ScotPHN report

Mental Health Care Needs Assessment of Looked After Children in Residential Special Schools, Care Homes and Secure Care

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FOREWORD

The Scottish Directors of Public Health commissioned this needs assessment in response to various concerns about looked after children, particularly the lack of clarity of residential status of children which may arise when accommodations are dual registered as both school and care homes. Without this clarity, there is uncertainty as to which Health Board is responsible for providing health care and this can result in difficulties in providing this care. There was also concern about the transfer of children between NHS Boards which could result in disjointed care and potentially impact on the mental health of the children.

The project group were aware of several issues relating to this population, but agreed that the scope should be limited to the mental health needs of looked after children in residential special schools, care homes and secure care to ensure that the scope of the project remained manageable. It is hoped that in undertaking this project, the wider needs of looked after children and the needs of those who are not accommodated will also be addressed.

This project has proved particularly timely, as the findings will feed into the work of the Looked After Children Strategic Implementation Group. The most striking finding is how passionate all those involved in the care of these looked after children are. It is vital that this report acts as a catalyst for moving the work of the Looked After Children Strategic Implementation Group forward so that the hard work of all those involved is not lost.

I would like to thank Maggie Lachlan whose particular passion for the subject has resulted in this report. I would also like to extend thanks to ScotPHN, the project and steering group members.

Anne Maree Wallace
Director of Public Health, NHS Forth Valley
Project Chair and Sponsor

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The lead author wishes to thank the many people who contributed to the report. This included all those who were interviewed and kindly agreed to being visited as identified in Appendix 9.

Particular thanks to the members of the project and steering groups and all those involved in the Getting it Right for Every Child (GIRFEC) mapping exercise (Appendix 6) who have guided and provided valuable information for this project led by the chair Anne Maree Wallace, Director of Public Health, NHS Forth Valley.

To the 32 local authorities who all provided data for the survey. To the Scottish Government who provided additional analysis on the Children Looked after Statistics data.

To the Looked after Nurses who took part in the survey, both those who completed the questionnaire and took part in telephone interviews.

To NHS Fife for its particular contribution in terms of personnel and providing its health plan which has informed this project.

To the ScotPHN team who coordinated, contributed and collaborated throughout.

FIGURES AND TABLES

COMMON ACRONYMS USED IN TEXT

BAAF	British Association for Adoption and Fostering Assessment Framework - http://www.baaf.org.uk/
CAMHS	Child and Adolescent Mental Health Services
Care Commission	Scottish Commission for the Regulation of Care
CLAS	Children's Looked After Statistics
SDsPH	Scottish Directors of Public Health
GIRFEC	Getting it Right for Every Child
HCNA	Health Care Needs Assessment
LA	Local Authority
LAC	Looked After Children
LAC Nurse	Looked After Children Nurse
LAAC	Looked after and accommodated children
LACSIG	Looked After Children Strategic Implementation Group
NHS	National Health Service
ScotPHN	Scottish Public Health Network
SIRCC	Scottish Institute of Residential Child Care
SCSWIS	Social Care and Social Work Improvement Scotland
SSSC	Scottish Social Services Council

EXECUTIVE SUMMARY

Background

All Local Authorities have a significant number of children and young people accommodated in residential care. Often these are in the private sector and may be out of area or even out of Scotland.

Anecdotal evidence suggested the health care received by these children and young people is highly variable with a suggestion of inequity. A number of concerns were raised by the Scottish Directors of Public Health Group (SDPHs):

- the confusion about the residential status of children in dual (school and care) registered homes which leads to a lack of clarity as to which Health Board is responsible for the healthcare;
- access to Child and Adolescent Mental Health Services (CAHMS);
- both a lack and multitude of relevant policy; and
- complex, cross-boundary funding.

In undertaking this mental health care need assessment (HCNA) the following objectives were set:

- to investigate and map the policy context and the work currently taking place in this area at local and national level;
- to identify the level of need and map current service provision; and
- to identify the inequalities resulting from current service provision.

Approaches Used

The HCNA was undertaken using epidemiological and corporate needs assessments from May to October 2010. Specific areas of work included:

- key policy and guidance documents were mapped against the 10 core Getting it Right for Every Child (GIRFEC) components;
- current service provision was mapped using both routinely collected statistics and specific qualitative and quantitative surveys of all local authorities and a sample of Looked After Children's Nurses; and
- interviews were held with a wide variety of stakeholders (Appendix 9) to gain views of current service issues, gaps, inequalities in provision and what may be done to improve the current position. They were carried out mostly as site visits and included meeting with staff, children and young people in a number of residential schools, care homes and secure units.

Results

The mapping of the current service provision showed a highly complex picture. Children may not receive timely care because of the lack of clarity about which Health Board is responsible for their healthcare. There is little formal involvement of the NHS in the placing or care of children and young people. There are gaps in the information that Local Authorities and NHS Boards have about the children they are responsible for especially if a child is placed out of area. Some progress has been made by Health

Boards in meeting the recommendations of CEL(2009)16; however, the progress is variable across Scotland.

Issues identified during the interviews included:
- the importance of GIRFEC;
- approaches to corporate parenting and partnership working;
- defining and strengthening the Looked After Children nurse role;
- planning and delivering care on a cross boundary basis;
- the implementation of CEL(2009)16;
- the qualifications and training of staff;
- enhancing the culture and ethos of the accommodation provided;
- access to CAMHS services; and
- access to through-care.

Conclusions

The HCNA shows that:

- looked after and accommodated children have both a greater number and also more complex mental health problems than their peers;
- there is a highly committed and passionate workforce caring for our looked after children;
- there are a plethora of policies and agencies involved in a very complex picture and a lack of joined up working;
- the complex funding arrangements of the services providing care can cause barriers preventing the needs of these vulnerable children and young people being met in an appropriate and timely manner; and
- there is no formal involvement by the NHS in placing and moving children.

There are many positive things happening to build on both locally and nationally, for example, the work of the Looked After Children Strategic Implementation Group (LACSIG). In general, the policies provided from government have been beneficial and are already leading to greater cross-sector working. However, even better co-ordination of these services would result in better outcomes for all looked after children.

Recommendations

The following recommendations are made by the HCNA:
- all agencies should work together to embed the GIRFEC approach in caring for looked after and accommodated children;
- the guidance on the identification of the responsible Health Board in relation to children placed into residential accommodation, particularly dual registered accommodation, should be reviewed and updated;
- CEL(2009)16 recommendations should be fully implemented and monitored by all NHS Boards and a reporting mechanism to the Scottish Government agreed;
- the Looked After Children nurse role should be clarified and strengthened according to the Capability Framework;

- Child and Adolescent Mental Health Services should organise their services for looked after and accommodated children and young people according to the recommendations of 'The Mental Health of Children and Young People: A Framework for Promotion Prevention and Care' , using the framework as their main planning and audit tool;
- there should be agreement on the qualifications and training required and central co-ordination of this for all involved in the care, which includes mental health care, of looked after and accommodated children and young people;
- the NHS should work with Social Care and Social Work Improvement Scotland to agree on the standards required for registration of care establishments to meet the mental health needs of their accommodated children and young people; and
- there should be involvement from the NHS in placing and transferring children within the care system and on their moving on from the care system.

SECTION 1: INTRODUCTION

Local authorities have a significant number of children and young people accommodated in residential care. At any given time in Scotland this number is around 1,600, about a tenth of all looked after children and young people[2]. Often these children are accommodated in the private and voluntary sector according to their need or the availability of places and many are placed out of area as their needs may not be able to be met in a resource run by their own local authority. A very few with specific needs are placed outside Scotland.

These looked after children and young people are among the most vulnerable members of our society and many of them have complex and challenging needs[3]. Many of them do not reach their full potential and go on to have major problems in later life[4].

Anecdotal evidence suggests that the health care received by these children and young people is highly variable with a suggestion of inequity.

The main concerns for consideration raised to a number of Scottish Directors of Public Health were:

- that although the general care of these children is the responsibility of the local authority, it is not always clear which NHS Board has responsibility for meeting the health care needs. There may be lack of clarity as to the residential status of the child or young person looked after away from home, which is crucial in the current system for determining the care received.
- the poor access to health services, particularly Child and Adolescent Mental Health Services (CAHMS). The problems of providing CAMHS input to residential care has been long running and affects many NHS Boards. This is a particular problem for smaller NHS Boards where children are cared for often in rural settings and a Board's resources have been developed according to the needs of their resident population and not for in-coming looked after children and young people;
- that there is both a multitude of relevant policy but a lack of relevant guidance causing difficulties in integrating and implementing the policy at local level;
- the complex financing of the services. For example, there are cross boundary issues, both geographical and between service providers. Children and young people may be moved a number of times between different types of accommodation; and

The SDsPH asked ScotPHN to carry out a mental health needs assessment for looked after children:

- to investigate and map the policy context and the work currently taking place in this area at local and national level;
- to identify the level of need and map current service provision; and
- to identify the inequalities resulting from current service provision.

At a meeting of stakeholders in April 2010, attendees agreed to form a steering group which would provide a wide range of expertise to the project. A project group including key contributors was formed to undertake the project. Details of membership can be found in Appendix 1. A copy of the project brief agreed by the group can be found in Appendix 2.

The Steering Group agreed the scope of the project should be limited to focus on looked after children accommodated in residential special schools, care homes and secure care. This accounts for only about a tenth of all looked after children and young people in Scotland. It was acknowledged that there are very serious needs and concerns for the other 90% children and young people not in these categories of accommodation but still the responsibility of local authorities and also for young people who leave the care system. However it was agreed by the steering group that, given the timescale available, the project should concentrate on these particular accommodated children and young people (aged between 0 and 21 years. Age 21 was chosen as the upper limit to ensure those with learning disabilities were included in the needs assessment) and that any learning may be extended to further areas.

Of particular concern to the stakeholders was the mental health and wellbeing of looked after and accommodated children and young people. And this is the focus of the report, although it is understood that separating physical and mental health issues is often not helpful and it is better to look holistically at needs and therefore the way they can be met.

What is mental health?

The World Health Organisation describes mental health as a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community[5].

What are mental health problems?

One difficulty in multi-agency and partnership working is that many different definitions may be used to describe the same conditions, however, this report adopts the *The Mental Health of Children and Young People A Framework for Promotion, Prevention and Care (2005)* working definition of mental health problems as difficulties in living, learning and relating which are expressed in terms of troublesome emotions or behaviours as well as more explicit psychological or psychiatric problems[6].

There are factors that make people more vulnerable and factors that provide resilience against developing mental health problems[3] as will be described later. Children and young people looked after away from home are often more vulnerable because of their background and when they enter the looked after system, the lack of cohesion of services can often add to these problems.

SECTION 2: NARRATIVES CONCERNING MEETING MENTAL HEALTH NEEDS

To help get a feel for the complexity of the issues, stories and poems about individual experiences have been included.

There is good evidence that many young people who have been looked after away from home have had their needs met as described by Jennie below:

Jennie, 17, gives her views about residential care

'I have been in and out of care practically my whole life.

When I went somewhere new I was always in a rush to get back home. I don't know why because it definitely wasn't the greatest place to be. Finally I moved into residential care at 15 and although it sounds like a horrible place, it was the best home I ever had.

There are a lot of staff in and out all the time which some people wouldn't like but it felt like one big family to me. I grew up a lot, I gained some responsibility and respect, with the help of others and grew to be a polite, sensible woman, which a lot of people would have never imagined.

Once I turned 16, I went on to supported housing and learnt everything I needed - budgeting, cooking, cleaning and having respect for neighbours; everything you need to manage your own home, and this was all done by the staff from the residential.

Now I have my house with everything I've ever really wanted - a stable home where I can feel safe and if it wasn't for social work I probably wouldn't have any of it.'[7]

This anonymous poem by another young person in care describes their experience. It is taken from 'This is Me'[8], a book of poems celebrating the creativity and achievements of young people in care in Scotland over 30 years:

Living in care is pretty good
They can help if you get in a mood
Even though you miss your mum and dad
They are always there if you get sad
The staff are not like staff more like mates
They are definitely at the top of my rates
When you get down or start to cry
They just want to help not to pry
It becomes your home for a short time
You can relax cause it's not a crime
I tried to run away cause I thought this home is cool
I thought I caused trouble but I was being a fool.

Sometimes they do get on your back
Cause there is only so much you can hack.
But if you give them a chance things will work out.
If you don't you won't

However, there are many anecdotal stories showing that there are still concerns and especially with the children and young people themselves feeling that they are not 'in control' and not involved in the decisions being made about them. The following examples describe some of the issues faced by these children and young people, for example, not being involved in decisions about their care, funding issues of the many agencies involved in their care, barriers in accessing services to which they are entitled, a lack of stability in their home setting and not having the consistent availability of a person in whom they can trust and confide.

This poignant poem by 17 year old Lisa is also taken from 'This is Me' [8]:

Being in care is like a haven
You isolate yourself in your bedroom
This is where you feel safe
From the world and everything around us
This is great
Until they decide they want us to move on
Shattered this is what our world is
How can they expect us to do this?
Move from what we thought was normal and home
To a scary big place
Called the world
So different and out of the norm

Further examples below have been provided from a large residential school providing a home and education for children and young people from all over Scotland. The school was evaluated against the quality indicators and found to be either very good or good by HM Inspectorate and the Scottish Commission for the Regulation of Care in 2010 with particular strengths in:

- young people's development of skills for life and work;
- approaches to promoting young people's self esteem and respect for others;
- effective teamwork of education and care staff and joint approaches to promoting young people's health and wellbeing;
- partnerships with parents, carers and external agencies; and
- leadership of the Director and senior managers.

With examples of good practice in:

- approaches to improving the participation of young people in learning and decision making; and
- high quality teamwork of care and education to support young people with additional needs.

The school also has a manager dedicated to looking after the children and young people's physical and mental health needs, who has kindly offered these anonomysed stories:

1. This example describes issues of a lack of communication and involvement of the young person in a decision on moving placement

A young person was placed in the residential school with us. The reason she was placed was for refusing to attend school in her home area. At that time it was expected that she would return to the care of her mother when the situation improved. However it was soon identified that there were other behavioural issues that resulted in a support package being put in place. During her stay she has voiced her concerns and stated she did wish to see and remain in touch with her family. The present circumstance is that her mother has recently had serious health issues and is not in the position to offer her the supports required.

She went to a hearing and she hoped she was going to be able to stay on in the school. The hearing's decision was to change the named place of residence. She returned from her hearing and had 2 hours to pack her bags. She was transferred to an alternative resource she had never heard of. She was taken by a staff worker whom she had never met before. Her only other option would have been to live with her sister. On the day of her hearing she did not know where she would be sleeping that night.

2. This example describes some of the cross boundary issues of a lack of clarity in who is responsible for how services should be accessed and provided

We referred a young person to the child development service requesting assessment of a longstanding history of inappropriate sexual behaviour. As he was not a child from within our local authority he did not meet eligibility criteria. We spoke with other professionals seeking advice on an appropriate service to work with him. We then referred him to the learning disabilities team who requested his educational psychologist assess him. We spoke with a resource from his local authority however they could not work with him until he was fifteen and a half years old. They did offer a supportive role and currently remain in that role as this young person will return to his local authority area.

The Social Worker contacted a voluntary organisation. They could not accept a referral without a prior assessment. The Social Worker also contacted another resource in another local authority but this was also not appropriate.

We then referred him to the learning disabilities team locally for assessment to help ascertain whether he has a diagnosable learning disability in order to clarify which services may support him best.

This assessment has recently been completed and his results indicate significant to severe impairment. The support strategies suggested by them we already have in place and the psychologist has said the sex education packages we are using with him are entirely appropriate. Although the focus of managing his inappropriate sexual behaviour will be on the grounds of risk management rather than education you can see how long this process has taken.

3. This example describes the problems of 'waiting lists' and registration with a GP when a young person's residence changes

We admitted a boy fairly recently who, prior to admission, was referred and waiting for an assessment by a consultant psychiatrist. To allow this appointment to happen we had to register the boy with a GP in a practice in the catchment area for the psychiatrist, otherwise he would lose his place on the list. We had great difficulty persuading a surgery to temporarily register him. They eventually said they would take him for 12 weeks only as he was now living out of their catchment area as well. We did get the assessment completed just in time before transferring him to our local GP.

4. This example describes problems in transition and throughcare for a young pregnant girl

Communication took place between the local unit and the social work department in her local authority to establish whether a suitable placement had been identified for young person to move onto. The original request was made when it became clear the young person was not managing her placement at the unit she was placed in and her complex needs could not be met.

This young person found herself pregnant and her advancing pregnancy was major factor in the urgency of a move.

It had been clearly stated that the unit where she was placed were not equipped or insured to care for a heavily pregnant girl or indeed a new mother and baby.

This young person had previously stated she may like to reside in another NHS Board area and therefore she was introduced to the through care services in that Board area. No suitable project or housing project could be found there. A local hostel was not suitable although they have young people who are pregnant they have no mum and baby unit and no additional supports could be offered.

A local homeless project had no options for pregnant girls.

Supported lodgings could not offer the supports she required. This young person was made very aware that her placement would be ending on a given date in a few weeks yet no clear plan had yet been made.

The young person's options were limited and a move back to the originating local authority was the only way forward.

The Social Work department were again informed of our concerns in relation to her pregnancy and wellbeing as well as her unborn child. The Family Health Team (midwife) was informed.

The young person's behaviour escalated to the extent that she required moving from her unit to a residential caravan and staffing by local services staff.

There was constant communication with Social Work staff at this time but still no resource found.

She continued to place herself and her unborn child at risk. Her behaviour deteriorated again and there was police intervention. The following day the young person was taken to another resource.

The scenarios described above are not unusual. They have been provided from the manager of a residential school dedicated to caring for the mental and physical health needs of the children and young people in their care and yet there are still many barriers preventing these children and young people from receiving the services to which they are entitled to help them in reaching their potential. As is set out in the GIRFEC Framework, a joined up approach by all services is needed to help tackle these issues.

This needs assessment aims to draw out these issues and offer suggestions on the way forward in improving the life chances of children and young people looked after away from home in residential care.

SECTION 3: APPROACHES USED

The general principles of health care needs assessment

The objective of any Health Care Needs Assessment (HNCA) is to specify services and other activities which impinge on health care relating to a specific disease or diseases. In general, the principal activities involved in HCNA are:

- an assessment of incidence and prevalence;
- an analysis of the effectiveness and/or cost-effectiveness of services; and
- establishing the existing service baseline to help guide service development and redesign.

From these three components, health care planners and commissioners, together with other stakeholders, can determine the policy direction they wish to pursue. There can also be other objectives in HNCA. These might include:

- improving access and the allocation of resources at local, regional and national levels;
- targeting resources at area(s) of highest need; and
- securing the active participation of key stakeholders and players in understanding the need for change and how it can be achieved.

Undertaking such work usually requires a collaborative approach bringing together people with the necessary knowledge base and those with the appropriate technical skills. Broadly speaking, this requires that there is:

- *Epidemiological Needs Assessment:*
  - incidence and prevalence;
  - effectiveness and cost effectiveness of services; and
  - description of baseline services.

- *Corporate Needs Assessment:*
  - reporting the demands, wishes and alternative perspectives of interested parties, for example, service users and their carers, and stakeholders including professional, political and public views.

- *Comparative Needs Assessment*
  - comparing and contrasting the services in the population under study with those provided elsewhere.

Taken together a HCNA should, insofar as there is appropriate data available, describe the capacity of the population to benefit from a service or intervention and to make suggestions as to how such benefits can be delivered. Health care need is not, however, the only important factor in planning and delivering health care. Consideration may be given to, for example, political direction, health care costs, legislation, competing NHS priorities, patient voices and public involvement, professional opinion, scarcity of resources or expertise and the existing pattern of services. Given the NHS is a public-funded institution, it is also important to recognise population perceptions and the impacts of political processes.

Approaches Used for this Needs Assessment

The specific approaches taken in this assessment of the mental health needs of looked after and accommodated children and young people were epidemiological and corporate.

In addition a specific policy review and mapping exercise was undertaken.

The main reasons for using these methods were:

- to help in the development of more systematic arrangements and guidelines about responsibilities for the mental health care of children looked after and accommodated by local authorities;
- to provide an evidence base to justify a more economically viable approach to delivering mental health care for children accommodated out with their home NHS Board; and
- to improve on equity of service provision for these vulnerable children and young people.

Epidemiological Needs Assessment

The current position and service provision has been mapped using routinely collected statistics available.

In addition, a specific quantitative survey with all local authorities was undertaken. The survey with local authorities was carried out to meet a knowledge gap for children for whom accommodation was provided from the responsible Health Boards perspective.
A questionnaire was developed, the aims of which were:

1. to get a picture of how many children are accommodated in NHS board areas outside the NHS Board of the Local Authority responsible for care;
2. to explore potential communication difficulties for local authorities and NHS Boards in identifying these children to NHS Boards, and arranging and agreeing responsibility for their mental health care; and
3. to gauge the adequacy of information available to local authorities and NHS Boards about children accommodated in their geographical area who are the responsibility of another local authority or NHS Board.

A copy of the questionnaire can be found in Appendix 4.

Corporate Needs Assessment

Semi structured interviews were carried out with a variety of stakeholders to gain views on current service issues, gaps, inequalities in provision and what may be done to improve the current position. Most of these interviews were carried out as site visits and included meeting with staff, children and young people in a number of residential schools, care homes and secure units.

In addition, a qualitative survey of looked after children's nurses has been undertaken. A telephone and email survey was carried out with 14 of the looked after and accommodated nurses employed by Health Boards. This was carried out towards the end of the project once the key role of these nurses in meeting the mental health needs of the study population

had been recognised through the stakeholder interviews and asked both quantitative questions and qualitative questions. It aimed to provide more clarity of the current roles and responsibilities of the Looked After Children Nurses. A copy of the questionnaire can be found in Appendix 5.

Policy Review and Mapping against GIRFEC

Children and young people may move in and out of the care system during their lifetime, sometimes being looked after and accommodated and the responsibility of local authorities at other times at home, in kinship or foster care or in secure accommodation. Therefore the literature, policy and guidance on the mental health needs of all children and young people in Scotland as well as those specifically in care has been reviewed.

The GIRFEC national programme aims to improve outcomes for all children and young people in Scotland. It seeks to do this by providing a framework for all services and agencies working with children and families to deliver a co-ordinated approach which is appropriate, proportionate and timely. It was agreed by the steering group of the project that a useful exercise would be to map the policy and guidance documents on the care of children and young people being looked after and accommodated against the 10 components of GIRFEC (Appendix 6).

SECTION 4: THE POLICY CONTEXT

There has been a plethora of policy and guidance documents relating to the care of looked after and accommodated children over the last 15 years. 30 of these documents are summarised in the Audit Scotland report of September 2010 Getting it Right for Children in Residential Care [9]. For example, The Children (Scotland) Act 1995 [10] reformed the law of Scotland relating to children and made provision in respect of residential establishments for children. In 2002 National Care Standards for School Accommodation [11] and National Care Standards for Care Homes for Children and Young People were developed, later revised in 2005 and are the standards being inspected against by Care Commission Officers (CCOs) now SCSWIS inspectors in all residences registered with the Scottish Commission for the Regulation of Care and now Social Care and Social Work Improvement Scotland. At present, the Social Care and Social Work Improvement Scotland inspects these services at least twice a year and one of the visits in unannounced. From 1 April 2011, care home services for children and young people receiving grades of 4 will receive an unannounced inspection every 24 months.

The main policy documents relating to health and healthcare are: CEL(2009)16, GIRFEC, the Scottish Needs Assessment report on Child and Adolescent Mental Health (2003) and the Mental Health of Children and Young People: a Framework for Promotion, Prevention and Care, and these will be discussed in more detail.

Implementing Action 15 of 'We can and must do better'[4], CEL(2009)16

A Scottish Government report in 2007, Looked After Children and Young People: We Can and Must Do Better, identified what was required to improve educational and other outcomes for looked after children and young people and care leavers. In particular it recognised that educational attainment cannot be seen in isolation but is dependant on other life circumstances, including health and wellbeing being addressed. This document helped the health service to take a more prominent role in the care of children looked after away from home in residential care which was still largely the concern of Local authorities, Education and Social Work. For the National Health Service, there was a specific action to be carried out, namely Action 15:

> *Each NHS Board will assess the physical, mental and emotional health needs of all looked after children and young people for whom they have responsibility and put in place appropriate measures which take account of these assessments. They will ensure that all health service providers will work to make their services more accessible to looked after and accommodated children and young people and to those in transition from care to independence.*

The recommendations on how NHS Boards were to implement this action was the substance of a Chief Executive Letter (CEL(2009)16).

The letter detailed the next steps as:

a) joint assessment and planning which takes into account the views of the young person and includes details of their particular health needs, including registration with a GP, dentist, regular health and dental checks, advice on sexual health, mental health and emotional wellbeing and access to any mental health services required;
b) NHS Education for Scotland (NES)[12] will scope the role and develop a competency framework for nurses of looked after children and young people. (Now available.); and
c) in partnership with NES, Learning and Teaching Scotland[13] will develop supports to ensure high quality sex and relationship education and drugs education.

For the first point a), each territorial NHS Board was required to nominate an NHS Board Director to take responsibility for looked after children and young people. The director was to be responsible for ensuring that NHS Boards fulfil their statutory duties under the Looked After Children Regulations 1996[14] to identify the children and young people in their areas.

The director was also to be responsible for ensuring that every looked after child and young person in their area was offered a health assessment by April 2010 and a mental health assessment to be phased in in line with the implementation of Mental Health of Children and Young People Framework for Promotion, Prevention and Care by 2015.

A system was to be put in place to report the progress of meeting the CEL(2009)16 requirements on both assessment and health outcomes annually to the Scottish Government.

Getting It Right For Every Child (GIRFEC)

The concept that meeting the holistic needs of children is required to achieve their potential had already been addressed with the development in 2006 of the visionary Getting it Right For Every Child (GIRFEC) national programme. GIRFEC's ambitious aim is to improve outcomes for all children and young people in Scotland. It seeks to do this by providing a framework for all services and agencies working with children and families to deliver a co-ordinated approach which is appropriate, proportionate and timely.

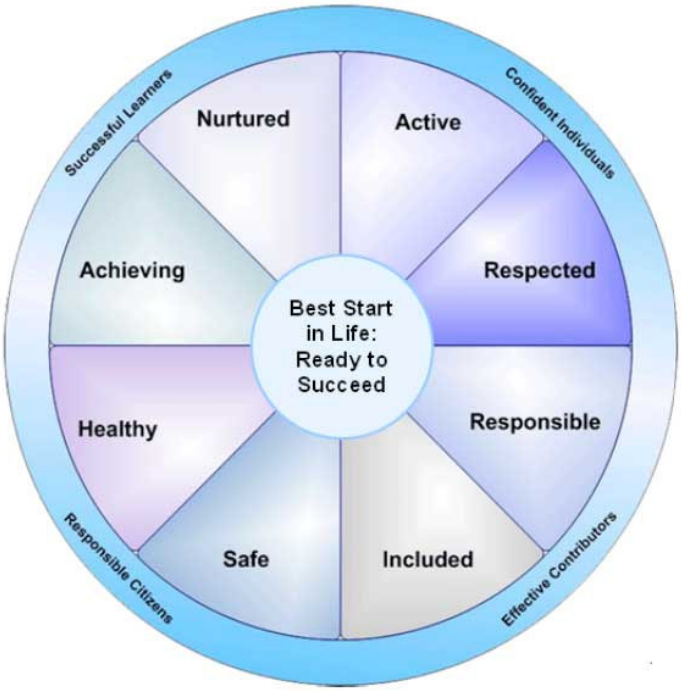
The ten GIRFEC core components are:

1. A focus on improving outcomes for children, young people and their families based on a shared understanding of well-being.
2. A common approach to gaining consent and to sharing information where appropriate.
3. An integral role for children, young people and families in assessment, planning and intervention.

4. A co-ordinated and unified approach to identifying concerns, assessing needs, agreeing actions and outcomes, based on the Well-being Indicators.
5. Streamlined planning, assessment and decision-making processes that lead to the right help at the right time.
6. Consistent high standards of co-operation, joint working and communication where more than one agency needs to be involved, locally and across Scotland.
7. A Lead Professional to co-ordinate and monitor multi-agency activity where necessary.
8. Maximising the skilled workforce within universal services to address needs and risks at the earliest possible time.
9. A confident and competent workforce across all services for children, young people and their families.
10. The capacity to share demographic, assessment, and planning information electronically within and across agency boundaries through the national eCare programme where appropriate.

The long term outcomes desired for all children are described in the Safe Healthy, Achieving, Nurtured, Respected, Responsible, Included (SHANARRI) wheel as follows:

Figure 1: SHANARRI Wheel



Source – Scottish Government: A Guide to Implementing Getting it right for every child: Messages from pathfinders and learning partners (July 2010)

GIRFEC clearly emphasises the need for all partners and service providers to work together to achieve these aims.

The recent Audit Scotland report[9] examined how effectively local authorities use their resources on residential placements for their looked after children and identified areas for improvement. However, the report, although summarising the main Scottish policy and Guidance documents relevant to looked after children and residential child care since 1995, did not include policy or guidance relating specifically to the health of these children.

There have been two key documents relevant to this needs assessment. They relate to the mental health needs of all children and young people and are very helpful in guiding the type of support which all involved in meeting the health needs of looked after children and young people should provide. These are:

- Scottish Needs Assessment Programme Report on Child and Adolescent Mental Health commissioned by the Scottish Government in 2000 and published in 2003; and
- Mental Health of Children and Young People: A Framework for Promotion Prevention and Care, which used the principles from the SNAP report to develop a very practical framework.

The recommendations from these documents are closely aligned with the GIRFEC approach. In particular, the steering group recognised that these documents offer essential principles and guidance for helping all involved in the care of children and young people looked after away from home in residential care, both to understand these children's health needs and take appropriate actions to improve the children's outcomes.

Scottish Needs Assessment Report on Child and Adolescent Mental Health (2003)

This report was commissioned by the Scottish Government in 2000 with the aim of identifying better ways of addressing the mental health needs of children and young people in Scotland. The report covers how best to promote mental health, how to prevent mental health problems and when and how to provide appropriate help for those children and young people who are experiencing mental health problems.

The issues then were substantial. About 125,000 young people (about 10% of the population under the age of 19) were having mental health problems which were so substantial that they were having difficulties with their thoughts, their feelings, their behaviour, their learning and their relationships on a day to day basis.

Three core themes emerged during a comprehensive needs assessment. These may be summarised as involving children, mainstreaming services and joining up promotion prevention and care.

First was recognising the right of children and young people to be heard, and their capacity to play a full part in thinking about mental health and in influencing the arrangements that we make to improve mental health.

Second was the importance of 'mainstreaming' mental health, such that the main focus of mental health work with children and young people should be in their communities, schools and families.

Third was the importance of addressing the whole continuum of mental health with an integrated, holistic approach –from mental health promotion through preventing mental health illness, to supporting, treating and caring for those children and young people experiencing mental health difficulties of all ranges of complexity and severity. This requires a co-ordinated and coherent combination of health promotion, prevention work and intervention and care services.

The report described some factors that increase children's vulnerability to mental health problems, these include:

- a learning disability of any kind;
- enduring physical ill health such as epilepsy;
- physical or sexual abuse;
- witnessing domestic violence; and
- a parent with serious mental disability.

Other factors help protect against the development of a mental health problem. These include:

- attributes of the individual child, such as an adaptable nature or good self-esteem;
- a range of relationship factors including peer and family relationships; and
- for children who experience adversity, the consistent availability of a person whom they can trust and in whom they confide fosters resilience.

The report states:

> *Social workers and mental health practitioners have much to contribute to one another's practice in relation to child protection, child abuse, fostered and adopted children, many of whom can be thought of as having attachment and post traumatic disorders*.

It goes on to say about child health:

> *Child health teams provide universal services and fulfil a very important role in the whole network of children's services in that they cover the spectrum from school health services to work with children with complex needs, including emotional and behavioural difficulties, They act as 'network facilitators' promoting communication and collaboration between all professionals to ensure that all children and young people requiring services are identified early and treated promptly and appropriately.*
>
> *There is a significant potential for joint service initiatives with mental health, particularly in relation to children with complex developmental issues, and with complex needs, such as abused children and those who are looked after and accommodated.*

It says:

> *There are many kinds of interventions of proven effectiveness with children who are in emerging or established difficulty. These are most likely to be effective when:*
>
> - *they are introduced early in the problem cycle and preferably early in age;*
> - *they involve familiar people or people who will be able to empower parents and work in partnership with professionals (eg health visitors or trained volunteers);*
> - *they are intensive and sustainable;*
> - *they are multifaceted and use interventions of proven effectiveness.*

The SNAP report provided a strategic vision for the mental health of children and young people in Scotland across promotion, prevention and care.

To deliver that vision a helpful framework was published in 2005.

Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care

The framework was developed to be used as a planning and audit tool and is intended to promote and shape coherent interagency planning. It endorsed the vision for an integrated approach to children's services planning and delivery, assuming a holistic approach with the child at the centre.

It is a practical guide which helps turn the theory into action. It does this by identifying the service elements, actions, hoped for outcomes and lead partners and setting these out in tables which can be used as a benchmark for local multi-agency development groups to work towards.

Establishing the responsible NHS Health Board for the provision of child and adolescent mental health care outside its usual place of residence.

All of the policy and guidance as to meeting the needs of looked after and accommodated children presume that there is clarity regarding which Health Board is responsible for providing the health care for the child when it is placed outside of its usual area of residence. For local authority functions, this is straight-forward as the local authority which places the child retains overall responsibility for the child's care. However, the existing guidance which applies to Health Boards is more complex. Having carefully reviewed the extant NHS guidance, the situation would seem to be that:

- if a child moves across Health Board boundaries for an purely educational reason (for example to an out of area boarding school), then the child is considered to have relocated and the usual guidance on cross-Health Board boundary transfers applies and the child is considered to have become the responsibility of the receiving Health Board once they have registered with a local General Practitioner;

- if the child has been placed in a special school to meet a special educational need, then the child is considered to not have relocated and remains a resident in their original home area. In such a circumstance, the original Health Board remains responsible for health care provision and the Health Board in the area the child is placed can charge for any specialist health care provision if such care is not covered by an inter-Health Board service level agreement. This would seem to apply even if the child is being cared for by a local General Practitioner following registration;

- for a child that is within the Looked After system, the guidance presumes that any child placed in foster care or a residential home for children, the Health Board responsible for the provision of health care is determined by the location of the placement. If the first placement is outside of the Look After Child's usual area of residence, then the receiving Health Board should be involved in the placement assessment and has responsibility for health care provision. If the Looked After Child moves to an out of area placement and is already receiving specialist healthcare, then there is a presumption that a transition of care between Health Boards will occur. Again, the receiving Health Board in the area the child is placed can charge for any specialist health care provision if such care is not covered by an inter-Health Board service level agreement.

If this were not complex enough, the existing guidance provides no clarity on those circumstances when a child is placed for both special educational and social residential purposes and where they are placed in an establishment which is registered to accommodate children for both types of provision. Nor does the guidance cover situations where a child within the Looked After system is placed out of area for solely educational purposes and then requires child and adolescent mental health care.

Setting the policies in context

To help tie the plethora of policy and guidance together and relate it to the needs of looked after and accommodated children and young people, the steering and project group agreed that it would be helpful to carry out a mapping exercise. A sub group of the project group has taken the 10 GIRFEC core components and for each has pulled out action points from the key documents which will assist in the implementation of GIRFEC (Appendix 6).

This exercise helped highlight the priorities, which the project steering group agreed required further action:

- implementing CEL(2009)16 across the whole of Scotland;
- embedding GIRFEC as the overarching framework, to be used by all agencies in improving the mental health of looked after and accommodated children; and
- clarifying the guidance of the responsible Health Board and developing the NHS role in the care of looked after and accommodated children.

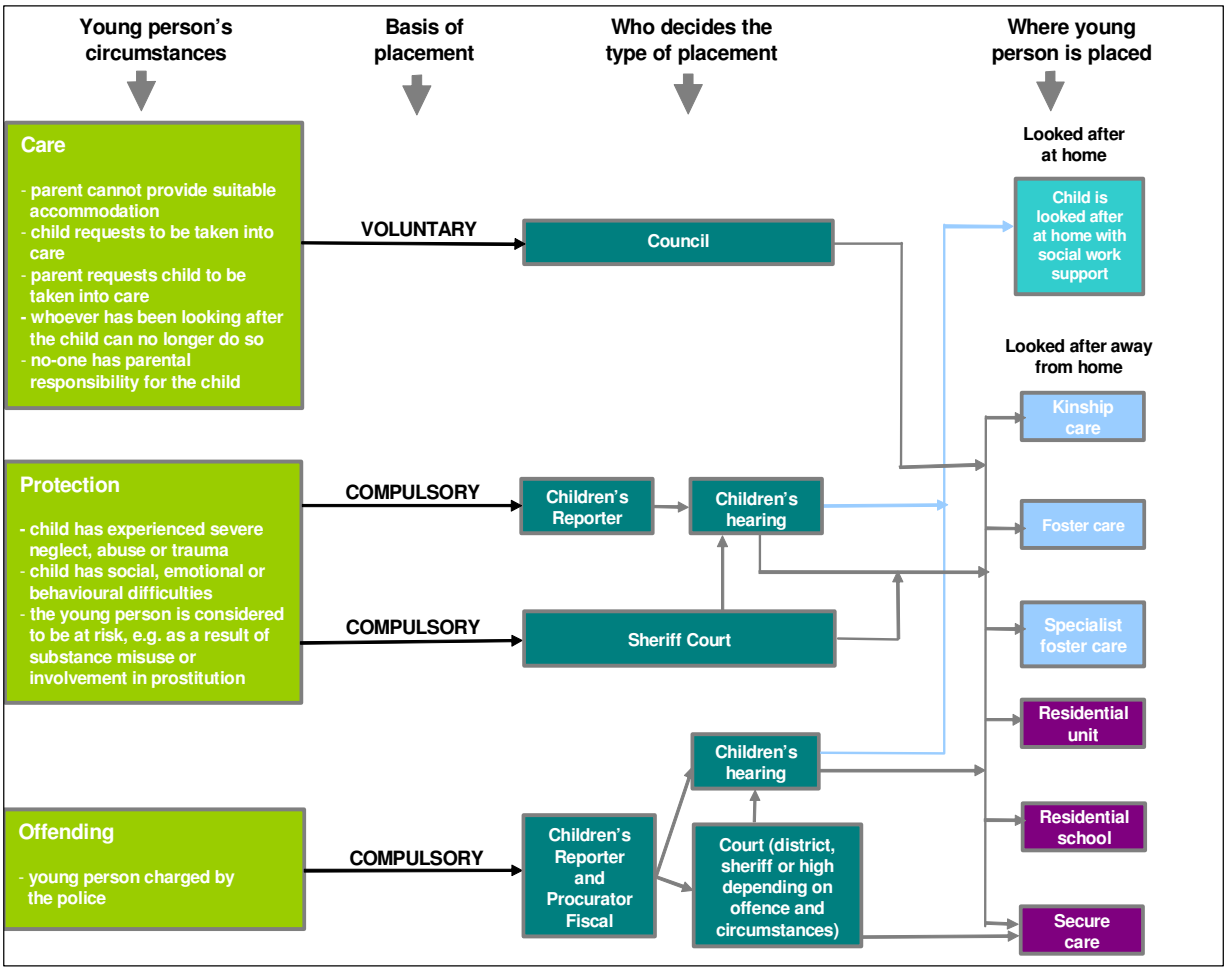
SECTION 5: EPIDEMIOLOGY

Current service

There are 32 local authorities and 14 territorial NHS Boards in Scotland. Most children and young people taken into residential care will remain in their own local authority area, and therefore in their own NHS Board area of residence where they will be registered in the primary care system in a local GP practice, and may be receiving specialist health services managed and funded from their NHS Board of residence area. However, a small number of these children and young people will be accommodated outside their home area at any one time. This may be for a number of reasons. For example, they may have been placed where there are the most appropriate services available for them, or because at the crisis time of need a place is available, or because a local authority has particular historical connections with a care home, or because a young person have been sentenced by the court to a secure unit through the justice system.

Children and young people become looked after by their local authority and are placed in different types of care setting through various routes as is shown in the following flow chart (Figure 2):

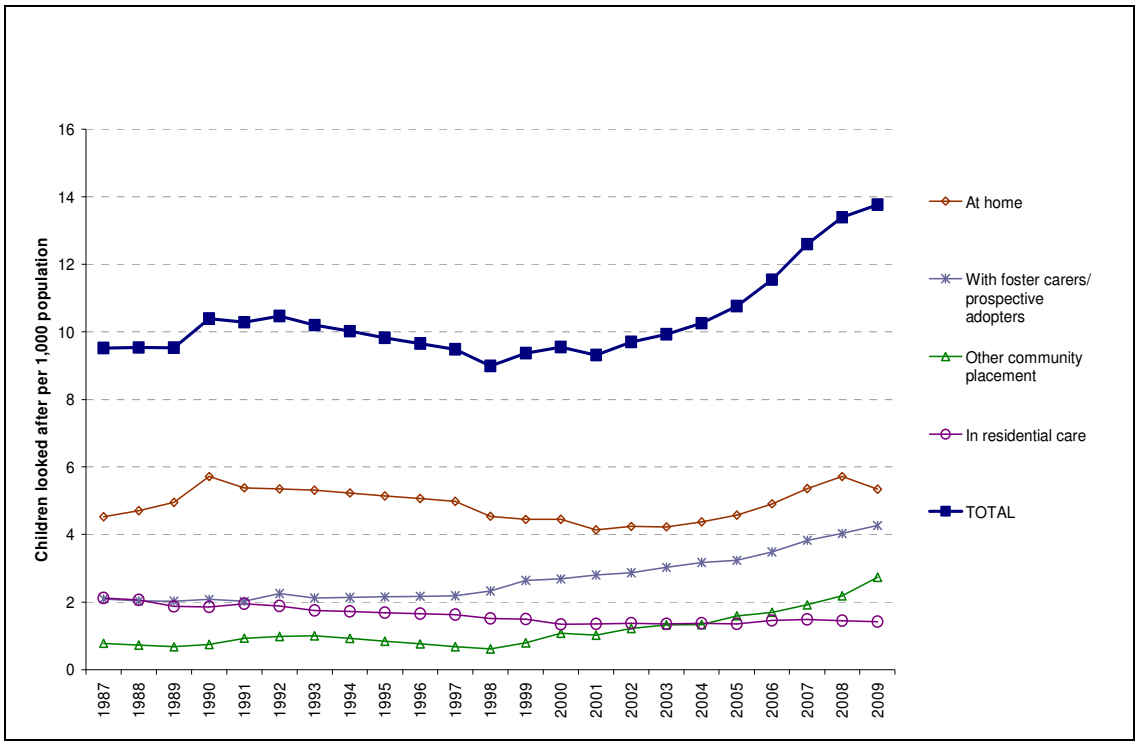
Figure 2: Flow Chart of how children and young people become looked after



Source - Audit Scotland Report:.Getting it right for children in residential care (2010)

At any given time there are nearly 15,300 children and young people being looked after by Scottish local authorities. About 10% of these are in residential care. Although the proportion of children who are looked after by the local authorities over the last decade has risen from just under 9 per thousand in 1988 to just under 14 per thousand in 2009, the number in residential child care has remained almost static, at 1.3 to 1.5 per thousand children (Figure 3).

Figure 3: Children looked after on 31 March 2010 by accommodation type, and rates per 1,000 of 0-18 population, March 1987-2009



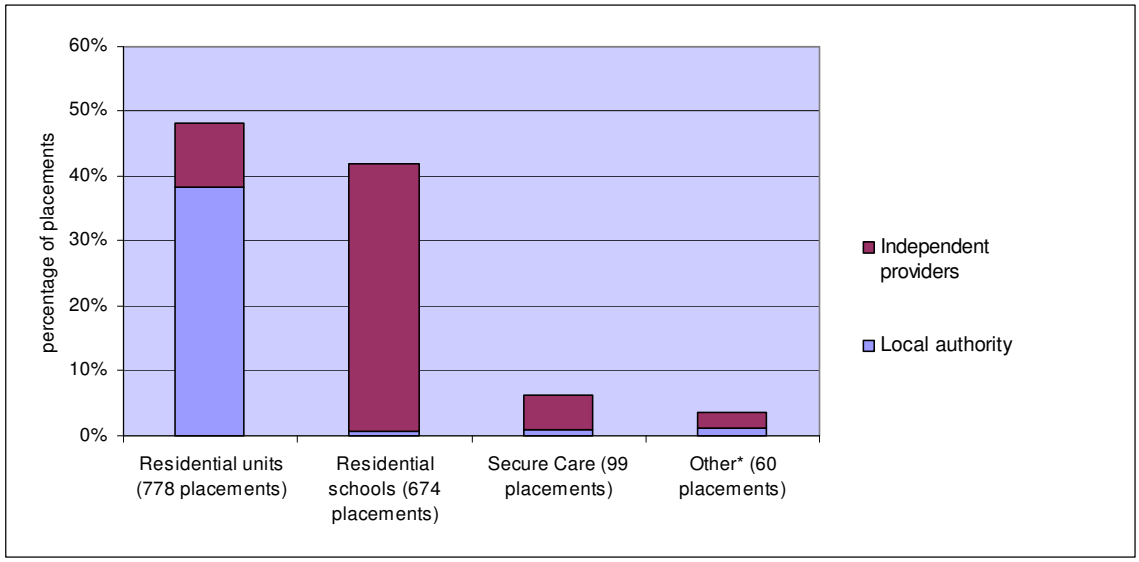
Source: Children looked after statistics 2008-2009. Scottish Government 2010

A point to note is that the Children Looked After Statistics are provided for the 0-18 year old population, while other figures in the report have used the 0-21 population. There are discrepancies in what age looked after young people leave the system. The average age for young people to leave the parental home in Scotland is 23 years, however, a child in care may cease to be the local authority's responsibility from age 16 onwards.

Types of residential child care placements

Most placements in residential units are provided by local authorities, while almost all residential school placements and the majority of secure care placements are provided by the independent sector (Figure 4).

Figure 4: Types of residential child care placements



Note: * Other includes crisis care and assessment units.

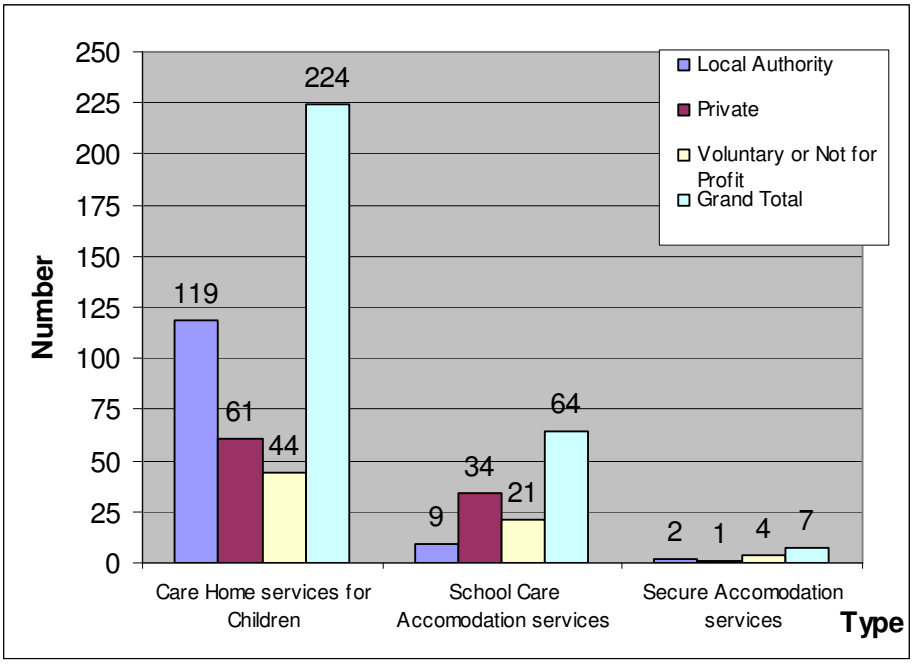
Source: Audit Scotland survey, 2009; Children Looked After Statistics 2008-09, Scottish Government, 2010

All residential accommodation for children and young people looked after by local authorities is registered by the Social Care and Social Work Improvement Scotland and regularly inspected against strict criteria of the services provided in all aspects of care.

In the last few years there has been a move to smaller care homes and although the numbers of children in residential accommodation has remained fairly static, there has been an increase in the number of registered care establishments providing for fewer children and young people and many of these smaller homes are in rural areas[15] as evidenced by registrations with the Social Care and Social Work Improvement Scotland.

In August 2010 there were 224 care homes, 64 residential schools and 7 secure units registered with the Scottish Commission for the Regulation of Care as shown in the Figure 5.

Figure 5: Care homes for children, school care accommodation and secure accommodation registered with Care Commission as at 31 August 2010

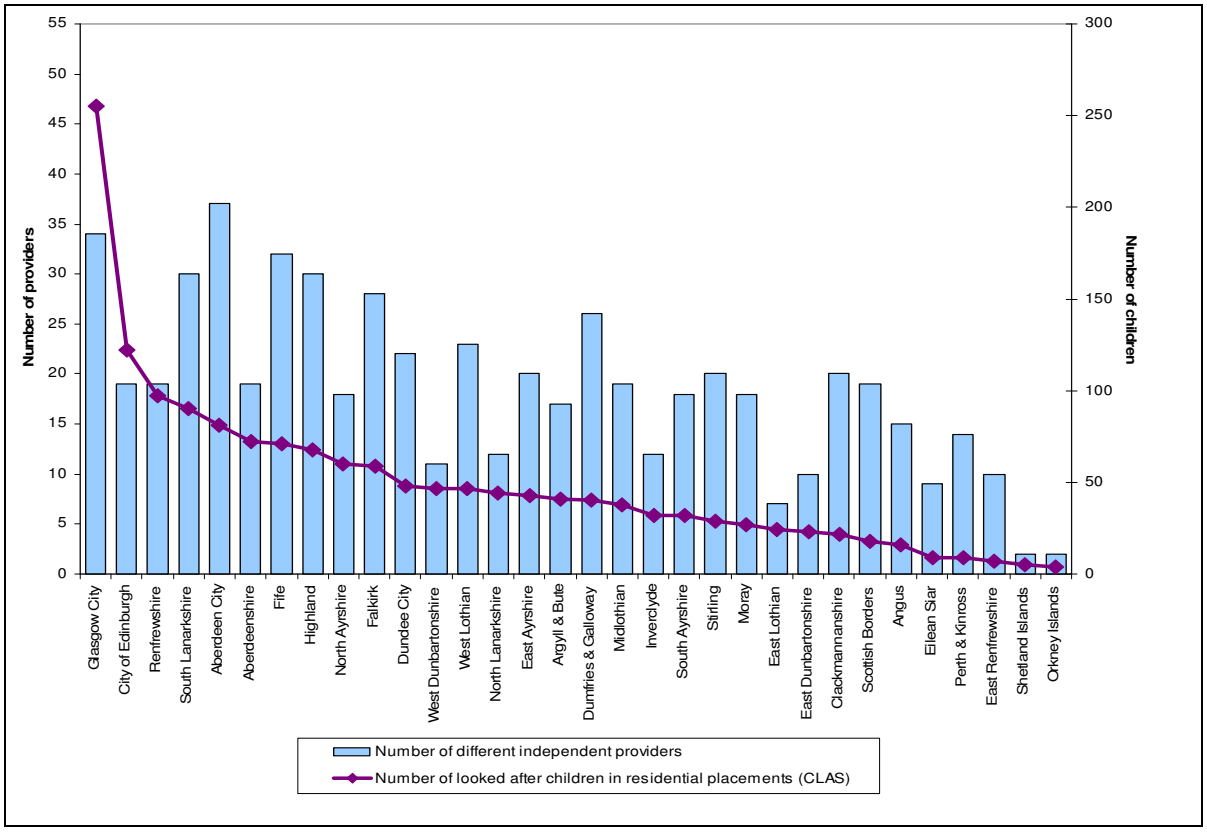


Source: Scottish Commission for the Regulation of Care, August 2010

Although where practicable local authorities place children in their own areas, this may not always be possible. There are only seven secure accommodation services across Scotland and some of the school care accommodation will be meeting specific needs for children and young people from across Scotland, such as autism.

Many of the larger residential schools may possibly have had children and young people from all the local authorities in Scotland at different times. Many local authorities will have children placed with different independent providers with thirteen local authorities working with at least 20 different providers, as shown below (Fig 6).

Figure 6: The number of different independent providers that councils use to place children



Source: Audit Scotland survey, 2009; Children Looked After Statistics 2008-09, Scottish Government, 2010

Cost of Care

The cost to local authorities to care for looked after children and young people in residential accommodation is high and rising.

Weekly costs vary between £800 and £5,500 depending on the type of placement and the complexity of the child's needs with an average spend of £150,000 per child each year[9].

In 2008/2009 local authorities spent around £250 million which is 30% of all social services expenditure on children and families and 6.5% of total social services expenditure.

Although the number of children in residential care remained largely static the cost of the placements has risen by approximately 68% from 2001/2 to 2008/9.

Of the £135 million paid in fees to independent providers, more than half was paid to residential schools (Table 1).

Table 1: Total fees paid by local authorities to independent providers in 2008-2009

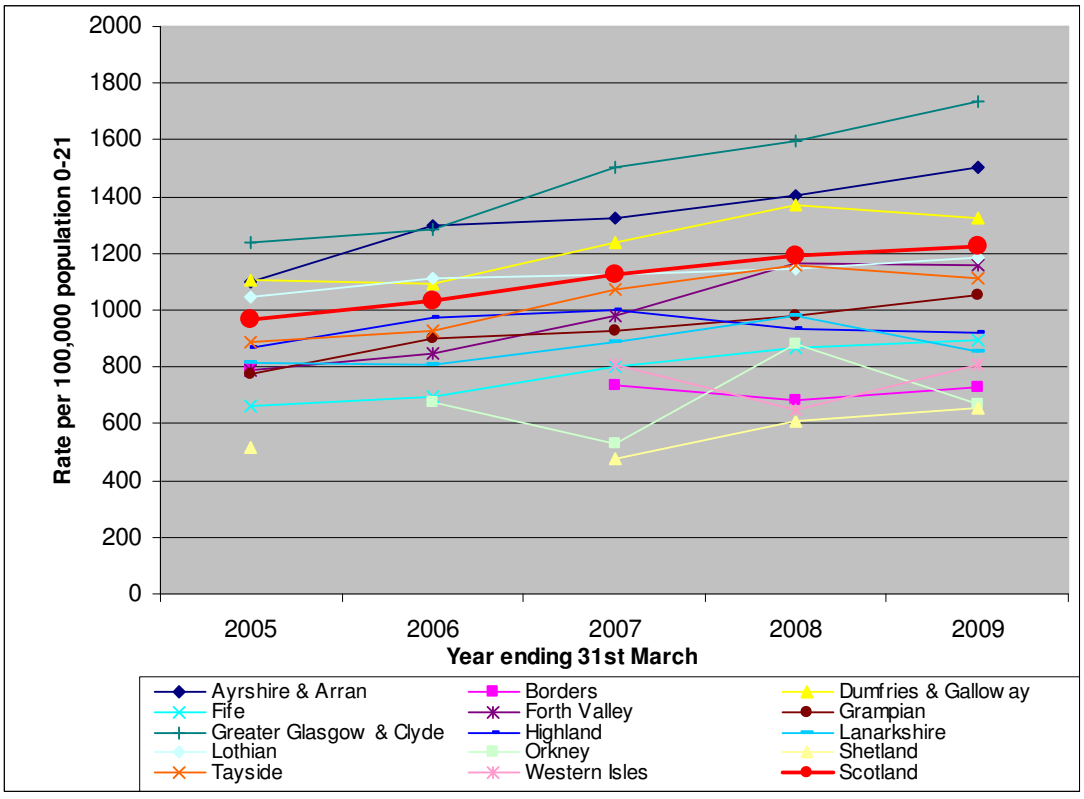
Type of provision	Total paid by all local authorities (£ million)	Number of weeks purchased	Typical weekly fee (£)
Residential units (including crisis care)	42.3	12,564	1,570 – 5,490
Residential schools	75.4	30,176	790 – 4,530
Secure care	17.3	3,762	3,190 – 5,390
Total	**135.0**	**46,500**	**790 – 5,490**

Source: Audit Scotland survey, 2009

Data by NHS Board areas

The following data is not available in this form nationally, it was therefore specifically drawn together by ScotPHN as shown in Figure 7 for this needs assessment using multiple sources. Children on a series of planned short term placements are excluded. Detailed notes as given at source are provided in Appendix 7; these include points relating to particular years. The LAC data came from yearly figures published by the Scottish Government, and the mid-year population estimates used to derive crude population rates for each year were as published by the General Registrars Office for Scotland.

Figure 7: Rate per 100,000 population aged 0-21 years* of all looked after children and young people per NHS Board, 2005-2009



Notes: for technical notes see the table of these figures given in Appendix 7.

Figure 7 shows the rate of all looked after children and young people in Scotland has been rising steadily in most NHS Board areas. The figure disaggregates the overall picture for Scotland, and highlights variation between NHS Board areas. It shows that some boards have experienced more steeply rising trends than others. NHS Borders and the island boards had both the lowest rates and the flattest trends.

NHS Greater Glasgow and Clyde has both the highest numbers and rate of all NHS Board areas of looked after and accommodated children and young people, and this has been rising somewhat faster than for Scotland in general over the last few years. In 2009 in NHS Greater Glasgow and Clyde there were 4,980 looked after children and young people and the rate was 1,735 per 100,000 0-21year old population. The Scottish rate in 2009 was 1,228 per 100,000 0-21 year old population.

There are also differences between NHS Board area according to whether the children and young people are placed in residential accommodation as shown in Table 2.

Table 2: Looked after children by whether in or not in residential accommodation at March 2009 – numbers by NHS Board

	Total not in residential accommodation		*Total in residential accommodation*		*Overall total looked after children*
Ayrshire & Arran	1180	89.7%	135	10.3%	1315
Borders	175	90.7%	18	9.3%	193
Dumfries & Galloway	401	90.9%	40	9.1%	441
Fife	728	91.1%	71	8.9%	799
Forth Valley	752	87.2%	110	12.8%	862
Grampian	1190	86.9%	180	13.1%	1370
Greater Glasgow &Clyde	4519	90.7%	461	9.3%	4980
Highland	551	83.5%	109	16.5%	660
Lanarkshire	1084	89.0%	134	11.0%	1218
Lothian	2058	89.9%	231	10.1%	2289
Orkney	27	87.1%	4	12.9%	31
Shetland	32	86.5%	5	13.5%	37
Tayside	972	93.0%	73	7.0%	1045
Western isles	39	81.3%	9	18.8%	48
Total (Scotland)	13708	89.7%	1580	10.3%	15288

Source: CLAS report 2008-09 (2010)

As can be seen, although the average is 10.3% accommodated, this ranges from 7.0% in NHS Tayside to more than double that in NHS Highland at 16.5% and 18.8% in NHS Western Isles. (Caution is needed when comparing rates in NHS Boards with small numbers and small populations as the rates will fluctuate more widely from year to year) (Table 2).

Survey of local authorities of children and young people in their care

A survey was undertaken in August 2010 specifically for this needs assessment to map the accommodation of children and young people looked after by the local authorities against their NHS Board of residence (Figure 9) as at spring 2010.

All 32 local authorities took part in the survey yielding a 100% return.

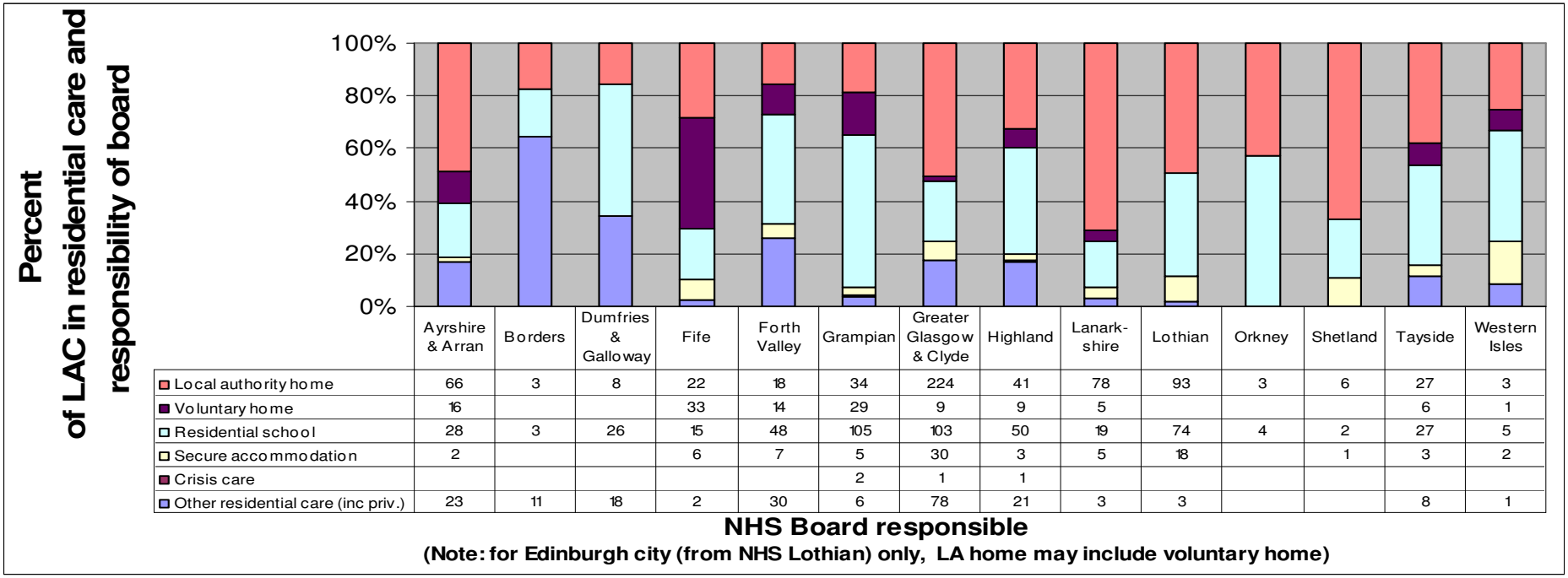
The findings are summarised in Table 3, which shows a complex mixed picture of where children are accommodated. Many of the local authorities did not have details of the children and young people living in their areas who were the responsibility of other local authority areas, especially if the children were cared for in the independent sector. (Please see Appendix 4 for reasons provided by local authorities for not having all the looked after and accommodated children and young people numbers.) However the results clearly show that in some parts of Scotland more than a quarter or even a third of the looked after and accommodated children and young people are the responsibility of local authorities out with the NHS Board area in which they are living.

Table 3 LAAC by NHS Board area for LA responsible against NHS Board area of accommodation (from ScotPHN survey data 2010)

	NHS Board of accommodation																
Home NHS Board with LA responsible	**Ayrshire & Arran**	**Borders**	**Dumfries and Galloway**	**Fife**	**Forth Valley**	**Grampian**	**Greater Glasgow & Clyde**	**Highland**	**Lanark-shire**	**Lothian**	**Orkney**	**Shetland**	**Tayside**	**Western Isles**	**UK**	**Grand Total responsible for**	**% LAAC (who are accommodated outside NHS BOARD**
Ayrshire & Arran	123	0	0	0	0	2	4	0	2	2	0	0	0	0	2	**135**	**8.9%**
Borders	0	17	0	0	0	0	0	0	0	0	0	0	0	0	0	**17**	**0.0%**
Dumfries & Galloway	0	0	52	0	0	0	0	0	0	0	0	0	0	0	0	**52**	**0.0%**
Fife	0	0	1	56	3	2	5	0	0	2	0	0	9	0	0	**78**	**28.2%**
Forth Valley	5	0	2	0	94	0	3	0	0	6	0	0	7	0	0	**117**	**19.7%**
Grampian	1	0	0	5	4	152	6	0	0	4	0	0	7	0	2	**181**	**16.0%**
Greater Glasgow & Clyde	26	0	13	12	23	2	327	0	19	13	0	0	6	0	4	**445**	**26.5%**
Highland	0	0	0	0	0	0	0	125	0	0	0	0	0	0	0	**125**	**0.0%**
Lanarkshire	0	0	0	0	0	0	0	0	110	0	0	0	0	0	0	**110**	**0.0%**
Lothian	1	0	1	15	5	4	7	0	3	147	0	0	3	0	2	**188**	**21.8%**
Orkney	0	0	0	0	0	0	0	0	0	0	7	0	0	0	0	**7**	**0.0%**
Shetland	1	0	0	0	0	0	1	0	0	0	0	6	1	0	0	**9**	**33.3%**
Tayside	0	0	0	0	0	0	0	0	0	0	0	0	71	0	0	**71**	**0.0%**
Western Isles	2	0	1	1	1	0	0	0	0	0	0	0	3	3	1	**12**	**75.0%**
Total by NHS Board care located in	**159**	**17**	**70**	**89**	**130**	**162**	**353**	**125**	**134**	**174**	**7**	**6**	**107**	**3**	**11**	**1547**	
% LAAC in NHS Board that LA in NHS Board is not responsible for.	**22.6%**	**0.0%**	**25.7%**	**37.1%**	**27.7%**	**6.2%**	**7.4%**	**0.0%**	**17.9%**	**15.5%**	**0.0%**	**0.0%**	**33.6%**	**0.0%**	**100.0%**		

The survey also explored the type of accommodation where the children and young people were living shown in Figure 8.

Figure 8: Looked after and accommodated children by care type and NHS Board of local authority responsible



	Ayrshire & Arran	Borders	Dumfries & Galloway	Fife	Forth Valley	Grampian	Greater Glasgow & Clyde	Highland	Lanark-shire	Lothian	Orkney	Shetland	Tayside	Western Isles
Local authority home	66	3	8	22	18	34	224	41	78	93	3	6	27	3
Voluntary home	16			33	14	29	9	9	5				6	1
Residential school	28	3	26	15	48	105	103	50	19	74	4	2	27	5
Secure accommodation	2			6	7	5	30	3	5	18		1	3	2
Crisis care						2	1	1						
Other residential care (inc priv.)	23	11	18	2	30	6	78	21	3	3			8	1

Source: Data from ScotPHN survey of local authorities, 2010

This survey has only given a snapshot at one point in time. Further complicating the picture is that although many looked after children and young people will be settled in a suitable placement, perhaps all through their secondary years, many others, and these often the most disturbed, will be frequently changing placements, on average three or four times during their time of being looked after. Also of concern is that there has to be a 'crisis care' category.

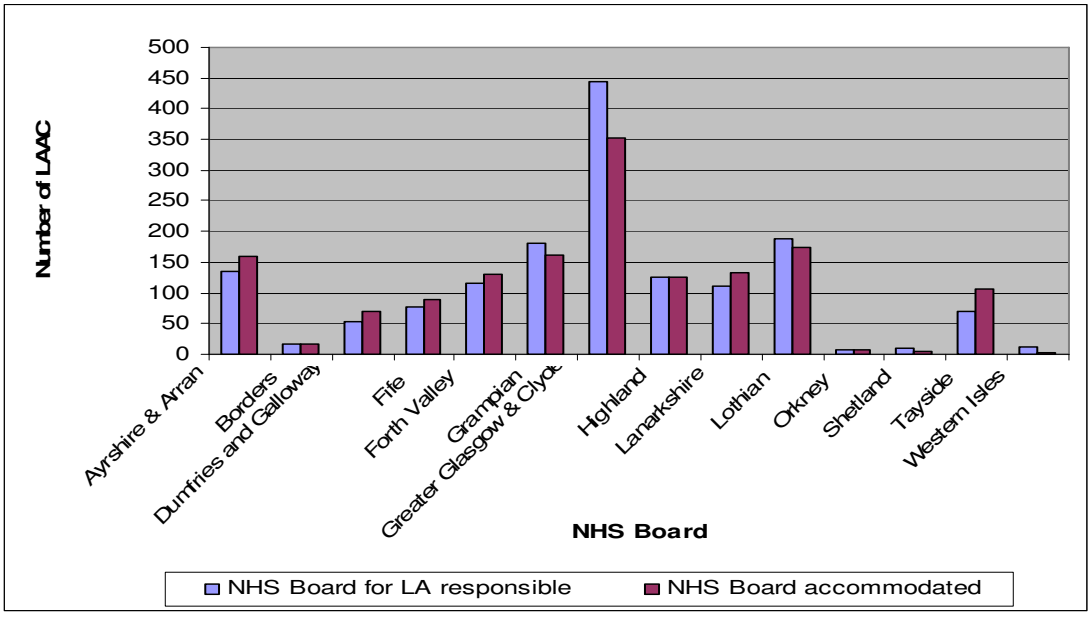
There can be confusion as to which NHS Board is responsible for a looked after child or young person's health needs, as it depends on clarity as to what is the child or young person's 'residence' as stated in the HDL(2004)15:NHS Scotland: Guidance on Establishing the Responsible Commissioner [16] (see Appendix 2). A child in a residential care home will have the care home as his or her residential address and the responsible NHS Board is the host Board, whereas if the child is in a special school, the residential address is not the special school but will still be the child's 'home' address and therefore the responsible NHS Board will be that from where the child has been sent.

Some accommodation is dual registered as both a school and a care home.

From the survey it is clear that some NHS Boards are net 'senders' of children and young people and some are net 'receivers'. This is not an issue for the residential schools, where the sending NHS Board is still responsible for meeting the health needs, however, there is a problem for smaller population rural Boards where a number of smaller care homes have recently been registered and who offer accommodation to children and young people with complex health needs requiring specialist care. This has been a particular concern for NHS Dumfries and Galloway, especially as the mechanisms for informing the Board that a child or young person has moved into the area is not always adhered to and the Board only hears of it when crisis intervention by specialist staff is necessary.

Figure 9 shows, for example, that NHS Ayrshire and Arran, NHS Dumfries and Galloway, NHS Fife, NHS Forth Valley, NHS Lanarkshire and NHS Tayside are receiving more children and young people than they send, while NHS Grampian, NHS Greater Glasgow and Clyde and NHS Lothian send more than they receive.

Figure 9: Number of looked after children and young people accommodated by NHS Board areas in which accommodated and by responsible local authorities which are within the NHS Board areas in which accommodated.



Source: Data from ScotPHN survey of local authorities, 2010

The mental health needs of looked after children and young people

The SNAP report previously referred to has provided a full review of the picture of mental health amongst the general population of children and young people. There have also been several surveys and reviews more specifically of looked after and accommodated children. These have been drawn together in:

'The health of looked after and accommodated children and young people in Scotland, messages from research[17] commissioned for the review of looked after children in Scotland. The messages included the following:

- in Scotland about 125,000 of all young people experience mental health problems that interfere with their daily lives;
- the mental health problems for looked after and accommodated children and young people are markedly greater than that of their peers in the community;
- reasons include the child's experience in terms of poor parenting, trauma, bereavement or serious illness, including mental health difficulties in both or one parents and the impact on the child of the environment such as poor neighbourhoods, deprivation, social exclusion and poverty;
- looked after and accommodated children and young people share many of the health risks and problems of their peers, but often to a greater degree; and
- the health issues or concerns are usually multifaceted. A concern in one area of a child's life should not be addressed in isolation from its impact on other parts of the child's development. Solutions to health concerns should be provided as a partnership across agencies and with carers.

The review described a survey by Meltzer *et al.* 2004[18] of 355 children in the looked after system in Scotland which found that, 45% of those aged between 5 to 17 years of age were assessed as having a mental disorder. Those aged 5 to 10 who were looked after at home or accommodated were six times more likely to have a mental disorder than those children living with families in the community (52% compared with 8%). The rates for the different types of disorder were as follows:

- emotional disorders: 14% compared with 4%;
- conduct disorders: 44% compared with 4%; and
- hyperkinetic disorders: 11% compared with 1%.

Some children had more than one type of disorder and these were more likely to be boys.

Those aged 11 to 15 and either looked after at home or looked after and accommodated were four times more likely to have a mental disorder that those children living with families in the community (41% compared with 9%). For different types of disorder the rates were as follows:

- emotional disorders: 14% compared with 5%;
- conduct disorders: 35% compared with 6%; and
- hyperkinetic disorders: 8% compared with 1%.

Again, some young people had more than one type of disorder.

Six per cent of children surveyed were reported to be taking one of 14 types of medication commonly used in the treatment of childhood mental disorders and a fifth diagnosed as having hyperkinetic disorders were taking some form of psycho-stimulant such as Ritalin.

As has been described in the framework for Mental Health Promotion Prevention and Care, and according the SNAP report, there is a need to mainstream the provision of services for children and young people with mental health problems. However, it is clear from the Mezler survey and others that there is a much greater need for specialist CAMHS services in the looked after and accommodated children and young people population. For example the proportion of looked after children requiring specialist interventions such as psychotherapy is likely to be four times higher than in the general population.

There is a complexity to the nature of the mental health problems that many children and young people in residential care have which means they are often not amenable to a single intervention. Most are presentations rooted in trauma and compounded by successive breakdowns in care relationships. The evidence about how to make a difference in these circumstances is thin and does not readily point in any one direction.

Mental Healthcare Resources

Children and young people looked after by local authorities are entitled to the same health promotion, prevention and treatment services and care as that of the general population delivered through the primary and community, secondary and tertiary care services. The GP and primary care team are the 'gatekeepers' for accessing more specialist services However it is known that there are barriers to the looked after children and young people accessing both the primary and specialist services which is one of the factors resulting in these children and young people's poorer physical and mental health. For example they have more dental decay, a lower rate of immunisations and a higher rate of teenage pregnancy than in the general population.

The scenarios described earlier detail some of the problems in accessing services.

Registering with a GP

Over the last few years it has been recognised that to meet the health needs of these children and young people there is a need for dedicated support and a new post of Looked After Children's Nurse has been introduced.

There has been a recent expansion in these posts and a development of a capability framework to give more clarity and meaning to these looked after children's nurses roles. They have been described as the 'Health Mammy' of a looked after child and young person while the 'corporate parent' has been described as the 'Health Pappy'.

The Scottish Looked After and accommodated children and through care nurses Resource Directory 2008[19] listed 31 nurses specifically identified as working with looked after children.

16 were looked after and accommodated children's nurses, 9 looked after children's nurses and 6 are through care/aftercare nurses who specialise in caring for young people who are leaving care settings. There were also six mental health nurses with a dedicated role with looked after children. In December 2010[20] the directory was updated and there are now 35nurses listed.

In addition, many of the private residential care settings employ nurses with their main remit to assess, maintain and improve the health of the children and young people in their care

The posts have a variety of titles, for example Specialist Nurse Looked After and Accommodated Children and Public Health Nurse/Looked After Children and the precise function of these nurses differs from region to region and service to service. However all are involved in activity relating to:

- holistic health assessments;
- health education and promotion;
- immunisations;
- attendance at 'reception into accommodation' and review meetings;
- notification and tracking of looked after children; and
- provision of emotional support;
- provision of advice and training for staff, services and carers; and
- provision of advice on access to appropriate services.

There is an active looked after children's nurses forum of peer support for these posts and a website of the Scottish Healthy Care Network[21] describing their activities.

Child and Adolescent Mental Health Services

As has been described in the SNAP report there should be a mainstreaming of mental health and an integration of promotion, prevention and care when looking after the mental health needs of children and young people, whether or not they are categorised as 'looked after.'

Thus, the term Child and Adolescent Mental Health Services are used to embrace the range of services across agencies that contribute to the mental health and care of all children and young people.

There have been different ways of describing the structure of these services. For example in the framework for promotion prevention and care they are explained as a functional framework in 'Tiers' of increasing complexity and specialism which may be delivered by a variety of individuals teams and agencies as described below. In Tier 1 a non specialist service will be delivered by an individual, whereas in Tier 2 specialist CAMHS staff are included and by Tier 3 there will be a team approach.

Table 4: Tiers of CAMHS

Tier 1: A primary level of service provided within universal services and including mental health promotion, general advice and identification of mental health problems early in their development.	Professionals providing the service include: • GPs • Public Health Nurses (Health Visitors and School Nurses) • Teachers • Social workers • Voluntary agencies
Tier 2: A level of service provided by uni-professional groups which relate to each other through a network rather than a team. Functions include assessment, care and treatment for children and young people, and consultation and advice to professionals in Tier 1.	• Practitioners with special interest • Clinical child psychologists • Paediatricians (especially community) • Educational psychologists • Child and adolescent psychiatrists • Community nurses/nurse specialists • Social workers • Voluntary agencies
Tier 3: A specialised service for more severe, complex or persistent mental health problems. Assessment and treatment is the core function.	• Child and adolescent psychiatrists • Clinical child psychologists • Nurses (community and inpatient) • Child psychotherapists
Tier 4: Essential tertiary level services such as day units, highly specialised outpatient teams and inpatient units. Assessment and treatment is the core function.	• Occupational therapists • Speech and language therapists • Art, music and drama therapists • Social workers • Voluntary agencies

Source: Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005)

Another way to describe the services is in 'Stages'. This is more in keeping with the GIRFEC approach as it describes a pathway for an individual child or young person to progress through depending on their assessed need. If a child is assessed as requiring a Stage 2 service this may be provided by members of a generic child health team, while a child in Stage 3 will require CAMHS specialist input.

Looked After Children's Nurses may act at any level in these Tiers or Stages, having a role in both co-ordinating the access to the services for individual children as well as providing the services directly.

Dedicated CAMHS staff

Table 5 shows the number of staff specifically working with a child and adolescent mental health team available by NHS Board. Tier 4 staff are excluded (see notes on table). This provides an average of about 10 WTE per 100,000 total NHS Board population which has been estimated by CAMHS staff to be about half the number required to meet the assessed need in the general population.

There has been recent progress in understanding the importance of meeting this need and there has been an increasing national investment in the CAHMS resources in Tier 3 and 4 services and in child psychology posts and training. In September 2010 there were over 800 WTE clinicians in post and an additional number about to start. Up to date figures for 2010 can be found at the following link:

http://www.isdscotland.org/Health-Topics/Workforce/CAMHS/CAMHS2010workbook01b(1).xls

This table shows 2010 data and as with much of the data available in the report must be taken in context and viewed with caution. The complexities of case load, geography and need cannot be covered in a simple look at the actual number of staff available. The denominator in the final column is the 'resident' population of the NHS Board and may not include the small numbers of looked after and accommodated children and young people with very complex needs moving in and out over short periods of time as they are placed by local authorities in the NHS Board areas as has been described above. For example although NHS Dumfries and Galloway have an apparently high resource of CAMHS staff compared with the Scottish average, they have a particular concern of being very stretched to meet the mental health needs of their child and adolescent population.

In general CAMHS services are provided for 0-18 years. There is a further challenge of providing a seamless service as young people move into adult services though they may still be in residential care.

Table 5: CAMHS Staff Resources by NHS Board

NHS board responsible	NHS Board pop 0-21** mid 2010$	Total population$ mid 2010	WTE CAMHS staff ex Tier 4*	CAMHS WTE staff (ex tier 4*) per 100,000 NHS Board pop 0-21**	CAMS WTE staff (ex tier 4) per 100,000 HB pop. (total)
Ayrshire & Arran	86,590	366,860	32.2	**37.22**	8.78
Borders	26,351	112,870	19.5	**74.11**	17.30
Dumfries & Galloway	32,987	148,190	21.9	**66.50**	14.80
Fife	89,267	364,945	38.3	**42.92**	10.50
Forth Valley	74,720	293,386	22.2	**29.68**	7.56
Grampian	130,591	550,620	44.3	**33.95**	8.05
Greater Glasgow & Clyde	285,919	1,203,870	147.1	**51.46**	12.22
Highland	71,018	310,830	29.7	**41.76**	9.54
Lanarkshire	141,522	562,477	55.3	**39.05**	9.82
Lothian	195,260	836,711	72.1	**36.92**	8.62
Orkney	4,624	20,110	1.3	**29.12**	6.70
Shetland	5,649	22,400	2.0	**35.40**	8.93
Tayside	94,432	402,641	55.2	**58.49**	13.72
Western Isles	5,856	26,190	3.7	**62.61**	14.00
Scotland	1,244,786	5,222,100	**544.9**	**43.77**	10.43

$ Source: GROS: http://www.gro-scotland.gov.uk/files2/stats/population-estimates/mid-2010/10mype-cahb-t2.xls (excludes those aged 21+)
* source: http://www.isdscotland.org/Health-Topics/Workforce/CAMHS/previous-publications.asp
*Tier 4 Includes all CAMHS workers who work in posts with any Tier 4 level of operation irrespective of setting.
*Tier 4 CAMHS describes essential tertiary level services such as day units, highly specialised outpatient teams
* These figures do not include trainees.
** CAMHS in most areas cover 0-18 years and in a few cases 0-16 years

Qualifications and training for all who work with looked after and accommodated children and young people

It is clear that there is a need for staff to be appropriately trained to look after the children in their care. They also need support in their role. This is particularly relevant for those who spend the most time with the children in place of their parents. This is understood by the Social Care and Social Work Improvement Scotland. The SSSC has responsibility for raising standards by registering people who work in social services and regulating their education and training. Staff being appropriately trained is a standard

which must be met for registration. As can be seen from Table 6, by far the majority of time spent with the children and young people is by the residential workers.

Table 6: number of hours of direct child contact by professional group

Professional group	Number	8-20 hours	More than 20
Residential workers	104	31 (30%)	46 (44%)
Social workers	105	35 (33%)	19 (18%)
Teachers	366	56 (15%)	34 (9%)
School nurses	100	1 (1%)	1 (1%)
Health visitors	71	3 (4%)	0 (0%)
Voluntary workers	55	5 (9%)	12 (22%)
Paediatricians	54	4 (7%)	1 (2%)
GPs	137	0 (0%)	0 (0%)

Source: Furnivall et al., 'Hard to know what to do': How residential child care workers experience the mental health needs of young people, Scottish Journal of Residential Child Care, Volume 6 No 1 Feb/Mar 2007, p1-13

However, the Audit Scotland report 2010 reported that in January 2010 only 32% of the residential childcare workforce was appropriately qualified, 42% of the managerial/supervisory staff and 30% of the other staff. In the local authority and voluntary sectors 36 and 39% were qualified leaving nearly two thirds to gain a qualification over the next few years, but in the private sector only 24 % were qualified leaving 76% to gain a suitable qualification.

Over the years, a number of training opportunities have been available from a number of sources both in general for improving the mental health of all children and young people and specifically for those caring for looked after children and young people. The Scottish Institute of Residential Child Care[22] (http://www.sircc.org.uk/) has received Scottish Government funding to provide many comprehensive courses for care staff for example two or three day courses covering specific issues such as attachment, self-harm, bereavement, bullying and family therapy (see Appendix 8). Very helpful websites developed by Hands on Scotland (http://www.handsonscotland.co.uk/) and the Playfield Institute in Fife (www.playfieldinstitute.co.uk) provide an online resource providing advice and training for parents and carers to help children flourish emotionally and advising on dealing with troubling behaviour issues.

With clear evidence of the importance of parenting in promoting the best outcomes in children, there is now a national commitment to deliver evidenced parenting support. A number of evidenced based parenting programmes are available for example Positive parenting programme Triple P[23] used in NHS Greater Glasgow and Clyde with some programmes particularly suitable for parents and carers of children and young people looked after by local authorities.

Epidemiology - Conclusions

- Children reach residential care through a variety of routes. On average 10% of all looked after and accommodated children are in residential care at any one time although the percentage varies between different NHS Boards.

- Although the rates of looked after children have been increasing over the past 5 years; the rates of those in residential care have remained static over this time.

- There are a variety of types of accommodation with a range of providers with a move from large homes to a greater number of smaller ones, often in rural areas. Thirteen local authorities work with at least 20 different providers.

- Costs vary between £800 and £5,500 per week and have been increasing.

- The percentage of looked after children in residential accommodation varies between different NHS Boards and local authorities and NHS Boards of residence are not always co-terminous.

- Six NHS Boards receive more children than they send. Five of these NHS Boards are small to medium sized NHS Boards, leading to issues around resourcing of the necessary healthcare.

- There is clear evidence that looked after and accommodated children were significantly more likely to have a mental disorder than those living in the community and these were likely to be of a higher complexity. There is therefore a greater need for specialist CAMHS services for this group of children.

- Responsibility for healthcare lies with the NHS Board of the child and young person's residence. This can cause confusion as the NHS Board of residence for a child in a care home is the NHS Board of the care home, while that of a child in a residential school is the NHS Board of the child's home address.

- Mental healthcare resources span the four tiers of care, and in addition, there are specialist nurses identified to work with all the health needs of these children.

- There is variability in the qualifications and training of many staff working with these children.

Overall, the analysis suggests that accommodating looked after children and young people is highly complex. There is mixed responsibility, little formal involvement of health in placing children in care and gaps in information made available by and to both local authorities and NHS Boards for the children and young people in their care. It is likely to be the most vulnerable children in these groups whose mental health needs are less well met.

SECTION 6: CORPORATE

"See the biggest things that a young person needs? See even an 18 year old, they need a lot of nurturing. All they need is TLC and love"[24]

This quote from an 18 year old who has been through the care system could have been made by any of the stakeholders whom we interviewed, a list of these can be found in appendix 9.

The stakeholders were, without exception, passionate, caring and concerned for the looked after and accommodated children and young people with whom they were working. Although there were many good points raised, for example areas of good practice, joined up working and developments described, such as implementing CEL16 (2009), there was also a common sense of frustration and 'lack of control' expressed with examples given of various barriers in the systems which added to the prevention of their looked after and accommodated children and young people from realising their full potential.

The stakeholders had a common aim and understanding of what was required to achieve that aim which is eloquently stated in 'The health of looked after and accommodated children and young people in Scotland. Messages from research':

Our aim is for looked after children to be physically and emotionally healthy as young people, and to grow into healthy and confident adults. To achieve this young people need appropriate responses from the adults around them, stable and consistent care which meets their needs, and help to recover from past trauma.[17]

Getting It Right for Every Child

A main area of agreement was the recognition across all agencies of the importance using the GIRFEC approach in meeting the needs and promoting the health and well being for the children and young people that they care for. However, it was also acknowledged that to use this approach requires, for many, a change in the way they work and therefore needs much resource in time and joint training and the development of trust between agencies to embed the GIRFEC components in their day to day practice**.** For example it means staff in different agencies must learn to use new, standardised tools for integrated assessment of a child's health and care needs and must learn to work together and agree responsibilities to deliver on a new, shared, integrated care plan for each child and young person.

Many interviewed have found the SHANARRI wheel concepts helpful and appropriate in focusing their work to jointly provide the environment to meet their children and young people's needs, recognising that all should be working together towards the children and young people being:.

Safe protected from abuse, neglect or harm
Healthy, experiencing the highest standards of physical and mental health, and supported to make healthy, safe choices

Achieving receiving support and guidance in their learning-boosting their skills, confidence and self esteem
Nurtured Having a nurturing and stimulating place to live and grow.
Active offered opportunities to take place in a wide range of activities-helping them to build a fulfilling and happy future.
Respected to be given a voice and involved in the decisions that affect their well being
Responsible taking and active role within their schools and communities
Included receiving help and guidance to overcome social, educational, physical and economic inequalities; accepted as full members of the communities in which they live and learn

However, the reality of putting these aspirations in place was described by a number of interviewees as very complex, especially if the child does not have a 'pushy parent' to assist. It was suggested that there are many barriers to being able to put the child first when the systems in place are not co-ordinated and the children may be frequently moved from placement to placement out with the control of the care providers.

One example given was of a child placed in a secure unit who was started on a support programme from a CAMHS service which could not be continued when the placement ended although the treatment was showing an improvement. Another interviewee described a young person taking part in a smoking cessation service provided by a local authority which was no longer available to that child when the child moved from a local authority to a private placement even though that placement was in the same local authority area (and in fact geographically closer to the new placement than the old.)

Another example given by education staff working on 'Curriculum for Excellence'[25] described several instances of a child being moved from one school to another because the child moved care home and the funding to transport the child to their previous school (by taxi) was not available. This was particularly frustrating as, with the new 'curriculum for excellence' programme, schools have been putting systems in place to provide a named person in whom the young person may confide and build up trust as is described in the SNAP report as a way of helping build resilience in a child.

Others interviewed raised the concern that one reason for children frequently moving placement is that there is a currently widely held view that it is in the best interests of a child or young person to be in their own 'home' whenever possible, and this may prevent a child or young person from receiving the benefits of a more long term, stable care placement. This was articulated as when the wishes of the family rather than the child or young person are put first, which conflicts with the GIRFEC components. One interviewee described the frustration of having known children who came into their residential setting and on showing improvement in their well being and behaviour, had then been returned to their family homes only to revert to their original behaviours which had caused them to be removed from their home in the first place and necessitate their being placed in residential care again. This again conflicts with the GIRFEC components requiring that children are respected and their input included in decisions regarding where their home will be.

Implementation of the recommendations in CEL(2009)16

The interviewees were all in agreement that implementing CEL(2009)16 recommendations were very important and helped to include the Health Service into the corporate parent role (as laid out in These are our bairns[26]) which has traditionally been seen as the responsibility of local authorities.
One issue of concern was that although it was important for raising the profile of the needs of looked after and accommodated children to have a senior person in the NHS Board (a director) named to lead on the corporate parent role, the actual work was often delegated. It was felt that the CEL(2009)16[27] recommendations and requirements were too strategic and not specific enough and that more work needed to be done to develop clear auditable and monitored pathways to fully meet the health assessment and subsequently deliver any required actions to improve the children and young people's health. An interviewee speaking on behalf of the looked after children and young people said that although there were many care plans written, few were implemented. The stakeholders were pleased at the national work being taken forward with the setting up of the Looked After Children Strategic Implementation Group (LACSIG)[22] and the associated Health Hub.

Several of the nurses answering the survey question: 'What do you think is the most important issue to tackle first in your NHS Board area to better meet the needs of these children?' said 'implement the recommendations of CEL(2009)16' (see Appendix Table 6) and many saw carrying out the health needs assessment and care planning as a major role for them.

Importance of defining and strengthening the looked after children nurse role

The social work director in Highland which was a main GIRFEC pathfinder site emphasised the importance of the key co-ordinating role of the Looked After Children's nurse by saying

> *'We have one full time LAAC nurse in Highland and could do with doubling this resource'*

Problems were raised by the nurses themselves of balancing their strategic and operational roles as they tried be both a co-ordinator for making sure all the children in their caseload (in some cases over 200 children) received the services they required and of also being very involved in individual cases that could take much time and include travelling outside their NHS area.

Reference was made to the importance of nurses working to the capability framework which has been developed for nurses who care for children and young people who are looked after away from home.

Cross boundary issues between sending and receiving NHS Boards, local authorities and service providers and referral processes

Of particular concern to many NHS staff interviewed, was that the mental health needs of looked after children and young people accommodated outside their NHS Board area were not being met. They were falling through the net, and this was worse for those

children and young people with more challenging behaviours as finding suitable accommodation for them was more difficult and they may be sent from placement to placement.

This was seen as a major issue particularly for accessing CAMHS services. Also raised was the perception that the CAMHS specialists were reluctant to provide services to children unless they were in a 'stable' situation.

The issue of residency and the responsible Health Board for the provision of care was also raised. The lack of clear responsibility for the provision of specialist mental health care for accommodated children was noted as a contributing factor to the potential inequality.

The nurses responding to the survey question, 'What is the main frustration you have in meeting the needs of these children?' said there were problems with knowing where the children were, a lack of communication with other NHS areas and not being clear who was responsible for the mental health of the looked after and accommodated children outside their 'home' NHS Board area, and being able to access the services of CAMHS teams. However in some NHS areas such as NHS Lanarkshire there was felt to be very good communication between the Looked After Nurses and CAMHS teams, with a joint approach to meeting the children's needs appropriately.

Qualifications and training of all front line care workers

SIRCC recommends that all residential care workers have specific training and qualifications in the mental health needs of all children and young people looked after in their care settings

Several interviewed spoke with great respect of the pedagogue approach used widely in Europe where there is combined training such that 'care and education meet' and many of the staff working with children in residential care are highly qualified pedagogues.

There was a need expressed that where possible parents and families should be involved in joint training and that inspections for residential settings should include the amount and type of contact with the parents and families in the day to day care of the children.

There were also suggestions of training residential staff in the parenting programmes being used with families, for example the Triple P positive Parenting programme being rolled out in NHS Greater Glasgow and Clyde could be extended to care home workers. The advantage of this would be that a consistent approach would be given to children and young people even if they were moving from one placement to another, for example to provide some stability in the use of appropriate assertive discipline.

Concern was expressed by those involved in providing CAMHS regarding the difficulties they can face in being able to offer care in residential and secure accommodation. This related to being able to access the child and having the necessary understanding and commitment from staff within units to supporting children with mental health care needs. The lack of understanding on the part of such residential staff was felt by CAMHS professionals to be a factor in what they saw as a difficulty in receiving an effective engagement between professionals to deliver necessary care on a shared basis.

The culture and ethos in the accommodation

Although difficult to articulate, or to explain what were the actual ingredients that made a home a real 'home', many interviewed saw the general culture and ethos of the care establishments as having a major influence on the children and young people's well being, It was recognised that different placements suited different children.

Corporate – Conclusions

The main issues highlighted by the corporate approach were:

- the importance of all partners using the GIRFEC approach in providing holistic multi-agency co-ordinated care;
- making the implementation of the CEL(2009)16 recommendations a priority;
- the need to further define and strengthen the Looked After Nurse role;
- cross boundary issues between sending and receiving NHS Boards, local authorities and service providers, particularly with the CAMHS services referral processes;
- qualifications and training of all front line care workers; and
- the major influence of the culture and ethos in the accommodation on the children and young people's well being.

SECTION 7: CONCLUSIONS AND RECOMMENDATONS

This needs assessment has found that there is an enormous concern and passion for the well being of children and young people looked after away from home in residential care from the government and all the partners and agencies involved in their care. There has also been and still is much on-going work towards improving 'health' in the widest meaning of the word of these children and young people. Although the focus of this needs assessment has been mental health, in undertaking this work, it has become clear that all needs have to be addressed – we must have a holistic approach and first get the 'basics' right. The co-ordination, organising and complex funding arrangements of the services providing care is not always meeting the needs of these vulnerable children and young people.

Services are clearly not arranged 'around the child' at present.

As Scott and Hill wrote in 2006:

> *Children and young people who are looked after by local authorities have the same health needs as other young people but their backgrounds and past experiences and sometimes their experiences while they are looked after, make them especially vulnerable. In particular many looked after young people have to cope with sadness, distress and trauma which affects their mental health and causes them to behave in ways that put their health and safety at risk.* ***Our aim is for looked after children to be physically and emotionally healthy as young people, and to grow into healthy and confident adults. To achieve this young people need appropriate responses from the adults around them, stable and consistent care which meets their needs, and help to recover from past trauma****.*

As is shown in the pathway of how children and young people become accommodated (Figure 2), there is currently no formal involvement by the NHS in the placement of children, and yet it is known that many of the children and young people being placed may have very serious health problems including challenging or self harming behaviours and a range of mental health disorders, complex disabilities and conditions for which the NHS provides care.

The Audit Scotland report 'Getting it Right for Children in Residential Care' recommends that NHS Boards ensure they participate fully with community planning partners in joint approaches to planning and commissioning residential child care places. As has been described, the action 15 of 'We Can and Must Do Better' does now include a requirement of the NHS to carry out a health assessment of all looked after children and young people. If the assessment identifies general and mental health needs, then the person undertaking the health assessment takes responsibility for ensuring their care plan is delivered/co-ordinated as appropriate.

Interviews with stakeholders describe various barriers of access to services to which looked after and accommodated children and young people are entitled. This shows the inverse care law in operation, where those most in need of services are least likely to receive them.

Recommendations

1. **It is recommended that GIRFEC forms the overarching approach to the work of all agencies and individuals involved in the care of looked after and accommodated children and young people.**
   GIRFEC provides a framework for all services and agencies working with children and families to deliver a co-ordinated approach which is appropriate, proportionate and timely.

2. The guidance on the identification of the responsible Health Board in relation to children placed into residential accommodation, particularly dual registered accommodation, should be reviewed and updated.

The recommendations can be matched to the GIRFEC components as follows:

3. **A focus on improving outcomes for children, young people and their families based on a shared understanding of well-being.**
   There should be co-ordinated and in many cases joint training for all involved in the care of looked after and accommodated children (health, including primary, secondary and tertiary services, social work, education, care commission inspectors, residential staff, voluntary organisations and parents) in how to work together to meet the SHANARRI outcomes.

4. **A common approach to gaining consent and to sharing information where appropriate.**
   In implementing CEL 16 (2009) there should be a standardisation of the tools used in the assessment, and a clear understanding of how the information gained from the assessment will be used to develop the care plan in agreement with the child or young person, their parents and corporate parents.

5. **An integral role for children, young people and families in assessment, planning and intervention.**
   Mechanisms must be set up to ensure children and their parents are involved in the above. This process should be agreed by the named director responsible for Looked after children in the NHS Board and the co-ordination of the process should be the responsibility of the Looked After Children's nurses. SCSWIS inspections should more specifically assess involvement by the care home, school or secure unit with the parents.

6. **A co-ordinated and unified approach to identifying concerns, assessing needs, agreeing actions and outcomes, based on the Well-being Indicators.**
   There should be clear guidance from the LACSIG on the implementation of the CEL 16(2009) recommendations with agreement and standardisation across Board areas as to how, when and by whom the assessments are to be carried out. Also standardisation of the content of the assessments.

7. **Streamlined planning, assessment and decision-making processes that lead to the right help at the right time.**

   NHS Boards should work with other agencies to develop appropriate pathways of care setting up systems with agreed timescales. For example there should be agreed mechanisms for informing the co-ordinator of the care (in most cases the Looked After Children's nurses) of when a child or young person is placed in care.

8. **Consistent high standards of co-operation, joint working and communication where more than one agency needs to be involved, locally and across Scotland.**

   This must include the involvement with staff in the independent sector homes. The looked after children's nurses whether NHS or privately employed, for example in the secure units and residential schools and working with local authorities should work together and all be members of the LAC nurses forum.

9. **A Lead Professional to co-ordinate and monitor multi-agency activity where necessary.**

   The health board named director should be responsible for developing this process according to specific guidance from the LACSIG. Pathways to allow formal involvement of the NHS in placing and moving children should be put in place.

10. **Maximising the skilled workforce within universal services to address needs and risks at the earliest possible time.**

    The mental health of children and young people: A framework for promotion prevention and care should be used as the main planning and audit tool to meet this principle.

    Five out of the six NHS Boards which receive children from other NHS Boards for residential care are small to medium sized boards. Specialist CAMHS services should be resourced to meet this need in these NHS Boards. Equally NHS Boards should have a greater role in the planning for and negotiation of new residential and educational facilities to inform and help in NHS planning.

11. **A confident and competent workforce across all services for children, young people and their families.**

    Training and agreement on qualifications required for all working with looked after and accommodated children should be co-ordinated by SIRCC in conjunction with the SSSC and with guidance from LACSIG, with the aim of all being trained to degree level. All care workers should have specific training on mental health problems for children in care. Particular thought should be given the possibility of introducing the pedagogue approach for staff training to work in care homes and all care workers should be take part parenting support programmes where possible sharing in these jointly with parents.

12. **The capacity to share demographic, assessment, and planning information electronically within and across agency boundaries through the national eCare programme where appropriate**

    Common integrated assessment framework tools should used across Scotland. LACSIG should co-ordinate the process of agreeing the tools to be used.

We recommend the following priorities for LACSIG to take forward via the Health Hub:

- assist in the work to clarify and update the guidance on the responsible Health Board for the provision of CAMHS and LAC nurse services;
- oversee the Implementation of CEL(2009)16 as priority in all NHS Boards. Agree what assessment tools, and by whom assessments should be carried out. Develop shared pathways for assessment and care planning;
- ensure CAMHS service and all providers are following the guidance of Framework for promotion, prevention and care. A review of levels of available specialist resources in NHS Boards which receive looked after and accommodated children should be undertaken;
- assist in clarifying and developing the key role of LACN. Build on competency framework. Work with review of community nursing services to integrate and facilitate joint work;
- facilitate Local Authorities to take forward recommendations from Audit Scotland Report; and
- with SIRCC and Who Cares Scotland? Further develop training for parents and care workers including parenting support training.

In addition, further work is recommended on:

- culture and ethos of accommodation;
- reviewing through care responsibilities of health service; and
- mental health needs of all looked after children and young people not accommodated.

APPENDIX 1: MEMBERSHIP

PROJECT GROUP MEMBERSHIP

Anne Maree Wallace	Director of Public Health, NHS Forth Valley (Chair and project sponsor)
Maggie Lachlan	Consultant in Public Health Medicine, NHS Greater and Glasgow (Lead author)
Ann Conacher	ScotPHN Co-ordinator
Judith Furnivall	Lecturer, Advice and Consultancy, Scottish Institute for Residential Child Care
Phil Mackie	Lead Consultant, ScotPHN
Lisa Tyrrell	Senior Administrator, ScotPHN

STEERING GROUP MEMBERSHIP

Anne Maree Wallace	Director of Public Health, NHS Forth Valley (Chair and project sponsor)
Maggie Lachlan	Consultant in Public Health Medicine, NHS Greater and Glasgow (Lead author)
Ann Conacher	ScotPHN Co-ordinator
Lawrie Davidson	Regional Manager, Scottish Commission for the Regulation of Care
Judith Furnivall	Lecturer, Advice and Consultancy, Scottish Institute for Residential Child Care
Bryan Livingston	Development Manager, Children's Services, Scottish Commission for the Regulation of Care
Deirdre McCormick	Nursing Officer for Children, Vulnerable Families and Early Years - Scottish Government
Phil Mackie	Lead Consultant, ScotPHN
Jane Park	Clinical Specialist, NHS Highland
Moray Paterson	Looked After Children Policy Manager, Scottish Government
Nick Putnam	Health Improvement Specialist, NHS Fife (until autumn 2010)
Elaine Samson	Policy and Research Analyst, Scottish Commission for the Regulation of Care
Lisa Tyrrell	Senior Administrator, ScotPHN
Lorna Watson	Consultant Public Health Medicine, NHS Fife

GIRFEC MAPPING EXERCISE

Nick Putnam	NHS Fife
Andrew Millard	ScotPHN
Moray Paterson	Scottish Government
Fiona McKinley	Scottish Government
Alison Melville	Scottish Government
Ann Conacher	ScotPHN
Maggie Lachlan	NHS Greater Glasgow and Clyde / ScotPHN

APPENDIX 2: PROJECT BRIEF

Project:	Mental Health Care Needs Assessment for looked after children in residential special schools, care homes and secure care accommodation. **Scope of project** The Directors of Public Health of NHS Boards have requested ScotPHN to undertake a health care needs assessment of young people in residential care and specifically the mental health care needs of such looked after young people. All Local Authorities have a significant number of children and young people accommodated in residential care. Often these are in the private sector and many are out of area or even out of Scotland. Anecdotal evidence across Scotland suggests that the health care received by these children and young people is highly variable and there is evidence of inequity. In particular, the problems of providing Children and Adolescent Mental Health (CAMH) input to residential care has been long running and affects several, if not the majority, of NHS Boards. There should be a more rational approach to this provision which would allow NHS CAMH services to plan and provide a better level of mental health support. Policies to address these issues are being put in place, for example embedding the Getting it Right For Every Child (GIRFEC) approach in meeting all children's needs is a priority. More specifically, 'Looked After Children & Young People: We can and Must Do Better (Jan 2007)' recommends that each NHS Board will assess the physical, mental and emotional health needs of all looked after children and young people for whom they have responsibility and put in place appropriate measures which take account of these assessments. Further recommendations are laid out in CEL 16 (2009) requiring each NHS Board to nominate a Board Director to take a corporate responsibility for looked after children and young people. Appropriate care plans are to be delivered and co-ordinated with annual reporting to the Scottish Government on the health outcomes of the assessments. The financing of these services is complex, for example there are cross boundary issues, both geographical and between service providers, children and young people may be moved an number of

	times between different types of accommodation. **Definition:** Residential Care: The steering group has agreed to use the definition for residential care used by the Care Commission. (See Appendix 1). Children: Children of all ages up to 21 years cared for in this accommodation. Mental health: The project will investigate mental health needs in their broadest sense. To include those with learning disabilities, substance misuse problems as well as forensic mental health. This area is a significant contributor to both current and potential future health inequalities. It is hoped that by concentrating initially on a specific assessment of the mental health needs of looked after children in residential schools there will be lessons learned to help tackle the wider problems experienced by this vulnerable population.
Timescale:	April to October 2010
Aim:	• To clarify and set the context of this work. • To investigate and map the policy context and the work currently taking place in this area and how it links with that of public health departments. • To identify the level of need and map current service provision. • To identify the inequalities resulting from current service provision.
Method:	Epidemiological and corporate Health Care Needs Assessment of all ages of looked after children. To include: 1. Interviews with stakeholders, leading to; 2. Mapping of policy, current work in area and stakeholders; 3. Construction of a pyramid of different levels of need and care for looked after children within key settings: ▪ Residential educational / secure accommodation / young offenders ▪ Private Sector- addressing special needs / community

	care packages community ▪ Broader – All looked after children ▪ Community
Stakeholders:	• NHS Boards • CAMH Services (to include broad range of mental health; learning disabilities and forensic) • Local Authorities - Education • Local Authorities - Social work • Scottish Commission for the Regulation of Care (now Social Care and Social Work Improvement Scotland) • Scottish Government • Scottish Institute for Residential Child Care • HMIE and Learning and Teaching Scotland • Social Work Inspection Agency • Scottish Healthy Care Network • ETC • Residential Providers • Young Scot • Who Cares (Heather Gray, Chief Executive) • Additional services around learning disabilities
Policy Context:	• Getting it right for every child (GIRFEC 2008) • Curriculum for Excellence (2008) • Scottish Needs Assessment on Child and Mental Adolescent Health (2003) • Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005) • HDL(2004)15: NHSScotland: Guidance On Establishing the Responsible Commissioner • More Choices, More Chances • Early Years and Early Intervention Framework • Equally Well (2008) • We Can and Must Do Better (2007) • These are Our Bairns (2008) • CEL 16: Looked After Children (2009) Implementation of Action 15 of We Can and Must Do Better • The Competency Framework LAAC Nurses (2009) • Towards a Mentally Flourishing Scotland

Please note that for the purpose of this project the following definitions of accommodation have been used:

Definitions of secure accommodation, care homes and school care accommodation

Regulation of Care (Scotland) Act 2001

PART 1

THE COMMISSION AND CARE SERVICES

2 Care services

(3) A “care home service” is a service which provides accommodation, together with nursing, personal care or personal support, for persons by reason of their vulnerability or need; but the expression does not include—

(a) a hospital;

(b) a public, independent or grant-aided school;

(c) an independent health care service; or

(d) a service excepted from this definition by regulations.

4) A “school care accommodation service” is a service which is provided to a pupil by an education authority or the managers of an independent or grant-aided school, or by any person under arrangements made by any such authority or managers—

(a) for the purpose of the pupil being in attendance at a public, independent or grant-aided school; and

(b) which consists of the provision, in a place in or out with the school, of residential accommodation, but a service may be excepted from this definition by regulations.

(9) A “secure accommodation service” is a service which provides accommodation approved by the Scottish Ministers in accordance with regulations made under section 29(9)(a) of this Act.

The Public Services Reform (Scotland) Act 2010

SCHEDULE 8
(introduced by section 37(2))

CARE SERVICES: DEFINITIONS

2 A “care home service” is a service which provides accommodation, together with nursing, personal care or personal support, for persons by reason of their vulnerability or need; but the expression does not include—

(a) a hospital;

(b) a public, independent or grant-aided school; or

(c) a service excepted from this definition by regulations.

3 (1) A “school care accommodation service” is a service which—

(a) consists of the provision of residential accommodation to a pupil in a place in or out with a public, independent or grant-aided school;

(b) is provided (whether or not during term-time) for the purpose of or in connection with the pupil’s attendance at the school (whether current or otherwise); and

(c) is provided to the pupil by—

(i) an education authority or the managers of an independent or grant-aided school; or

(ii) any person under arrangements made between that person and any such authority or managers.

6 A “secure accommodation service” is a service which—

(a) provides accommodation for the purpose of restricting the liberty of children in residential premises where care services are provided, and

(b) is approved by the Scottish Ministers for that purpose.

APPENDIX 3: DEFINITIONS

Child and Adolescent Mental Health Services (CAMHS): Child and adolescent mental health services (CAMHS) is sometimes used to embrace the range of services across agencies that contribute to the mental health and care of children and young people. These are sometimes referred to as universal or Tier 1 services and include those services whose primary function is not mental health care, such as general practice, schools and social services. The term is also used to describe specialist CAMHS, which mainly comprise professionals who have specific training in children's and young people's mental health, and which provide specialist mental health assessment and treatment. Specialist CAMHS are sometimes referred to as Tier 2, 3 or 4 services. They include generic multi-discipline teams, single professional teams, targeted teams (eg for looked after children and young people), "outposters" (ie people who are CAMH-trained and employed, but who work in non- CAMHS settings), and specialist care teams (eg day patient, inpatient, intensive outreach).

Children's Hearing - A lay tribunal composed of three panel members one of whom chairs the proceedings. Both genders must be represented. The hearing is charged with deciding if a child requires compulsory measures of supervision.

Contact - Contact between children and their parents (and brothers, sisters) is a basic right which should only be regulated if the welfare of the child might be compromised. Contact includes face to face meetings, letters, phone calls etc. Requirements for contact may be stated in supervision requirements. Contact should contribute to the well-being of the child and helps to retain active links with his/her family.

Child in Need - The Children (Scotland) Act 1995 defines a child as being in need of care and attention if:

- he or she is unlikely to achieve or maintain a reasonable standard of health or development unless services are provided by the local authority
- his or her health and development is likely to be seriously impaired or further impaired without such services
- he or she is disabled
- he or she is affected adversely by the disability of a member of the family.

A local authority must provide a range and level of services to safeguard and promote the welfare of children in its area who are in need and to promote the upbringing of children in need by their families.

Corporate Parenting - meaning the formal and local partnerships needed between all local authority departments and services, and associated agencies, who are responsible for working together to meet the needs of looked after children and young people. (Looked After Children and Young People: We Can and Must Do Better, Scottish Executive 2007)

Corporate Parenting offers the opportunity to improve the futures of Looked After children by all parts of a Council and partners making their contribution to the well being of the children.

Curriculum for Excellence – aims to achieve a transformation in education in Scotland by providing a coherent, more flexible and enriched curriculum from 3 to 18. The curriculum

includes the totality of experiences which are planned for children and young people through their education, wherever they are being educated.

Family Group Conferences (FGC) - the process brings together parents, relatives, grandparents and other concerned family members to decide on and take responsibility for a family plan for the care and protection of the child or young person. Children 1st has pioneered the use of FGC in child welfare and protection since 1998. Evaluations have demonstrated the value of this formal process in reaching decisions.

Family Meetings - these may take a variety of shapes but the basic purpose is to bring together wider family members and friends to develop a plan for the care of a child either at home with parents or away from home. The goal is to identify the supports that the wider family can provide for the child and his/her carers.

Foster Care - involves looked after children and young people living and being cared for in an ordinary family home by carers who are not their parents. Foster carers are assessed and approved by agencies and must have the skills and capabilities to care for the whole child and promote their well-being.

Foster carers are regularly reviewed to ensure that they are continuing to provide safe and nurturing care to the child.

GIRFEC (Getting it Right for Every Child) - is the programme that aims to improve outcomes for all children and young people by promoting a shared approach that builds solutions with and around children and families. It enables children to get the help they need when they need it; supports a positive shift in culture, systems and practice; involves working together to make things better.

Hands on Scotland - A toolkit of responses to encourage children and young people's emotional wellbeing. http://www.handsonscotland.co.uk/

Integrated Care Pathways (ICPs): A multi-disciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes. ICPs are important because they help to reduce unnecessary variations in patient care and outcomes. They support the development of care partnerships and empower patients and their carers.

Kinship Care - this is the term used to describe care provided by the wider family members or friends of a child when they have to leave the care of their parents.

LAC Nurses: Nurses who work specifically with children and young people who are looked after and accommodated. Usually employed by the NHS, these staff attend to the health needs of the whole child. Not all areas have LAC Nurses.

Looked after children - Children who are looked after are those who are:

- provided with accommodation by a local authority under s.25 of the Children (Scotland) Act 1995)
- subject to a supervision requirement (whether living at home or away from home)

- subject to an order, warrant or authorisation under which the local authority has responsibilities for the child.

The local authority has a duty to looked after children to:

- safeguard and promote the child's welfare
- provide family support services where the child is living at home
- promote contact between child and parents
- ascertain and take account of the child's views and views of parents and other relevant adults
- have regard to the child's religion, race, culture and linguistic background
- review the child's case at regular intervals.

Looked after at home - this will be where the child is the subject of a supervision requirement but continues to live at their normal home of residence. Supervision requirements can impose a number of measures on the child, for protection, guidance, treatment or control. The local authority is required to provide supervision of the child and his welfare and access services for the child as required.

Looked After away from home - (i.e. away from their *normal* place of residence)**,** where the child or young person is subject to a **supervision requirement *with a* condition of residence** through the Children's Hearing system, or is provided with accommodation under section 25 (voluntary agreement) or is the subject of a Parental Responsibility Order (section 86). The child or young person is cared for away from their normal place of residence, e.g. in a foster care placement, residential/children's unit, a residential school, a secure unit or a kinship placement. Other placements may be made at the request of the parents of the child when they are prevented from providing care.

Looked after child in kinship care - this is where a child has been placed by a local authority with a kinship carer or a Children's Hearing has made a supervision requirement including the child being cared for by kinship carers.

Looked After Children Strategic Implementation Group (LACSIG) - A new strategic group has been brought together by Scottish Government to lead and drive forward an implementation programme to improve the outcomes for looked after children and young people in Scotland. http://www.sircc.org.uk/lacsig

Mental health

The World Health Report (2001) as referenced in The Scottish Needs Assessment on Child and Mental Adolescent Health (2003) describes mental health as a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Mental health problems

One difficulty in multi-agency and partnership working is that many different definitions may be used to describe the same conditions, however, this report adopts the *The Mental Health of Children and Young People A Framework for Promotion, Prevention and Care (2005)* working definition of mental health problems as difficulties in living, learning and

relating which are expressed in terms of troublesome emotions or behaviours as well as more explicit psychological or psychiatric problems.

There are factors that make people more vulnerable and factors that provide resilience against developing mental health problems as will be described later (SNAP 2003 report)[3] Children and young people looked after away from home are often more vulnerable because of their background and when they enter the looked after system, the lack of cohesion of services can often add to these problems.

Mental Health Promotion: This involves any action to enhance the mental wellbeing of individuals, families, organisations and communities. Mental health promotion is essentially concerned with:

- How individuals, families, organisations and communities think and feel
- The factors which influence how we think and feel, individually and collectively
- The impact that this has on overall health and wellbeing

Everyone has mental health needs, whether or not they have a diagnosis of mental illness. Mental health promotion programmes that target the whole community will also include and benefit people with mental health problems.

Mental Welfare Commission (MWC): An independent organisation set up by the Scottish Parliament with the responsibility for protecting the welfare of people with mental disorder (including learning disabilities and dementia) in Scotland. The work of the MWC includes visiting people in hospital and in the community, investigating cases of deficiency in care or treatment and providing information and advice. See www.mwcscot.org.uk .

Parental Responsibilities - Under the Children Scotland Act, parents have the following responsibilities towards their children:

- to safeguard and promote child's health, development and welfare until the child is 16
- to provide appropriate direction until the child is 16 and guidance until 18
- maintain good personal relationships and contact with the child until 16
- to act as a legal representative until child is 16.

Parental Rights - Under the Act, parents have rights to:

- regulate the residence of a child under 16
- direct the child's upbringing
- maintain contact
- act as a legal representative

where this in the child's best interests.

Parental Responsibilities Order - A sheriff may transfer parental responsibilities to a local authority where a parent has:

- persistently failed, without reasonable excuse to fulfil their parental responsibilities
- has seriously ill-treated the child and return home is unlikely.

This order lasts until the child is 18.

Pedagogy - The principles of pedagogy are that people working with the child focus on "the whole child, their body, mind, feelings, spirit, creativity and the relationship of the child to others- their connectedness" (Petrie 2001).

The goal of developing pedagogy in Scotland is to create a workforce which can address the needs of the whole child and contribute their different skills to that process but all sharing common values and principles.

Permanency - involves making decisions about the long-term future of children who have been removed from their families' care. Its purpose is to ensure that the child has a permanent, stable and secure upbringing either with their original family or with alternative high quality care. Permanence is a permanent solution for the child whether in their own family or in alternative care.

Residence Order - An order made by a court which regulates the arrangements about where, and with whom a child will live. If an order is made in favour of someone who does not have parental responsibilities and rights (e.g. grandparents, aunts) then that person will hold responsibilities and rights until or unless the order is changed. This lasts until the child is 16.

Scottish Institute for Residential Child Care - was established in April 2000 and is a partnership of the University of Strathclyde, The Robert Gordon University, Who Cares? Scotland and Langside College, funded primarily by the Scottish Government. It acts as a catalyst to influence and improve the quality of care and outcomes for children and young people living in residential care. http://www.sircc.org.uk/

Who Cares? - a voluntary organisation supporting all of Scotland's children and young people in care. It provides a voice by working directly with young people, listening to what they say and speaking out with them. It promotes and protects their rights and involves them in decision-making. At the heart of its work is enabling young people in care to enjoy a positive life now, and reach their full potential in the future. http://www.whocaresscotland.org/

Appendix 4: Questionnaire to local authorities and reasons given by LAs who did not have details of numbers of LAAC in their area from other LAs, and who gave reasons

Questionnaire

Location of Looked After Children (LAC) in Residential Settings in Local Authorities in Scotland

Name of Local Authority _____ Name of Health Board _____

Name of respondent _____Role of respondent_____Contact email_____ Tel no_____

Date of completion of questionnaire _____

This short questionnaire seeks to map the use of services by LAC in residential settings only, that your local authority has responsibility for (funds their care) and service use by children from elsewhere who are placed or accommodated in services within your local authority. This information will support a mental health care needs assessment for LAC in residential settings in Scotland which will improve equity of service provision for this important group.

Date for which this information is given _____

Question 1
How many LAC in residential settings is your Local Authority responsible for and where are they?

Using the following matrix, please indicate, for the latest date information is available, for each local authority, the number of LAC in residential settings from your Local authority placed in your own and other local authorities by accommodation type. Definitions for each type are given at the end of the questionnaire.

Local authority name: Please enter your LA name below.	Number of LAAC **this Local Authority is responsible for in Residential services only**, by their **service location** in each local authority area (including this one)	
	Placed or	Type of **Residential** Accommodation (see CLAS statistical returns definitions below)

	accommodated? (see definitions below)							
	Placed	Accommodated	Number In local authority home	Number In voluntary home	Number In residential school	Number In secure accommodation	Number In crisis care	Number In other residential care (includes private)
Aberdeen City								
Aberdeenshire								
Angus								
Argyll & Bute								
Clackmannanshire								
Dumfries & Galloway								
Dundee City								
East Ayrshire								
East Dunbartonshire								
East Lothian								
East Renfrewshire								
Edinburgh, City of								
Eilean Siar								
Falkirk								
Fife								
Glasgow City								
Highland								
Inverclyde								
Midlothian								

Moray								
North Ayrshire								
North Lanarkshire								
Orkney Islands								
Perth & Kinross								
Renfrewshire								
Scottish Borders								
Shetland Islands								
South Ayrshire								
South Lanarkshire								
Stirling								
West Dunbartonshire								
West Lothian								
Within UK excluding Scotland								
Outside of UK								

Question 2

Does your local Authority have information on how many LAC in residential settings in your local authority are from any other Local Authorities? (Please tick one)

Yes □ **No □**

If the answer to 2 was no, please briefly describe the main reasons for this

If the answer to question 2 was yes, please answer question 3:

Question 3
Please give the overall number of LAC children in residential settings who are the responsibility of other Local Authorities but are accommodated in a residential service located in your Local Authority area (no breakdown by the other Local Authority is required here)

Number of LAC **other local authorities are responsible for, in residential settings located in your LA**						**otal looked after children in your Local thority in residential settings who are the esponsibility of other Local Authorities**
nber In local authority home	ıber In voluntary home	ıber In residential school	Jumber In secure accommodation	ber In crisis care	Jumber In other esidential care ncludes private)	

Definitions for residential settings:

Local authority home: in local authority children's home/hostel, local authority home/hostel for children with learning disabilities, local authority home/hostel for physically disabled children
Voluntary home: in voluntary children's home/hostel, in voluntary home/hostel for children with learning disabilities, in voluntary home/hostel for physically disabled children
Residential school: in local authority residential school (home/hostel), in voluntary residential school (home/hostel), in private school, in independent school
Secure accommodation: in secure accommodation
Crisis Care: for example: in women's refuge, in local authority hostel for offenders, in voluntary hostel for offenders, in local authority hostel for drug/alcohol abusers, in voluntary hostel for drug/alcohol abusers
Other residential: a known residential setting, including privately run establishments, which does not fit with one of the above

Thank you for your help.

Results

Reasons given by LAs who did not have details of numbers of LAAC in their area from other LAs, and who gave reasons		
NHS Board	Local authority	Q2 (if blank can provide Q3)
Ayrshire & Arran	East Ayrshire	Our information system holds information on children who are being looked after by East Ayrshire Council. You would get information on children from the authority which looks after them. There are no children from any other council currently in East Ayrshire Council children's houses. We cannot answer for voluntary or private establishments.
Borders	Scottish Borders	There are 2 Crisis care bases within Scottish Borders Council but these are not registered by the Care Commission in Scottish Borders Council, being registered through Dumfries and Galloway. We are not routinely informed of placements in these short term units.
Fife	Fife	Other local authorities do not routinely notify Fife Council if LAC cases are in statutory or voluntary residential placements within Fife. Additionally, Fife Council is not routinely notified by third party residential units within Fife if there are children from external local authorities placed with the respective unit.
Forth Valley	Clackmannanshire	The only residential unit in Clackmannanshire is a very small unit, all places are taken by Clackmannanshire children due to demand.
Forth Valley	Stirling	Not all local authorities notify Stirling Council that they have placed children in residential settings. We have two large residential schools and we are not notified by them or local authorities.
Grampian	Aberdeen City	Our residential children's unit capacity is all used by us. Our capacity is planned to meet need in the city. Other Local authorities have similar arrangements. At present we have no specialist residential provision that other Local authorities would require to purchase**.**
Grampian	Aberdeenshire	Our Local authority only holds the records for LAC where they have the responsibility for that child's care.
Greater Glasgow & Clyde	East Dunbartonshire	East Dunbartonshire has one children's unit which is managed by the Council and placements are only for children from within the Authority. St Mary's Kenmure Secure Unit is also located within East Dunbartonshire but the Council has no information on placements as it is by run Cora
Greater Glasgow & Clyde	East Renfrewshire	We have no residential home for children in East Renfrewshire
Greater Glasgow & Clyde	Glasgow City	On question 2 - we don't have any LAC in residential settings in Glasgow from any other LA yet, as the only residential provision in GCC is our own provided units. CareVisions are just about to open a 4 bedded unit in Ibrox, so this will change. Answers to 3 would therefore be 0 for each, although private will change.
Greater Glasgow & Clyde	Inverclyde	This has rarely been requested but we don't have capacity to give places to children out with this local authority as we need all of our resources to meet our own needs.
Greater Glasgow & Clyde	Renfrewshire	We do not have any children from other local authorities placed within our own local authority units. Any information on children from other areas placed in private residential settings would be dependent on Social Work colleagues in other local authorities informing us of such placements.
Highland	Highland	Almost no provision, and that which is in place is short term. Other LAs rarely notify us.
Lanarkshire	North Lanarkshire	We do not have information on our system for young people who are not the responsibility of North Lanarkshire Council. It is unlikely that there would be young people within our local authority homes who are not from the North Lanarkshire area due to the limited number of places we have available. Private establishments will have young people from out with our area and would have their own records on these young people. Any young people who were placed in establishments in our area who are from other local authority areas would be counted in that areas statistics and therefore, any numbers provided by authorities in part 3 would result in double counting.
Lothian	Edinburgh, City of	LA was not able to get this info - lack of time
Lothian	Midlothian	There is an Edinburgh resource (Wellington school) within our local authority boundaries – we have no involvement with it. Not even sure if it's still functioning.
Lothian	West Lothian	We are only aware of Children in Foster Placement if the placing authority informs us. Other Local authorities do not routinely inform us if they place a child in a residential setting within West Lothian

Appendix 5: Questionnaire to Looked After and Accommodated Children Nurses and summary responses

Questionnaire

Looked After and Accommodated Children (LAAC) staff telephone survey

About the research
This short questionnaire seeks to map LAAC nurses involvement with LAAC in residential settings only. This information will support a mental health care needs assessment for LAC in residential settings in Scotland which will improve equity of service provision for this important group.

Notes for interviewer, to be read to interviewee before starting:
This interview covers LAAC in residential accommodation only. Residential accommodation is defined as below:

Definitions for residential settings:

Local authority home: in local authority children's home/hostel, local authority home/hostel for children with learning disabilities, local authority home/hostel for physically disabled children
Voluntary home: in voluntary children's home/hostel, in voluntary home/hostel for children with learning disabilities, in voluntary home/hostel for physically disabled children
Residential school: in local authority residential school (home/hostel), in voluntary residential school (home/hostel), in private school, in independent school
Secure accommodation: in secure accommodation
Crisis Care: for example: in women's refuge, in local authority hostel for offenders, in voluntary hostel for offenders, in local authority hostel for drug/alcohol abusers, in voluntary hostel for drug/alcohol abusers
Other residential: a known residential setting, including privately run establishments, which does not fit with one of the above

Looked After and Accommodated Children (LAAC) staff telephone survey

Health board_____

Local authority_____

Contact name_____

Contact role/job title_____

Contact tel No_____

Contact email_____

Date of completion of questionnaire_____

Date for which this information is given _____

1. How many LAAC nurses are there in the health board area? WTE and headcount Employed by NHS	Headcount					Whole Time Equivalent						
2. How many LAAC nurses in each payband? (WTE)	Band	4	5	6	7	8a						
	Number											
3. How many LAAC is each WTE LAAC nurse responsible for?	LAAC number inside HB	0-10		11-50		51-75		76-100		More than 100		
	Outside HB?	0	1-5		6-10	11-15		16-25		>25		
4. How much of the total time (all LAAC nurses) do they spend on LAAC who are accommodated outside the HB?	Percentage within health board area					Percentage outside health board area						
5. What are the monthly estimated travel expenses for LAAC work?	Inside health board area					Outside health board area						
6. What is mechanism for informing LAAC staff that children have been taken into care?	Inside Health Board Area					Outside health Board Area						
7. When are LAAC staff informed of child taken into care?	Inside health board area					Outside health board area						

8. Who does health assessment?	Inside health board area	Outside health board area
9. Where is health assessment done for children outside Board area (ie do they come back to own HB?)?	Inside health board area	Outside health board area
10. What assessment tools are used for the health assessment?	Inside Health board area	Outside health board area
11. What is the main frustration you have in meeting the needs of these children?		
12. What do you think is the one most important issue to tackle first in your health board area to better meet the needs of these children		

Results

Table 6 Telephone survey: summary of results of LAC nurses employed by NHS Boards
There were 11 responses, representing 6 NHS Boards as five responses came from Local authorities in Greater Glasgow & Clyde (GGC) and two from Lothian. Not all NHS Boards have dedicated LAC nurses.
Qs 1-5 There were generally between 1 and 2 LAC nurses in the responding NHS Boards , with 10 in GGC, 2.8 in Ayrshire, and 2.6 in Lothian, with median grade 7 overall. They had responsibility for from 11-50 to >100 LAAC inside the home NHS Board area and for 1-5 to >25 outside the NHS Board. The LAAC nurses spent between 22% and 95% of their time within the home NHS Board area. The highest recorded annual mileage within the home NHS BOARD was 4000, and outside it 300 per month, but data on that was often not available, or could not be split in/out NHS Board .
Q6 **Mechanisms for informing LAAC staff of children taken into care**: Inside the NHS Board all communications came from social work using a variety of methods - meetings, emails, telephone calls, forms, with one mention of a referral pathway. Outside the NHS Board: usually the same methods, but with even les consistency
Q7 **When LAAC staff were informed of a child taken into care**: varied between immediately and at 6 weekly meetings within and outside the NHS Board (but again the question did not apply in the same way outside)
Q8 **Who did the health assessment**: Paediatricians were often involved for younger children, (age cut off at 10-12) LAAC nurses throughcare nurses, other doctors and school nurses were involved. Outside the home NHS Board LAC nurses would involve LAC or school nurses in the placement area, but quite often the child would come back to the home NHS Board and see the same people.
Q9 **Where the health assessment was done**: varied, with assessments done in the home NHS Board opportunistically when the child came back for other meetings, or the child might be brought back especially for assessment. In the placement NHS Board the LAC nurse might visit, but generally only if not far to go, and they might engage other LAC nurses especially school nurses (residential schools) to do it and support them with sharing case information.
Q10 **Assessment tools**: used within the NHS Board were mainly BAAF, but two mentions of SHANARRI , one of the my world triangle (from GIRFEC), and two mentions of local systems. For children accommodated outside the home NHS Board it was a similar range of tools, though practice varied on whether the home NHS Board or the local placement method was used if the assessment was done in the placement NHS Board.
Q11 **Main frustration of LAAC staff** (see separate word summary document) The respondents' main frustrations in meeting the needs covered the following themes: Knowing who and where the children were, including lack of communication with other NHS Board areas, and not knowing about children from outside the NHS Board area who are accommodated within it. Problems with assessment referral and acceptance by CAMHS (especially not clear who is responsible for the mental health of the looked after children and young people outside the home NHS Board), (poor emotional health being a key factor in preventing the children and young people from making health improving changes), problems with the time taken to return the BAAF assessment forms, having to chase social work for information, and general problems with record keeping - duplication, loss, and inaccuracy of patient records
Q12 **The one most important issue to tackle first in their NHS Board Area**: Implementation of CEL 16, better information on where the children and young people are and who they are, better and more robust referral information from social work, improving mental and emotional health for the children and young people - and to that end making CAMHS more flexible so that these looked after children and young people find it easier to engage with the service.

APPENDIX 6: MAPPING OF GIRFEC COMPONENTS

How the policy and guidance in documents relating to the care of LAAC can help providers meet the 10 Core Principles from GIRFEC and the actions currently being carried out in these areas.

Policy and guidance documents included:

- Getting it right for every child (GIRFEC 2008)
- Curriculum for Excellence (2008)
- Scottish Needs Assessment on Child and Adolescent Mental Health (2003)
- Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005)
- HDL(2004)15: NHSScotland: Guidance On Establishing the Responsible Commissioner
- More Choices, More Chances (2006)
- Early Years Framework (2008)
- Equally Well (2008)
- We Can and Must Do Better (2007)
- These are Our Bairns (2008)
- CEL 16: Looked After Children (2009) Implementation of Action 15 of We Can and Must Do Better
- The Competency Framework LAAC Nurses (2009)
- Towards a Mentally Flourishing Scotland (2009)
- Achieving our Potential (2007/08)
- Extraordinary Lives (2006)
- Getting it Right for Children in Residential Care (Audit Scotland) (2010)
- National Care Standards (school and care homes) (2005)
- Caring about success-Young People's stories (2008)

GIRFEC CORE PRINCIPLE	KEY POINTS IN THIS DOCUMENT THAT DEMONSTRATE HOW TO TRANSLATE GIRFEC PRINCIPLE INTO ACTION	ACTIONS CURRENTLY BEING TAKEN AND BY WHOM	ACTIONS THAT NEED TO BE TAKEN AND BY WHOM
1. **A focus on improving outcomes for children, young people and their families based on a shared understanding of well-being**			
Curriculum for Excellence (2008)	Comprehensive health and well being curriculum introduced for all children Build on health promoting school work Tightens up Additional Support for Learning (ASL) needs and how they should be met	Introduced in schools from August 2010	Education, Health, Social work to work more closely for LAC children
Scottish Needs Assessment on Child and Adolescent Mental Health (2003)	Describes factors that make children vulnerable to and others that promote resilience to developing mental health problems		
Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005)	Provides planning and audit tool for local agencies to identify goals and milestones for improvement especially chapter 7	Local CAMHS team being set up in all NHS Boards	LAC Nurse role to be enhanced in taking actions forward
More Choices, More Chances			
These are Our Bairns (2008)	Introduces corporate parent role	Action 15 being implemented Who Cares? is providing training to corporate parents	Corporate parent role to be clearly understood across all agencies NHS Board Director with corporate responsibility for LAC should be included in Who Cares? training for corporate parents.

Early years framework	Developing a sense of how to sustain the intervention beyond early years and how the early years framework will connect to *Curriculum for Excellence*, the *More Choices, More Chances* agenda and *Getting it Right for Every Child*, with the aim of improving outcomes for all children.		
Equally Well	Very young children need secure and consistent relationships with other people, or else they will not thrive, learn and adapt to their surroundings. *targeting* efforts at people, families, groups, communities and geographical areas that are at greatest risk of poor mental health and who may have complex and multiple needs		All involved in caring for LAC to be trained in understanding attachment theory
Towards a mentally flourishing Scotland			
Achieving our Potential	an approach which supports empowering people to make a difference to their own lives		
Extraordinary Lives	Highlights a range of factors which make care leavers feel more safe, secure and valued. Concludes that the single most important thing that will improve the futures of Scotland's LAC is for local authorities to focus on and improve their corporate parenting skills.	Who Cares? is providing training to corporate parents	
Getting it right for children in residential care	Makes recommendations on how Councils, the Scottish Government, COSLA and NHS Boards can make improvements to service provision to improve the care and longer term outcomes for C&YP.		
Caring About Success	Stresses the importance of recognising and celebrating all types of success. Highlights that stigma is a barrier to success.	Who Cares? Scotland's 'Give Me	

		a Chance' campaign is specifically designed to address the misconceptions and negative attitudes towards LAC & YP within the care system.	

GIRFEC CORE PRINCIPLE	KEY POINTS IN THIS DOCUMENT THAT DEMONSTRATE HOW TO TRANSLATE GIRFEC PRINCIPLE INTO ACTION	ACTIONS CURRENTLY BEING TAKEN AND BY WHOM	ACTIONS THAT NEED TO BE TAKEN AND BY WHOM
2. **A common approach to gaining consent and to sharing information where appropriate**			
Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005)			
CEL 16: Looked After Children (2009) Implementation of Action 15 of We Can and Must Do Better	Health needs assessment at entry to residence	All NHS Boards have named Director for LAAC Named person will be responsible for care plan	
LAC competency framework	The key co-ordinating role of the LAC nurse	LAC nurse and social work to develop appropriate pathways of information sharing	
Caring About Success	Recommends that members of the corporate family including local authority departments and associated agencies should develop strategies and guidance to ensure 'Realising Success' support and outcomes are delivered.		

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3. **An integral role for children, young people and families in assessment, planning and intervention**		Who Cares advocacy role on new LACSIG and involvement in multidisciplinary training of professionals to be strengthened	
Scottish Needs Assessment on Child and Adolescent Mental Health (2003)	Core theme is recognizing the right of children and young people to be heard, and their capacity to play a full part in thinking about mental health and improving the arrangements that we make to improve mental health.		
Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005)			
LAAC competency framework	the important public health function LACNs perform and how their multidisciplinary, multi-agency working practices stand as exemplars of true partnership working		
Achieving our Potential	an approach which supports empowering people to make a difference to their own lives		
Extraordinary Lives	Sets out how children and young people can be active, informed participants in assessment of their health needs and how they should be consulted about their care.		
Care homes for children and young people	The care standards have been developed from the point of view of children or young people who use the services. They describe what each individual can expect from the service provider. They focus on the quality of life that the child or young person using the service actually experiences.		

GIRFEC CORE PRINCIPLE	KEY POINTS IN THIS DOCUMENT THAT DEMONSTRATE HOW TO TRANSLATE GIRFEC PRINCIPLE INTO ACTION	ACTIONS CURRENTLY BEING TAKEN AND BY WHOM	ACTIONS THAT NEED TO BE TAKEN AND BY WHOM
4. **A co-ordinated and unified approach to identifying concerns, assessing needs, agreeing actions and outcomes, based on the Well-being Indicators**			
Scottish Needs Assessment on Child and Adolescent Mental Health (2003)	Mainstreaming mental health and integrating promotion prevention and health. Recommends developing links between specialist mental health teams and work done by social work and education services with very vulnerable groups such as those who are looked after and accommodated		Develop local multidisciplinary teams with key players (CAMHS, LAC Nurses, social work etc)
Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005)			
More Choices, More Chances			
CEL 16: Looked After Children (2009) Implementation of Action 15 of We Can and Must Do Better	Requires co-ordinated care plan to be developed according to health assessment		Time given to training in assessment tools Agreement on who carries out assessments Common tools for assessment to be used across all Boards
Responsible commissioner	Defines whose responsibility it is i to meet children's health needs		Clarity on definitions required at Government level. Starting with LACSIG
Early years framework	Integrated and partnership working	Multidisciplinary teams to care fro LAC children at NHS Board level	
LAC competency framework	Defines key competencies for LAC nurses		

Towards a mentally flourishing Scotland	*targeting* efforts at people, families, groups, communities and geographical areas that are at greatest risk of poor mental health and who may have complex and multiple needs		
Getting it right for children in residential care	Key message is that councils need to improve their joint planning and management of services to help children in residential care achieve their full potential.		

GIRFEC CORE PRINCIPLE	KEY POINTS IN THIS DOCUMENT THAT DEMONSTRATE HOW TO TRANSLATE GIRFEC PRINCIPLE INTO ACTION	ACTIONS CURRENTLY BEING TAKEN AND BY WHOM	ACTIONS THAT NEED TO BE TAKEN AND BY WHOM
5. **Streamlined planning, assessment and decision-making processes that lead to the right help at the right time**			
Scottish Needs Assessment on Child and Adolescent Mental Health (2003)			
Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005)	Provides clear planning and audit tool		
More Choices, More Chances			
CEL 16: Looked After Children (2009) Implementation of Action 15 of We Can and Must Do Better	Gives deadlines for assessment to take place 2009 for physical health 2015 for mental health		NHS Boards to prioritise meeting these deadlines
Responsible commissioner	Where a patient moves **during the course of treatment**, every effort should be made to ensure continuity of care. In all cases, the originating NHS Board must liaise with the receiving NHS Board. This applies also to LAC children moving placement		Clarity of responsibility for looked after children out of area between NHS Boards.
LAAC competency framework			
Towards a mentally flourishing Scotland	*targeting* efforts at people, families, groups, communities and geographical areas that are at greatest risk of poor mental health and who may have complex and multiple needs Looked after and accommodated children, children whose parents have problems with drugs and/or alcohol, children whose parents have a mental illness.		Develop parenting support mechanisms for LAC families co-ordinated by LAC nurses. LAC nurses to be trained in parenting support.
Achieving our Potential	This new flexibility [as outlined in the Concordat between national and local		

	government] for local partners and the move away from ring-fenced funding provides greater opportunities for local partnerships to develop policies and approaches which work in the local circumstances.		

GIRFEC CORE PRINCIPLE	KEY POINTS IN THIS DOCUMENT THAT DEMONSTRATE HOW TO TRANSLATE GIRFEC PRINCIPLE INTO ACTION	ACTIONS CURRENTLY BEING TAKEN AND BY WHOM	ACTIONS THAT NEED TO BE TAKEN AND BY WHOM
6. **Consistent high standards of co-operation, joint working and communication where more than one agency needs to be involved, locally and across Scotland**			
Curriculum for Excellence (2008)			
Scottish Needs Assessment on Child and Adolescent Mental Health (2003)			
Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005)			
Early years framework	Integrated and partnership working		
LAAC competency framework	the important public health function LACNs perform and how their multidisciplinary, multi-agency working practices stand as exemplars of true partnership working		

GIRFEC CORE PRINCIPLE	KEY POINTS IN THIS DOCUMENT THAT DEMONSTRATE HOW TO TRANSLATE GIRFEC PRINCIPLE INTO ACTION	ACTIONS CURRENTLY BEING TAKEN AND BY WHOM	ACTIONS THAT NEED TO BE TAKEN AND BY WHOM
7. **A Lead Professional to co-ordinate and monitor multi-agency activity where necessary**			
HDL(2004)15: NHSScotland: Guidance On Establishing the Responsible Commissioner			
CEL 16: Looked After Children (2009) Implementation of Action 15 of We Can and Must Do Better	Named director from NHS Board	Directors in place. Scottish Government co-ordinating monitoring of meeting CEL(2009)16requirements.	
LAAC competency framework			
Extraordinary Lives	Sets out the risks in the care of children being held by a group, especially one which has many responsibilities and functions.		

GIRFEC CORE PRINCIPLE	KEY POINTS IN THIS DOCUMENT THAT DEMONSTRATE HOW TO TRANSLATE GIRFEC PRINCIPLE INTO ACTION	ACTIONS CURRENTLY BEING TAKEN AND BY WHOM	ACTIONS THAT NEED TO BE TAKEN AND BY WHOM
8. **Maximising the skilled workforce within universal services to address needs and risks at the earliest possible time**			
Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005)	CAMHS 4 Tier approach. Train residential care staff to handle in Tier 1 and 2 delivery.		Much work to be done on improving training and qualifications. SIRCC, Who Cares, Young Minds to offer additional multidisciplinary training. Qualifications of care staff required by Care Commission to be met.
More Choices, More Chances			
Early years framework			
LAAC competency framework			

GIRFEC CORE PRINCIPLE	KEY POINTS IN THIS DOCUMENT THAT DEMONSTRATE HOW TO TRANSLATE GIRFEC PRINCIPLE INTO ACTION	ACTIONS CURRENTLY BEING TAKEN AND BY WHOM	ACTIONS THAT NEED TO BE TAKEN AND BY WHOM
9. **A confident and competent workforce across all services for children, young people and their families**			
Curriculum for Excellence (2008)			
Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (2005)			
LAAC competency framework			
Towards a mentally flourishing Scotland			

GIRFEC CORE PRINCIPLE	KEY POINTS IN THIS DOCUMENT THAT DEMONSTRATE HOW TO TRANSLATE GIRFEC PRINCIPLE INTO ACTION	ACTIONS CURRENTLY BEING TAKEN AND BY WHOM	ACTIONS THAT NEED TO BE TAKEN AND BY WHOM
10. **The capacity to share demographic, assessment, and planning information electronically within and across agency boundaries through the national eCare programme where appropriate**			
CEL 16: Looked After Children (2009) Implementation of Action 15 of We Can and Must Do Better			Common approach to assessments
Extraordinary Lives	All health professionals should have some mental health input into their pre and post registration training generally and specifically in relation to young people and self harm.		
Caring About Success	Recommends training for service providers and others to build competence and confidence, with a particular focus on the key worker role and of the unit team within the group living setting. Also, guidance and training to ensure children's hearings and panel members consider 'Realising Success' support and outcomes in their decision making.		

APPENDIX 7 – Rate per 100,000 population aged 0-21 years of all looked after children and young people per NHS Board, 2005-2009 (See Figure 7, page ? of report)

NHS Board	Total LAAC: rate per 100,000 population aged 0-21 by NHS Board of LA responsible				
	2005	2006	2007	2008	2009
Ayrshire & Arran	1101	1296	1323	1404	1501
Borders	803	-	737	684	728
Dumfries & Galloway	1105	1095	1237	1374	1323
Fife	665	696	803	868	893
Forth Valley	789	845	980	1166	1162
Grampian	774	899	929	979	1055
Greater Glasgow	1236	1285	1500	1597	1735
Highland	866	971	998	937	922
Lanarkshire	814	810	888	981	857
Lothian	1049	1115	1127	1144	1184
Orkney	*	677	532	879	667
Shetland	516	*	477	608	658
Tayside	886	930	1071	1156	1111
Western Isles	*	*	807	652	810
Scotland	966	1034	1124	1193	1228

Notes

2009 Table excludes children who are on a planned series of short term placements. Figures are provisional and may be revised in 2009-10.
2008 Table excludes children who are on a planned series of short term placements. Figures are provisional and may be revised in 2008-09.
2007 Table excludes children who are on a planned series of short term placements. Aberdeen City did not provide full information on stability of placements of children looked after away from home. Figures for this section for this NHS Board (Grampian) are therefore substantial underestimates.
2006 Data points left blank represent small numbers that are suppressed to maintain confidentiality, or indicate information not provided. East Renfrewshire and Scottish Borders did not provide information in time for inclusion. 2004-05 figures for these NHS Boards (Greater Glasgow and Borders) have been incorporated into the Scotland total and do not include young people aged 18-21.

2005 Table excludes children who are on a planned series of short term placements. Statistics refer to the current episode of care. Data points left blank represent small numbers that are suppressed to maintain confidentiality

Sources:
LAC
2009 http://www.scotland.gov.uk/Publications/2010/02/22133946/0
2008 http://www.scotland.gov.uk/Publications/2008/11/25103230/0
2007 http://www.scotland.gov.uk/Publications/2007/11/27100107/0
2006 http://www.scotland.gov.uk/Publications/2006/12/08105227/0
2005 http://www.scotland.gov.uk/Publications/2005/10/2791127/11278

Mid year Population estimates: GROS website:
http://www.gro-scotland.gov.uk/statistics/publications-and-data/population-estimates/mid-year/index.html

APPENDIX 8: TRAINING

SIRCC courses delivered April 2009-April 2010

- Attachment – seven, three day courses (131 participants)
- Autism – five, one day courses (62 participants)
- Drugs and alcohol – four, one day courses (37 participants)
- Sexually problematic behaviour two, two day courses (27 participants)
- Mental health (disabilities) two, two day courses (37 participants)
- Health and health promotion – two, one day courses (25 participants)
- Self harm – three, two day courses (35 participants)
- Bereavement – two, two day courses (18 participants)
- Bullying – two, two day courses (27 participants)
- Family therapy – two, three day courses (30 participants)
- Therapeutic use of group living – three, three day courses (27 participants)
- Therapeutic residential child care – one, four day course (11 participants)
- Trauma informed residential child care – one, three day course (10 participants)

APPENDIX 9: CORPORATE INTERVIEWS

Date	Organisation	Person(s) seen	Designation	Interviewer
12/05/10	NHS Greater Glasgow and Clyde	Stephen McLeod	Children and Young People's Specialist Services Manager	Maggie Lachlan
28/05/10	Scottish Commission for the Regulation of Care (now Social Care and Social Work Improvement Scotland)	Elaine Samson Bryan Livingstone	Policy Analyst Development Manager, Children's Services	Maggie Lachlan
1/6/10	Starley Hall	Liz Duff Phil Barton	Mental and Medical Health Manager Director	Maggie Lachlan Nick Putnam
4/6/10	Scottish Government	Moray Paterson	Looked After Children Policy Manager	Maggie Lachlan
9/6/10	LAAC nurse meeting	Kathy Pickles (Chair)	Specialist Nurse LAAC	Maggie Lachlan
18/6/10	Scottish Institute for Residential Child Care	Judith Furnivall	Lecturer, Advice and Consultancy	Maggie Lachlan Ann Conacher
18/6/10	Mental Welfare Commission for Scotland (Previously seconded to Mental Health Division, Primary Care Directorate, Scottish Government)	Margo Fyfe	Nursing Officer	Maggie Lachlan Ann Conacher
23/6/10	NHS Lanarkshire - CAMHS	Duncan Clark	Lead Clinician	Maggie Lachlan
23/6/10	North Lanarkshire Council	Ailsa Clunie	Health Liaison Officer Community Alternatives Children and Families	Maggie Lachlan
24/6/10	Rossie Secure Unit	Pam Morrison David Mitchell	LAAC Nurse Professional Services Development Manager	Maggie Lachlan Nick Putnam
24/6/10	Scottish Commission for the Regulation for Care	Elaine Samson	Policy Analyst	Maggie Lachlan
15/7/10	Seamab	Ann Kennedy	Depute Principle	Nick Putnam
3/8/10	NHS Highland	Jane Park	Clinical Nurse Specialist	Maggie Lachlan Nick Putnam

				Ann Conacher
5/8/10	Scottish Government	Moray Paterson	Looked After Children Policy Manager	Maggie Lachlan
10/8/10	National Autistic School, Daldorch House School and Continuing Education Centre	Michael McCreadie	Head of Education	Maggie Lachlan
12/8/10	Spark of Genius	Tom McGhee Moyra MacLean	Director Operations Manager	Maggie Lachlan
25/8/10	NHS Forth Valley	Maureen Berry	Nurse Consultant Child Protection	Maggie Lachlan
2/9/10	Learning and Teaching Scotland	Alistair Cairns	Education Manager	Maggie Lachlan
6/9/10 +++ dates	NHS Greater Glasgow and Clyde Children and Young People's Specialist Services	Graham Bryce	Child and adolescent psychiatrist	Maggie Lachlan
9/9/10	Who Cares?	Heather Gray	Chief Executive	Maggie Lachlan Nick Putnam
Sep 10	NHS Greater Glasgow and Clyde	Jackie Dougall	Clinical Nurse Specialist LAAC Secretary, LAAC Scottish Nurse Forum	Maggie Lachlan
16/9/10	Highland Council Highland Pathway	Bill Alexander	Director of Social Work	Maggie Lachlan
5/10/10	Scottish Government	Deirdre McCormick Graham Monteith	Nursing Officer for Children, Vulnerable Families and Early Years CAMHS Nurse Advisor	Maggie Lachlan
6/10/10	Kibble Education and Care Centre	Denise Carroll	Research and Development LAC Specialist Nurse	Maggie Lachlan

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ScotPHN report

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