young people with complex needs is highly valued by the recipients. In sites where carers are accessing this type of support, respondents spoke positively about the benefits. However, the evidence suggests that support to carers should be an additional service to the therapeutic intervention that should also be on offer to looked-after children and young people and not an alternative to this.

Evidence statement C3.11

Respondents in three sites named that there should be consistency in the ages that all work to in responding to the needs of looked-after children and young people. In particular they felt CAMHS interventions should continue when young people reach 18 years and should mirror the longer-term responsibilities of education and social care staff.

Evidence statement C3.12

Looked-after children and young people's access to dental care is a concern to respondents. Sometimes they need to travel considerable distances to access a dentist that has the capacity to take them. A looked-after child or young person may not attend a planned dental check for reasons relating to unplanned placement moves, fear, phobias or confidence issues. Missed appointments result in some dental practices de-registering them. Some dentists are reluctant to embark on a treatment programme if a child is in a short-term placement. There are particular needs around meeting the specialist dental needs of disabled children and young people.

Evidence statement C3.13

Life-story work takes place inconsistently with looked-after children and young people. Evidence suggests that they would benefit from having access to consistent information about their history and the reasons for their being looked after. This needs to be an ongoing process with information updated as the child or young person moves through developmental stages. There

appears to be little consistency in approach to life-story work and there is a tendency for it to be resource-driven rather than needs-led.

Evidence statement C3.14

Respondents at some sites reported 'models of good practice' in helping children and young people placed out-of-area access services. However, this was not the case across all sites which means that some children and young people are not receiving the same level services. Evidence suggests that this inconsistency in service delivery impacts on their future health and wellbeing.

Evidence statement C3.15

Sites would welcome national guidance to support the delivery of care to children placed out-of-area, and to children placed in area when they are looked after by another local authority.

Evidence statement C3.16

Evidence suggests that there has been a significant change in the demographics of the looked-after children and young people population in the last 5 years. Sites have accommodated increasing numbers of asylum seeking children and young people, a good proportion of which are unaccompanied (UASCYP). There appears to be a lack of appropriate, mental health services for UASCYP and furthermore, services are unable to meet the complex needs of this vulnerable group. Young people express concern at the poor quality of accommodation in which some UASCYP are placed and considered that their eligibility and access to support did not match that provided to other care leavers.

Evidence statement C3.17

The high levels of support and in-depth training provided to foster carers on specialist schemes was seen as a benchmark that mainstream foster carers would welcome. In particular, out-of-hours support from a mental health (CAMHS) worker was seen as an effective way to manage a crisis and help prevent breakdown.

Evidence statement C3.18

In the main, looked-after children and young people interviewed did not speak positively about their relationships with social workers. Social workers are considered to have control and to make decisions, however they are not trusted by young people to carry through agreed actions. Evidence suggests a high degree of turnover in social workers working with looked-after children and young people. Children and young people say that they do not feel listened to by their social workers and that they are hard to reach. More typically, children and young people named foster carers, staff at school, independent reviewing officers and independent visitors as a source of trusted support.

Evidence statement C3.19

Evidence suggests that in circumstances where respectful relationships are built between carers and birth parents, this will assist in enabling a looked-after child or young person to thrive in their placement. Ongoing work with birth parents appears to be a neglected area although the likelihood is that looked-after children and young people are likely to return back to their care at some stage in their lives.

Evidence statement C3.20

Although most looked-after children and young people express high levels of satisfaction with their current placement, some were critical of the motivation of their previous foster carers and of the care that they had received. Young people advocate that there should be more regulation, inspection and spot checks of foster care placements.

Expert testimony

- Expert paper 1: 'Patterns of instability in the care system'
- Expert paper 2: 'Stability and wellbeing in the care system'
- Expert paper 3: 'Learning from Sheffield: services to meet the needs of the most challenging children'
- Expert paper 4: 'The role of the Healthcare Commission in improving outcomes for looked-after children'

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- Expert paper 5: 'Social pedagogy – an example of a European approach to working with looked-after children'
- Expert paper 6: 'Improving outcomes for looked-after children and young people'
- Expert paper 7: 'Revised government guidance and policy developments on the health of looked-after children'
- Expert paper 8: 'The contribution of inspection to the health and wellbeing of looked-after children'
- Expert paper 9: 'The physical and emotional health and wellbeing of children and young people growing up in foster care: support and training for carers'
- Expert paper 10: 'Making sense of performance problems in public organisations'
- Expert paper 11: 'Working with complex systems and networks around looked-after children and young people'
- Expert paper 12: 'Care planning – the social work task for looked-after children'
- Expert paper 13: 'Multi-agency partnerships'
- Expert paper 14: 'Labels that disable – meeting the complex needs of children in residential care'
- Expert paper 15: 'Siblings in care'
- Expert paper 16: 'Participatory approaches to involving looked-after children and young people in the design and delivery of services'
- Expert paper 17: 'Social pedagogy in children's residential care: DCSF pilot programme'
- Expert paper 18: 'Pathways to permanence for black, Asian and mixed ethnicity children; dilemmas, decision-making and outcomes'
- Expert paper 19: 'Kinship care'
- Expert paper 20: 'Promoting the resilience and well-being of young people leaving care: messages from research'
- Expert paper 21: 'Improving health and well-being outcomes of children under five years of age looked after in the care of local authorities'

- Expert paper 22: 'Mental health of looked-after children in the UK: summary'

Cost-effectiveness evidence

The cost effectiveness modelling for review 1 (see Appendix B) estimated that interventions that support the transition of looked-after children and young people to adulthood are likely to be cost effective. Helping young people to find employment or continue with higher education improves health and social outcomes and is estimated to make long-term cost savings.

In line with the approach outlined in appendix B, the recommendations that were agreed by the PDG to result in more good than harm compared with current practice, which were of relatively small additional cost and which would probably yield cost savings in the long run, were considered to be cost effective. Indeed, the recommendations would in many cases be less expensive and more effective than current practice.

The PDG examined one draft recommendation – ensuring that all looked-after children and young people had a complete assessment of their physical, mental and emotional health at the time of entry to the care system – in some detail. The PDG concluded that the recommendation was likely to do more good than harm compared with current practice and, since resources should already be in place, the level of resources need not change, or need not change by very much.

As a result of data limitations, there is uncertainty regarding the cost-effectiveness of the remaining recommendations, in particular those that relate to system-level changes, training, auditing/monitoring, multi-agency working and information sharing. For these, the PDG judged that they would do more good than harm compared with current practice, based on evidence it was presented with. In addition, the PDG judged that many of the recommendations were likely to have low or no additional cost, and so were very likely to be cost effective.

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However, the PDG expected that some of the recommendations were likely to be costly. For these recommendations, the PDG did not have enough evidence on the magnitude of the costs and/or the effects to reach an informed conclusion about their cost effectiveness. This does not mean that these recommendations are not cost effective, just that the extent, if any, of their cost effectiveness is not known.

Appendix D Gaps in the evidence

The Programme Development Group (PDG) identified a number of gaps in the evidence related to the programmes under examination based on an assessment of the evidence and expert testimony. These gaps are set out below.

1. There is limited evidence of the effectiveness and cost effectiveness of interventions for looked-after children and young people.
2. There is limited evidence from the UK about interventions that:
 - provide support to looked-after young people who are leaving care and moving into adulthood
 - aim to improve access to health and mental health services for looked-after children and young people from birth up to the age of 25.
3. There is a lack of research on the effectiveness of universal or specialist services in the UK for certain groups of looked-after children and young people, including:
 - groups for which health inequalities may exist, such as those with complex needs or disabilities, unaccompanied asylum seekers, and black and minority ethnic groups
 - babies and very young children under the age of 5
 - siblings and sibling groups.
4. There is a lack of evidence from the UK of the relative impact of types of placement (local authority carers, private fostering agency carers, residential homes and kinship care) on access to services and support and on different health and social outcomes.
5. There is no evidence in most of the studies about the long-term impact of interventions on adults who were looked-after children or young people.
6. There is limited evidence from the UK about the effectiveness of training and support for carers, professionals and volunteers working with

looked-after children and young people. In particular, there is a lack of research on the extent and effectiveness of training for certain groups, including teachers, health professionals, youth workers and volunteers, and the outcomes for looked-after children and young people.

7. There is a lack of evidence on which components of an intervention are effective. For example, few studies assessed the influence of different actors and actions, or the intensity or duration of an intervention, on effectiveness or duration of effect.
8. These details were often missing from descriptions of interventions:
 - the content of an intervention, when it was delivered, by whom, in what setting, at what point in the care pathway, how frequently and for how long
 - characteristics of participants in studies, including reasons for entry into care, and length of time in care
 - variations in effectiveness and cost effectiveness according to characteristics such as gender, sex, age, ethnicity, disability, sexual orientation, race and faith
 - controls and comparisons.
9. There is a lack of effectiveness research from the UK on how best to target and configure services for looked-after children and young people to meet the needs of particular groups, such as infants, unaccompanied asylum seekers, and children and young people from migrant or traveller communities.

Appendix E: supporting documents

Supporting documents are available at

www.nice.org.uk/guidance/PHG/Wave17/24 These include the following.

- Evidence reviews:
 - Review 1: ‘The effect of support services for transition to adulthood/leaving care on the adult outcomes of looked after young people’
 - Review 2: ‘The effectiveness of training and support for carers/professionals/volunteers working with looked-after children and young people on the physical and emotional health and wellbeing of looked-after children and young people’
 - Review 3: ‘The effectiveness of interventions aimed at improving access to health and mental health services for looked-after children and young people’
 - Review 4: ‘A correlates review: factors associated with outcomes for looked-after children and young people: a review of the literature’
 - Review 5: ‘A qualitative review of the experiences, views and preferences of looked-after children and young people and their families and carers about the care system’
- Cost-effectiveness review:
 - Review 1: ‘The cost-effectiveness of support services for transition to adulthood/leaving care on the adult outcomes of looked after young people’.
- Primary research and commissioned reports:
 - Report 1: ‘Qualitative research to explore the priorities and experiences of practitioners working with looked-after children and young people’

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- Report 2: ‘The health and wellbeing of looked-after children and young people: a brief review of strengths and weaknesses in service provision from inspection and review data’
- Report 3: ‘Practice survey: the physical, emotional health and wellbeing of looked-after children and young people’
- Expert testimony:
 - Expert paper 1: ‘Patterns of instability in the care system’
 - Expert paper 2: ‘Stability and wellbeing in the care system’
 - Expert paper 3: ‘Learning from Sheffield: services to meet the needs of the most challenging children’
 - Expert paper 4: ‘The role of the Healthcare Commission in improving outcomes for looked-after children’
 - Expert paper 5: ‘Social pedagogy – an example of a European approach to working with looked-after children’
 - Expert paper 6: ‘Improving outcomes for looked-after children and young people’
 - Expert paper 7: ‘Revised government guidance and policy developments on the health of looked-after children’
 - Expert paper 8: ‘The contribution of inspection to the health and wellbeing of looked-after children’
 - Expert paper 9: ‘The physical and emotional health and wellbeing of children and young people growing up in foster care: support and training for carers’
 - Expert paper 10: ‘Making sense of performance problems in public organisations’
 - Expert paper 11: ‘Working with complex systems and networks around looked-after children and young people’
 - Expert paper 12: ‘Care planning – the social work task for looked-after children’
 - Expert paper 13: ‘Multi-agency partnerships’

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- Expert paper 14: ‘Labels that disable – meeting the complex needs of children in residential care’
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- Expert paper 22: ‘Mental health of looked-after children in the UK: summary’

For information on how NICE public health guidance is developed, see:

- ‘Methods for development of NICE public health guidance (second edition, 2009)’ available from www.nice.org.uk/phmethods
- ‘The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)’ available from www.nice.org.uk/phprocess

For information on SCIE methods, see:

- SCIE research resource 1: ‘The conduct of systematic research reviews for SCIE knowledge reviews (2006)’ available from www.scie.org.uk
- SCIE research resource 4: ‘Practice enquiry guidelines: a framework for SCIE commissioners and providers (2009)’ available from www.scie.org.uk