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Promoting the health of looked after children

Government proposals demand leadership and a culture change

The Waterhouse report on the widespread abuse of children in care in north Wales from 1974 has focused attention on the issue of how vulnerable such children are to abuse.[1] But these children are vulnerable in many ways, not least in terms of their health care, and they are often let down by those who are meant to serve them. The government has been making attempts to improve their overall care and welfare and is currently consulting on improved arrangements for health care.

In December 1999 the English Department of Health issued proposed new guidance on the health care of looked after children.[2] "Looked after" is the term introduced by the Children Act 1989 to cover all children in public care, including those in foster or residential homes and those still with their own parents but subject to care orders. The new guidance on health care is one of a series of publications that include a revised edition of *Working Together to Safeguard Children*,[3] which updates the guide to interagency working to promote children's welfare and protect them from abuse, and a new *Framework for Assessment of Children in Need and their Families*.[4] All these aim to help local authorities demonstrably improve outcomes for children in need, by meeting stringent objectives, which include the requirement "that children looked after achieve a standard of health and development as good as all children of the same age living in the same area."[5]

Only a very small number of children (53 300) are looked after on any one day, and most of these will return to their families within six months. However, those who come into the system are among the most vulnerable children in our society. They have a higher level of health, mental health, and health promotion needs than others of the same age. Though the health needs of many of these children derive from poverty,[6] undiagnosed health problems, poor uptake of preventive health care in their birth families, and physical and sexual abuse or neglect, other children are looked after because their parents need support in helping them cope with a disability.[7] Many reports and publications have drawn attention to the spiralling costs[8] and poor outcomes for looked after children, especially when placed in residential care.[9] Seventy five per cent of young people leaving care have no educational qualifications, 30% of single homeless people have been in care, and one in seven young women leaving care is pregnant or already a mother.[10]

The potential for the care service to compensate for previous deficits rather than simply to provide accommodation until children reach adulthood is not always explicitly understood.[11] The Children Act 1989 requires local authorities to monitor children's developmental progress and to ensure that each looked after child has an annual medical report. However, expectations remain low, and there is substantial evidence that common physical and mental health problems often fail to be identified or adequately managed.

Several reasons explain why the health needs of looked after children are inadequately addressed. There is no specification for the content of medical reports, which are often of poor quality and carried out by doctors who do not have access to the medical or family history. Very few young people view their annual medical assessment in a positive light, and many refuse to attend: indeed, the uptake of health assessments is as low as 25% in some authorities.[12] A

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common criticism is that children are administered rather than parented.

Paradoxically, when children become looked after, the "inverse care law" may apply: these vulnerable children are 10 times more likely to be excluded from school than their peers and thereby be denied the input that school health services may have to offer. Placements are notoriously unstable: each year about 19% of looked after children move through three or more different addresses.[13] Such moves result in discontinuity of health treatment and knowledge: an unknown number of looked after children spend long periods as temporary residents of general practices.

The new proposals will reinforce the responsibility of local authorities to fulfil the role of an active and concerned parent. To do this they will need to develop key skills and knowledge about child health. Individual medical practitioners will also need specific training, and an approved list may be required. Two steps for medical assessment are proposed: an initial assessment followed by a comprehensive health assessment for those who remain in care after 12 weeks. The question of whether the annual health assessments should be replaced by individual healthcare planning is discussed, as is the role of other health professionals such as community nurses. Much better coordination and faster transfer of records is advocated. A designated nurse and doctor would oversee the process to ensure that assessments are carried out, that they are used to formulate a healthcare plan for each child, and that the plan is implemented. Adequate resources, especially in mental health services, will have to be in place.

The new proposals are currently out for consultation: joint responses are invited from local health and social services departments. If implemented, these measures should provide both a structure and a process to carry out the tasks required of the health service. However, bringing about better outcomes for this socially and often professionally excluded group of young people will also require exceptionally high levels of commitment and a culture change. There needs to be a both a continuity of policy and a continuity of relationships between looked after young people and their health and social service professionals. For the children, "I care" should mean more than "I look after."

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Good practice in sterilisation

New British guidelines will help

Compared with other Western European countries, Great Britain has a high rate of sterilisation, 23% of women of reproductive age or their partners using this method. For New Zealand these figures are even higher, 38% of couples relying on sterilisation.[1] Although these figures may fall with the introduction of other long acting contraceptive methods and a shift to delayed childbearing, it is timely to have guidelines from the Royal College of Obstetrics and Gynaecology on such common procedures.[2]

The guideline on male and female sterilisation synthesises the available evidence and categorises it according to its strength as A (based on adequately designed randomised controlled trials), B (other experimental or observational evidence), or C (consensus among experts).[2] The guideline emphasises the specific consent issues for different procedures together with a revised estimate of failure of tubal ligation. Previous studies of failure rates after tubal ligation have often had only one or two years of follow up. The revised pregnancy rate after tubal ligation quoted by the guideline is 1 in 200. The large multicentre study from the Centers for Disease Control, with a 10 year follow up found even higher failure rates—from 18.0 to 18.8 per 1000 procedures.[3] Factors associated with increased failure were age under 30 and the use of bipolar coagulation. Improper application of the occlusive devices was also a constant factor in failures in one residency training centre. The recommendation in the guideline of standards for trainees should lead to improved effectiveness of tubal ligation, and its recommendation for a national register and continuing audit should help to clarify long term failure rates.

Ectopic pregnancies after tubal ligation are common, accounting for 75% of pregnancies in women who have undergone tubal ligation.[4] The

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