Chapter 11

Looked-after children and young people

Chapter author
Doug Simkiss[1,2]

1 Clinical Director, Children and Families Division, Birmingham Community Healthcare NHS Trust
2 Honorary Associate Clinical Professor in Child Health, Warwick Medical School, University of Warwick

Key statistics

- In England, there were 67,050 looked-after children (0.6% of the childhood population) on 31 March 2012. Of these, 28,220 started to be looked after during the year 1 April 2011–31 March 2012.[1]

- Some 56% of the children who started to be looked after during the year became so because of abuse or neglect.[1]

- Following a significant fall in the number of children in care over the past 30 years, numbers rose in the UK between 2008 and 2012, from 81,315 to 91,667.[1]

- Around 13% of children remain in the care system for more than five years.[1]

- An analysis of serious case reviews in England shows that 10% (2003–2005) and 13% (2005–2007) related to a child in care.[1]

- There have been 33 child deaths in youth custody since 1990.[1]

- Looked-after children and care leavers are between four and five times more likely to self-harm in adulthood. They are also at five-fold increased risk of all childhood mental, emotional and behavioural problems, and six to seven times more likely to have conduct disorders.[2]

- Looked-after teenage girls are 2.5 times more likely to become pregnant than other teenagers.[3] ChildLine counselled 3,196 children and young people in 2009–2010 about problems related to being looked after – this is 1 in 26 of all looked-after children in the UK.[1]

- The cost of a foster care placement is £676, and the cost of living in a children's home is £2,639 per week (2010).[4]

Overview

Looked-after children and young people in care are a vulnerable group; their issues feature prominently in the United Nations Convention on the Rights of the Child (UNCRC).[5] Article 9 of the convention emphasises the importance of family life, except when this is not in the best interests of a child; article 20 lays out the responsibilities of the state to children who enter public care; article 21 describes the place of adoption; and article 22 summarises governmental responsibilities to asylum-seeking and refugee children. Article 25 outlines the need for regular reviews of a child's plan while in care, which is called a statutory review in England (see Box 11.1). This operational statement is remarkable in a global document such as the UNCRC and reflects real concern for the wellbeing of these children. This chapter will summarise the evidence for why looked-after children are a vulnerable group and look at what we can do to build their resilience.

'If someone hurts you it can break your heart'.
Source: Kids Company

Box 11.1 Relevant articles from the UNCRC for looked-after children

- **Article 9 –** *States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child.*

- **Article 20 –** *A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State… Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.*

- **Article 21 –** *States Parties that recognize and/or permit the system of adoption shall ensure that the best interests of the child shall be the paramount consideration.*

- **Article 22 –** *States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties… In cases where no parents or other members of the family can be found, the child shall be accorded the same protection as any other child permanently or temporarily deprived of his or her family environment for any reason, as set forth in the present Convention.*

- **Article 25 –** *States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.*

Epidemiology of children in care

The term 'looked after' was introduced by the Children Act 1989[6] and refers to children and young people under the age of 18 who live away from their parents or family and are supervised by a social worker from the local council children's services department. A 'looked-after child' may either be accommodated (which means that the council is looking after them with the agreement, at the request or in the absence, of their parents) or subject to an order made by the family courts.[6,7]

On 31 March 2012, there were 67,050 children in care in England, more than 1 in 200 of the total child population, and over a 12-month period more than 95,000 children will have an episode in public care, almost 1 in 100 of the total child population.[8] Spending some time in care is relatively common; even more common are referrals to social care, which have remained relatively static over the last 10 years: 4.9% of all children in 2001 and 5.6% in 2011. The percentage placed on a plan has stayed at 0.3–0.4% of all children.[9] While each child in care has a unique story with a different set of circumstances leading to the care episode, there are recognisable patterns which mean that children can usually be placed in groups that share characteristics. Some children enter care for a short time period and then return home. Other young children enter care and, if the assessment of the birth parents is unfavourable and a search for extended family members does not identify suitable carers, a plan for permanency by adoption is usually made. If children enter care at an older age and with a strong relationship with their parents who are unable to care for them (because of issues which often include mental illness, drug or alcohol misuse or learning difficulties), a plan for long-term fostering and contact with parents may be appropriate. Some young people, usually from conflict zones around the world, come as unaccompanied asylum seekers and are accommodated by the local authority. Children with disabilities are another distinct group of children in public care.

'They took my mummy away from me'.
Source: Kids Company

Current outcomes of care

Research on the 1970 birth cohort, which enrolled 16,567 infants born between 5 and 11 April 1970, provides **evidence of the adverse outcomes experienced by people who spent time as looked-after children**. Viner and Taylor reported the adult outcomes for the cohort population who spent time in public care (n=343) compared with the rest of the cohort (n=9,214). After controlling for socio-economic status, men with experience of care were significantly more likely to have been homeless (odds ratio (OR) 2.0; 95% confidence interval (CI) 1.1–3.8), have a conviction (OR 2.3; 95% CI 1.5–3.4), have psychological morbidity (OR 1.8; 95% CI 1.1–3.0) and be in poor general health (OR 1.6; 95% CI 1.1–2.6). They were less likely to

attain high social class (OR 0.6; 95% CI 0.4–0.9). Similar associations were identified for women. Men, but not women, with a history of care were more likely to be unemployed (OR 2.6; 95% CI 1.4–5.0) and less likely to attain a higher degree (OR 0.4; 95% CI 0 2–0.7).[10] It is possible that the real outcomes for people who spent time in care as children are worse than this study suggests, as only people with data collected at all the time points were included in this study, and people with a history of care are often mobile and would be over-represented in the group excluded from the study population because of missing data. Clearly the people in this study were children in the 1970s and 1980s and the care system has changed a great deal since then, but nonetheless the findings are important and similar outcomes have been reported from the USA,[11–13] Sweden[14] and Spain.[15]

The Department for Education collects data on educational outcomes for looked-after children compared with other children at Key Stage 2 and GCSE. While the recent cohorts taking examinations do show improving outcomes, the gap remains very wide and **the educational attainment of children in care lags well behind that of their peers**.[16]

Another key concern is the mental health and wellbeing of children and young people in public care. In 2003, a major study by Meltzer et al. used versions of the Strengths and Difficulties Questionnaire (SDQ) tailored for carers, teachers and young people followed up by an interview with a mental health practitioner to validate the SDQ scores.[17,18] Mental health issues were described as emotional, hyperkinetic or conduct disorders. The research team had used the same methodology to evaluate the mental health of children and young people living at home two years earlier and so a comparison group was available. Children in care have significantly higher rates of mental health problems than the general child population and this rate did not fall quickly with longer time in care.[17] There is also evidence of an increased prevalence of mental illness rates for children in care in the USA,[19,20] Australia[21] and Denmark.[22] The risk of suicide for care leavers in Sweden is more than twice the general population risk[23] and other Scandinavian population studies have found excess mortality risks for care leavers.[24,25]

Children and young people in care also have high levels of risk-taking behaviours such as smoking, and alcohol and drug misuse.[17,26–29] In Sweden, research has investigated the prevalence of teenage parenthood and it is clear that populations with social welfare interventions show high teenage parenthood prevalence figures and highly elevated odds ratios in some sub-groups, but there is also significant variation.[30] A follow-up study looking at teenagers placed in public care found that every third girl placed in a secure residential unit and every fourth girl placed in other residential homes because of behavioural problems became mothers as teenagers.[14]

Children and young people in care are also at increased risk of sexual exploitation, as recent high-profile media cases have identified.[31]

Sometimes the care system can add to distress, with looked-after children moving placements too frequently and at short notice. Some 23% of those changing were informed on the day of the move, and 55% were given less than one week's notice.[32]

Case study

Happy Hands – Central London Community Healthcare NHS Trust

The looked-after children nursing service provided by Central London Community Healthcare is aimed at improving the health outcomes of looked-after children. Service users are some of the most vulnerable children in the community, with a range of profiles, including safeguarding backgrounds, mental health and behavioural issues, and drugs and substance misuse.

Due to their specific needs, this group of children and young people can be particularly challenging and resistant to care. However, the looked-after children service truly puts the children and young people at the heart of everything it does, embedding engagement within its everyday practice in innovative and creative ways to ensure that the service is completely shaped by service users.

Some examples of how the service puts the individual at the centre of everything it does include:

- meeting for health assessments at times and sites chosen by the service user
- communicating with the service user by their chosen method (for example, email or text) and in ways that are flexible/accessible
- making changes to language used and using cultural references specific to the user group
- limiting note-taking during health assessment discussions to retain personal connection, with assessments written up directly after the discussion.

Creative arts are used to elicit feedback from children using the service; children are asked to draw around their hand and then write on the hand shape their feedback about their nurse. This feedback informs ongoing service delivery. Specific changes have been made in response to feedback; for example, staff now wear jeans and more casual clothing to be more approachable.

Risk factors associated with entering care and outcomes

Key risk factors of children entering care have emerged from research in England,[33,34] Scandinavia[35–37] and the USA.[38,39] A recent systematic review of the risk factors associated with children entering care found, for mothers, evidence of association with socio-economic status, benefit receipt, single parenthood, ethnicity, age, disability, smoking in pregnancy, mental illness, alcohol misuse and learning difficulties. For children, there was evidence of association with low birth weight and prematurity, disability, injuries and attendance at Accident & Emergency departments. None of these risk factors were very specific, and research using longitudinal data sets is needed to identify more specific risk factors associated with children entering care and to combine risk factors in a cumulative risk model.[40]

In 2010, the National Institute for Health and Clinical Excellence (NICE) and Social Care Institute for Excellence (SCIE) published guidance on promoting the quality of life of looked-after children and young people.[41] A review of correlates commissioned by the Topic Expert Group explored the interventions and factors associated with outcomes for children and young people in public care. Ninety-two studies were included in the review and the key factors were the number of placements, behavioural problems and age at first placement. Placement stability was a key mediator.[42] A different approach to caring for children and young people in care called social pedagogy, which emphasises holistic education and care, has been developed in countries such as Denmark, Germany, Holland and Hungary. **With the growth of more integrated children's services in Britain, there has been an interest in social pedagogy as a means of making sense of the professional development of staff, as it embraces the activities of youth workers, residential or day care workers (with children or adults), work with offenders, and play and occupational therapists.** Pedagogues are trained to master's degree level and provide ongoing support to children and young people in small residential units. There has been one pilot study of social pedagogy in England which did not demonstrate an effect but recognised the link between social pedagogy, the society in which it is located and wider social policy. The authors concluded that for social pedagogy to develop in England it is likely that wider changes would also be required to the role and status of children's residential care.[43]

Box 11.2 The experiences, views and preferences of looked-after children and young people[44]

Love – Looked-after children and young people say that:

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

A sense of belonging – Looked-after children and young people feel that:

- a sense of belonging is desirable, yet often lacking in their lives
- their sense of identity is compromised by a lack of sense of belonging

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

Being supported – Looked-after children and young people say that:

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

Having someone to talk to – Looked-after children and young people report that:

- opportunities to talk to someone about their concerns were often not available, but they appreciated them when they were
- they were often mistrustful of talking to professionals as they could not be sure that what they said would be kept confidential.

Contact with birth parents

- Many children and young people in public care have a strong desire to maintain contact with their birth families.
- Maintaining contact with birth families is important for supporting their self-identity.
- Children and young people in public care felt that social workers and care providers can obstruct their efforts to maintain contact with their families, and were resentful of this.
- A lack of contact causes significant emotional upset for children and young people in public care.
- Contact with birth families is a complex issue: although an overwhelming majority of children and young people in public care saw it as positive, not all felt the same.

Stigma and prejudice – Looked-after children and young people reported that:

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

Education – Important issues for looked-after children and young people were that:

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

Looked-after children and young people who had achieved success in education cited their self-reliance as the key factor which helped them overcome the barriers mentioned above.

raise the following concerns:

- the issue of continuity in their relationships with professionals
- the negative impact of a lack of continuity
- a desire to form a personal relationship with professionals

Professionals – Looked-after children and young people the need to have professionals who listen, are accessible, can be relied upon to be there for children and young people and have the ability to get things done.

Preparation and support for leaving care – In order to improve the process of leaving care, looked-after young people would like:

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

Box 11.3 NICE quality standard for the health and wellbeing of looked-after children and young people

Statement 1: Looked-after children and young people experience warm, nurturing care.

Statement 2: Looked-after children and young people receive care from services and professionals that work collaboratively.

Statement 3: Looked-after children and young people live in stable placements that take account of their needs and preferences.

Statement 4: Looked-after children and young people have ongoing opportunities to explore and make sense of their identity and relationships.

Statement 5: Looked-after children and young people receive specialist and dedicated services within agreed timescales.

Statement 6: Looked-after children and young people who move across local authority or health boundaries continue to receive the services they need.

Statement 7: Looked-after children and young people are supported to fulfil their potential.

Statement 8: Care leavers move to independence at their own pace.

Improving outcomes for children and young people in care

In 2000, at the start of the Quality Protects programme,[46] Professor Leon Polnay wrote on how to improve outcomes for children and young people in public care: 'What is needed is much earlier intervention with the aim to avoid children developing major social, educational and behavioural problems, combined with innovative, skilled and consistent care for those where early intervention has not been available or successful.'[47] Children and young people in care and care leavers continue to experience significant disadvantages and do require a comprehensive approach to reducing the impact of adverse early life experiences; this strategy could be thought of as primary prevention, early identification and intervention with families in need, and specialist expertise to address the issues of children and young people in care.

In this context a primary prevention approach includes the policy objectives recommended in the report *Fair Society, Healthy Lives* to reduce social disadvantage. This review contains policy recommendations to '**Give every child the best start in life**' and '**Enable all children... to maximise their capabilities and have control over their lives**'.[48] Sure Start Children's centres are a key foundation of this strategy and, once children are safe and their basic health needs met, children's centres should focus on children's health and development, parenting and parents' lives.[49]

What young people tell us about the care system and how to build resilience

Another document underpinning the NICE/SCIE guidance on looked-after children was *What outcomes matter to looked-after children and young people and their families and carers? A systematic review of their experiences, views and preferences.*[41,44] This research eloquently communicates what looked-after children and young people see as the important issues impacting on their health and wellbeing and therefore what could improve their resilience (see Box 11.2).[44]

The brief of one of the first social care quality standards developed by the new National Institute for Health and Care Excellence was promoting the health and wellbeing of looked-after children and young people.[45] This took the 2010 NICE/SCIE guidance,[41] including the systematic review[44] described above, and created eight statements[45] (see Box 11.3) to describe high-quality care.

Early identification

A secondary prevention approach is **embodied in the proportionate universalism of the Healthy Child Programme** with targeting of resources at families in need. Children in need and looked-after children are identified as vulnerable groups within the Healthy Child Programme.[50,51] Attachment to primary care givers is often disturbed and these experiences underpin the relational difficulties that some children have with foster carers and residential staff. Access to evidence-based parenting interventions to promote healthy attachments is needed.

Meeting the needs of children and young people in care

A tertiary prevention strategy **starts with the comprehensive implementation of *the Statutory Guidance on Promoting Health and Wellbeing of Looked-After Children*[52] by the health service and its partners**, but is more fully embodied by the social care quality standards described in Box 11.3.[45] Young people tell us that they want to have continuity of professional contact, and services that are joined up and co-ordinated. They are particularly concerned about transition to adulthood and access to adult health and care services.

Leon Polnay and Harriet Ward expressed the challenge for those working with and for looked-after children and young people: 'bringing about better outcomes… will also require exceptionally high levels of commitment and a culture change. **There needs to be both a continuity of policy and a continuity of relationships between looked-after young people and their health and social service professionals.**'[53]

'Love'
Source: Kids Company

Conclusion

Looked-after children are a vulnerable group highlighted by the UNCRC. Compared with their peers they have significantly more educational and mental health problems and care leavers have worse adult outcomes. There are socio-economic, parental and child-based risk factors associated with children entering public care. Looked-after young people have clearly stated what they feel is lacking in their lives and what could help them overcome their difficult earlier experiences, and a primary, secondary and tertiary prevention approach is needed. Warm, nurturing care in a stable placement is a key component of this strategy.

What we still need to find out

- What interventions improve outcomes for children with disorganised attachment?
- Are combinations of child, parental and socio-economic risk factors able to predict which children enter care?
- What interventions improve parenting in vulnerable families and reduce the risk of children entering care?
- What interventions improve educational outcomes for children in care?
- What interventions improve adult outcomes for care leavers?
- What interventions improve transition for young people in care, particularly around mental health and wellbeing?
- What interventions reduce risk-taking behaviours in looked-after children and young people, particularly early sexual activity, sexual exploitation, smoking, and alcohol and drug use?
- Does a public health approach to health, embodied in *Fair Society, Healthy Lives*, reduce the number of children entering care?
- What interventions promote wellbeing for looked-after children and young people?

Case study

Siblings Together

The charity Siblings Together champions, builds and strengthens relationships between brothers and sisters, aged 7–18 years, separated by the care system. It uses creative activities and skilled adult support to help the young people it works with in rebuilding their sibling relationships, supporting their broader social welfare and emotional wellbeing. Its role is to provide the guidance, structure, consistency and opportunities that children and young people should receive within a family but often lose when in care.

It has a lively annual programme of opportunities for siblings. The residential summer camps, which have been the cornerstone of Siblings Together's work since its conception, have gone from strength to strength as it continues to implement and develop its tried and tested camp model and to expand the number of camps available to siblings.

In addition to camps, Siblings Together has developed a range of other initiatives to encourage sustained positive contact between siblings. It has piloted and developed a monthly activity day programme which provides an opportunity for regular sibling contact. This programme provides a model for supporting siblings that can be applied throughout the country. It also organises a range of other 'one-off' educational and creative activities, such as a theatre project with the Roundhouse Theatre and the Arvon writers' camp, which encourage positive sibling contact in the context of learning new creative and educational skills.

Key messages for policy

- Implementing the United Nations Convention on the Rights of the Child in full is a priority.

- Addressing socio-economic determinants is a primary prevention strategy that may reduce the number of children entering public care.

- Implementing the proportionate universalism inherent in the Healthy Child Programme may limit children developing major social, educational and behavioural problems.

- Primary care and adult mental health workers should assess and support the parenting capacity of patients with mental illness, alcohol and drug misuse issues or learning disability. Implementing evidence-based interventions to promote secure attachment may limit children developing major social, educational and behavioural problems.

- Promoting resilience is a focus of the eight social care quality standards for the health and wellbeing of looked-after children and young people. This includes warm, nurturing care, a sense of belonging and emotional support.

- Further evidence is needed on effective interventions across a primary, secondary and tertiary prevention strategy.

- Action plans are needed to address the barriers to full participation in life and promoting wellbeing for looked-after children and young people.

- All parties must address the obstacles preventing access to Child and Adolescent Mental Health Services for looked-after children and young people.

- Ensure that staff in contact with looked-after children are trained to identify signs of sexual exploitation.

- Ensure that care leavers move to independence at their own pace, with a network of support to provide ongoing practical help and emotional support after leaving care

References

1. www.nspcc.org.uk/Inform/resourcesforprofessionals/lookedafterchildren/statistics_wda88009.html. Accessed 8.7.13.

2. Department of Health. Preventing suicide in England: A cross-government outcomes strategy to save lives. 2012.

3. Social Care Institute for Excellence. Preventing teenage pregnancy in looked after children. 2004, Briefing 9, Social Care Institute for Excellence, London.

4. Berridge,D, Biehal, N, Henry, L. Living in Children's residential homes. Department for Education, Research Report DFE-RR20, 2010.

5. United Nations Convention on the Rights of the Child. www.ohchr.org/Documents/ProfessionalInterest/crc.pdf. Accessed 3.6.13.

6. Children Act 1989, The Stationery Office.

7. Children and Young Persons Act 1969, The Stationery Office.

8. Department for Education. Children looked after in England (including adoption and care leavers) year ending 31 March 2012. Office for National Statistics, 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/167451/sfr20-2012v2.pdf.pdf. Accessed 2.6.13.

9. Department for Education. Children in need in England, including their characteristics and further information on children who were the subject of a child protection plan (Children in need census – final) Year ending 31 March 2010.

10. Viner RM, Taylor B. Adult health and social outcomes of children who have been in public care: population-based study. Pediatrics 2005;115(4):894–99.

11. Cook-Fong SK. The adult wellbeing of individuals reared in family foster placements. Child and Youth Care Forum 2000;29(1):7–25.

12. Schneider R, Baumrind N, Pavao J, Stockdale G, Castelli P, Goodman GS, Kimerling R. What happens to youth removed from parental care? Health and economic outcomes for women with a history of out-of-homne placemeent, Children and Youth Services Review 2009;31440–44.

13. Pecora PJ, Kessler RC, O'Brien K, White CR, Williams J, Hiripi E, English D, White J, Herrick MA. Educational and employment outcomes of adults formerly placed in foster care: results from the Norhtwest Foster Care Alumni Study. Children and Youth Services Review 2006;28(12):1459–81.

14. Vinnerljung B, Sallnäs M. Into adulthood: a follow-up study of 718 young people who were place in out-of-home care during their teens. Child & Family Social Work 2008;13(2):144–55.

15. del Valle JF, Bravo A, Álvarez E, y Fernanz A. Adult self-sufficiency and social adjustment in care leavers from children's homes: a long term assessment. Child & Family Social Work 2008;13(1):12–22.

16. Department for Education. Outcomes for Children Looked After by Local Authorities in England, as at 31 March 2012. Office for National Statistics, 2012. www.gov.uk/government/uploads/system/uploads/attachment_data/file/191969/SFR32_2012Text.pdf. Accessed 2.6.13.

17. Meltzer H, Gatward R, Corbin T, Goodman R, Ford T. The mental health of young people looked after by local authorities in England. London: The Stationery Office, 2003.

18. Ford T, Vostanis P, Meltzer H, Goodman R. Psychiatric disorder among British children looked after by local authorities; comparison with children living in private households. British Journal of Psychiatry 2007;190(4):319–25.

19. Kerker BD, Dore MM. Mental health needs and treatment of foster youth: barriers and opportunities. American Journal of Orthopsychiatry 2006;76(1):138–47.

20. Pilowsky DJ, Wu L-T. Psychiatry symptoms and substance misuse disorders in a nationally representative sample of American adolescents involved with foster care. Journal of Adolescent Health 2006;38(4):351–58.

21. Tarren-Sweeney M. The mental health of children in out-of-home care. Current Opinion in Psychiatry 2008;21(4):345–9.

22. Tine E, Mette L. Prevalence of mental health problems among children placed in out-of-home care in Denmark. Child & Family Social Work 2009;14(2):156–65.

23. Hjern A, Vinnerljung B, Lindblad F. Avoidable mortality among inter-country adoptees and child welfare recipients – a national cohort study. Journal of Epidemiology and Community Health 2004;58:412–417.

24. Kalland M, Pensola TH, Meriläinen J, Sinkkonen J. Mortality in children registered in the Finnish child welfare registry: a population based study. BMJ 2001;323:207–8.

25. Vinnerljung B, Ribe M. Mortality after care among young adult foster children in Sweden. International Journal of Social Welfare 2001;10:164–173.

26. Williams J, Jackson S, Maddocks A, Cheung W-Y, Love A, Hutchings H. Case control study of the health of those looked after by local authorities. Arch Dis Child 2001;85(4):280–5.

27. Thompson Jr RG, Auslander WF. Risk factors for alcohol and marijuana use among adolescents in foster care. Journal of Substance Abuse Treatment 2007;32(1):61–9.

28. Vaughn MG, Ollie MT, McMillen JC, Scott Jr L, Munson M. Substance use and abuse among older youth in foster care. Addictive Behaviors 2007;32(9):1929–35.

29. Wall AE, Kohl PL. Substance use in maltreated youth: findings from the National Survey of Child and Adolescent wellbeing. Child Maltreat 2007;12910:20–30.

30. Vinnerljung B, Franzén E, Danielsson M. Teenage parenthood among child welfare clients: a Swedish national cohort study of prevalence and odds. Journal of Adolescence 2007;30(1):97–116.

31. The Children's Society submission to the Home Affairs Select Committee – Localised Child Grooming, November 2012.

32. Growing Up in the UK: Ensuring a Healthy Future for our Children. BMA Board of Science May 2013.

33. Bebbington A, Miles J. The background of children who enter local authority care. British Journal of Social Work 1989;19:349–68.

34. Simkiss DE, Spencer NJ, Stallard N, Thorogood M. Health service use in families where children enter public care: a nested case control study using the General Practice Research Database. BMC Health Services Research 2012, 12:65.

35. Franzén E, Vinnerljung B, Hjern A. The epidemiology of out-of-home care for children and youth: a national cohort study. British Journal of Social Work 2008;38(6):1043–59.

36. Kalland M, Sinkkonen J, Gissler M, Meriläinen J, Siimes MA. Maternal smoking behaviour, background and neonatal health in Finnish children subsequently placed in foster care. Child Abuse & Neglect 2006;30(9):1037–47.

37. Christoffersen MN, Soothill K. The long-term consequences of parental alcohol abuse: a cohort study of children in Denmark. Journal of Substance Abuse Treatment 2003;25(2):107–16.

38. Friedlaender EY, Rubin DM, Alpern ER, Mandell DS, Christian CW, Alessandrini EA. Patterns of health care use that may identify young children who are at risk for maltreatment. Pediatrics 2005;116(6):1303–8.

39. Needell B, Barth RP. Infants entering foster care compared to other infants using birth status indicators. Child Abuse & Neglect 1998;22(12):1179–87.

40. Simkiss DE, Stallard N, Thorogood M. A systematic literature review of the risk factors associated with children entering public care. Child: Care, Health and Development 2013;39(5), 628–642.

41. National Institute for Health and Clinical Excellence and Social Care Institute for Excellence. Promoting the quality of life of looked-after children and young people, Public Health guidance 28. National Institute for Health and Clinical Excellence, 2010.

42. Jones R, Everson-Hock ES, Papaioannou D, Guillaume L, Goyder E, Chilcott J, Cooke J, Payne N, Duenas A, Sheppard LM, Swann C. Factors associated with outcomes for looked-after children and young people: a correlates review of the literature. Child: Care, Health and Development 2011; 37(5):613–22.

43. Berridge D, Biehal N, Lutman E, Henry L, Palomares M. Raising the bar? Evaluation of the Social Pedagogy Pilot Programme in residential children's homes. Research Report DFE-RR148, 2011, Department for Education.

44. Dickson K, Sutcliffe, K and Gough D (2009) The experiences, views and preferences of Looked After children and young people and their families and carers about the care system. Social Science Research Unit Institute of Education, University of London. www.nice.org.uk/nicemedia/live/11879/47416/47416.pdf. Accessed 2.6.13

45. National Institute for Health and Care Excellence. Quality standard for the health and wellbeing of looked-after children and young people, NICE quality standard 31. National Institute for Health and Care Excellence, 2013.

46. Department of Health. The Quality Protects Programme: Transforming Children's Services 2000–2001 – District Council's Role, Department of Health, 2000.

47. Polnay L. Take it with a pillar of salt or "ambitious but achievable targets". Arch Dis Child. 2000;82(4):278–279.

48. Marmot M. Fair Society, Healthy Lives: UCL, 2010.

49. UCL Institute of Health Equity. An Equal Start: Improving outcomes in Children's Centres. 2012, UCL Institute of Health Equity.

50. Department of Health. Healthy Child Programme; Pregnancy and the first five years of life. London: The Stationery Office, 2009.

51. Department of Health. Healthy Child Programme: From 5–19 years old. London: The Stationery Office, 2009.

52. Department of Health. Statutory Guidance on Promoting the Health and Wellbeing of Looked after children. London: The Stationery Office, 2009.

53. Polnay L, Ward H. Promoting the health of looked after children. Government proposals demand leadership and a culture change. BMJ 2000;320(7236):661–2.