Children in care and physical health – a neglected topic?

Introduction

Most children and young people who remain in care on a long-term basis have been abused and neglected, with compulsory measures used to separate them from their birth parents. It is understandable that there is considerable emphasis upon the traumas that they have experienced, with accompanying emphasis upon the insecurity of their attachments and other mental health challenges. In comparison the state of their physical health is not so much debated.

However, an individual's physical health may inter-relate with their mental health; that is so for all individuals. Physical exercise, for example, may enhance an individual's sense of well-being while an inadequate diet may affect self-image if seriously over or under weight. For looked after children there may be additional associations to what they eat relating to availability and comfort.

Nevertheless, an aspiration for local authorities as corporate parents is to ensure that the health of children in care is at least as good as that of their overall peer group.

Case example:

Carl (aged 9) is in a specialist placement residential placement; his behaviour towards other children can sometimes be unpredictable and aggressive. He has had various therapeutic interventions - cognitive–behavioural, life-history based, etc: he has said that if neuro-linguistic therapy programming 'doesn't work' he 'doesn't know what' he will do'.

He is interested in rugby – walls of his room are plastered with information about St Helens rugby league club. At a placement review [and having consulted Carl] the social worker queried whether attending rugby training with the aim of attending matches – and the potential discipline, friendships that could bring – might potentially be of as much benefit to him as organised therapies.

The National Context

In making such comparisons some acknowledgement should be made of dominant national discourses in relation to children's physical health. For example, their diet, weight and the amount of exercise that they take are inter-related factors that have received much publicity, with talk of problems in these areas that have reached 'pandemic' proportions [1]. When considering health beliefs since the creation of the NHS, there has been a move from seeing medical professionals as those who will both solve and prevent ill health to greater emphasis upon individual responsibility. That perspective will influence the behavior of local authorities having parental responsibility for children and young people in care, as well as the subjects themselves.

Concerns about standards of care for looked-after children

There are several reasons for assuming that children in care will be disadvantaged in relation to physical health. Generally, looked-after children come from economically poor backgrounds, with evidence that the recent growth in the number of children in care relates to increased poverty [2]. There is a proven link between poor diet and income [3]. In addition, parents' attention may have been diverted by mental illness, substance misuse, etc, leaving limited encouragement within the home for sport and physical activities generally.

There have also been criticisms about the standards of parental care offered by local authorities. National statistics in relation to education, for instance, depict children and young people in care / recently left care as being very considerably behind in all aspects of educational attainment [4]. Figures in relation to standards of physical health are not so readily available: however local studies such as one in Tower Hamlets in England [5] as well as the whole of Scotland [6] would suggest that standards of dental health for this group are considerably below that of their peers, the latter study finding that extractions were twice as common. Debates continue as to the extent to which these disadvantages relate to backgrounds and experiences before or after children enter care - and the extent to which the present system 'fails' children [7] [8]. A challenge for 'corporate' care, with parental responsibilities being shared between birth parents and local authorities - foster and residential carers having delegated responsibilities - is who takes responsibility for health recommendations made at reviews. One study found that follow-up happened

in only 54% of cases [9]. Parenting that is 'Good Enough' will sometimes depend upon attention to detail, and also carers who have the confidence to discuss and question the views of professionals around them – not necessarily straightforward for those having day to day responsibilities for children in care.

Case Example

It is agreed that Carl would benefit from Rugby training at a local club. With Carl's agreement, his keyworker at the children's home is prepared to liaise with the club, explain something of Carl's position and take him / collect him from training / matches. The managers at the home are uncertain whether they have resources to allow that.

The policy framework

The boarding out regulations used by the post war Children's Departments included expectations that health would be discussed when children in care had placement reviews and that they had regular medicals. It is only since local authorities adopted the looked-after children materials at the turn of the last century that guidelines for health assessments and planning for this group have been more detailed. In addition to health medicals [which teenagers who are Gillick competent can refuse] each child in care has a health plan which should be considered at statutory reviews under the Care Planning, Placement and Review Regulations, 2010. Fostering Services Regulation 15 [2011] states that in addition to being registered with a GP a care provider must have 'access to such medical, dental, nursing, psychological and psychiatric advice, treatment and other services as the child may require' and receive 'guidance, support and advice on health, personal care and health promotion issues appropriate to the child's needs and wishes'. At foster carer reviews 'Being Healthy' is one section that has to be completed in relation to the work that they are doing with a child they are fostering.

In addition, designated nurses and doctors must be identified in each area who will take a strategic interest in improving health outcomes for looked after children, reflecting a need for multi-agency co-operation and input if efforts to improve the health of looked after children are to be successful [10]. As with Education plans, these developments appeared to represent clear improvements on what went before – if fully implemented. An impediment to improving the health of looked after children can be changing placement while

in care, as well as moving in and out of care. That may mean that continuity in terms of identifying individual health issues and treatments is lost, with a reluctance to register children with GPs if it is thought placements might be short term, appointment details being mislaid, etc [11]. Children may also suffer if parents don't share hereditary and other health related details with subsequent carers, perhaps because they underestimate their importance or because they are reluctant to co-operate with key professionals.

Case example

Lorna, (3) was placed for adoption soon after birth. She has suffered considerably with breathing problems, and following investigation was found to have Cystic Fibrositis a genetic / hereditary condition. Nothing in the information about her medical background received before the adoption order was made had prepared her adoptive parents for this. Subsequent research with the help of the adoption support team has suggested that there is some history of Cystic Fibrositis within her birth father's family.

The physical health of looked after children – possibilities for imaginative practice

(a) Weight and Diet

Obesity within the UK population and its relationship with diet has become a dominant societal discourse, that has particular ramifications for parenting. The quality of parenting experienced by looked-after children relies upon the resources and skills of foster and residential carers.

We know that children in care come disproportionately from low income backgrounds and where family dynamics are also chaotic: factors likely to influence both the quality of food that they are offered before they come into care and - just as importantly - the circumstances in which eating takes place. There have been several local studies regarding obesity in looked after children, however there does not seem to be consensus whether children in care are more likely to be overweight than peers living with birth parents or, importantly, whether that group is likely to lose or gain weight while in care [12], [13] [14].

Detailed nutritional guideless are available in relation to children of all ages in care and for care leavers [15]. The importance of a balanced diet**,** not

dominated by salt, sugars and processed foods is highlighted in foster parents training, with some agencies providing 'Food in Care' courses [16]. It is also a matter considered and documented at foster carer reviews. Stirling University has produced a workshop facilitators' pack aiming to introduce participants to the symbolic implications of food [17]. There are anecdotal examples illustrating the sometimes complex relationship between emotions and food for children in care, which can make the requirement they have a healthy diet a challenging task.

Case Example:

Kieran's mother was his main carer until age 4 but her life was dominated by drug taking, prostitution and poverty. His staple food at the time he came into care was curry, chips and a fizzy drink, although at 15KG his weight gave no cause for concern. He has found it extremely difficult to adapt to the 'healthy diet' now offered to him, discarding green vegetables as 'yuk' and constantly asking for curry and chips. He eats these ravenously and has been found hiding bits of this meal under his bed. He eats mainly with his fingers. His foster carers are discussing with their supervising social worker how to combine listening to Kieran's preferences with the need to promote healthy eating. They see this as a gradual process: encouraging him to help putting food shopping lists together, explaining the origins of vegetables, having guessing games relating to the smell and texture of food, offering treats such as ice cream following a 'healthy' plate of food.

The balance aspect of diet is important: the local authority as corporate parent should be concerned about a healthy diet. There are further issues to consider for children in care in terms of children's rights to be involved in decisions about what they eat and also emotions associated with eating / mealtimes. Mealtimes can be used as an opportunity to relax and communicate; on the other hand children may react badly to over-strictness about food, refusing to eat for instance. They may have food preferences that evoke past memories, etc. These are all factors that may be as important for children in care as dietary ones [18].

An important related matter is ensuring knowledge knowing about dietary preferences of children carers are looking after by including that in assessments when they enter care or change placement. A useful model here could be Essential Lifestyle Planning, an approach initially developed in relation to needs of people with learning disabilities [19]. It recognizes that new carers

are often given insufficient information, and aims to improve quality of care, emphasizing individual need by detailing what is essential / important and preferences. That could apply to what food a child or young person wants to eat.

Purchasing and preparing food of good nutritional quality is a task that young people leaving care should be familiar with but that they have frequently self-identified as lacking skills [20]. For this group, some of who may have limited support from family, it should be part of the preparation process for leaving care.

On local levels there have been noteworthy attempts to improve awareness of nutritional issues amongst looked after children and their carers. The Hearty Lives project in Liverpool was one example [21]. Young people aged 11-17 and their carers [mainly foster parents and residential workers] were involved in a project to raise awareness of issues relating to diet and exercise, these included cooking and taste courses and workshops and food growing workshops, as well as exercise sessions. A focus group of seven young People involved in the project from the local Children in Care Council shared their ideas about keeping fit, exercise and healthy eating, exchanging ideas about healthy diet and related recipes.

A question about initiatives such as Hearty Lives is how lessons learnt can be integrated into everyday practices. Ultimately the 'agency' of carers, children and young people involved will be crucial in influencing and changing dominant discourses and cultures around 'being healthy'.

(b) Exercise

As with diet, exercise can be a means of regulating weight, can contribute to general fitness and is the subject of popular discourses about unhealthy sedentary lifestyles. Surveys by the Youth Sport Trust [22] indicated that the majority of parents were not aware of the NHS guideline that 11 to 19-year-olds should have at least an hour of exercise every day, only 45% of young people averaging that amount during a week [23]. The points already made in respect of diet and knowledge of child's preferences and capabilities will be relevant to exercise, also carers' knowledge and interest.

Some of the literature on looked after children and exercise concentrates quite heavily upon school sport [24], but it is important to remember that team

sports may be anathema for some children and that there will be other contexts – in their lives with foster carers or in out of school clubs - in which fitness can be encouraged [25].

Case Example: *At eight years of age Martin is facing a transfer from his present foster home to a 'permanent' one. Teachers say they find him a 'handful', particularly in terms of a tendency to get into 'scraps' with other pupils; that he struggles to concentrate upon school syllabus, including organised sport, although his proficiency at swimming and roller-blading has brought him some accolades from his peers. His present foster carers recount how he initially found the countryside near them 'green and boring' but that turning walking into 'discovery' sessions sparked his enthusiasm. Martin's new foster father is a keen footballer and is looking forward to playing with him and introducing him in a local boys' team, wanting to encourage involvement in 'team' sports.*

Fitzgerald and colleagues [26] discussed an initiative in which young people in residential care were encouraged to increase physical training which helped them to lose weight. As with initiatives relating to diet and nutrition, a challenge is maintaining momentum in relation to such improvements and working out their relevance to all children and young people in care. There is an argument for exercising 'positive discrimination' in relation to this group, by making local authority sports centres free to looked after children, as has happened in some areas [27].

Research elsewhere has involved young people more directly. In his participative study involving five young men in residential care, Quarmby [28] identified three themes relating to their involvement in sport and exercise. The first was engagement with sport being disrupted by coming into care and changes of placement/ school, with young people not always having the confidence or encouragement to continue. The second was institutional constraints, with young people requiring assistance – not always available - in getting to events where there was physical activity. Elsewhere, Quarmby and colleagues [29] give the example of 'Meg' not being allowed to have her picture taken with her football team, because of the need for corporate permission. The third theme related to 'sport as a means to an end', recognizing the 'latent functions' that sport may have in making friends and contacts outside the care system, for example.

Promoting 'resilience' is an important objective in relation to supporting children in care deal with the challenges of their lives [30]. Developing skill in

an area such as football can potentially raise confidence and a feeling of self-efficacy – that as an individual you can influence events though your own actions; helpful when tackling life challenges more generally. Such activities might also result in making a new group of friends, or involve interest / mentorship from others and help them to accumulate 'social capital', important resilience factors for children not living with their birth families [31].

Summing up

Concerns about the quality of the citizen's physical health are common in professional and public discourses and not confined to children and young people in care. Because of poverty and parenting that has not been seen as 'good enough', assumptions can be made that looked-after children will be more disadvantaged than their peers in health matters before they enter care - and that with the challenges of corporate parenting those disadvantages will continue. There is some evidence, research-based and anecdotal, for both those propositions, although there are also examples of greater awareness and detailed associated assessments and interventions. Writing in the British Medical Journal of Clinical Research in 2000, Polnay and Ward [32] depicted health provisions for children in care that were inefficient and often ineffective – hopefully increased interest and guidance means that practice has improved since then.

When reviewing the literature on physical wellbeing it is noticeable that, with some exceptions, the voices of children and young people in care are often muted/ absent, relying heavily on those who were co-operative with researcher initiatives and on small samples. Greater understanding of their perspectives on this topic will no doubt be central to success in making improvements in this area. Research, policy and awareness initiatives can all contribute positively in improving the well-being of looked after children, but ultimately progress in this area will rely heavily on well-informed practice by carers, health workers and social workers and their ability to engage the young people they are involved with.

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