



## Models of Child Health Appraised (A Study of Primary Healthcare in 30 European countries)

# Health care in Europe for children in societal out-of-home care

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## Introduction

For decades, studies from Europe, North America and Australia have consistently reported that children entering and residing in societal out-of-home care (OHC; foster and residential care, secure units) have radically more health problems and more health care needs than other children in national populations. This is the case for

- Somatic health (e.g. Schor, 1982; Bamford & Wohlkind, 1988; Chernoff et al, 1994; Haflon et al, 1995; Bundle, 2001; Hill & Thompson, 2003; Hill & Watkins., 2003; Anderson et al, 2004; Hansen et al, 2004; Kristoffersen, 2005; Leslie et al, 2005; Miller et al, 2007; Nathanson & Tzioumi, 2007; Kaltner & Rissel, 2011; Nelson et al, 2011; Schnedierman et al, 2011; Simkiss, 2012a; Köhler et al, 2015; Szilagy et al, 2015; Tanguy et al, 2015; Kling et al, 2016a, -b; Dunnigan et al, 2017; Randsalu & Laurell, 2017).<sup>1</sup> One concrete example is that a high prevalence of asthma has been reported from several countries (e.g. Nelson et al, 2011; Jaudes et al, 2015; Kling et al, 2016b; Dunnigan et al, 2017). In the US, several studies have found that children in OHC have the highest rates of chronic health conditions of any studied child population (Leslie et al, 2005; Jee et al, 2006; Stein et al, 2013; Jaudes et al, 2015, 2016). High levels of indications of disabilities compared to general population peers, including mental health related conditions, have been reported from several countries (e.g. Zewdu, 2010; Lightfoot et al, 2011; Aguila et al, submitted).
- Dental health - although there is far less research in this field compared to somatic and mental health (e.g. Swire & Kavalier, 1977, Olivan, 2003; Nathanson & Tzioumi, 2007; Sarri et al, 2012; Melbye et al, 2014; Haysom et al, 2015; Kling et al, 2016a –b; Randsalu & Laurell, 2017).
- Mental health – the most thoroughly studied health aspect among children in OHC (e.g. McIntyre & Keesler, 1986; Bamford & Wohlkind, 1988; McCann et al, 1996; Stein et al, 1996; Dimigen et al, 1999; Kjelsberg & Nygren, 2004; Minnis et al, 2006; Ford et al, 2007; Saywer et al, 2007; Schmid et al, 2008; McAuley & Davis, 2009; Egelund & Lausten, 2009; Pecora et al, 2009; Damjanovic et al, 2011; Lehmann et al, 2013; Havnen et al, 2014; Maaskant et al, 2014; Sainero et al, 2014; Cohn et al, 2015; Greger et al, 2015; Tanguy et al, 2015; Bronsard et al, 2016; Jozfiak et al, 2016; Turney & Wideman, 2016; Gonzalez-Garcia et al, 2017; Vasileva & Peterman, 2017). Excess rates of psychiatric morbidity are reflected in very high rates of psychotropic medication of children in foster and residential care, in comparison to general population peers (e.g. Zito et al, 2008; Socialstyrelsen, 2014), including frequent use of anti-psychotics (Socialstyrelsen, 2014; Tai et al, 2016). Several European studies have also affirmed that OHC-children with indications of psychiatric disorders are underserved by child/adolescent mental health

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<sup>1</sup> An exception from the UK is Williams et al, 2001

services (eg. McCann et al, 1996; Phillips, 1997; Mount et al, 2004; Minnis et al, 2006; Sainero et al, 2014; Butterworth et al, 2017; Gonzalez-Garcia et al, 2017).

Another recurrent message from international research concerns low immunization rates among OHC-children compared to general population peers (e.g. Williams et al, 2001; Ashton-Key & Jorge, 2003; Hill et al, 2003; Morrith, 2003; Rodrigues, 2004; Barnes et al, 2005; Köhler et al, 2015; Kling et al, 2016a; -b; Randsalu & Laurell, 2017). Walton and Bedford (2017) reviewed 32 studies (half of them from the UK) and found this result to be consistent, over time and between countries. The only exception we have found comes from Northern Ireland, where Farrell (2003) found similar immunization rates among 75 children in OHC as among other peers. The author's explanation was that in Northern Ireland, health and social services have been integrated since the 1970s.

In addition, a large body of research has produced convincing evidence that many of these children will suffer substantial health problems over the life course - somatic, dental and mental health problems (e.g. Viner & Taylor, 2005; Vinnerljung et al, 2006; 2015; Kessler et al, 2008; Vinnerljung & Sallnäs, 2008; Schneider et al, 2009; Berlin et al, 2011; Villegas et al, 2011; Zlotnick et al, 2012; Björkenstam et al, 2013a; von Borczykowski et al, 2013; Bruska & Tessin, 2013; Ahrens et al, 2014; Vinnerljung & Hjern, 2014; Socialstyrelsen, 2016). High excess rates of premature death in adulthood, especially for suicide, have been reported in several studies (Vinnerljung, 1995; Barth & Blackwell, 1998; Christoffersen, 1999; Kalland et al, 2001; Vinnerljung & Ribe, 2001; Vinnerljung et al, 2010), also after adjustments for socio-economic confounders (Hjern et al, 2004; Gao et al, 2017).

### *Why?*

The reasons for this dismal picture are several, most likely operating in combinations on the individual level:

Firstly, most of these children have a history of parental neglect or abuse before entering care. The links between poor health – also in a life course perspective – and childhood maltreatment are well known and considered causal by most scientists (e.g. Norman et al, 2012; Fryers & Brugha, 2013).

Secondly, many children in OHC care have parents with serious mental health problems, which make the offspring a genetically vulnerable group for developing mental health disorders over time (e.g. Vinnerljung et al, 2006; Dean et al, 2010; Simkiss et al, 2013).

Thirdly, several studies have uncovered strong associations between chronic childhood stress and later psychiatric morbidity (e.g. Blair et al, 2011; Gard et al, 2017). This background is shared by many OHC. Other scholars have focused on early imprinting of social disadvantage and its salient links to health problems over the life course (e.g. Ferraro et al, 2016).

Fourthly, before entry to care a sizeable proportion of OHC children have suffered neglectful health care due to inadequacies of parental supervision, also in countries with a comprehensive and cost free child health care system (e.g. Köhler et al, 2015; Randsalu & Laurell, 2017).

Fifthly, some older children tend to ignore scheduled visits to health and dental health care providers (e.g. Morritt, 2003; Kling et al, 2016b; Walton & Bedford, 2017). Among the adolescents, many have in addition destructive and risk-taking life styles that include substance abuse and violent behavior (e.g. Farrington, 1995; Wade & Pevalin, 2005).

Sixthly, a contributing reason for poor health outcomes in adult age for this group is most likely aggregations of adverse childhood experiences (ACE). Examples of ACE are childhood abuse/neglect, poverty, and various forms of family dysfunction (parental mental health problems, substance abuse and criminality). A host of studies have found that clusterings of ACE have strong links to somatic and mental health problems in adult age, including premature death (eg. Felitti, 2002; Felitti et al, 1998; Chapman et al, 2004; Harkonmäki et al, 2007; Björkenstam et al, 2013b, 2016a –b, 2017a, -b). So far, we have relatively few ACE-studies on child welfare clients. But they show consistently that aggregations and complex combinations of ACE are – as may be expected – highly prevalent. In addition, even in this extreme population, accumulations of ACE are linked to higher levels of mental health problems, psychological distress and various psychosocial problems (Bruskas & Tessin, 2013; Basto-Pereira, 2016; Fridell et al, 2016; Rebbe et al, 2017; Turney & Wildeman, 2017).

But there is also evidence over many years for negative consequences of a common lack of systematic routines for provision of health services in OHC, over-reliance on carer observations, and even of neglect of health issues by child welfare authorities (e.g. Butler & Payne, 1997; Ward et al, 2002; Ashton-Key & Jorge, 2003; Kessler et al, 2008; Kling, 2010; Kaltner & Rissel, 2011; Kling et al, 2016a, -b; Randsalu & Laurell, 2017). The endemic instability of OHC (multiple placements/changes of residence over time are common) probably contributes significantly to this problem (e.g. Ward et al, 2002; Nelson et al, 2011). These children do not seem to be well served by general child health care systems in European welfare states. Everything cannot be blamed on the birth parents or on the children themselves.

With this overwhelming body of scholarly work as a background, MOCHA has undertaken a study of how countries in Europe handle the issue of health/health care for children in OHC. The aim is to report on the organization and practice of provision of health care for children in foster and residential care, with a special focus on systematic routines for assessing and monitoring the health of this vulnerable and in many ways excluded minority in the population. A sizeable proportion of a country's child population will have experienced placement in OHC some time during their childhood (0-17 years): 3-5 percent in studies from England and Scandinavia, roughly corresponding to one child in an average primary school class (Vinnerljung, 1996; Vinnerljung et al, 2007a; Fallesen et al, 2014; McGrath-Lone et al, 2016). Based on national surveys, Eurochild (<http://eurochild.org>) estimated that at any given day in 2010 roughly 1 million children in the European Union were in foster or residential care (Eurochild, 2010).

The ethics and moral values underlying this report (cf. Myrdal, 1969) is best summarized by the credo *in loco parentis*, 'in the place of parents' (e.g. Jackson, 1994; Mather et al, 1997; Smithgall et al, 2004). When the state assumes responsibility for non-temporary 24 hour care of children, the state should act like what we would expect from reasonably able parents, for example by taking good care of the children's health.

## Method

Through the MOCHA network of informants, we sent out a questionnaire to 30 European countries with queries about how health care for OHC children is organized (see appendix 1). The questions were guided by results from relevant research, briefly summarized in the introduction. Key questions in the survey concerned legislation and practice regarding routines for assessing health when children enter the care system and for monitoring health while they are residing in foster homes or residential care. The main reason for this focus is that the research community (and others) has for decades repeatedly and consistently recommended that child welfare authorities create systematic and statutory routines for health assessment and health monitoring of children in OHC, in view of the high prevalence of health problems and health care needs in this group (e.g. Hochstadt et al, 1987; CWLA, 1988; AAP, 1994; 2001, 2002; 2011; Butler & Payne, 1997; Leslie et al, 2003; Hill & Mather, 2003; Hill & Thompson, 2003; Nelson et al, 2011; Leve et al, 2012; Luke et al, 2014; Szilagy et al, 2015; Kling et al, 2016a, -b; Swank & Gagnon, 2017).

We received completed questionnaires from 24 countries, corresponding to a response rate of 80 percent<sup>2</sup>. These replies were supplemented by information we received during a workshop in Stockholm in April 2017 with participants from a dozen countries, and also with information from government reports and research literature. When we in this report refer to ‘informants’, this term includes both the responders of the survey and participants in the workshop.

In addition, within this sub-project of MOCHA we are performing a systematic literature review on evaluations of methods and models for health assessments and service delivery for children in OHC, in cooperation with The Swedish Agency for Health Technology Assessment and Assessments of Social Services (Swedish acronym SBU; <http://www.sbu.se>). The review will be published in spring 2018. Much of the literature cited in this report was found in the literature searches that will be the base of that review. But in contrast to the proceedings of a systematic review, we have not systematically assessed bias of the works cited.

### *Methodological considerations relating to the survey*

It is probable that our informants in the MOCHA-network were not fully familiar with all aspects of current legislation and practice in their home countries. Therefore it is important

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<sup>2</sup> Non-responders were Bulgaria, Cyprus, Hungary, Luxembourg, Slovakia and Slovenia.

that the reader does not place excessive value on details describing health care for the target group in individual countries – they may contain errors - and instead maintain a focus on the overall picture that is revealed by the data from the survey.

## Results

The operational organization of child welfare varies considerably between nations (see Table 1). In seven countries child welfare is administered by national government agencies, in four by regional authorities, in eight by local/municipal authorities, and in five countries responsibility is shared by different levels of government. In half of the countries participating in the survey (n=12), governments on the national level have at least some form of operational responsibility. More would be added if we included auditing and legislative functions. Henceforth, in most countries national governments have a decisive influence on how a country's child welfare is structured and operated.

Table 1: Level of administrative/operative responsibility of child welfare.

Country	National	Regional/provincial	Local/municipal
Austria			x
Belgium		x	
Croatia	x		
Czech Republic		x	
Denmark			x
England	x		
Estonia	x		
Finland			x
France		x	
Germany			x
Greece	x		
Iceland	x		x
Ireland	x		
Italy			x
Latvia	x	x	
Lithuania			x
Malta	x		
Netherlands			x
Norway	x	x	x
Poland	x	x	x
Portugal	x		
Romania	x	x	x
Spain		x	
Sweden			x

(no missing data)

### *Provision of health care to children in out-of-home care*

In all countries (with minor exceptions regarding some forms of specialist dental health care in a couple of countries), children in OHC are fully integrated in the national insurance system that covers access and costs for somatic, dental and mental health care. In some countries, children in foster families are covered by the foster parents' insurance, in others by a national insurance not connected to their residence. In general, they have access to health care in the same way as all other children in their home country. In Ireland, legislation gives these children *priority access* to all forms of health care (the national informants pointed out that this principle may not be as evident in daily practice as in the legislation, especially regarding mental health services). Respondents from several countries remarked that there was a general shortage of some forms of health services (mainly mental health), which naturally affected children in OHC. In Greece, this problem was often amended by accessing services provided by charity organizations.

Most countries in our survey have health professionals – doctors, nurses, dentists or psychologists - employed or contracted within their child welfare organizations, mainly in residential care facilities (see table 2). However, these arrangements may vary substantially between different residential units in the same country. Some have a doctor attached to the facility and others will use general health services for their children. In England, mandatory rules for the health care systems include appointments of *designated doctors and nurses*, responsible for overseeing provision of health care within a geographical area for children in foster families or in residential care. In addition, England has *named doctors, named nurse, specialist nurses and medical advisors* (physicians) in local medical practice that are responsible for the OHC-children's health care (see more detailed description on pp. 16-17). A similar system was launched in France in 2016, through a new legislation.

Table 2: Health care professionals employed/contracted by child welfare authorities or care providers<sup>3</sup>. Blanks indicate ‘no’.

Country	Foster care	Residential care
Austria	yes	yes
Belgium	yes	yes
Croatia		yes
Czech Republic	yes	yes
Denmark		
England	yes	yes
Estonia		yes
Finland		
France	yes <sup>4</sup>	yes <sup>4</sup>
Germany		
Greece		yes
Iceland	yes	yes
Ireland		
Italy		
Latvia		yes
Lithuania		yes
Malta		yes
Netherlands		yes
Norway		
Poland		yes
Portugal		
Romania		yes <sup>5</sup>
Spain		yes
Sweden		

(no missing data)

*Health assessments when children enter out-of-home care and systematic monitoring of health while in care*

In the questionnaire, we asked

<sup>3</sup> Or – as in the case of England – designated/named health care professionals within the health care system with a special and regulated responsibility for children in out-of-home care.

<sup>4</sup> New legislation March 2016, yet not implemented in all regions.

<sup>5</sup> Not in all regions

- if the child welfare legal framework included *statutory or recommended health assessments* (somatic, dental and mental health) when children enter OHC
- if there was a standard practice that included such health assessments
- if the legal framework included mandatory systematic procedures for *monitoring health* while the children were in OHC
- if there was a standard practice for monitoring health while children were in care

In table 3 we list responses to these questions. ‘Yes’ in the table indicates that there are specific procedures for children in OHC in legislation, guidelines or standard practice, above guidelines/practice for preventive care to all children.

### *Somatic health*

Table 3: Somatic health assessments and monitoring in legal framework and standard practice, targeting children in out-of-home care. Blanks indicate ‘no’.

Country	Mandatory assessment	Std practice of assessment	Mandatory monitoring	Std practice of monitoring
Austria	yes		yes	
Belgium	yes			
Croatia	yes	yes		
Czech Republic	yes <sup>6</sup>	yes <sup>4</sup>	yes <sup>4</sup>	yes <sup>4</sup>
Denmark				
England	yes	yes	yes	yes
Estonia				
Finland	yes			
France	yes		yes <sup>7</sup>	
Germany				
Greece				
Iceland	yes			
Ireland	yes	yes	yes	yes
Italy				
Latvia	yes		yes	
Lithuania				
Malta				
Netherlands				
Norway				

<sup>6</sup> For children  $\leq 3$  years.

<sup>7</sup> New legislation March 2016, yet not implemented in all regions.

Poland				
Portugal				
Romania	yes	yes		
Spain				
Sweden	yes <sup>8</sup>			

(no missing data)

As can be seen from Table 3, half of the countries (n=12) participating in the survey have some form of legally mandated (or recommended) assessments of somatic health when children enter OHC. A standardized practice for implementing the legislation is less common (n=5 countries). Few countries have legally mandated procedures for monitoring the somatic health of the target group (n=6) or a standard practice for this (n=3). However, it should be noted that several nations have systematic health monitoring of all children in certain ages, for example Spain, Romania and Poland, which also apply to children in OHC.

#### *Dental health*

Only one country – England – has statutory controls of dental health when children enter OHC, and a standardized practice to enforce this rule. England also has mandatory guidelines and a standardized practice for monitoring dental health while children are in care. The latter is also the case for children in Romania’s residential care system.

#### *Mental health*

Very few countries have guidelines/legislation or a standardized systematic practice concerning assessment and monitoring of mental health of children in OHC. In Spain, national and regional guidelines stipulate that children entering residential care should receive a mental health assessment. These guidelines include a process of monitoring the children’s mental health/development over time. In England, guidelines for local authorities mandate the use of SDQ (Strengths and Difficulties Questionnaire)<sup>9</sup>, both at care entry and for continuous follow up of children’s mental health. At least five studies from four different countries have affirmed that SDQ is a good-enough or promising instrument for identifying high-risk individuals in OHC who warrant more exhaustive clinical assessment (Janssens & Deboutte, 2009; Jee et al, 2011a, -b; Goodman & Goodman, 2012; Lehmann et al, 2014)<sup>10</sup>. However,

<sup>8</sup> New legislation in April 2017, not yet implemented

<sup>9</sup> see e.g. Muris et al, 2002; Warnick et al, 2008

<sup>10</sup> For an example of practice experiences from using the SDQ, see Richards et al, 2006

this instrument is mostly administered by clinicians (pediatricians and nurses) trained in physical/somatic health. Government audit inspections in England found that although over 70 percent of children aged 5-16 in OHC had a SDQ-screening in 2015, in the majority of cases the SDQ-scores were not routinely used to trigger a full mental health assessment by specialists (CareQuality Commission, 2016).

Finally, in Poland all children placed in OHC are under the observation of a psychologist during time in care.

### *Reproductive/sexual health*

Since children placed in OHC have high excess risks of becoming parents during their teens (eg. Vinnerljung et al, 2007b), we also asked about provision of sex education and contraceptives to this group. No country had special guidelines or a standardized practice targeting the sexual health (e.g. provision of contraceptives) of children/youth in care.

### *Immunizations*

With the notable exception of England, none of the countries participating in the survey had guidelines or a systematic practice for monitoring immunizations specifically targeting children in OHC. In all countries, these children receive the same program as all other children.

### *Other forms of preventive health care*

Finally the questionnaire contained questions about legislation/guidelines and standard practice concerning other preventive health care targeting OHC-children, for example regarding smoking, diets and physical activities. Only Ireland has such regulations, including mandatory provision of training for foster carers on first aid, hygiene and other health issues, with particular emphasis on health promotion and communicable diseases.

## Broad models/categories of health care arrangements for children in out-of-home care

Below the surface of these perfunctory data it is possible to discern several different models for provision of health care to children in OHC, and models of handling the problems of health care for this vulnerable group. We have used the survey, published literature and the proceedings of the before mentioned workshop to sketch the various models we have encountered. First we start with three broad models that crudely enable us to categorize each country participating in the survey.

### *1. 'One size fits all' - the universal welfare state model*

In this group we have included countries that a) have integrated health care for children in OHC fully into the universal child health care system, without any special arrangements or legislation/guidelines for OHC children's health care and b) that mostly have no care professionals (doctors, nurses or psychologists) employed inside or contracted to their child welfare system. This is the classic universal welfare state approach - 'one size fits all'. In this category we find Denmark, Norway, Germany, Italy and Portugal; five of the 24 responders of our survey.

### *2. The universal welfare state model, supplemented with some special arrangements for children in out-of-home care*

This category spans considerable variation between countries but also great local variations within single countries. In these nations, OHC-children are fully integrated in the universal health care system but their health care have in addition been reinforced by a) health care professionals employed in or contracted to the child welfare system, most commonly in some – but not all - residential care facilities. b) special legislation/national guidelines for health assessment when children enter OHC or for monitoring health while in OHC c) or both a and b above.

This is the most common European model, covering 16 of the 24 countries in the survey. Finland has recently made health assessment of children entering OHC mandatory by law, but little is known of the local implementation of this legislation. Finland has no health care professionals attached to their child welfare system. Sweden has a new legislation (spring 2017) about mandatory health controls of children entering OHC, but this has yet not been implemented. In six countries, health care professionals are part of the internal resources of

the country's child welfare (usually attached to larger residential care facilities), but there is no special legislation regulating provision of health care for children in OHC. In this category we find Estonia, Lithuania, Greece, Malta, Netherlands and Poland. Finally in eight nations we see both special legislation/national guidelines for the health care of children in OHC and a child welfare system with their own health care professionals, usually attached or contracted to some – but not all – of the residential care units in the country. We have included Austria, Belgium, Croatia, France, Iceland, Latvia, Romania and Spain in this group.

### *3. The universal welfare state model, supplemented by comprehensive specific services*

Finally there are three countries where children in OHC are integrated into the universal health care system but the state has made more or less comprehensive arrangements aiming to systematically reinforce the health care of children who end up in OHC. The Czech Republic has legally mandated rules for mandatory health assessments for children 3 years or younger entering both foster and residential care, and for monitoring health care needs for children in the same age group who reside in OHC (but not for older children). In addition, the Czech Republic has health care professionals employed within their child welfare system, covering both children in foster care and residential care.

England and Ireland has a legal framework with statutory health assessments and standardized procedures for health monitoring for all children – regardless of age – entering or residing in OHC. Policies and practices in England are wide ranging, covering among other factors appointments of special functions on different levels in the nation's health care structure, performance standards, auditing practices and provision of educational material for health workers. These policies and practices are described more in detail in the next section.

In France, new legislation from 2016 is taking the nation's health care for children in OHC in a similar direction, but as yet, little is known about the regional implementation of this law. A proposal for a new Norwegian child welfare legislation and recently proposed national guidelines are suggesting that Norway may also take steps to improve health care for children in OHC in ways that resemble the English system (Helsedirektoratet, 2015; Barne-, ungdoms og familiedirektoratet & Helsedirektoratet, 2015, 2017; NOU, 2016:16).

## A closer look at existing or emerging models of ‘good practice’

Among or inside the 24 countries we can discern several examples of existing or emerging models for improving health care to children in OHC that – in our view - warrant further elaboration as potential examples of ‘good practice’.

### *The Systematic Comprehensive Approach - England*

From looking at the data in the survey, the literature and the experiences from the workshop, it is obvious that England is the European country that has invested most efforts towards a systematic approach for providing adequate health care to children in OHC, with guidelines that are mandatory for local health and child welfare authorities (Dept of Education and Dept of Health, 2015).

In England, doctors and nurses with special expertise in health issues for children in OHC must be appointed in all geographical sections of health care and within local health care providers (ibid.):

- a) Designated doctors and nurses. The term designated doctor or nurse denotes professionals with specific roles and responsibilities for looked after children, including the provision of strategic advice and guidance to service planners and commissioning organisations. In England Designated Professionals (Doctors and Nurses) are statutory roles.
- b) ‘Named doctors’ and ‘named nurses’ who are responsible for promoting good practice for services to children in OHC within the local health care provider, including providing supervision, advice, expertise, and training for their colleagues
- c) ‘Nurse specialists’ who have expert knowledge in working with OHC children. They are responsible for assessing and promoting the health and wellbeing of these children.
- d) ‘Medical advisors’ who are pediatricians or general practitioners with relevant skills who have a particular role in assessing OHC-children and providing medical advice to child welfare agencies involved with foster and residential care, and adoption.

Requirements and standards for these posts have been specified in guidelines from an Intercollegiate Role Framework (Royal College of General Practitioners, Royal College of Nursing, and Royal College of Paediatrics and Child Health, 2015).

The English national policy is outlined in several concisely phrased policy documents as guidelines for local authorities, including identification of indicators for monitoring of policy

implementation (see eg. Dept of Health, 1999, 2002; Simkiss, 2012b; NHS, 2013, 2015; Dept of Education and Dept of Health, 2015). Five key performance indicators have been set for health services to children/youth in OHC, and are monitored in all health care districts:<sup>11</sup>

- Percentage of OHC children with completed health assessment
- Percentage with completed dental checks
- Percentage with up-to-date immunizations
- Percentage of OHC-children under 5 years with completed developmental screening
- Percentage of completed SDQ-scores for OHC children over the age of four years

Quality standards covering health and wellbeing for OHC children/youth (including secure settings) have been compiled by independent experts (eg. NICE, 2013, 2015; RCPCH, 2013). The NICE quality standards are compiled in eight statements. Three deal explicitly with health care:

1. Children in OHC should receive care from health services and professionals that work collaboratively.
2. They should receive specialist and dedicated health services within agreed timescales.
3. OHC-children who move across local authority or health provider geographical boundaries should continue to receive the health services they need.

The considerable problems of provision of mental health care for children and youth in OHC have been discussed in detail on a national government level (House of Commons, 2016, Department of Health & Department of Education, 2016) and in auditing reports (CareQuality Commission, 2016). As an example of outcomes from this process, the government has agreed with a special committee's proposal that placement instability is not a valid reason for refusing children in OHC access to child/adolescent psychiatric services (Dept of Education and Dept of Health, 2015; Dept of Health and Dept of Education, 2016; House of Commons, 2016).

In addition, supportive material for training of health care professionals has been available for almost two decades (eg. Mather & Batty, 2000; Royal College of General Practitioners, Royal College of Nursing, and Royal College of Paediatrics and Child Health, 2015). The implementation process of these guidelines has been monitored by scholars, who for example have highlighted gaps between national intentions and actual local practice (eg. Hill et al, 2002; Hill & Thompson, 2003; Hill & Watkins, 2003; Rodrigues, 2004; Butterworth et al, 2016). A notable scoping review on barriers for children's and youths' access to mental health services has recently been published (Anderson et al, 2017; see also systematic review by Jones et al, 2012). Furthermore, leading researchers have produced state-of-the-art reviews of

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<sup>11</sup> For an example, see NHS North East Lincolnshire Clinical Commissioning Group, 2016

effective interventions targeting mental health problems among children in OHC (eg. Leve et al, 2012; Luke et al, 2014; Guishard-Pine et al, 2017).

In a comparative European perspective, these English efforts paint an impressive picture when seen together, even though our informants have been anxious to point out shortcomings in several areas (mainly access to and provision of mental health care services; see also eg. CareQuality Commission, 2016). It is ‘a national model’, probably facilitated by child welfare being mainly the responsibility of authorities on the national government level. This approach may be more difficult in countries where health and child welfare is operated and financed on a regional or local government level (eg. the Nordic countries and Spain).

### *The Enhanced Cooperation Model – Norway*

In Norway the ministries responsible for child welfare and health care have made detailed recommendations for a substantial reinforcement of health care provision to children in OHC, but these recommendations mainly target mental health care needs of children/youth in residential care (only 10-15% of all children in Norwegian OHC are in residential care; Statistics Norway, 2015). All residential care units for children/youth are now obliged to have a named person responsible for health care issues. In addition, the government agency responsible for child welfare services has started a program for training residential care workers in the area of child/adolescent mental health (Barne-, ungdoms og familjedirektoratet & Helsedirektoratet, 2015).

National recommendations include initiating arrangements resembling the English designated/named doctors in both somatic and mental health care, but so far only for youth (age 12+) in residential care. Central to these recommendations, and the proposed new child welfare legislation, has been defining a more clear responsibility for child and adolescent mental health services in their collaboration with child welfare services (Helsedirektoratet, 2015; Barne-, ungdoms og familjedirektoratet & Helsedirektoratet, 2015, 2017; NOU, 2016:16).

In sum, these efforts on the national level are mainly aimed at enhancing cooperation between local child welfare agencies (run by over 400 municipalities) and regional health care providers (run by 19 provinces), but is at present primarily focused on mental health care needs of children/youth in residential care (Lehmann & Kayed, submitted). Scholars have raised serious concerns about the proposed reforms: In practice, the new guidelines will probably have only minor effects on the health care needs of the large majority (9/10) of children in Norwegian out-of-home care, who are residing in foster families (ibid.)

### *The Local Model – Mariagerfjord municipality in Denmark<sup>12</sup>*

From an initiative originating from local community nurses, a more or less comprehensive local model for improving the health care of children in OHC has been staged in Mariagerfjord municipality in Denmark. The setting is local primary care, run by the municipality. Responsibility for monitoring OHC children's health care has been moved from the local child welfare authorities to community health services. In practice, this has meant that local visiting nurses now execute a standardized practice for all children from Mariagerfjord placed in OHC. Standardized procedures include:

- An annual health assessment by a visiting nurse, done in the foster home, at school or at the residential care facility.
- Standardized checklists that differ with respect to the child's age. These checklists have been constructed and compiled locally. They are informed by routines for assessments of 'normal population children' but also by research on health of OHC-children. The questions to the child involve somatic and mental health, social functioning, well-being and also if the child is reasonably happy in the foster home/residential facility and at school.
- Observations of interactions between the child and her/his carers and also with her/his birth parents.
- Standardized guidelines about procedures applicable when the nurses find indications of health problems or health care needs, for example for referrals to a community pediatrician or to specialist medical care. Commonly identified health care needs are lack of nationally recommended immunizations, scoliosis, obesity/overweight/underweight, indications of vision problems, asthma, persistent headaches, psychological/developmental problems, and issues relating to sexual health. In the health assessments around 40 percent of the children are found to need medical attention.
- Guidance to children and carers about nutritional issues, sleep and child development.
- All teenagers who ask for birth control devices receive them cost-free.
- Follow-up visits.
- Results are communicated in a report to case workers at the child welfare authorities.

The community nurses work in close cooperation with the community pediatrician and with case workers from the child welfare authorities. Anecdotal evidence suggests that many

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<sup>12</sup> So far, this model has not been described or reported comprehensively. This section is mainly based on conference and work-shop presentations from the specialist nurses, and from an brief web-article <http://www.sundhedsplejersken.nu/artikel/sundhedstjek-af-anbragte-boern-et-nyt-kerneomraade-for-sundhedsplejersker/>

children's school achievements have improved simply by supplying spectacles to the children, after vision checks. Recently, the program has been extended to also include care leavers up to age 22.

*The medical home/foster care clinic – a US model replicated locally in Uppsala county, Sweden*

In the US, federal law has since 2008 specified that child welfare agencies are required to screen, assess and treat health care needs for children in out-of-home care (Zlotnik et al, 2015). One of several responses to these requirements<sup>13</sup> has been the establishment of 'Medical homes' for OHC-children, community based clinics targeting children in OHC. This model has actually been tried in the US locally in various forms since the late 1980ies (Simms, 1989; Jaudes et al, 2004, 2012; Leslie et al, 2005). In most cases it has the form of a centralized clinic, specialized in serving children in out-of-home care in a specific geographic area. Medical homes are usually staffed with a multi-disciplinary team of health professionals and perform systematic health assessment for children entering OHC and systematic monitoring of the health of OHC children, but – perhaps most crucially – also provide, manage and coordinate comprehensive health care services, even when children are moved from one OHC-facility to another (Jee et al, 2010a; Jaudes et al, 2012). Guiding principles are detailed recommendations from the American Academy of Pediatrics, including rapid identification of health care needs when children enter OHC (see eg. Szilagy et al, 2015).

This centralized model is at present being replicated in Uppsala county in Sweden, an area covering eight municipalities with 360.000 inhabitants. Multidisciplinary services are delivered at Uppsala University Hospital, including systematic somatic, dental and mental health assessment for all children entering OHC, based on published guidelines (Regionförbundet Uppsala Län, 2016). As far as we know, this is the first time the US model with a 'medical home' is being tried in Europe.<sup>14</sup>

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<sup>13</sup> See Greiner & Beal, 2017 for a discussion of the most common models

<sup>14</sup> Chambers et al (2010) have reported experiences from a regional trial with a similar model in Australia.

## What works?

In a systematic review, Jones and colleagues (2012) tried to identify evidence of effectiveness of interventions aiming to improve access to health services for children and youth in OHC. Five studies passed their inclusion criteria, and the authors concluded (p 82): *“The evidence base for the effectiveness of interventions aimed at improving health and mental health services access for [children in OHC] is at a very early stage, and little appropriate evidence was identified by this review.”*

Ethical concerns render rigorous evaluations with traditional design (randomized control trials) of health care delivery system for children in OHC difficult (eg. it would not be ethically defensible to randomize children to a systematic dental health assessment at care entry vs. no assessment, and then perform a follow-up two years later of their dental health status). However, Helen Minnis and colleagues in Glasgow, Scotland are at present running an on-going trial with mental health care services to maltreated children 0-5 years, placed in foster family care (Pritchett et al, 2013, 2016; Boyd et al, 2015; Turner-Halliday et al, 2015). In the trial, outcomes of a model from New Orleans (USA) for delivering specialized mental health services to infants and their families will be compared to outcomes for children who receive treatment as usual from social workers in child welfare agencies.

Another difficulty for evaluations is that changes in national legislation about health care services are usually mandatory for all local authorities, thus excluding the possibility to perform evaluations with quasi-experimental designs.

It is therefore unsurprising that we so far have found few scientific studies that can shed light on the obvious question: what works in health care for OHC children? This is the case, even with a broad, inclusive definition of ‘evaluation’. However, this issue is central to the before mentioned systematic literature review that is in progress.

Several British studies have affirmed that statutory systematic health assessments identify a multitude of health care needs that may otherwise go unrecognized (eg. Hill et al, 2002; Hill & Watkins; 2003). Results from two recent Swedish studies of systematic health assessments at care entry support this conclusion (Kling et al, 2016a –b). In fact, several studies comparing systematic mental health assessments using standardized instruments (e.g. SDQ) with non-systematic clinical assessments or carer information have found that far more children are identified as having indications of mental health problems that require treatment when

standardized instruments are used (e.g. Jee et al, 2010b, -c; 2011a; Undheim et al, 2016; cp. Romanelli et al, 2009).

Evaluations of local projects with nurse-led health assessments, comparing data from before and after the start of the project have found positive improvements on all outcome indicators (eg. immunizations), most pronounced for provision of dental care to children in residential care (Hill et al, 2002; Hunter et al, 2008). National data from England show that the proportion of children in OHC with up-to-date immunizations increased substantially between 2010 and 2015, even though there were large local variations, and questions remain about data quality (Walton & Bedford, 2017). Improvements over time in the number of OHC-children who had an annual dental health check have also been reported, but rates are still below figures for national population peers (e.g. Poynor & Welbury, 2004). In a local English trial with a ‘designated dental pathway’ for children in OHC, the authors concluded that the model had good impacts on dental care access for the children, met their dental care needs, and offered a consistent dental service even if the children moved between different OHC-facilities. In addition, both child welfare professionals and users reported high levels of satisfaction with the service model (Williams et al, 2014).

Among the models discussed previously, the US ‘medical home’ has been studied the most, however not evaluated with a rigorous study design. In two studies, children in foster care enrolled in a ‘medical home’ model (HealthWorks in Illinois) were compared to children remaining at home in poor families, receiving state subsidized medical care. Jaudes and colleagues found that the foster care group had higher rates of immunization and greater odds of receiving medical services. Generally, the data indicated a more cost-effective use of primary health care (Jaudes et al, 2004, 2012). In another study, OHC children attached to a ‘medical home’ were found to have high rates of timely identification of mental health care needs (two months or less after care entry) which resulted in equally high rates of mental health service delivery (Jee et al, 2010a). Jee and associates (2015) compared adherence to guidelines from the American Academy of Pediatrics (AAP) concerning initial health assessment of OHC-children (at time of entry into OHC) between ‘medical home’ sites and three other forms of health care management models. Looking at results, the study found wide variations within each model across sites but no site – or model - had 100 percent adherence to AAP guidelines. In sum, the study found no indications of undisputable superiority of ‘medical homes’. However, several studies on this model for primary health care, targeting populations with special health care needs, have found numerous examples of positive health outcomes, including reduced hospitalization rates. For general population children, evidence of efficiency is limited (Hadland & Long, 2014).

Another example of the benefits of systematic approaches concerns the use of psychotropic medication for children in foster and residential care. For years, scholars<sup>15</sup> have raised concern about high rates of psycho-pharmaceutical consumption in OHC, especially of prescribed antipsychotics (mainly used against aggressive behavior) and poly-medication (e.g. Zito et al, 2008; Crismon & Argo, 2009; dosRheis et al, 2011; Miller et al, 2013; Kling et al, 2016b). Many psycho-pharmaceuticals have considerable metabolically related side effects. Examples include effects on appetite and weight regulation, dry mouth leading to increased risks for dental decay, fatigue, gastrological and urinary problems, headaches, nausea and sleep deprivation. Children and adolescents are more susceptible to these kinds of side effects than adults (Nahrendorf et al, 2011; Panagiotopoulos et al, 2010). Poly-medication is an especially complex issue, which requires specialist competence, and close attention to potential side effects (Bertram, et al, 2013; Crismon & Argo, 2009; Zito et al, 2008). Several studies have found that poly-medication of children and youth in OHC often involves prescriptions from several different clinics or physicians. A prominent reason is that many have experienced several changes in care environments. New placements have resulted in contacts with new doctors, and the consequence has often been new diagnoses leading to new prescriptions of new forms of psycho-tropics (McMillen et al, 2007; Nahrendorf et al, 2011; Bertram et al, 2013). Four US studies examined the effects of systematic re-assessments on prescribed psycho-pharmaceuticals for youth in residential care. All found that relatively radical reductions of such medications (including antipsychotics) did not result in an increase of youths' aggressive behavior or a decrease of placement stability (Huefner et al, 2014; Bellconci et al 2013; Lee et al, 2016; Tai et al, 2016), in fact two studies reported substantial decreases in the number of assaultive incidences in the residential care facility and in the use of physical restraints.

A potentially influential path to evaluation of health care models targeting OHC-children, including assessments of impact of new legislation/guidelines, is the classic approach of comparing real-world conditions with aims/intentions in legislation, government directives and national guidelines (an auditing approach). In research literature, there are several examples of well-done studies in this genre (eg. Gallagher & Dobrin, 2007 from the US on adherence to AAP guidelines for health care of anti-social youth in secure residential care). In England, such auditing studies have produced a wealth of data on the health care needs in the OHC-population, confirming results from previous research studies (eg. Price Williams & Nicholes, 2016; 68% of 237 children had at least one somatic health care need. Figures were even higher for the youngest children, 0-4 years). Audit reports have also found high variability in health care service delivery to OHC-children between different geographical areas, and between different sectors in the health system (CareQuality Commission, 2016).

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<sup>15</sup> Mostly from the US, but Swedish data provides a similar picture (Socialstyrelsen, 2014; Kling et al, 2016b)

## Discussion

### *Summary of the results from the survey*

Responses came from 24 out of 30 countries. The administrative responsibility of child welfare/child protection varies from country to country: local, regional, national or combinations of different government levels. But in most nations the national government has operational involvement, either directly through a national child welfare system (e.g. England and Ireland) or through monitoring or legislation (e.g. Spain and the Nordic countries).

In all countries, children in OHC have access to health care like other children in the population. In Ireland, national legislation stipulates in addition that children in out-of-home-care have prioritized access to somatic, dental and mental health care. In all countries these children are included and covered by the national insurance/health system.

Most nations have health care professionals (doctors, nurses, psychologists) within their child welfare system, mainly working with residential care populations. According to our informants, this can vary substantially between locations within the same country.

For health care of OHC-children and youth, England stands out with its comprehensive system (with national coverage), with specific posts - within a multi-level health care framework - that are specifically designed for promoting the health of children in OHC.

When it comes to national guidelines or legislation for health assessment and health monitoring specifically targeting children in OHC, the overall picture is one of variation between different health arenas. Half of the countries have some form of legally mandated rules for somatic health assessments of children when they enter OHC, but a standardized practice for doing this is less common. National guidelines for monitoring somatic health are relatively uncommon (5 countries) and a reasonably standardized monitoring practice even rarer (3 countries). England and Ireland stand out as the countries with most comprehensive legislation, and the Czech Republic for very young children (< 3 years).

Guidelines or a standardized practice for systematic assessment and monitoring of dental health specifically targeting children in OHC are conspicuously absent in all but two countries. England has statutory controls of dental health at care entry and mandatory rules for monitoring dental health while children are in care. The other exception is Romania where there is a standardized practice for monitoring dental health for children in residential care.

A host of studies, spanning at least 5 decades, have reported very high rates of mental health problems among children and youth in OHC. It is therefore somewhat surprising that only a couple of countries have legislation or a standardized practice for assessment and monitoring of these children's mental health at care entry or while they are in societal care. Spain and England are the only exceptions. The latter country has statutory use of the SDQ-scale in national guidelines, and compliance is monitored by auditing agencies.

No country has guidelines specifically concerning sexual health of youth in OHC, for example sex education and access to contraceptives. The same goes for monitoring immunizations - with England as an exception - which again is somewhat surprising since many studies have reported that this group has far lower immunization rates than the national child populations.

Preventive health care, for example diets, smoking etc, was covered by national and mandatory guidelines (specifically for OHC-children) in only one country: Ireland. This country is also notable for having legally mandatory training of foster parents on first aid, hygiene and other forms of health promotion.

We crudely categorized the policies of the responding countries in three categories.

1. *'One size fits all' - The universal welfare state model.* In these countries there were no special arrangements for securing good health and health care to OHC-children. Six countries seemed to fit this heading.
2. *The universal welfare state model, supplemented with some special arrangements for children in OHC.* In these countries, OHC children are fully integrated in the universal health care system, but their health care is reinforced in some countries by having health care professionals employed in or contracted to child welfare agencies or OHC providers. Other countries have legislation or guidelines for health assessment and/or monitoring of health for OHC-children. This is the most common European model, found (with large variations) in 15 of the 24 responding countries.
3. *The universal welfare state model, supplemented by comprehensive specific service targeting OHC children.* This is a small category of European nations. The Czech republic has mandatory health assessments and health monitoring for all OHC children 3 years or younger, but not for older children or adolescents. Ireland and England have a legal framework with statutory health assessments and health monitoring of children in OHC. England has, by far, the most comprehensive policies and standardized practices in Europe for health care provision and health promotion to OHC children and youth.

### *Good practice models*

We found four different examples of ‘good practice models’ (but probably there are more). The first was England, a national model with a systematic approach to most – but not all – aspects of health care provision and health promotion to OHC-children. The second was Norway, where national legislation and guidelines stressed the necessity of close cooperation between local child welfare authorities and regional health care providers. The third was a local model from a municipality in Denmark. In Mariagerfjord, community nurses in local primary care have assumed responsibility for the health issues of OHC children, and have brought systematic routines into local practice. Finally, the fourth model has its origin in the US – ‘the Medical home’ – and is being tried in a Swedish region. In the model, one specialized clinic (in Sweden a hospital clinic) performs systematic health assessments of all children entering OHC, but also provides and coordinates health services for these children while they are in care.

### *What works?*

We have so far located very few studies that can shed light on the obvious question: what actually works in health care for OHC-children (cp. Jones et al, 2012). Ethical concerns are important – but necessary – obstacles to evaluations with traditional robust designs (experimental or quasi-experimental studies). But most time-series data, e.g. on immunizations, indicate that the English policies have made a difference. Also, several studies – but not all – suggest that the ‘Medical home model’ has notable advantages in comparison with usual practice.

## Limitations

As mentioned before (p 6) it is probable that the informants did not have exhaustive knowledge of current legislation (child welfare and health care legislation) in their countries. Details about individual countries may therefore contain errors. It is important that the reader does not place excessive value on details describing each country but instead look at the overall picture from the survey.

Concerning the literature cited in this report, the selection is obviously biased. Due to the limitations of the authors' language skills, we have restricted the literature searches to publications in English or any of the Scandinavian languages (Danish, Norwegian and Swedish).

## Implications

In view of the high prevalence of health problems and health care needs among OHC children, the research community (and others) has for 40-50 years consistently recommended that child welfare and health authorities create systematic and statutory routines for health assessment and health monitoring of these children. Henceforth, there is ample room for improvement in most of the countries that participated in the survey, if the aim is to handle health related issues of children in OHC on par with what we could expect from reasonably good parents (*in loco parentis*). All available research show that systematic approaches constitute a key component, e.g. a health assessment and a dental care visit for *all* children and youth who enter foster homes or in residential care.

In the section of ‘good practice models’ there are inspiring examples for a nation, a region or a local authority that set out on a path toward improvement. All four models are based on strong components of systematic routines, applicable to all OHC-children within their jurisdiction. Minimum standards include a health and a dental health assessment at care entry, reinforced with systematic routines for monitoring children’s health and development while they are in societal care. Another dimension of the ‘good practice models’ is a shift of operational responsibility for health issues of OHC-children from child welfare to health care agencies, most pronounced in the English comprehensive model. In several countries, research spanning decades has found that child welfare authorities/agencies have a poor record of ensuring that children in OHC get ‘good enough’ health care (e.g. Butler & Payne, 1997; Ashton-Key & George, 2003; Kling, 2010; Kaltner & Rissel, 2011; Kling et al, 2016a, -b; Randsalu & Laurell, 2017).

Several countries have national legislation or statutory guidelines specifically targeting health care of OHC-children. However, knowledge about implementation and outcomes of legislative changes is thin on the ground – with the exception of England. The main purpose of a national legislation or statutory guidelines is to offer OHC-children a form of protection by law, a minimum standard of systematic health care that should be non-negotiable for local authorities, care providers and child welfare/health care professionals. But a lesson learned from England is the value – and the necessity – of follow-ups and evaluations of new practice, if new guidelines are expected to be more than just ‘beautiful words’. Also, experiences from England clearly show that follow-ups and evaluations are crucial tools for both adapting clinical practice to new guidelines and for adapting guidelines to real-life clinical practice.

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# Models of Child Health Appraised

(A Study of Primary Healthcare in 30 European countries)

## Appendix

### Round 9: Country Agent Questions: WP7: Health care for children in the child protection/child welfare system

We would like to know about the provision of health care (as described in national laws and guidelines) and in standard practice for children in the child protection/child welfare system who are placed in foster family care or in institutional care.

If you find that a law/regulation or standard practice is not clear in a certain area we inquire about, please simply answer: “unclear”. If you do not know the answer to a question, simply answer “don’t know”. Please also feel free to add in extra comments where you think these are appropriate.

#### Purpose and Context of Use

WP7 is investigating inequity in primary care services for children. Apart from more general aspects of inequity, WP7 also focuses on primary care for particularly vulnerable child populations. In these questions, we would like to look at children in the child protection/child welfare system as a ‘tracer’ for populations who are a high risk of inequity in the primary care system. This follows on from our investigation into migrant children: our report is posted on the MOCHA website <http://www.childhealthservicemodels.eu/publications/deliverables>

This work will result in a second WP7 report, on health care for children in foster and institutional care. This report will be based on this questionnaire together with a systematic literature review and a workshop with selected experts and MOCHA members in April 2017.

The report will describe how this care is organised and carried out in the 30 participating countries with a more in depth description of some selected examples of good practice.

Please see the glossary below for clarifications/definitions of central terms used in the questionnaire.

Please send your answers to **Denise Alexander by January 20<sup>th</sup> 2017**. If you have any questions concerning the questionnaire, please contact Professor Bo Vinnerljung, [bo.vinnerljung@socarb.su.se](mailto:bo.vinnerljung@socarb.su.se) or phone +46-8-674 40 78.

**Country:**

**Informant (name, email-address):**

## Glossary/terms

**Child protection/child welfare authority** The national/regional/municipal government authority (-ies) in a country responsible for child protection and interventions for abused, neglected, and abandoned children and for other children whose basic needs cannot be met by their parents. Some countries use the term ‘child protection’, others use ‘child welfare’ -

**Children in the child protection/child welfare system/CWC** In this questionnaire, CWC are children placed by child protection/child welfare authorities in foster family care or in institutional care/residential care/group care. These forms of care are often referred to as ‘out-of-home care’, in British English the children are often referred to as ‘looked after’ children. To save space, we call these children **Child Welfare Children/CWC**. There are many other children receiving in-home interventions/policlinic interventions (while living with their parents) from child protection/child welfare authorities. But since these children’s health care normally is the responsibility of their parents, they are outside the scope of this study.

**Foster family care** Children are placed by child protection/child welfare authorities in care of a family that is not their own (foster family care does not include adoptions or arrangements by the family themselves where a child lives with a relative, e.g. a grandmother).

**Institutional care/residential care/group care** Children are placed by child protection/child welfare authorities in institutional facilities (e.g. orphanages, children’s homes, youth homes) manned by professional staff, together with other children.

**Somatic health care** Health care of the physical body (as opposed to mental health care / psychological health care).

**Standard practice** ‘Normal’ procedure/practice/care, regardless of legal requirements, provided to a majority of CWC in a country.

**Contracted health provider** A health care provider (e.g. a hospital, medical clinic etc.) that has been contracted by child protection/child welfare authorities or by e.g. a institutional care organisation to provide health care for CWC.

# 1 Organisation

1.1. Is child protection/child welfare in your country mainly regulated by:

- National legislation
- Provincial/regional legislation

Other; please describe briefly below:

Click here to enter text.

1.2 Is child protection/child welfare the main administrative/operational responsibility of:

- A national government authority
- Provincial/regional government authorities
- Municipal or other local government authorities

A non-government agency, , appointed by the official authority

Please specify .....

Other, please describe below...

Click here to enter text.

**In the next section we would like to know about how health care for CWC is organised. We are especially interested in knowing:**

- if CWC receive health care by the same providers/in the same way as other children in your country
- by the same ‘normal’ pattern of provision, but by a practitioner geographically related to the foster family/institution (i.e. same system, but change of provider due to location)
- or if the child protection/child welfare authorities usually have their own health care personnel (employed doctors, nurses, dentists, psychologists etc.)
- or if child protection/child welfare authorities have their own contracted health care providers
- if foster family care or institutional care providers usually have their own health care personnel or if they have their own contracted health providers
- if there are large variations within your country in how health care for CWC are organized

**1.4** Please describe briefly how somatic health care for CWC in **foster family care** is provided in your country.

Click here to enter text.

**1.5** Please describe briefly how somatic health care for CWC in **institutional care** is provided in your country.

Click here to enter text.

**1.6** Please describe briefly how dental health care for CWC in **foster family care** children is provided in your country

Click here to enter text.

**1.7** Please describe briefly how dental health care for CWC in **institutional care** is provided in your country

Click here to enter text.

**1.8** Please describe briefly how mental health care for CWC in **foster family care** is provided in your country

Click here to enter text.

**1.9** Please describe briefly how mental health care for CWC in **institutional care** is provided in your country

Click here to enter text.

## 2. Somatic health care

**2.1** If the legal/regulatory framework for the child protection / child welfare system in your country includes provision of somatic health care for CWC in foster family care, or CWC in institutional care, please describe (briefly) the law/regulation, national/regional guidelines etc. If there are national guidelines, please provide us with a copy or a reference.

Click here to enter text.

**2.2** How is somatic health care funded for:

- CWC in foster family care

Click here to enter text.

- CWC in institutional care

Click here to enter text.

**2.3** Does the child protection/child welfare legal/regulatory framework include compulsory or recommended somatic health screenings/health examinations for CWC

- when they enter foster family care
- when they enter institutional care

If you have ticked one, or both, of the above , please summarise the procedures included in the regulatory framework. If there are guidelines for somatic health screenings/health examinations for CWC, please send us a copy or a reference.

Click here to enter text.

**2.4** Is there a standard practice for providing somatic health screenings/health examinations for CWC

- when they enter foster family care
- when they enter institutional care

If you have ticked one, or both, of the above, please summarise the procedures usually included in standard practice.

Click here to enter text.

**2.5** Does the legal/regulatory framework include compulsory or recommended procedures for monitoring somatic health of CWC

- when they are in foster family care?
- when they are in institutional care?

If you have ticked one, or both, of the above, please summarise the regulatory framework. If there are guidelines for somatic health .monitoring for CWC, please send us a copy or a reference.

Click here to enter text.

**2.6** Is there a standard practice for monitoring somatic health of CWC

- when they are in foster family care?
- when they are in institutional care?

If you have ticked one, or both, of the above , please summarise briefly the procedures usually included in standard practice.

Click here to enter text.

**2.7** Are there in your country any clinics or other facilities specialised in somatic health care for CWC, see for example: “Foster care clinics” in USA (e.g.

<http://www.uwmedicine.org/locations/foster-care-harborview> or

<https://www.childrens.com/specialties-services/specialty-centers-and-programs/foster-care>)?

Yes

No

If yes, please describe briefly and provide references, web-sites etc.

Click here to enter text.

### 3. Dental health care

**3.1.** Does the legal/regulatory framework for the child protection/child welfare system in your country include provision of dental health care for:

- CWC in foster family care?
- CWC in institutional care?

If you have ticked one, or both, of the above, please describe (briefly) the law/regulation, national/regional guidelines etc. If there are national guidelines, please provide us with a copy or a reference.

Click here to enter text.

**3.2** How is dental health care funded for:

- CWC in foster family care?

Click here to enter text.

- CWC in institutional care?

Click here to enter text.

**3.3** Does the child protection/child welfare legal/regulatory framework include compulsory or recommended dental health screenings/examinations for CWC

- when they enter foster family care?
- when they enter institutional care?

If you have ticked one, or both, of the above, please summarise the procedures included in the regulatory framework. If there are guidelines for dental health screenings/examinations for CWC, please send us a copy or a reference.

Click here to enter text.

**3.4** Is there a standard practice for providing dental health screenings/examinations for CWC:

- when they enter foster family care?
- when they enter institutional care?

If you have ticked one, or both, of the above, please summarise the procedures usually included in standard practice.

Click here to enter text.

**3.5** Does the legal/regulatory framework include compulsory or recommended procedures for monitoring dental health of CWC:

- when they are in foster family care?
- when they are in institutional care?

If you have ticked one, or both, of the above , please summarise the regulatory framework. If there are guidelines for dental health monitoring for CWC, please send us a copy or a reference.

Click here to enter text.

**3.6** Is there a standard practice for monitoring dental health of CWC:

- when they are in foster family care?
- when they are in institutional care?

If you have ticked one, or both, of the above , please summarise briefly the procedures usually included in standard practice.

Click here to enter text.

**3.7** Are there in your country any clinics or other facilities specialised in dental health care for CWC?

- Yes
- No

If yes, please describe briefly and provide references, web-sites etc.

Click here to enter text.

## 4. Mental health care

4.1. Does the legal/regulatory framework for child protection/child welfare in your country include provision of mental health care for:

- CWC in foster family care?
- CWC in institutional care?

If you have ticked one, or both, of the above, please describe (briefly) the law/regulation, national/regional guidelines etc. If there are national guidelines, please provide us with a copy or a reference.

Click here to enter text.

4.2 How is mental health care funded for:

- CWC in foster family care?

Click here to enter text.

- CWC in institutional care?

Click here to enter text.

4.3 Does the child protection/child welfare legal/regulatory framework include compulsory or recommended mental health assessments for CWC:

- when they enter foster family care?
- when they enter institutional care?

If you have ticked one, or both, of the above, please summarise the procedures included in the regulatory framework. If there are guidelines for mental health assessments for CWC, please send us a copy or a reference.

Click here to enter text.

4.4 Is there a standard practice for providing mental health assessments for CWC

- when they enter foster family care?
- when they enter institutional care?

If you have ticked one, or both, of the above, please summarise the procedures usually included in standard practice.

Click here to enter text.

**4.5** Does the legal/regulatory framework include compulsory or recommended procedures for monitoring the mental health of CWC:

- when they are in foster family care?
- when they are in institutional care?

If you have ticked one, or both, of the above, please summarise the regulatory framework. If there are guidelines for mental health monitoring of CWC, please send us a copy or a reference.

Click here to enter text.

**4.6** Is there a standard practice for monitoring the mental health of CWC:

- when they are in foster family care?
- when they are in institutional care?

If you have ticked one or both of the above, please summarise briefly the procedures usually included in standard practice.

Click here to enter text.

**4.7** Are there in your country any clinics or other facilities specialized in mental health care for CWC, e.g. similar to the Michael Rutter Centre, Maudsley Hospital in London/UK (<http://www.slam.nhs.uk/our-services/service-finder-details?CODE=SU0260>)?

Yes

No

If yes, please describe briefly and provide references, web-sites etc.

Click here to enter text.

## 5. Reproductive health care/birth control

**5.1.** Does the legal/regulatory framework for the child protection/child welfare system in your country include provision of a) sex education and b) contraceptives for adolescent CWC:

- in foster family care?
- in institutional care?

If you have ticked one or both of the above, please describe (briefly) the law/regulation, national/regional guidelines etc. If there are national guidelines, please provide us with a copy or a reference.

Click here to enter text.

**5.2** Is there a standard practice for providing a) sex education and b) contraceptives for adolescent CWC

- in foster family care?
- in institutional care?

If you have ticked one or both of the above, please summarise the procedures usually included in standard practice.

Click here to enter text.

## 6. Preventive health care

**6.1.** Does the legal/regulatory framework for the child protection/child welfare system in your country include a) provision and b) monitoring of immunizations/vaccinations (following national standards) for CWC:

- in foster family care?
- in institutional care?

If you have ticked one or both of the above, please describe (briefly) the law/regulation, national/regional guidelines etc. If there are national guidelines, please provide us with a copy or a reference.

Click here to enter text.

**6.2** Is there a standard practice for a) providing and b) monitoring immunizations/vaccinations for CWC:

- in foster family care?
- in institutional care?

If you have ticked one, or both, of the above, please summarise the procedures usually included in standard practice.

Click here to enter text.

**6.3** Does the legal/regulatory framework for the child protection/child welfare system in your country include any other rules or recommendations about other forms of health promotion (concerning smoking, diets, physical activities etc.) for CWC:

- in foster family care?
- in institutional care?

If you have ticked one or both of the above, please describe (briefly) the law/regulation, national/regional guidelines etc. If there are national guidelines, please provide us with a copy or a reference.

Click here to enter text.

**6.4** Is there a standard practice in your country that includes other forms of health promotion (concerning smoking, diets, physical activities etc.) for CWC:

- in foster family care?
- in institutional care?

If you have ticked one or both of the above, please summarise the procedures usually included in standard practice.

[Click here to enter text.](#)

## **7. Three final questions...**

**7.1** Please list references to important publications from your country about health care for CWC, in your country's language (s) or in English (research articles, research reports, government reports etc).

[Click here to enter text.](#)

**7.2** Please list names and email-addresses to researchers in your country that have studied health problems of CWC and/or health care for CWC.

[Click here to enter text.](#)

**7.3** We are planning an international workshop in October 2017 where we will present and discuss the results of this survey. In your opinion, who from your country should we invite? Please list names and email-addresses for two persons.

[Click here to enter text.](#)

**Thanks so much for taking the time and trouble to answer this questionnaire.**