Health Needs Assessment for Looked After Children and Care Leavers

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Executive Summary

Looked-after children (LAC) and care leavers (CL) are a vulnerable sub-group of the population. Most children enter care often following a range of Adverse Childhood Experiences (ACE's), often as the result of abuse or neglect. Whilst they have many of the same health issues as their peers, the extent of these is often greater as a result of their past experiences. The available evidence suggests LAC and CL experience poorer health outcomes which can persist into adulthood.

In 2017/18 around 800 children and young people have been cared for, 1 in 3 children who enter care are under 1 years, 4 out of 5 come into care due to abuse or neglect and 2 out of 3 children and young people are placed in foster care. Durham County Council has seen a 53% increase in the number of LAC between 2011 and 2018.

As a corporate parent, local authorities should have the same high aspirations for the children they look after as any parent and should ensure looked-after children and young people have the care and support they need in order to be healthy, happy and reach their full potential. Supporting those leaving care to successfully transition into adulthood is also of key importance to ensure they are well prepared for adulthood, with support now provided for care leavers up to the age of 25 years.

The HNA had three key processes for gathering relevant information. A literature review was conducted to understand, from published evidence, the burden of physical and mental health problems and health risk-taking behaviours among LAC and CL. Secondly, local data was also gathered to identify what local intelligence was available to identify needs and health service use across County Durham. Lastly, stakeholder engagement was conducted with LAC and CL and with carers and professionals who work with them in County Durham.

In order to provide focus to the HNA, four priority areas were selected:

HNA Priority Areas:

1. **Mental health and emotional wellbeing**
2. **"Risk-taking behaviours" – including smoking, substance misuse, sexual health and teenage conceptions**
3. **Speech, language and communication needs (SLCN) and Special Educational Needs and Disability (SEND)**
4. **Wider determinants of health for care leavers: e.g. education, employment and training; accommodation and financial management**

The HNA commenced in February 2018, produced draft recommendations in July 2018 and completed in August 2018.

Summary of the HNA findings

Understanding health and wellbeing of LAC and CL population:

LAC and CL have a range of needs that can impact on their overall health and wellbeing. Key findings are summarised from various national and local evidence and data. Further details and data sources are all noted within the body of this document.

Priority Area: Mental Health and Emotional Wellbeing

National

- Evidence indicates that ACE's can have a long term effect on mental wellbeing and life satisfaction. Pre-care experiences of abuse or neglect are categorised as an ACE, as is the act of going into care itself. For this reason, all LAC and CL should be considered to be at-risk.
- Around half of all LAC have a diagnosable mental health disorder and/or behavioural conduct disorders, which is significantly higher than their non-looked after peers.
- Studies indicate that placement stability has a positive impact on mental health and emotional wellbeing
- Difficulties in accessing appropriate support for child and adolescent mental health services (CAMHS) has been persistently highlighted as a key area for improvement
- Recent studies estimate that each unsupported experience of care costs £22,415 per person more than a supported alternative

Local

- Local evidence highlights that mental health pathways for LAC and CL in County Durham are not robust and are difficult to navigate
- The Strengths and Difficulties Questionnaire process in County Durham does not routinely share total scores for LAC with key stakholders including the Virtual Head, or are they used to inform wider health assessments

- The proportion of LAC in County Durham whose SDQ score is “of concern” is higher than North East and England averages (35% in 2017/18 compared to 32% North East and 29% England), and this trend is consistent over time.
- It is acknowledged that CAHMS services provided locally experience many of the operational pressures reflected in national trends
- Current pathways to support the mental health and emotional wellbeing of LAC and CL typically focus on moderate to high level need through specialist support services provided by CAMHS and Full Circle.
- If a young person does not meet the eligibility criteria for either CAMHS or Full Circle, referrers are often unsure of what steps to take next.
- Uncertainties around pathways can create delays for those LAC and CL who require support. Leading to increased, inappropriate use of urgent and emergency services, such as mental health crisis and liaison services and accident and emergency services
- There are a number of young people requiring emergency support on repeated occasions.
- Concerns were raised in relation to the timely and appropriate support for young people leaving care and transitioning into adult services due to a reported increase in young people feeling socially isolated.
- Positive feedback was received from stakeholders regarding the training provided by Full Circle, with a recognition that additional training particularly focusing on supporting young people and self-harm and suicide would enhance this.
- Entry into care data is collated as part of the Initial Health Assessment (IHA). As this data is combined for both County Durham and Darlington it is not possible to determine the health needs for this cohort of children and young people, further work with County Durham and Darlington Foundation Trust (CDDFT) is required to develop these data sets.

Priority Area: Risk-taking Behaviours

National

- Emerging evidence indicates that ACE's can increase the risk of a young person engaging in risky behaviours, such as substance misuse and having an unplanned teenage pregnancy
- The most recent study highlighted that LAC were much more likely than their peers to smoke, take illicit drugs and engage in sexual activity that could leave them vulnerable to developing sexually-transmitted infections and unintended pregnancies.
- Risk-taking behaviours were also more likely to cluster in the LAC population where young people were four times more likely than children living in private households to smoke, drink alcohol and take drugs (8% compared with 2%)
- LAC are more likely to become sexually active at a younger age and have a higher number of sexual partners than their non-looked after peers
- Evidence suggests that around 20-50% of 16-19 year old females with a history of being in care become mothers.

Local

- A high proportion of female care leavers aged 17-21 years in County Durham are pregnant or mothers (around 40%). This appears to be a rising trend.
- A small scale, local review of CL in County Durham who are pregnant or mothers identified some potential common themes; including previous placement instability, entered care at a later age and had current or previous involvement with mental health and/or substance misuse services. These findings should be reviewed with caution due to the small sample and lack of comparable data.
- Initial Health Assessment (IHA) and Review Health Assessment (RHA) include an assessment of risk-taking behaviours; the transfer of RHA by Harrogate Foundation Trust (HFDT) to electronic recording should allow for much improved collation and understanding of local intelligence.
- Professionals and carers working with LAC and CL felt able to support young people who approached them in relation to sexual health, however felt that their knowledge was not always as up to date as possible.

- It is estimated that in County Durham 12% of children and young people in drug and alcohol treatment services are in care. This is comparable to the national average

Priority Area: Speech, Language and Communication Needs (SLCN) and Special Educational Needs and Disability (SEND)

National

- Failure to identify SLC skills and address needs can lead to a range of negative outcomes in relation to health and wellbeing, educational attainment, future employment prospects and participation in society.
- Limited evidence that does exist indicates that needs are often under-identified meaning that LAC are less likely to be receiving therapeutic intervention.
- Around two-thirds of LAC have identified SEND. When considering a breakdown of SEND by need, a higher proportion of LAC have needs associated with “social, emotional and mental health” compared to non-looked after peers

Local

- No prevalence data exists within County Durham. IHA and RHA, completed by clinicians with expertise in developmental paediatrics, include reference to SLCN. Collecting data electronically should in time improve understanding of prevalence, although no specific screening tool is currently used as a standard practice
- A review of speech and language therapy undertaken in County Durham estimated the prevalence of needs across three key priority areas, this included the importance of foster carers providing communication rich environments
- Specialist support provided to LAC with SEND was highlighted as an area of good practice in the most recent OFSTED SEND inspection of County Durham which was published in January 2018.

- Virtual School commission a bespoke set of services to support LAC with SEND, including educational psychology and speech and language therapy (SLT). Whilst still developing, evidence shows that these services can provide valuable support to those LAC who access them.

Priority Area: Wider Determinants of Health (Care Leavers)

There are a variety of factors that influence the health and wellbeing of young people leaving care that have been taken into consideration as part of the HNA:

Education, Employment and Training

National

- CL can often experience difficulties in moving into further education, employment and training
- Around 40% of CL in England are not in education, employment or training (NEET) compared to around 13% of 19-24 year olds in the general population
- Only around 6% of CL move into higher education compared to 27% of their peers aged 18
- There is limited evidence on the long-term outcomes of CL however one study observed that at the age of 30, 7.1% of participants with a history of care were unemployed compared to just 3.1% of those who had never been in care

Local

- County Durham has a lower proportion of CL who are NEET compared the North East and England average (29.3% compared to around 40% in the NE and England).
- Data relating to NEET figures of the general population aged 17-21 years is unavailable; therefore we are unable to determine how CL destination information compares to the general population
- Positive examples of partnership working exist, the multi-agency Care Leavers Steering Group continue to identify gaps in provision

Accommodation

National

- In April 2018 the government introduced revised statutory guidance in line with the Homeless Reduction Act 2017
- Despite local authority statutory duties to support CL into suitable accommodation, evidence suggest that around one-third of care leavers experience homelessness at some stage after leaving care

Local

- Significant work has been done to improve the accommodation offer across County Durham, particularly for those with moderate-high level needs.
- Accommodation is provided by a range of providers and there is currently limited information available on accommodation outcomes and user experiences

Welfare Rights and Managing Finances Independently

National

- CL are identified as being over-represented in the number of benefit sanctions suggesting they are less well equipped to navigate the welfare system

Local

- Durham County Council fund a dedicated Welfare Rights Officer specifically for CL, this post is in its infancy therefore limited quantifiable data is available; early indications show that the post holder is supporting a high number of young people, with a range of more complex needs specifically around the impact of Universal Credit
- Some support and training is offered within County Durham to ensure CL are financially independent, although it is noted that the training offer could be improved

Social Isolation

National

- A CL is surrounded by a range of carers and professionals during their time in care. Some evidence suggests that young people leaving care will experience social isolation

Local

- Stakeholders consulted during the course of the HNA likened the transition into leaving care as “falling off a cliff edge” for some young people, even if up to the point of leaving care they had craved independence.

Health Passports

National

- National guidance mandates Health Passports should be offered to all CL to support them in their future clinical care

Local

- Numbers of health passports issued in County Durham are low and some stakeholders reported delays in the process

Recommendations

A summary of key recommendations for County Durham can be collated into the following key themes:

1. Leadership and Partnerships
2. Strategic
3. Operational
4. Prevention and Early Help
5. Data and Intelligence

Leadership and Partnerships

1. Ensure that there is a clear lead for the health and wellbeing of LAC and CL within each appropriate agency to provide strategic oversight, drive forward recommendations from the HNA and act as an advocate for LAC and CL within their organisation.
2. Ensure that the designated lead for the health and wellbeing of LAC and CL within each agency provides regular updates and is appropriately challenged by multi-agency partners, for example the LAC Strategic Partnership Group

Strategic

1. Development of a holistic, patient centred pathway for mental health, that provides a graded response to need is linked to ACE's and considers the impact of social isolation on CL
2. A review of the Strengthens and Difficulty Questionnaire process and how this can be developed as part of a patient centred pathway for mental health is required in order to better understand the needs of LAC in county Durham.
3. Ensure that all services are developed and designed 'through the eyes of the child' and that methods to routinely capture the voice of LAC and CL are developed and implemented
4. Develop work in line with findings from the recent review of Speech, Language and Communication needs in County Durham to ensure that LAC and CL are appropriately supported

Operational, **Prevention and Early Help**

1. Improve identification of SLCN through IHA and RHA
2. Adaptation of the Clear Cut Communication screening tool developed by CDYOS to support the detection of SLCN and embedded across Children and Young People's Services to support the identification of LAC with SLC difficulties
3. Ensure that all LAC and CL have access to high quality relationship and sex education (RSE)
4. All LAC and CL have access to appropriate sexual health services including appropriate contraception

5. Development of a training offer for professionals and carers that considers the following:

    - ACE's and trauma based approach
    - Mental Health First Aid for LAC/CL at risk of self-harm and suicide
    - Risk taking behaviours
    - The importance of providing communication rich households
    - The importance of SLC development in the early years

Data and Intelligence

1. Development of a health dashboard to better understand and monitor LAC and CL health and wellbeing and support the identification of emerging local themes and trends
2. Development work with CDDFT and HDFT to ensure that the data collated through the IHA and RHA are specific to County Durham and can be incorporated into the health dashboard
3. To ensure that SDQ scores are revisited with LAC and CL as part of a wider assessment of mental health needs and better utilised to track population trends over time
4. Identify a solution to improve the identification of all LAC and CL who are teenage parents, with a particular focus on fathers; reviewing the age range of the data set to ensure that that the data collated is comparable to the general teenage population
5. It was agreed that LAC who are accommodated outside of County Durham would remain out of scope of this HNA, however it is recognised that a further review into the health needs of this cohort may be required to better understand their needs

Next Steps

- This Health Needs Assessment will support the development and commissioning intentions of health services, in respect of looked after children and care leavers from 2018 onwards.

- As most health and wellbeing needs are inter-related, solutions to address the identified needs and recommendations must take a multi-agency approach and will require meaningful engagement of commissioners and providers

The County Durham Looked-After-Children Strategic Partnership Group provided oversight and held overall responsibility for the HNA. Small task and finish groups were established within each of the four priority areas as appropriate.

Chapter 1: Introduction

Purpose of the Health Needs Assessment

The evidence from this Health Needs Assessment (HNA) is essential to ensure strategic alignment of service planning and delivery. This will ensure effective and efficient services are delivered to support young people who are looked after children (LAC) or Care Leavers (CL) with their health needs and reduce the health inequalities where they exist. A clearer understanding of the health needs is required to be able to best offer support and services that meet the needs of young people.

There is a clear commitment from the LAC and CL strategic partnerships and the Corporate Parenting Panel, to improve the health and wellbeing outcomes for young people who are LAC or CL across County Durham. This HNA highlights the need to develop a well-co-ordinated and strategic approach that is systematic in its application of interventions which are proportionate to the identified level of need. Partners are keen to work collaboratively with better identification and use of resources to achieve a more integrated approach focussed on improving health and wellbeing support to young people.

Health Inequalities for Looked After Children and Care Leavers

Looked-after-children (LAC) and care leavers (CL) are a vulnerable sub-group of the wider population of children and young people. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences.

Research tells us that LAC and CL are more likely to have been affected by Adverse Childhood Experiences (ACE's). ACE's are described as traumatic and/or stressful events that occur during childhood and adolescence. Adversities can include experiences of neglect, violence and/or abuse, the loss of contact with a sibling or care giver. Evidence suggests that emotionally distressing, difficult and traumatic situations will have a long lasting impact on children and young people's development, health and lifestyle.

National evidence suggests that around half of all LAC have a diagnosable mental health disorder (Department for Education and Department for Health, 2015; Meltzer, et al., 2003), which is significantly higher than their non-looked after peers. Prevalence is particularly high in behavioural and conduct disorders (Scott, et al., 2013)

Delays in identifying and meeting the health and wellbeing needs of LAC and CL can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy, healthy and dignified lives as adults.

Looking after and protecting children and young people from harm is one of the most important jobs that a Local Authority can do. Where a child cannot remain safely at home for whatever reason and comes into the care of the Local Authority and becomes 'Looked After' the council becomes the 'corporate parent' for that child.

Durham County Council is committed to being the best parent it can be for our Looked after Children and Care Leavers.

As a corporate parent, it is therefore important to understand the key health needs of LAC/CL and assess how those needs are currently being met by services across the local system to ensure LAC and CL are receiving appropriate care and support.

A Health Needs Assessment (HNA) offers a comprehensive and systematic format to assess the health needs of a defined population. A HNA will be conducted which focuses specifically on the health and wellbeing needs of LAC and CL living in County Durham to assess current need and current service provision. It will conclude by providing a set of recommendations for multi-agency partners involved in the care of this cohort of children and young people.

Methodology

Various methods were used to collect the information held within this HNA including

- **Quantitative analysis**
  Quantitative analysis of national and local data relevant to children and young people who are looked after and/or care leavers, Durham County Council (DCC), Children's Services, health and a range of other data sources.

Due to the variation in data sources and data quality, caution must be noted in comparing national and local data.

- **Qualitative consultations**

  Consultation events and focus groups were held with young people, parents/carers and professionals who are engaged in supporting looked after children and/or care leavers from across County Durham.

Chapter 2: Context

Literature review

Academic databases

A literature search was performed with the aim of identifying, from peer-reviewed literature, the burden of physical and mental health problems and health risk-taking behaviours among LAC and CL.

Four academic databases were searched: MEDLINE, PsychInfo, Web of Science and Scopus. Inclusion criteria included any primary research (experimental, observational, descriptive and qualitative) conducted in the UK and Ireland. This decision was taken given noted variation across international care systems. Some data from international studies – that was referenced in included UK and Ireland studies – has been quoted, primarily where data was lacking or not available for the UK and Ireland. Appendix 1 outlines the search strategy used in MEDLINE which was adapted for other databases.

Grey literature

Grey literature refers to material which is not commercially published and can include, for example, reports produced by government, industry and third-sector organisations. Searches were performed on the UK government website (www.gov.uk) and third-sector organisations that worked with LAC and CL, for example Barnados and The Children's Society. Sources of information are listed in Appendix 1.

National Policy and Guidance Overview

Local authorities have a duty under section 22(3)(a) of the Children Act 1989 to safeguard and promote the welfare of the children they look after, including eligible children and those placed for adoption, regardless of whether they are placed in or out of authority or the type of placement. This includes the promotion of the child's physical, emotional and mental health and acting on any early signs of health issues.

In 2015, the NHS England published statutory guidance on "Promoting the health and wellbeing of looked-after-children" (Department for Education and Department for Health, 2015). The guidance outlines joint responsibilities for local authorities,

clinical commissioning groups and NHS England. Key areas of the guidance are highlighted in Table 1:

Table 1: Key areas of "Promoting the health and wellbeing of looked-after children" (Department for Education and Department for Health, 2015)

- **Responsibilities – the guidance outlines key responsibilities for planning and commissioning health services. This includes the role of the Designated Doctor and Nurse who have an important strategic role in promoting the health and welfare of looked-after-children**
- **Information sharing - ensure there are effective arrangements in place to share information about a child's health.**
- **Health assessments and planning - local authorities are responsible for ensuring that a health assessment of physical, emotional and mental health needs take place on entry to care and at regular intervals to support effective health planning**
- **Mental health services – including targeted and dedicated support for mental health (e.g. through Child and Adolescent Mental Health Services (CAMHS) should be commissioned to support this well-established area of need**
- **Special Educational Needs (SEN) – acknowledging that around two-thirds of looked-after-children have SEN there is a responsibility to ensure needs are identified and met, for example through following requirements set out in the *Special educational needs and disability code of practice: 0-25 years* (Department for Education and Department for Health, 2015)**
- **Role of health and non-health professionals in promoting and supporting health – including the role of social workers, primary care teams, Virtual School Heads and Independent Reviewing Officers (IROs)**
- **Engagement – ensuring the voice of looked-after-children is taken into account in the commissioning and delivery of services**
- **Transitions – ensuring transition arrangements are in place for children who cease to be looked after so that their health need continues to be met whether they are returning home, being adopted or making the transition to adulthood.**

Building on previous guidance, the Children and Social Work Act (2017) sets out corporate parenting principles for local authorities with regards to LAC and CL (HM Government, 2017). It includes an extension of responsibilities relating to care leavers, including extending the provision of Personal Advisors up to the age of 25 years old to all care leavers (not just those in full-time education) and delivering the Local Offer. By March 2019, all local authorities must publish a Local Offer for care leavers to provide information about services available to support them in preparing for adulthood and independent living, including services relating to health and well-being, relationships, education and training, employment, accommodation and participation in society.

Mental Health and Emotional Wellbeing

Summary points

- **National evidence suggests that around half of all LAC have a diagnosable mental health disorder (Department for Education and Department for Health, 2015; Meltzer, et al., 2003), which is significantly higher than their non-looked after peers. Prevalence is particularly high in behavioural and conduct disorders (Scott, et al., 2013).**
- **There is an increasing body of evidence about the short and long-term impact of adverse childhood experiences (ACEs), including increased risk of poor mental wellbeing and life satisfaction. Pre-care experiences of abuse or neglect are categorised as an ACE, as is the act of going into care itself (Fonagy, 2018). For this reason, all LAC and CL should be considered to be at-risk.**

Estimating the prevalence of mental health disorders in looked after children and care leavers

Looked After Children

It is estimated that around half of LAC have a diagnosable mental health disorder (Department for Education and Department for Health, 2015; Meltzer, et al., 2003). Numerous academic studies have attempted to estimate the burden of mental health disorders in looked after children however there is often considerable variation in results. Variation in findings is largely due to differences between the studies, for example variation in age ranges of young people assessed, placement types (e.g. kinship/foster/residential care), diagnostic criteria applied and differences in care systems between countries.

Furthermore, the last large-scale prevalence study published in England was in 2003, almost 15 years ago (Meltzer, et al., 2003). This was raised as an issue by the Education Select Committee in 2016 who noted that an up-to-date study was planned for publication in 2018 (House of Commons Education Committee, 2016).

Despite these limitations, it is clear that children and young people in care experience a high burden of mental ill health. Table 2 is adapted from a 2013 Health Needs Assessment conducted in Scotland which pooled results of commonly observed mental health problems in the LAC population from 11 relevant studies (Scott, et al., 2013).

Table 2: Point prevalence rates for mental health problems for LAC (Scott, et al., 2013)

Mental Health Problem	Prevalence rate in identified studies
One or more mental health problems	25-72%
Behaviour problems, unspecified	2-61%
Conduct disorder	2-50%
Adjustment disorder (including Post-Traumatic Stress Disorder)	0.5-29%
Attention Deficit Disorder	10-21%
Mood disorder (including depression, dysthymia, bipolar affective disorder)	2-15%
Anxiety	3-12%
Attachment disorder	3-17%
Oppositional defiant disorder	4-12%
Intentional self-harm	7-10%

Socioeconomic deprivation is a well-established risk factor for mental health disorders in children and young people. Ford et al (2007) compared the prevalence of mental health disorders in LAC and those living in private households and found that British children looked after by the local authority had a higher prevalence of both psychosocial adversity and psychiatric disorder than the most socio-economically disadvantaged children living in private households (Ford, et al., 2007). This finding suggests that other factors exist among LAC, in addition to socioeconomic deprivation, which increases their risk of developing a mental health disorder.

Care Leavers

Most published studies identified during the literature review focus on children currently in care, rather than care leavers. This is in part due to a lack of routinely collected information on long-term outcomes for care leavers (Cameron, et al., 2018). A report from Barnados in 2017 titled “Neglected Minds” highlighted concerns about unidentified and unmet mental health needs among care leavers (ref). In a case audit of 274 care leavers, a mental health need was identified in 46% (125/274) cases and 1 in 4 had experienced a mental health crisis since leaving care (Smith, 2017).

Sex and age

As previously noted, a large-scale prevalence study into LAC health needs in England was conducted in 2003 by Meltzer and colleagues (Meltzer, et al., 2003). In

this study it was observed that the prevalence of mental health disorders in looked after children and adolescents was higher among boys compared to girls (49% overall –v- 39% overall), however this gap narrowed as children aged and there was no difference in prevalence for 16-17 year olds (both around 40%).

Older children were more likely to have generalised and other anxiety disorders, post-traumatic stress disorder (PTSD), depression and conduct disorder whereas younger children were more likely to have oppositional defiant disorder, hyperkinetic disorder and separation anxiety disorder (Ford, et al., 2007).

Girls were more likely to be diagnosed with PTSD and emotional disorders and boys were more likely to be diagnosed with hyperkinetic and conduct disorders (Meltzer, et al., 2003).

Adverse Childhood Experience (ACE's)

It is not surprising that the circumstances that lead a child into care can have long-lasting effects on mental health and emotional wellbeing. Physical abuse, sexual abuse and neglect, for example, have repeatedly been shown to increase risks of behavioural problems, mental health disorders and suicide (Gilbert, et al., 2009).

There is an increasing body of evidence about the short and long-term impact of adverse childhood experiences (ACEs), including increased risk of poor mental wellbeing and life satisfaction. Pre-care experiences of abuse or neglect are categorised as an ACE, as is the act of going into care itself (Fonagy, 2018). For this reason, all LAC and CL should be considered to be at-risk in respect of developing mental health disorders. This evidence suggests a proactive and holistic approach to emotional wellbeing.

Placement Setting and Stability

The prevalence of psychiatric disorders is noted to be particularly high among those living in residential care (Meltzer, et al., 2003). Often looked after children are placed in residential care for specific reasons, e.g. emotional or behavioural difficulties, which may explain this finding.

Meltzer et al (2003) also observed that there was a gradient in the prevalence of mental health disorders according to time spent in current placements, with those who had spent the least time in their current placement having the highest proportion

of mental health disorders. This suggests that placement stability is a protective factor for mental health. This finding should also be viewed with caution because a significant mental health disorder may impact on the stability of a placement.

Transitions

Transitions can represent a significant upheaval in a young person's life, for example changing placements, leaving care or moving from child to adult services, which may trigger or exacerbate existing mental health disorders (Stein & Dumaret, 2011).

Genetics

The role of genetics may be a contentious one when thinking about LAC, however Woolgar (2013) notes that there is a well-established body of evidence for a genetic contribution some mental health disorders, e.g. depression, psychosis and severe anxiety disorders (Woolgar, 2013). These genetic influences cannot, however, be considered in isolation and should be viewed alongside environmental and social influences.

Understanding the emotional and behavioural needs of LAC children and young people is important. In England, it is a government requirement to use the Strengths and Difficulties Questionnaire (SDQ) to assess the wellbeing of LAC. The SDQ is an internationally validated brief behavioural screening questionnaire for 4-16 year olds. It exists in three parts: one for the carer, another for the child's teacher and a third part for the child. The Department for Education requires local authorities to provide SDQ data to be completed for looked-after children by their main carer (foster carer or residential care worker) only, this is usually facilitated by the LAC social worker. National good practice states that the SDQ should be completed well in advance of any health assessment so that the completed SDQ can meaningfully inform the wider assessment. Information in the completed questionnaires is collected by the local authority and the child's total difficulties score is worked out and available to inform the child's health assessment. This should help the social worker and health professionals to decide whether to triangulate the scores with an SDQ completed by the child's teacher and (if the child is in the relevant age bracket) the child, and whether the child needs to be referred for further diagnostic assessment of their mental health (Department of Education Statutory Guidance 2015).

SDQ scores form part of local authorities routine performance monitoring reports in England, suggesting these scores are used as a proxy measure for the mental health and emotional wellbeing of looked after children.

In addition, the NSPCC report in 2015, "*Achieving emotional wellbeing for Looked After Children"* reported that a high SDQ score indicating severe emotional and behavioural difficulties appeared to increase the risk of instability on placements, in turn having a detrimental impact on LAC achieving good outcomes.

The Rees Report, published in 2015, whilst recognising that the SDQ data has limitations, still concluded it to be a good predictor of outcomes for LAC. As with the Rees Report, wider evidence supports the use of the SDQ as a screening tool (Goodman & Goodman, 2012), whilst cautioning about its limitations. A 2016 report from the Education Select Committee highlighted that the SDQ was just a starting point, and should be accompanied by a full mental health assessment as part of initial and review health assessments (House of Commons Education Committee, 2016).

Meeting needs

Access

A qualitative study by York and Jones (2016) explored the views of foster carers around mental health services (York & Jones, 2017). Although this was a small study, foster carers identified that issues tended to arise not in identifying need but rather once a looked after child was "in the system", e.g. waiting times or transitions (York & Jones, 2017). The complex and often fragmented nature of services reflects wider concerns about systems designed to meet the mental health needs of children and young people in England (Care Quality Commission, 2017).

In its 2017 "Neglected Minds" report, Barnados found that almost two-thirds of care leavers identified (65%) were not receiving any formal support from statutory services (Smith, 2017).

Transitions for those leaving care

Within the UK context, issues surrounding the transition from children to adult mental health services is frequently highlighted as a concern (House of Commons Education Committee, 2016). The Children's Society highlighted

> *"The period of transition for many children can be characterised by confusion, a lack of coordination and participation. It is known that mental health needs become more acute as children progress through adolescent years and when they leave care. Yet it is then that the access to services becomes more difficult"*

Care leavers often struggle to access support from adult services due to their typically higher thresholds for access that are required (HM Government, 2016). Personal advisors who support care leavers often have heavy caseloads and whilst heavily skilled and experienced, often do not have the specialist training required to identify mental health needs.

The Care Leavers Strategy encourages commissioners of mental health services to think of innovative solutions to transitions for care leavers with mental health needs (HM Government, 2013). Whilst it is not felt appropriate to mandate that CAMHS services are available to care leavers up to the age of 25 (as some care leavers may benefit from accessing adult services), examples from areas that have extended access are highlighted. As an example, Birmingham have extended CAMHS services up to age of 25 years and in Sheffield a Community Psychiatric Nurse from the CAMHS service is available for consultations for care leavers to help them gain access to adult mental health teams and to provide one-to-one support (HM Government, 2016).

Cost-effectiveness

Identification and provision of appropriate support for the mental health of looked after children and care leavers is the right thing to do to support young people to live a dignified life. There is also a cost to a lack of intervention, with a study by Loughborough University and the NSPCC estimating that for each unsupported experience of care costs £22,415 per person more than a supported alternative (House of Commons Education Committee, 2016).

Risk-Taking Behaviours

Summary

- **Emerging evidence indicates that adverse childhood experiences can increase the risk of a young person engaging in risky behaviours, such as substance misuse and having an unplanned teenage pregnancy**
- **LAC and CL are much more likely than their peers to smoke, take illicit drugs and engage in sexual activity that could leave them vulnerable to developing sexually-transmitted infections and unintended pregnancies (Meltzer, et al., 2003).**
- **Whilst it is acknowledged that teenage pregnancy can have positive effects for some young parents, it is important that any decisions are planned and taken from an informed perspective**

Sexual Health and Conceptions

Whilst research in this area is limited, there is a small body of evidence which indicates that LAC and CL are more likely to engage in risky sexual behaviours and become a teenage parent than their non-looked-after peers.

Prevalence of risky sexual behaviours

In the latest large-scale England prevalence study by Meltzer et al (2003), it was observed that around a third (31%) of LAC had had sexual intercourse (after excluding children with a history of rape or sexual abuse). Over half (55%) of young people reported that the last time they had sex they did not use contraception, with the highest proportion in younger age groups (74% of 11-15 year olds reported having had unprotected sex). Children with a mental health disorder were more likely than those without a disorder to have had unprotected sex the last time they had sexual intercourse (Meltzer, et al., 2003).

Around 20-50% of 16-19 year old females with a history of care will become a mother compared to 5% of the general population. Young people in care or with a history of care are also more likely to carry their child to term rather than terminate the pregnancy (Meltzer, et al., 2003).

The evidence points towards a range of explanations for these findings:

Risk factors

There are well-established risk factors linked to teenage pregnancy including socioeconomic deprivation, an “unhappy childhood”, “low expectations for the

future", learning difficulties and being NEET (not in education, employment or training). A history of abuse and neglect as well as child sexual exploitation are further risk factors. These risk factors tend to be more prevalent among children in care (or with a history of care) compared to their non-looked-after peers (Meltzer, et al., 2003).

There are also links to other risk-taking behaviours, for example having unprotected sex under the influence of drugs and alcohol (Dale, et al., 2010; Carpenter, et al., 2001; Meltzer, et al., 2003).

Studies have also identified that LAC are more likely to engage in risky sexual behaviours that could in turn lead to sexually transmitted infections and teenage pregnancy, for example becoming sexually active at a younger age and having a higher number of sexual partners than non-looked-after peers (Carpenter, et al., 2001).

"Knowledge deficit" gap

Children in care are less likely to receive meaningful relationship and sex education (RSE) from parents or carers than their peers (Meltzer, et al., 2003). Evidence suggests that RSE appears to be more effective when coming from a trusted person, which may be lacking for a child in care (Fallon & Broadhurst, 2015). It is also felt this may explain lower rates of teenage pregnancy among children living in foster care compared to residential care (Lyons, et al., 2016).

A young person in care may also not receive effective RSE in school if, for example, they are subject to frequent placement/school moves (Fallon & Broadhurst, 2015; Lyons, et al., 2016).

Dale et al (2010) observe that this may result in a LAC or CL having a "knowledge deficit" around safe sexual behaviours, STIs and conception (Dale, et al., 2010).

"Knowledge-behaviour" gap

Dale et al (2010) also identified that LAC may also experience a "knowledge-behaviour gap", or in other words they know how to practice safe sex but didn't always feel able to apply that knowledge. The study authors observed that many of

the looked-after children they interviewed had low self-esteem which impacted on their confidence to practice safe sex (Dale, et al., 2010).

Pre-care experiences also play a significant role. Studies have reported that LAC are more likely to experience attachment issues as a result of previous abuse or neglect. Engaging in sexual activity and becoming a parent may be understood as a form of affection seeking (Dale, et al., 2010; Meltzer, et al., 2003).

Research also indicates that young people in care may also experience peer pressure to engage in sexual activity, particularly within residential settings (Fallon & Broadhurst, 2015).

Leaving care

In terms of sexual health and conception, there is limited data available on care leavers as a specific group however a US-based study observed that remaining in care beyond the age of 18 years old decreased the risk of experiencing teenage pregnancy, even after other effects had been taken into account (Dworsky & Courtney, 2010).

Right to privacy

Another emerging finding from the literature is that in the routine care process detailed information about the sexual history of a child in care is often collected and shared between multiple agencies, for example social work teams, health services and schools. An Irish study observed that the intimate details about a young person in care's private life are often shared even when there is no discernible child protection issues. Young people interviewed saw this as an invasion of their privacy and that it often deterred young people from being open and honest with the team around them for fear of professionals "being on top of you" if you reported any sexual activity (Hyde, et al., 2016).

Substance Misuse, Alcohol and Smoking

Research from the UK and beyond suggests that while risky substance use in adolescence tends to be recreational, it can lead to problematic use in later life and significantly increases the risk of mental disorders, crime and poverty in adulthood (Ward, 1998; Alderson, et al., 2017)

In the recently published NICE (National Institute for Health and Care Excellence) Quality Standard for 'Drug Misuse Prevention', LAC young people as a group that are vulnerable to drug misuse (National Institute for Health and Care Excellence, 2018). About 7% of the approximately 21,000 young people accessing specialist drug and alcohol services in the UK in 2012 self-reported that they were in care (Alderson, et al., 2017)

Risk factors

Looked-after-children have multiple risk factors for substance abuse, including parental poverty, absence of support networks, early family disruption and, in many cases, a history of abuse and neglect (Alderson, et al., 2017).

Estimated substance use

The most valid and relevant prevalence data for estimated substance use comes from the 2003 large-scale prevalence study conducted by Meltzer et al (2003) and these are reported here:

Smoking

Around one-third (32%) of young people reported being a current smoker. For those young people living in residential care, 69% reported being a current smoker which again may be partially explained by the older average age of LAC living in residential compared to other care settings.

Alcohol

A quarter of LAC aged between 11-17 years old drank alcohol at least once a month compared to 9% of those living in private households. As may be expected, older children (16-17 years) were much more likely to drink, for example over a third (34%) of 16-17 year olds surveyed reported drinking alcohol at least once or twice per week.

Children living in residential care were more likely to drink alcohol than those in foster care, although this again could reflect the greater proportion of older children living in residential care.

Drug use

The most popular illicit drug reported to be used among 11-17 years olds surveyed by Meltzer et al was cannabis, with 1 in 5 young people reporting use at some point in their lives. Recent cannabis use was higher in males compared to females and in those living in residential care compared to foster care.

Clusters

With regards to the 'clustering' of behaviours, LAC were four times more likely than children living in private households to smoke, drink alcohol and take drugs (8% compared with 2%). Children with a mental health disorder were more likely to engage in all three lifestyle behaviours than those with no mental health disorder (13% compared to 4%).

Care Leavers

Data around care leavers is more limited. A national survey of care leavers from 2003 found high levels of self-reported drug use compared to the general population with cannabis use highlighted as a specific issue (32% reported daily use). (Ward, et al., 2003)

Risky Substance Use

The SOLID study, led by Newcastle University, aims to investigate the feasibility of interventions to support LAC with risky substance use. As part of a preliminary study, data was gathered on almost 400 children in care in the North-East of England to ascertain levels of risky substance use. The CRAFFT screening tool was used as a validated measure (Alderson, et al., 2017). This study found that almost one in five (19%) of LAC were identified through screening as having risky substance use including, for example, being in a car driven by someone (including themselves) under the influence of alcohol or drugs and having gotten into trouble due to their alcohol or drug use (Alderson, et al., 2017).

Speech Language and Communication and Special Educational Needs

Key points

- **Speech, language and communication skills are essential in the development of skills for life and work. Failure to identify and address needs can lead to a range of negative outcomes in relation to health and wellbeing, educational attainment, future employment prospects and participation in society**
- **Prevalence of SLCN among LAC is an under-researched area. Limited evidence that does exist indicates that needs are often under-identified meaning that LAC are less likely to be receiving therapeutic intervention**
- **Nationally, around two-thirds of LAC have identified SEND (Department for Education and Department for Health, 2015). When considering a breakdown of SEND by need, a higher proportion of LAC have needs associated with "social, emotional and mental health" compared to non-looked after peers**

Speech, Language and Communication Needs (SLCN)

Speech, language and communication needs is the umbrella term most commonly used to describe a wide range of difficulties related to all aspects of communication in children and young people. These can include difficulties with fluency, forming sounds and words, formulating sentences, understanding what others say and using language socially. Children with speech, language and communication needs may have difficulty with only one speech, language or communication skill, or with several. For example, children may have difficulties with listening and understanding or with talking or both.

The severity of children's speech, language and communication difficulties can also vary significantly from child to child due to the complex interplay of physical, neurological, sensory and environmental factors alongside each child's unique combination of strengths. This means that every child with SLC needs is unique.

In terms of causation, there may be a medical cause in some cases which affects the child's development of speech, language and communication (for example, neurological damage, hearing impairment, autism or cleft palate) or an environmental trigger such as limited exposure to language in the early years. However, in some cases there is no recognisable cause. The definition of speech, language and communication needs, therefore, encompasses children with difficulties as diverse as language delay, language disorders, additional medical and sensory needs, stammers, voice disorders, as well as those children with complex social communication needs including autism.

National School Census data provides a breakdown of the various types of special educational needs and disabilities (including speech, language and communication needs) that are prevalent across children of statutory school age, the census is limited in that it only captures the primary special educational need and/or disability of a child and does not therefore capture those children whose speech, language and communication needs co-exist alongside other conditions and/or disabilities. Where the census does identify children with speech, language and communication needs it does not provide a more detailed breakdown of the severity and/or different types of need which further limits its application for the purpose of this needs analysis.

To overcome this deficiency, this needs assessment instead makes full use of the prevalence data referenced within the Bercow Review of Services for children and Young People (0-19) with Speech, Language and Communication Needs (2008). The Bercow Review concluded that this prevalence data can be taken to broadly represent the levels of speech, language and communication needs across Local Authorities in England and provided the following three categories of need to enable commissioners to be able to differentiate between the severity of children's speech, language and communication needs across the cohort:

- Pervasive speech, language or communication needs
- Significant speech, language or communication needs
- Impoverished speech, language or communication development

Pervasive speech, language or communication needs

The Bercow Review identified that 1% of children will have severe, complex and pervasive speech, language or communication needs who will require long term specialist support, often of an intensive nature for the remainder of their lives. These children will often also have significant physical and/or sensory impairments and/or complex and life-long conditions such as cerebral palsy, deafness or severe autism and can require significant support and adaptations to be made across many aspects of their day to day lives.

Pervasive speech, language or communication needs are often present from birth. Children will typically experience difficulty articulating particular speech sounds, while some cannot make themselves understood at all. For example, the National

Children's Bureau (2012) estimate that a quarter of children with cerebral palsy are nonverbal. Similarly, a study undertaken by Bedrick (2015) identified that nearly a third of people with autism use no spoken language or only a few words.

Where a child has very limited speech or no speech at all it is anticipated that Alternative and Augmentative Communication (AAC) strategies (training re AAC needs to be referenced as a role for SALT service) will be developed to assist the child's communication. Alternative and Augmentative Communication is any form of communication other than speech and includes use of pictures, symbols, sign language and electronic aids as forms of communication.

Significant speech, language or communication needs

The Bercow Review identified 7% of children will have significant speech, language or communication needs which will not improve without specialist intervention as part of the team working with the child, including the parents/carers. Children in this category can be expected to have long term needs but their access to learning and the community can be improved with appropriate support.

These children have speech, language or communication needs which are often associated with an underlying speech, language and communication impairment or as a further need associated with other special educational needs and/or disabilities (SEND). The Communication Trust (2013) estimate that the majority of children with (SEND) will also have some degree of speech, language and communication needs.

Impoverished speech, language or communication development

The Bercow Review further highlighted that in the most deprived and disadvantaged areas of England, approximately 50% of children and young people will potentially have speech, language and communication skills that are immature or poorly developed and significantly below those expected for their age. The children's speech may be unclear, vocabulary is smaller, sentences are shorter and they may struggle to understand instructions.

Impoverished speech, language and communication development is strongly linked to environmental factors such as the child's background, the home environment and the capacity of parents/carers to promote and support language acquisition in the early years which can have a life-limiting effect (ICAN 2009; Department of Health

2009; The Communication Trust 2013). Whilst many families who experience difficulties are able to provide their children with a communication rich environment to support their development, studies consistently highlight that children from deprived and disadvantaged households remain at greater risk of experiencing impoverished speech, language and communication development than their more affluent peers (Locke et al 2002; Centre on the Developing Child 2007; Law et.al 2008; Royal College of Speech and Language Therapists 2018). Families who experience social disadvantage often have to contend with a multitude of stresses which impact upon their ability to interact with and actively cultivate their children's language acquisition. Findings suggest that not only do many children in areas of high deprivation have limited language skills, but that this seems to persist and for some children, get worse (reference needed). Studies highlight that this, in turn, frequently leads to a downward spiral of associated difficulties with broader learning, friendships, behaviour, exclusions, criminal activity, unemployment, mental health difficulties and in some instances: prison (ICAN 2007).

However, it is anticipated that the difficulties associated with children who have impoverished speech, language and communication development are transient and if they are identified early and provided with appropriate support, particularly during the early years, these children can catch up with their peers (reference needed).

The Bercow review suggested that 50% of children in 'the most deprived areas of England' are likely to have impoverished speech, language or communication development.

SLC skills are essential in the development of skills for life and work. Failure to identify and address needs can lead to a range of negative outcomes in relation to their health and wellbeing, educational attainment, future employment prospects and participation in society. Risks include:

- Mental health and emotional wellbeing needs - up to one-third of young people with SLCN will develop subsequent mental health disorders (Children's Communication Coalition, 2010)
- Education, employment and training – it has been shown that experiencing vocabulary difficulties aged 5 is significantly associated with poor literacy, mental health and poorer employment outcomes aged 34 (Blanden, 2006)

- Offending behaviour – studies have identified that around 60-90% of young people who offend have SLCN, compared to around 6% of the general population (Bryan, 2008)

Understanding the communication needs of LAC is an under-researched area, however emerging studies and reports demonstrate a significant proportion of unidentified and unmet need (RCSLT, 2018).

Children in care (or with a history of care) are often at greater risk of developing SLCN as a result of their pre-care experiences, for example experiencing trauma or neglect may have an impact on the development of a child's communication skills (RCSLT, 2018).

In North Yorkshire an integrated service for vulnerable young people (including LAC) "No Wrong Door" includes a screening and intervention arm for SLCN. Among LAC 67% of those screened had SLCN identified (increasing to 74% in looked-after males). In the vast majority of cases no previous intervention had been provided. Interventions took place through a dedicated Communication Support Worker and specialist education provision and the costs of this were partly met through use of the Pupil Premium (LAC are one of the groups of pupils who are entitled to "Pupil Premium Plus" funding which is aimed at closing the attainment gap between them and their peers) (Lushey, et al., 2017).

Evidence also indicates that LAC living in residential care experience high levels of SLCN. In a small study of 30 LAC living in residential care in Scotland, 63% were identified with SLCN and (where data was available) it was clear that 90% had not previously had needs identified or addressed, despite the intensive nature of the support they received in this care setting (McCool & Stevens, 2011).

Special Educational Needs and Disability (SEND)

Looked-after-children are significantly more likely than their peers to have SEND (Department for Education, 2018). In a UK-based review of the educational progress of LAC in England it was identified that over 70% of children who had been in care for over 12 months at Key Stage 4 had an identified SEND compared to just 15% of

those who were identified as a child “not ‘in need’ or looked-after” (O’Higgins, et al., 2015).

This review also considered which needs were identified as having the biggest impact on educational attainment. It was found that autism spectrum disorder, “social, emotional and mental health” needs, moderate and severe or multiple learning difficulties were associated with the worst Key Stage 4 outcomes. It observed that “of all children with identified SEN the children with these four particular types of need were most often also in need or in care” (O’Higgins, et al., 2015).

Children in care with SEN have poorer educational attainment than children with SEN who are not in care (Sebba, et al., 2015). This finding may be associated with other factors associated with being in care, for example education may be disrupted if a child moves placement and transitions to a new school.

Evidence also suggests this may be explained by difference in SEND type. Around half of LAC who had SEN had needs linked to “social, emotional and mental health”, which compares to 28.2% of children not in need or care (Sebba, et al., 2015). Ensuring access to specialist support, for example through specialist CAMHS services or school counselling services where appropriate, is therefore key.

Wider Determinants (Care Leavers)

Key points

- **There are a variety of factors that influence the health and wellbeing of young people leaving care, including education, employment and training, access to safe and secure accommodation and being empowered to be financially independent**
- **Around 40% of care leavers in England are not in education, employment or training (NEET)**
- **Nationally, care leavers also face considerable challenges in securing suitable accommodation.**
- **Care leavers often become financially independent at a much younger age than their non-looked after peers. Nationally they are over-represented in those receiving “benefit sanctions”.**

Education, Employment and Training

Young people leaving care can often experience difficulties in moving into further education, employment and training. Around 40% of care leavers in England are not in education, employment or training (NEET) compared to around 13% of 19-24 year

olds in the general population (Department for Education, 2017). Only around 6% of care leavers move into higher education compared to 27% of their peers aged 18 (Department for Education, 2017).

Pre-care experiences can continue to have an impact on the young person throughout their life course if they remain unaddressed (NAO, 2015). A systematic review (a rigorous review of the available evidence on a subject) by the Rees Centre at the University of Oxford found that children in care lagged behind their peers on a range of educational outcomes at all stages of learning (O'Higgins, et al., 2015) As an example, 17.5% of LAC achieved a pass in English and Mathematics GCSE compared to 58.9% of non-looked after peers (Department for Education, 2017). As highlighted previously, some of these differences are driven by the higher proportion of LAC who have identified SEN although analysis confirms that attainment at Key Stage 4 is poorer for LAC with SEN compared to non-looked after peers with SEN (Department for Education, 2017).

Young people leaving care typically become independent at a younger age than their peers, for example over half of 20-24 year olds still live with their parents (56%). Evidence suggests that a young person leaving care often needs to deal with multiple complex changes in relation to securing accommodation, employment and managing finances all at once at a more "accelerated and compressed" pace than their peers (Cameron, et al., 2018).

Care leavers are more likely to engage in risk-taking behaviours, such as substance misuse and youth offending, which can impact on their ability to stay in education, employment and training (Smith, 2017).

There is limited evidence on long-term employment outcomes for people leaving care in the UK. Data has been historically reported in England up to the age of 21 years only (the previous cut-off age for care leavers in England).

One longitudinal study was identified during the literature search. This study used data from the British Cohort Study (a longitudinal study of 17,000 participants born in 1970) to look at outcomes in participants who reported a history of care. At the age of 30, 7.1% of participants with a history of care were unemployed compared to just 3.1% of those who had never been in care (Cameron, et al., 2018). Whilst this is an

isolated study, it provides compelling evidence to suggest that barriers to the employment market persist long after a young person leaves care.

Accommodation

Securing high-quality accommodation can support a positive transition into adulthood for care leavers and local authorities have a statutory duty to support care leavers to move into secure, appropriate accommodation (HM Government, 2017).

In a 2010 survey, care leavers felt "safe, settled accommodation" related to (Barnados, 2014):

- Having **choice** about when to leave care and about accommodation options
- Being **prepared** to leave care
- Being and feeling **safe**
- Having practical and personal **support**
- Having appropriate **financial support**
- **Being involved** in services affecting them

Care leavers are at increased risk of becoming homeless. Reports suggest that around one-third of care leavers experience homelessness at some stage after leaving care, with one survey from the youth homelessness charity Centrepoint finding that 26% had "sofa surfed" and 14% had slept rough (Centrepoint, 2017).

Managing Finances Independently

As previously highlighted, care leavers often experience "accelerated and compressed transitions" to adulthood and may be required to manage finances independently at a much younger age than their peers (Cameron, et al., 2018).

They may also struggle to appropriately access the welfare support they are entitled to. As an example, care leavers appear to experience a high proportion of benefit sanctions. An investigation by the Children's Society found that from 2013-2015, nearly 4,000 benefit sanctions were applied to care leavers. Compared to the general population, a smaller proportion of care leavers appealed sanctions (16% of care leavers compared to 23% overall). Of those who did, 60% were overturned on appeal (compared to 50% overall) (Ayre, et al., 2016). These findings suggest that

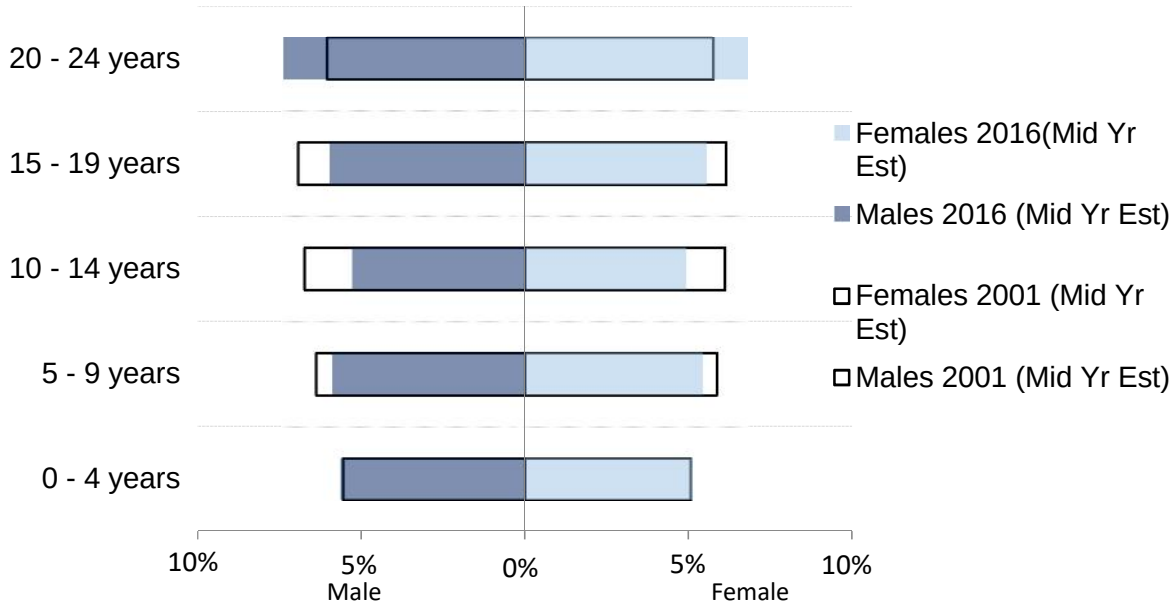
care leavers may need additional support to navigate the welfare system to appropriately access support.

Chapter 3: County Durham's Population

Age Profile

County Durham has an estimated population of 522,143 (2016, ONS). Since 2001 the population has increased by 28,400 people (5.8%). County Durham has an ageing population structure. This follows national and historical trends brought about by the post Second World War spike in births, followed by steadily decreasing birth rates until the start of the new millennium. Unlike the national trend (0-17 years) the county has seen a gradual fall in the number of its children and young people since 2001. The 2016 figure was 5.8% lower than in 2001 compared to a 5.1% increase nationally. This represents a fall of 6,200 children and young people in the county over this period.

Figure 1: Population age pyramid for County Durham 2001 to 2016, ages 0 to 24 years. Source: ONS



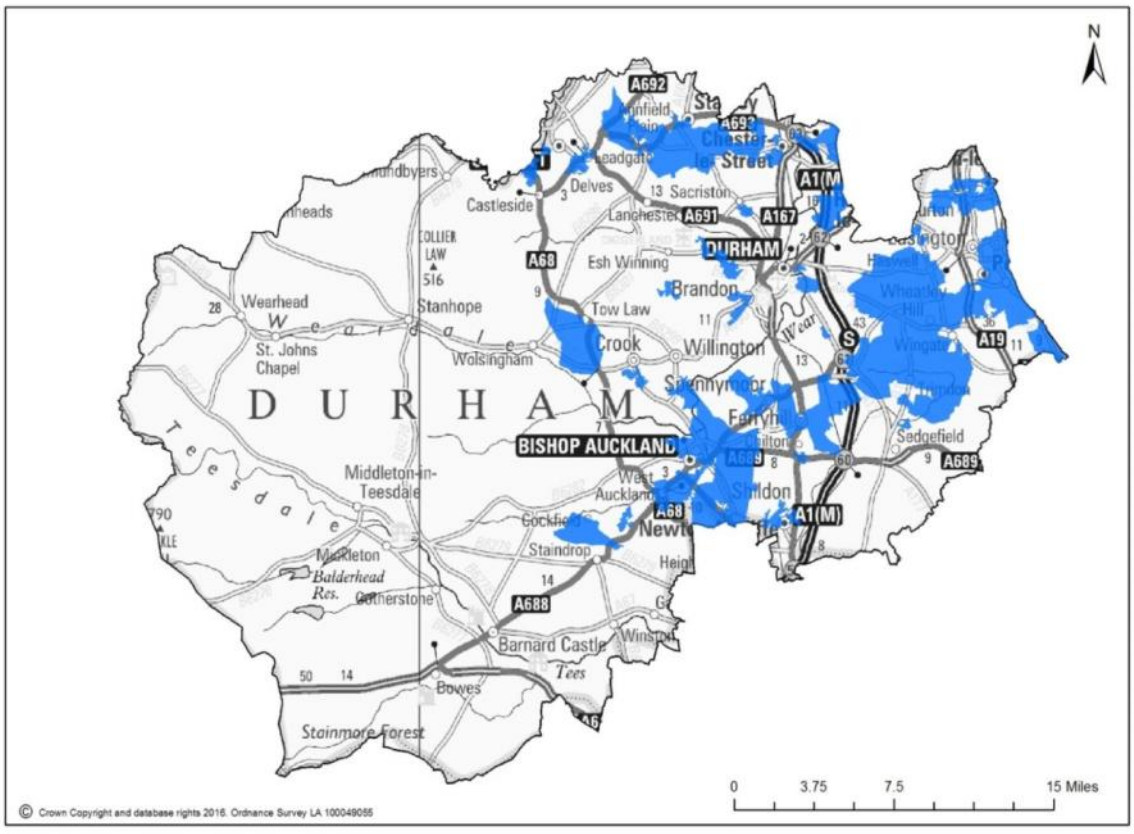
The most notable changes to the County Durham population are in the older age bands of the 0-24 population. The county's 20-24 year old population has increased while there has been a fall in the number of children aged 5 to 19 years.

Deprivation within County Durham

The health and wellbeing of the people in County Durham has improved significantly over recent years but remains worse than the England average. Health inequalities remain persistent and pervasive. Levels of deprivation are higher and life expectancy is lower than the England average. There is also inequality within County Durham for many measures (including life expectancy, childhood obesity and premature mortality for example). Overall, the health and wellbeing of children in County Durham is generally worse than the England average, as are the levels of child poverty.

County Durham is a large and diverse area and over 40% of our population live in relatively deprived areas (43% of County Durham's Lower Super Output Areas (LSOAs) are in the 30% most deprived nationally). The variation in County Durham is shown on the map below (figure 2).

Figure 2: Map showing County Durham's most 30% most deprived LSOAs nationally. Source: ID2015, DCLG



The more deprived an area is, the poorer health outcomes that would be expected. Overall, the health and wellbeing of children in County Durham is generally worse than the England average, as are the levels of child poverty. County Durham is the 75th most deprived local authority in England (out of 326) and as such would be expected to have lower than average health outcomes (ID2015).

Understanding the health needs of children and young people in County Durham

Child health and wellbeing in County Durham is mixed compared to the England average. Many indicators show an experience locally that is significantly worse than the England average but many of these have shown improvement over a longer time period. However, some have not. The health and well-being outcomes of an area are greatly shaped by a wide variety of social, economic and environmental factors (such as poverty, housing, ethnicity, place of residence, education and environment). It is clear that improvements in health outcomes cannot be made without action in these wider determinants. Health inequalities are disparities between population groups that are systematically associated with these socio- economic and environmental factors. Such variations in health are avoidable and unjust. There is a clear social gradient to many health outcomes.

The 2018 Child Health Profile provides an overview of child health and wellbeing in County Durham.

https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-overview/data#page/9/gid/1938132992/pat/6/par/E12000001/ati/102/are/E06000047

The profiles are designed to help local authorities and health services improve the health and wellbeing of children and tackle health inequalities.

The profile is also available as an interactive version within PHE's Fingertips tool, where CCG profiles are available:

https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-overview/data#page/0/gid/1938132992/pat/6/par/E12000001/ati/102/are/E06000047

Further relevant information relating to Child and Maternal Health in County Durham is available within PHE's Fingertip's tool by life course stage and theme here: https://fingertips.phe.org.uk/profile-group/child-health

Figure 3: Overview of child health, County Durham, 2018. Source: PHE, Fingertips.

Indicator	Period	County Durham		North East	England
		Count	Value	Value	Value
Infant mortality	2014-16	24	**4.6**	3.7	3.9
Child mortality rate (1-17 years)	2014-16	12	**12.8**	12.1	11.6
MMR vaccination for one dose (2 years) **<90% ≥90%**	2016/17	5,383	**97.0%**	94.9%	91.6%
Dtap / IPV / Hib vaccination (2 years) **<90% ≥90%**	2016/17	5,467	**98.6%**	97.4%	95.1%
Children in care immunisations	2017	415	**84.8%**	90.4%	84.6%
Children with a good level of development at the end of reception	2016/17	4,046	**71.9%**	70.7%	70.7%
GCSEs attainment: Attainment 8 Score	2016/17	-	**44.6%**	44.6%	44.6%
GCSEs attainment: Attainment 8 Score of children in care	2016/17	-	**31.3%**	25.9%	22.8%
16-17 year olds not in education, employment or training	2016	610	**5.6%**	5.4%	6.0%
First time entrants to the youth justice system	2016	168	**391.3**	409.8	327.1
Children in low income families (under 16 years)	2015	18,695	**21.4%**	22.0%	16.8%
Family homelessness	2016/17	101	**0.4**	0.7	1.9
Children in care	2017	815	**81**	92	62
Children killed or seriously injured (KSI) on England's roads	2014-16	22	**24.4**	23.3	17.1
Low birth weight of term babies	2016	146	**3.0%**	3.0%	2.8%
Obese children (4-5 years)	2016/17	589	**10.3%**	10.7%	9.6%
Obese children (10-11 years)	2016/17	1,211	**22.6%**	22.5%	20.0%
Children with one or more decayed, missing or filled teeth	2016/17	-	**25.8%**	23.9%	23.3%
Hospital admissions for dental caries (0-4 years)	2014/15 – 16/17	32	**112.6**	299.5	234.7
Under 18 conceptions	2016	173	**21.6**	24.6	18.8
Teenage mothers	2016/17	77	**1.5%**	1.4%	0.8%
Hospital admissions due to alcohol specific conditions – under 18s	2014/15 – 16/17	56	**56.2**	64.8	34.2
Hospital admissions due to substance misuse (15-24 years)	2014/15 – 16/17	63	**92.0**	113.2	89.8
Smoking status at time of delivery	2016/17	867	**16.7%**	16.1%	10.7%
Breastfeeding initiation	2016/17	2,924	**56.0%**	59.0%	74.5%
Breastfeeding prevalence at 6-8 weeks after birth	2016/17	1,490	**27.9%**	31.4%	44.4%
A&E attendances (0-4 years)	2016/17	24,072	**861.4**	928.5	601.8
Hospital admissions caused by injuries in children (0-14 years)	2016/17	1,453	**173.1**	146.4	101.5
Hospital admissions caused by injuries in young people (15-24 years)	2016/17	1,048	**156.4**	151.5	129.2
Hospital admissions for asthma (under 19 years)	2016/17	264	**248.0**	266.2	202.8
Hospital admissions for mental health conditions	2016/17	95	**94.7**	99.3	81.5
Hospital admissions as a result of self-harm (10-24 years)	2016/17	377	**400.8**	425.3	404.6

	worse than England
	similar to England
	better than England

Benchmarking against statistical neighbours

When looking at any health profile for County Durham, the natural comparison that is always made is how it compares against the England average. Whilst this is vital for understanding the wider picture of health and which areas are of particular concern it often shows County Durham performing significantly worse than England for most indicators. This type of comparison can be misleading as it does not consider the social or economic nature of each individual County. Benchmarking County Durham against similar local authorities gives local context enabling a more detailed look at whether local people's health is better, worse or similar to like authorities.

The following charts, compare County Durham with its Children's Services Statistical Neighbours (CSSN) family group. This group includes St. Helens, Stockton-On-Tees, Sunderland, Darlington, Gateshead, Halton, Wakefield, North Tyneside, Wigan, and Barnsley.

It is important to note that when looking at the data for each local authority there may be significant differences in population that are not taken in to account, this includes age, gender and ethnicity.

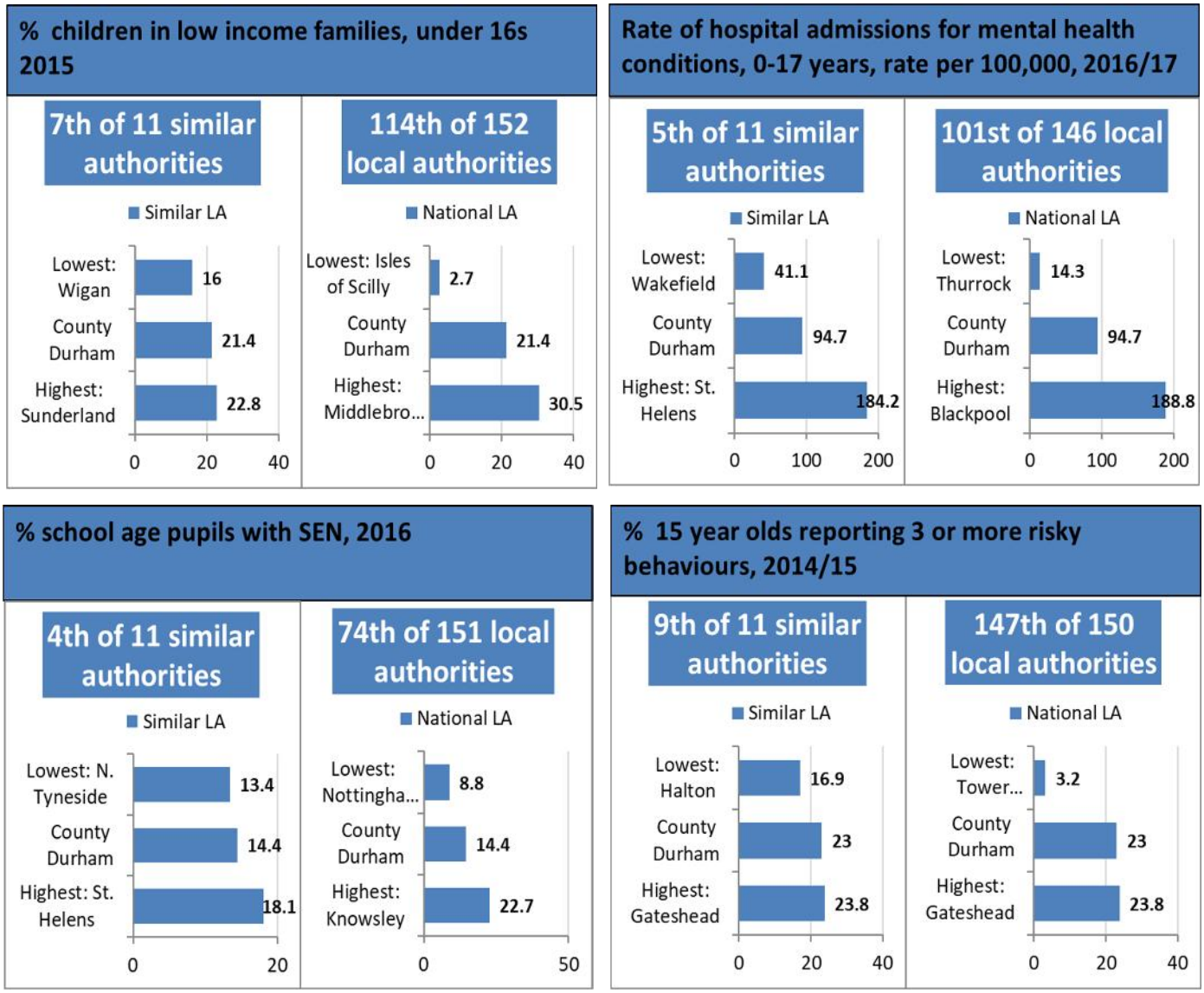
What is benchmarking?

Benchmarking is defined as a measurement of the quality of organisation's policies, procedures or strategies and their comparison with standard measurements, or similar measurements of its peers. In this case we are looking at indicators relating to health outcomes in looked after children via selected indicators from Child Health profiles and further.

Why benchmark?

The reasons for benchmarking are to determine where improvements may be needed and to consider how other local authorities achieve the higher levels. Benchmarking in this way allows comparison with 'like' areas enabling a deeper look at what the differences are and if there is a systematic way of improving them.

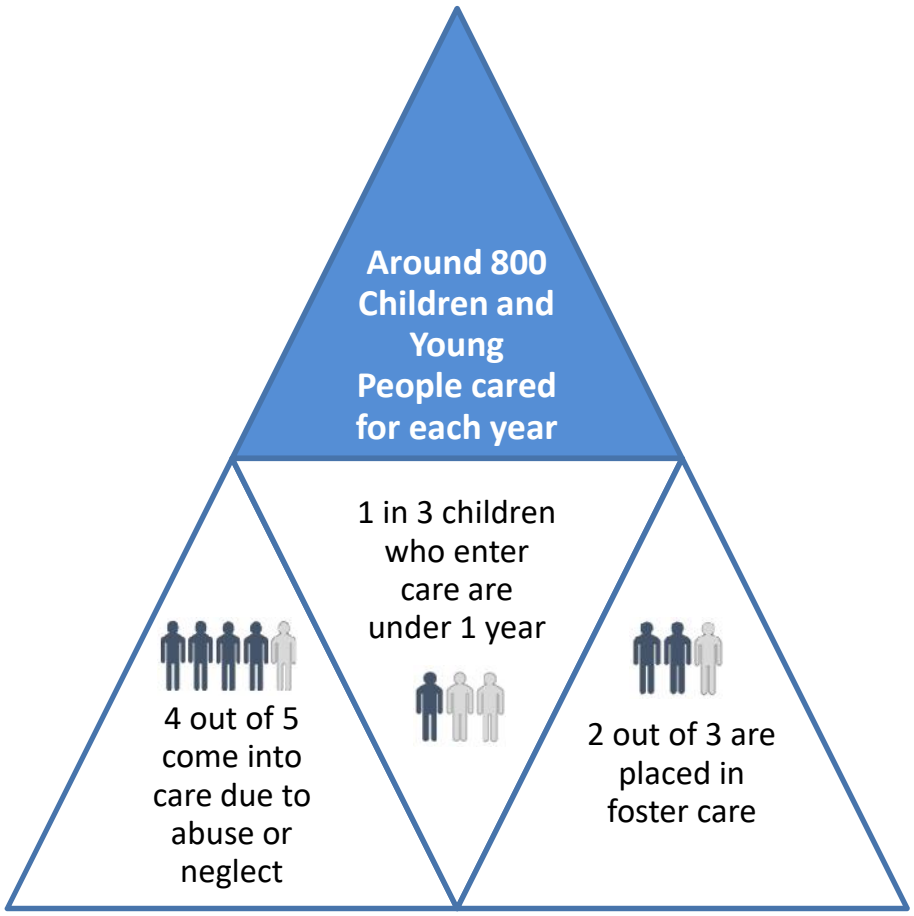
Figure 4: Various indicators related to the 4 priority areas of the HNA, County Durham compared to similar local authorities and all local authorities. Source: Fingertips, PHE



* Ranked from best to worse where 1 is best.

Durham Data – the local picture and how we compare

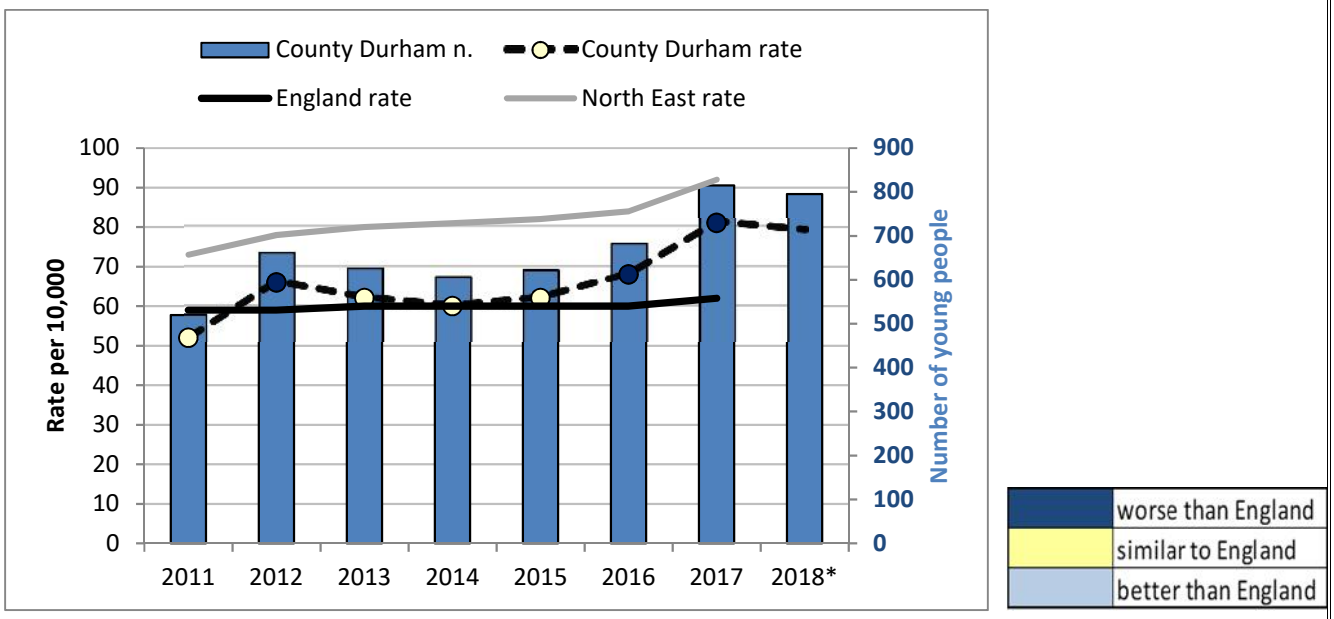
Figure 5: Overview of Looked after Children in County Durham, 2017/18, Children and Young People's Services (CYPS), Durham County Council (DCC).



Durham County Council has seen a 53% increase in the number of looked after children between 2011 (520) and 2018 (795) (figure 6).

Published data is available up to 2017. For 2016 and 2017, the rate of children in full time looked after care in County Durham is significantly higher than England and lower than the North East. Provisional data for 2018 shows that the number and rate of looked after children has dropped slightly; 795 children and young people looked after and a rate of 79 per 10,000.

Figure 6 - Rate of children looked after as at 31st March each year per 10,000 population aged under 18, 2011 – 2018. County Durham, North East and England. Source: Fingertips and CYPS DCC.



*2018 data is provisional

Within County Durham there is geographical variation in the number of children and young people becoming looked after. Between 2014/15 and 2016/17 just one 1,000 children and young people became looked after. Table 3 shows the where they were living prior to becoming looked after.

Table 3: Number and proportion of children becoming looked after by Clinical Commissioning Group (CCG) and commissioning localities, 0-17 years, 2014/15-2016/17. Source: CYPS DCC.

	2014/15 – 2016/17		
	Number of children becoming looked after	%	Rate per 10,000
North Durham CCG	***341***	***36***	***34.4***
Derwentside	164	17.3	36.1
Chester-le-Street	78	8.2	40.3
Durham	99	10.5	28.8
Durham Dales, Easington and Sedgefield (DDES) CCG	***605***	***64***	***45.7***
Durham Dales	140	14.8	37.9
East Durham	298	31.5	58.2
Sedgefield	167	17.7	37.8
County Durham	***946***	***100***	***40.9***

Between 2014/15 and 2016/17 the majority of children and young people becoming looked after had been resident in DDES CCG (64%) and almost a third had been living in East Durham (31.5%). As a rate per 10,000 population the rate in DDES CCG is over 10 per 10,000 higher than North Durham CCG; 45.7 per 10,000 compared to 34.4 per 10,000. The rate in East Durham of 58.2 per 10,000 is twice as high as the rate in Durham 28.8 per 10,000.

Chapter 4: Local Review of Data and Intelligence in County Durham

Mental Health and Emotional Wellbeing

Summary points

- **There is limited local data available to understand the prevalence of mental ill health and gauge the overall wellbeing of LAC and CL. The Strengths and Difficulties Questionnaire (SDQ) is used as a proxy measure of wellbeing and the reported proportion of LAC with a SDQ score considered to be "of concern" is higher than North East and England averages**
- **SDQ scores are not routinely used to inform health assessments, shared with young people or reviewed with other key stakeholders, for example the Virtual Head**
- **There are a number of LAC young people requiring emergency support on repeated occasions.**
- **An over-arching pathway to support the mental health and emotional wellbeing is considered to be lacking, with many referrers unsure where to turn if a young person does not meet the criteria for input from CAMHS or Full Circle.**

Strength and Difficulty Questionnaire (SDQ)

SDQ Submission

SDQ scores are requested from carers for all children and young people in County Durham aged between 4 – 17 years who have been in care for longer than 12 months. Whilst national guidance does not stipulate how the SDQ questionnaire should be implemented, Durham unlike other neighbouring LA's, utilise a postal return process.

The postal return process presents its own challenges and may impact on the volume of returns, data collated and its analysis. The response rate is often sporadic, meaning that the results may not be a true reflection of this cohort of children and young people. Results are not routinely used to inform health assessments, shared with young people or reviewed with other key stakeholders for example the Virtual Head.

Figure 8 below reports the percentage of LAC who have a SDQ score submitted with figures for North-East England and England provided for comparison.

Figure 8: Percentage of LAC for whom a SDQ score was submitted (looked after >12 months, County Durham, North East and England, 2011-2017. Source: Department for Education.

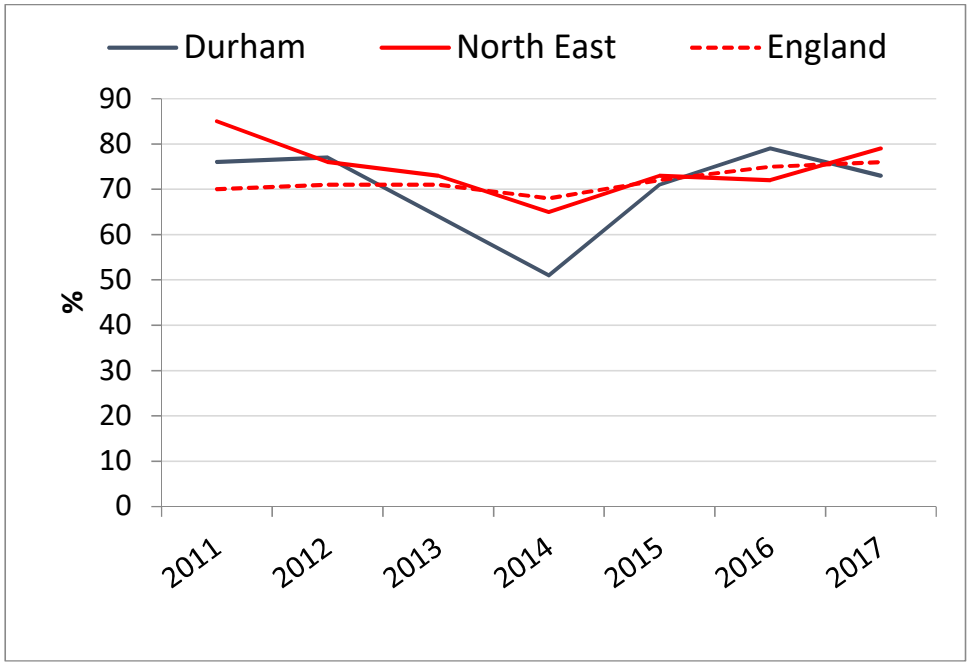


Figure 8 shows that around three-quarters of LAC have a SDQ submitted. Submissions in County Durham can often be lower than North East and England comparators.

Whilst assumptions are made by partners that the variation in response rate can be accredited to the postal return process, a review of the SDQ process is required to better understand how these scores can better influence and inform health assessments and interventions as part of a more holistic mental health pathway.

SDQ Results

In order to understand the results of SDQ scores obtained, Figure 9 shows the average total SDQ scores for County Durham compared regionally and nationally. It should be noted that the higher the score, the greater the risk of developing a mental health disorder.

Figure 9: Average difficulties score for all LAC (looked after >12 months), County Durham, North East and England, 2009-2017. Source: Department for Education.

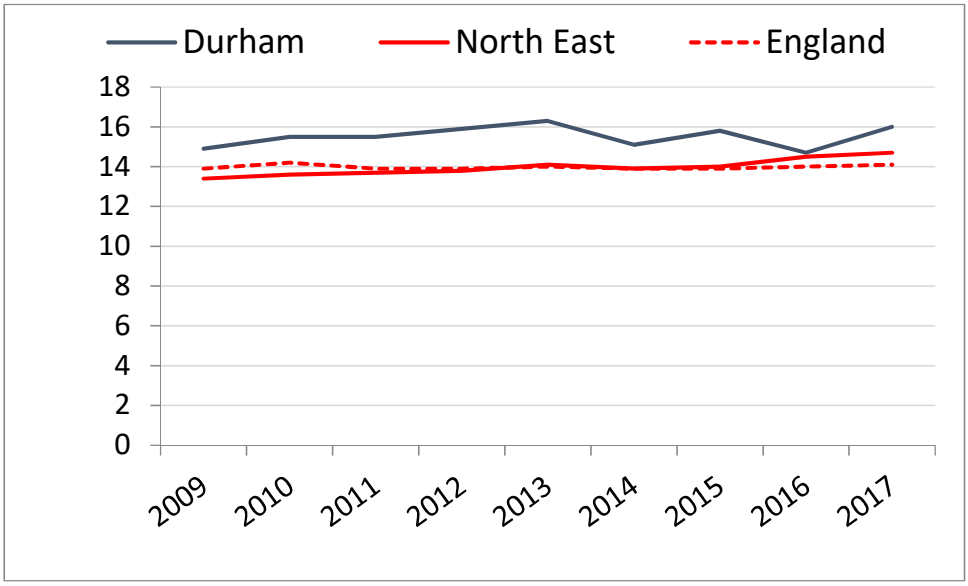
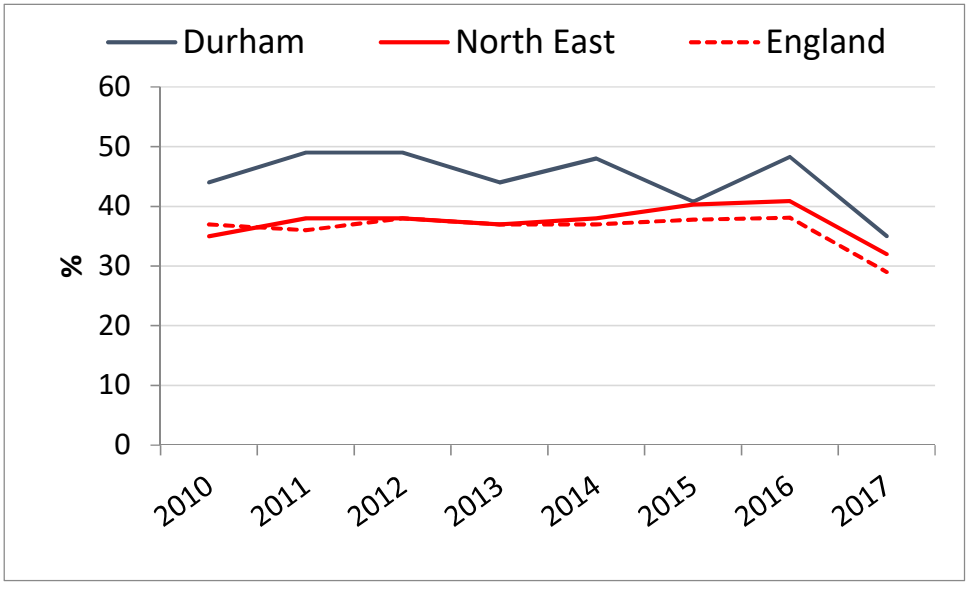


Figure 10 below shows the proportion of LAC who have a SDQ score considered to be "of concern" (>17) in Figure 9.

Figure 10: Percentage of eligible LAC with a SDQ score that is considered to be of concern (>17), County Durham, North East and England, 2010-2017. Source: Department for Education.



These results show that for those LAC who had a SDQ score submitted in 2016/17, just over a third (35%) had a SDQ score which indicated they are at a high risk of developing a mental health disorder. Whilst the proportion of young people with a SDQ score "of concern" has come down overall (and most significantly within County Durham) the results for County Durham are higher than the national England and North-East average.

Guidance suggests that specialist input, e.g. therapeutic support or consultation with CAMHS is required for young people with a total score of over 17.

The Full Circle

The Full Circle provides a post-trauma service for children and young people up to 18 years of age and/or their families and carers. The age range is extended to 25 for care leavers and those eligible for Adoption Support Fund.

The service is for children & young people who have experienced trauma as a result of abuse or neglect, where the impact of this trauma continues to affect day to day functioning and emotional wellbeing. The need for therapeutic support should be identified by professionals as part of a current plan. Eligibility criteria is as follows:

- Children and young people who are Looked After by Durham County Council and young people who are care leavers.
- Children in Need including those with a mild learning disability and children who are subject to a Child Protection Plan, provided they are now in a safe, supportive environment.
- Adopted children and children subject to a Special Guardianship Order who may be eligible for Adoption Support Funding (i.e. previously Looked After).
- Children who have suffered sexual abuse but who may not be in need of services other than therapeutic input.

Children and young people who may not be eligible for support include the following:

- Some children and young people with developmental difficulties will have their needs best met within the Child Development Centres/Paediatric teams or Learning Disability CAMHS.
- A number of young people will present with mental health difficulties where CAMHS / another mental health service may be more appropriate.

It should also be noted that the service for care leavers is limited to exploring the impact of early life experiences and helping young people to understand their history, rather than an alternative to adult mental health services.

The service plays a role in supporting the mental health and emotional wellbeing of those most vulnerable LAC and CL in County Durham, providing direct interventions for young people themselves as well as providing training and support for their carers.

In addition, Durham County Council provide funding for a Consultant Clinical Psychologist and a Clinical Nurse Specialist who are employed by Tees, Esk and Wear Valley NHS Foundation Trust to work exclusively for Full Circle.

Referrals into Full Circle

Table 4 demonstrates the number of referrals into the Full Circle team, broken down into whether referrals were for ongoing work/support or one-off consultations.

Table 4: Full Circle Referrals, County Durham, 0-25 years, 2014/15 – 2017/18. Source: Full Circle.

Year	Number of referrals	Ongoing Work		Consultations	
		No.	%	No.	%
2014-15	490	185	38%	305	62%
2015-16	527	243	46%	284	54%
2016-17	550	227	41%	323	59%
2017-18	547	207	38%	340	62%

Over the four years of data the proportionate split between ongoing work compared to consultations has remained fairly constant at 40/60.

The consultation service exists to support foster carers, prospective adopters, adoptive parents and a range of professionals and care planning teams (including social workers and residential carers). Consultations provide a reflective space in which to think about children and understand their behaviours and needs within the context of their trauma and experience. The majority of consultations are undertaken by the team's Consultant Clinical Psychologist.

The number of consultations undertaken by the Consultant Clinical Psychologist in 2017/18 are broken down by type in Table 5.

Table 5: Full Circle consultations by type, County Durham, 0-25 years, 2017/18. Source: Full Circle.

Consultation Type	Number	%
Psychological/attachment/behaviour	101	38%
Care Planning	40	15%
Pre-adoption match	30	11%
Residential	26	10%
Post adoption	23	9%
Pre-adoption advice	15	6%
Post Adoption pre order	14	5%
Pre-fostering match	10	4%
Fostering and Adoption Assessment	6	2%
Total	265	100%

A further 75 consultations were undertaken by therapeutic workers in the team. The main topics of these consultations were:

- Placement stability
- Care planning decisions
- Behavioural issues.

With regards to the 207 referrals for ongoing work, the top 10 primary reasons for referral are listed in Table 6:

Table 6: Top 10 Primary Referral Reasons for ongoing work in Full Circle, County Durham, 0-25 years, 2017/18

Primary Referral Reason	Number	%
Adoption - Post Work	27	17%

Primary Referral Reason	Number	%
Behavioural	24	15%
Attachment	21	13%
Placement Stability	19	12%
Separation/loss	17	10%
Mental Health (Young Person)	14	9%
Domestic Abuse/Violence	11	7%
Neglect	11	7%
Sexual Abuse	10	6%
Permanence Prep	9	6%
Total	163	100%

Outcomes

Child Global Assessment Scale (CGAS) are used to chart the progress made by children who receive a therapeutic service. The CGAS is undertaken on entry to the service and at case closure within the Full Circle team. Whilst the service have no defined performance targets, based on 78 follow-up scores in 2017/18:

- **87%** of children achieved an improved score after undertaking therapeutic work
- **72%** of children moved to an improved banding on the scale (e.g. from 'Severe Problems' to 'Serious Problems') showing improved scores across a range of day to day activities
- **26%** remained in the same banding

Child and Adolescent Mental Health Services (CAMHS)

Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) provide specialist Child and Adolescent Mental Health Services (CAMHS) which cover County Durham. Whilst no specific pathway is in place, LAC who meet the eligibility criteria for CAMHS can access the multi-professional team where a range of treatment or therapies may be offered.

Data presented below demonstrates the number of initial assessments and face-to-face contacts TEWV conducted among LAC. It is important to acknowledge that TEWV collect data based on the clinical commissioning group (CCG) in which the young person lives, rather than local authority boundaries. There is a facility within the patient information system used by TEWV (PARIS) to 'flag' a looked-after child

and data has been extracted based on those young people who are registered to North Durham CCG or Durham Dales, Easington and Sedgefield CCG which cover County Durham boundaries who are flagged as being a LAC. Stakeholders from TEWV advise that flagging a child in the system is dependent upon the young person being identified as LAC, which may not be clear until the initial assessment has been made. Data will also include looked-after young people who reside in County Durham but who are looked-after by another local authority.

Table 7: No. of CAMHS initial assessments and face-to-face contacts with LAC in 2017/18

CCG (and sub-CCG area)	Initial Assessments	Face-to-Face Contacts
NHS North Durham CCG		
Chester-le-Street	25	479
Derwentside	68	498
Durham City	46	368
NHS North Durham CCG Total	***139***	***1345***
NHS Durham Dales, Easington and Sedgefield (DDES) CCG		
Durham Dales	*66*	*572*
Easington	*80*	*491*
Sedgefield	*63*	*472*
NHS DDES CCG Total	**209**	**1535**
Grand Total	**348**	**2880**

CAMHS also provides a crisis and liaison service for young people experiencing a mental health emergency, for example suicidal behaviour or intention or during a psychotic episode. In order to understand service use among LAC, Table 8 below shows the number of individuals patients who had contact with the Crisis team alongside the total number of attended contacts. This data shows that in 2017/18, 54 individual LAC were seen within the Crisis and Liaison team across County Durham which generated 229 contacts with the team, or, on average, 4.2 contacts per service user. This suggests that there are a number of young people requiring emergency support on repeated occasions.

Table 8 CAMHS Crisis and Liaison 2017/18 service use data for looked-after-children

Clinical Commissioning Group	Individual Patients	Total attended contacts with Crisis teams
NHS North Durham CCG	24	73
NHS Durham Dales, Easington and Sedgefield CCG	30	156
Grand Total	**54**	**229**

Feedback from Stakeholders

What worked well

There was broad consensus among those working with LAC and CL that this population often experienced high levels of need in relation to their mental health and emotional wellbeing.

Many stakeholders, including social workers and independent reviewing officers (IROs), commented that they found it useful that there were two CAMHS employees (Consultant Clinical Psychologist and Clinical Nurse Specialist) working in the Full Circle team because these team members could provide specialist advice and supported them in navigating the wider CAMHS teams. Both CAMHS and Full Circle team members commented that this arrangement supported good working relationships and understanding between the two teams.

It was also noted that over the years the Full Circle team have developed the training and support they provide to carers, in terms of both 1:1 and group support, which was felt to be a positive development.

Stakeholders, including residential workers, noted that Crisis and Liaison teams were very responsive to urgent situations where support was required.

Identifying and Monitoring of need over the long-term

As previously described, local authorities are mandated to collect SDQ scores for every looked-after child on an annual basis. In a more recent development in County Durham, SDQ scores are now shared with health teams conducting review health assessments to support these processes.

One concern raised, however, was that SDQs represent a 'snapshot' in time and limited analysis is currently done to monitor trends across the LAC population over time. As an example, it is not known how many young people whose SDQ score was "of concern" were still of concern when the scores are repeated 12 months later. A review by the Care Quality Commission of health services for children looked-after and safeguarding in County Durham which reported in April 2017 highlighted the need to "use the SDQ to inform the health review more meaningfully", for example

enabling the young person to reflect on scores tracked over time (CQC, 2017). Further work is required to fully embed this into practice.

"Ownership" of young people with identified mental health and emotional wellbeing needs

In a number of consultation sessions, issues around access to support for some mental health needs was highlighted as an issue. A number of stakeholders highlighted that there were a number of young people who had a need identified who met neither the eligibility criteria for CAMHS or Full Circle. As an example, whilst some interim support can be provided to carers through Full Circle, these teams require a young person to be in a settled placement in order to access services – on the basis that in order to safely and effectively address trauma based issues the child or young person should be in a stable placement. Several stakeholders reported, however, that it can often be difficult to establish placement stability in a young person as a result of their mental health needs.

In these cases it was felt by professionals working with LAC that they were sent back to teams with limited signposting for further support. Stakeholders felt that despite the many teams and professionals involved in supporting LAC, there was at times a "lack of ownership" around the mental health needs of the young person. Some carers were also often uncertain about what alternative options may exist outside of CAMHS and Full Circle which led to a feeling among many that some young people "slipped through the net" and received a lack of support to address their needs.

Access to services

In order to access services some stakeholders, including social workers, residential carers and foster carers, commented that they often felt they needed to take an assertive and persistent to get a young person support for their mental health needs. As an example, some carers identified they felt they often needed to chase referrals and appointments in order to ensure progress was made. Professionals escalated concerns through their managers, although there was no formal escalation routes described.

Support and training for carers

A number of foster and residential carers and social workers acknowledged that Full Circle provided some useful training courses to support them in identifying and managing need. Courses are primarily aimed at supporting LAC in relation to trauma and attachment (e.g. nurturing attachment group training based on the Kim Golding 'House Model of Parenting').

Support to access Mental Health First Aid training and training to help support young people at risk of suicide or self-harm was highlighted as potential opportunities to improve the care and support these professionals were able to deliver.

Transitions

Similar to national findings from the published evidence, transitions out of care were highlighted as a period that can generate disruption for a young person. Transition planning for mental health service has been a strong focus for TEWV and they now aim to have the first conversation with young people at 17 years and 3 months so that by 17 years and 6 months an initial plan is in place. This falls in line with an organisational Commissioning for Quality and Innovation (CQUIN) indicator that 90% of 17.5 year olds have a transition plan. As part of transition planning, TEWV aim for a panel to be convened with representatives from both adult and child mental health services to support the development of an effective transition plan. Within the transition plan, a key worker should be identified.

In discussions with stakeholders there appear to be two key issues around transitions to adult services for care leavers:

Access to support

Stakeholders from TEWV explained that the CAMHS service takes a needs-based approach, looking at the individual needs of a young person and addressing these directly. For this reason, CAMHS are often reluctant to place a specific diagnosis on a young person unless certain. This individualised approach to care can provide many benefits to the young person, and avoid potentially stigmatising labels. It can, however, lead to obstacles at the point of transition to adult services. In order to be able to access many adult mental health services provided by TEWV, a diagnosed mental health condition is often a pre-requisite of eligibility criteria.

It was identified by a number of stakeholders as part of the consultation that this can create a gap in service that could lead to care leavers "slipping through the net" at a time when they might need support the most. Whilst Full Circle continue to provide services for care leavers, a number of stakeholders felt that there was a cohort of care leavers who didn't meet the eligibility criteria for either service but who had a moderate level of need which could escalate if unaddressed. Some stakeholders referred to Talking Changes (a self-help and talking therapies service delivered in County Durham and Darlington) however advised concerns that this service was less likely to understand the specific needs of young people with a history of care and noted that in their experience a number of care leavers had struggled to engage effectively with this service (for example, some care leavers found it difficult to stick to appointed telephone consultations).

Planning/preparedness

A number of stakeholders acknowledged the complexity of transition planning and noted that in some cases it can be difficult to predict what the plan will be if there is a complex situation, for example co-existing learning difficulties. A general feeling from those involved in transition planning with a young person, for example social workers, residential carers and independent reviewing officers (IROs) felt the mental health component of transitions occurred quite late and often felt quite rushed. Compounded with the issues of access to support listed above some remarked that transitions could "feel quite chaotic" and that there could be a sudden and stark drop in support once the young person left care.

Risk Taking Behaviours

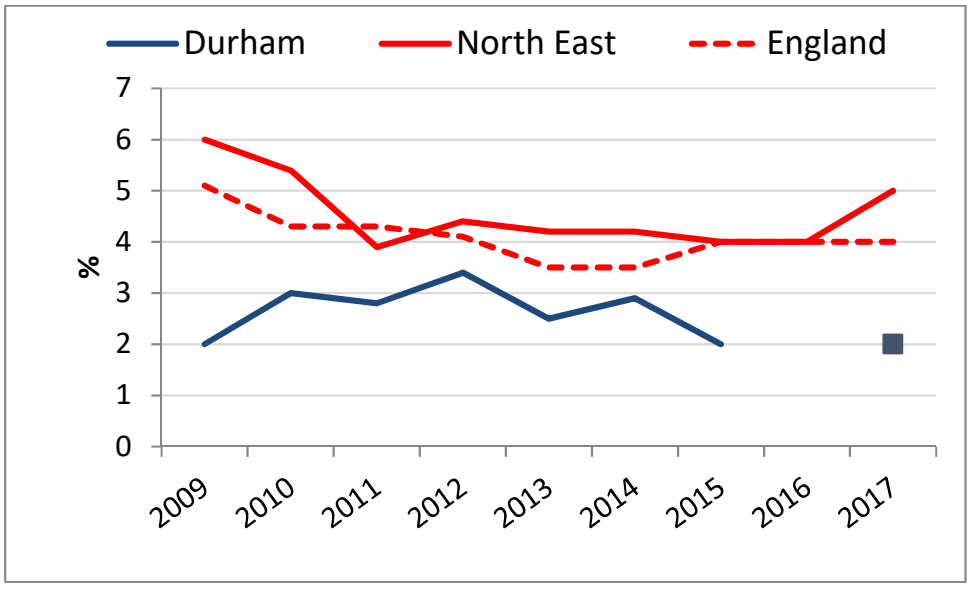
Summary points

- **Whilst it is acknowledged that teenage pregnancy can have positive effects for some young parents, it is important that any decisions are planned and taken from an informed perspective. Meaningful relationship and sex education can empower young people to have control over their lives – and this may be lacking for children in care.**
- **Evidence suggests that around 20-50% of 16-19 year old females with a history of care become mothers. This trend is observed within County Durham where a high proportion of female care leavers aged 17-21 years in County Durham are pregnant or mothers (around 40%). This appears to be a rising trend.**

Substance misuse

In County Durham a smaller proportion of LAC are identified as having substance misuse problems than regionally or nationally. This is consistent over time.

Figure 11: Percentage of LAC identified as having a substance misuse problem during the year (looked after >12 months, County Durham, North East and England, 2009-2017. Source: Department for Education.



Public Health England reported that in County Durham in 2016/17, 12% of children and young people accessing specialist substance misuse services were identified as being a looked-after child. This proportion is comparable to the England average (also 12%) (Public Health England, 2018).

Feedback from Stakeholders

A number of professionals who worked with LAC and CL felt that use of illegal substances was higher among this population compared with their peers. A number of professionals felt illicit drug use was for many LAC/CL primarily recreational, although there were some concerns that this could lead to long-term health issues.

Substance misuse services in County Durham were largely considered to be responsive to the needs of the young person. It was noted that providers of specialist substance misuse services had changed over time but, usually, staff remained consistent so carers quite often would go directly to a professional that had supported them in the past. A number of carers indicated that further clarity on the most recent change to services (in 2018) would be helpful to support them in understanding referral pathways.

Sexual Health and Conceptions

Within Children's Services, the number of care leavers who are pregnant and/or mothers is reported on a quarterly basis.

Figure 12: Percentage of female care leavers, aged 17-21, who are pregnant and/or mothers, 2017-2018. Source: Children and Young People's Services, Durham County Council.

	March 2017	March 2018
% (No.) female care leavers who are pregnant and/or mothers	31% (32)	36% (40)

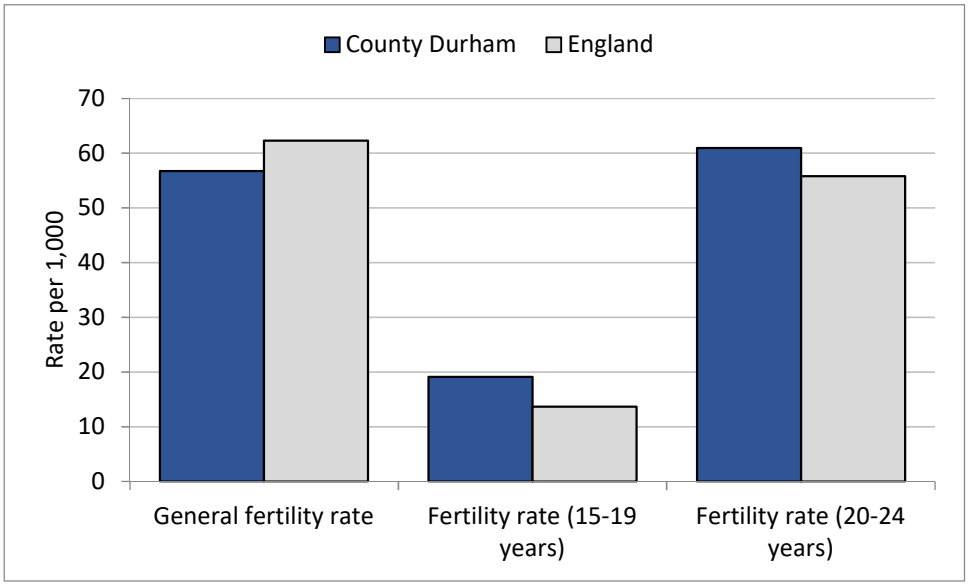
The indicator does not have any comparators to either the wider population of 17-21 year old females in County Durham or to Care Leavers in other LAs, the region or England. The indicator is a summary of three states relating to pregnancy and birth; conceptions, births and motherhood. The age category, 17-21, overlaps the age-bands used by Office of National Statistics there for it is difficult to find complement this data with that from other sources. The following gives some context.

There are around 5,300 live births to County Durham mothers each year:

- Just over 10% are to females aged between 17 and 21 years
- There were 602 births to 17-21 year olds in County Durham in 2016.

The general fertility/birth rate for County Durham females (aged 15-44 years) (figure 13) is below the England rate (57 per 1,000 compared to the England rate of 63 per 1,000). Whilst ONS does not publish the England age-specific fertility rates for 17-21 year olds, they do for 15-19 years and 20-24 years. For both of these rates County Durham in higher than England.

Figure 13: General and age-specific fertility rates comparing County Durham and England, 2016. Source: ONS and NHS Digital



In order to further investigate the seemingly high proportion of female care leavers who are pregnant or mothers a “deep dive case review” for 20 female care leavers was conducted. The case review represents 50% of the current female care leavers who are pregnant or mothers (n=40) and cases were selected at random. Case information was collated from Durham County Council’s SSID database and discussion with social work teams. Information was obtained on a range of placement factors (e.g. age at entry to care, reason for entry to care, number of placement moves within the past 24 months) and established risk factors for teenage pregnancy (e.g. previous or current issues for mental health and substance misuse disorders). Key findings from the case review are reported below:

- **Age at entry to care:** Over half (65%) of females entered care at 13 years or over, suggesting a later entry to care
- **Placement stability:** 70% had experienced 3 or more placement moves within the previous 24 months

- **Stable relationship:** Children and Young People's team record information on whether a young person is in a 'stable' relationship. Whilst it is acknowledged this could be a problematic term with numerous interpretations, 65% of females were not considered to be in a stable relationship
- **Substance misuse:** Almost half of females (45%) had experienced past issues with substance misuse problems
- **Mental health:** Over half of females (65%) had had previous or current involvement with specialist mental health services
- **Education, employment and training:** The majority (85%) of females were not currently in education, employment or training

It is important to note that the numbers contained in this review are low, and should therefore be viewed with a degree of caution. There is also a lack of comparator, i.e. we aren't able to make a comparison of how these highlighted factors compare to the wider population of female care leavers aged 17-21 years as much of the information collected in this audit is not available from the current information system (SSID). This again indicates that the results should be viewed with care.

Feedback from Stakeholders

Sexual health and conceptions

Professionals working with LAC and CL recognised that conception rates for these groups appeared high, particularly in residential settings. A number of carers and social workers reported they had C-Card training, which aims to support easy access to sexual health advice and provide free condoms to young people. Access to long-acting reversible contraception, e.g. contraceptive injections or intrauterine devices (IUDs) appeared to be less well understood.

In consultation with foster carers, there was some concern that RSE provided in schools may not be specifically focused to meet the needs of LAC. One carer raised a specific concern that failure to consider the needs and pre-care experiences of some LAC when providing RSE in schools could have an adverse impact on the young person, for example if they had been a victim of sexual abuse.

Some stakeholders commented that the focus of conceptions appears to be in female care leavers and that much less attention is paid to LAC/CL who are males. In some cases this may be recorded on SSID although this is not done routinely. It is also dependent on knowing whether a male has fathered a child which may not be disclosed.

Special Educational Needs and Speech, Language and Communication Needs

Key points

- **Locally, there is no data available to describe the impact of SLCN in the LAC or CL population. This could mean that there is unidentified – and unmet – need.**
- **SLCN support is typically provided by specialist speech and language therapists, however there may be a role for extending training and support for professionals and carers working with lack to facilitate early identification of need and support for low-level (non-specialist) needs**
- **A review of speech and language therapy has been conducted across County Durham to ensure capacity meets demand.**

Special Educational Needs

LAC are known to have high rates of SEN. In 2016, 53.4% had some level of SEN provision, slightly lower than the national rate of 57.3%.

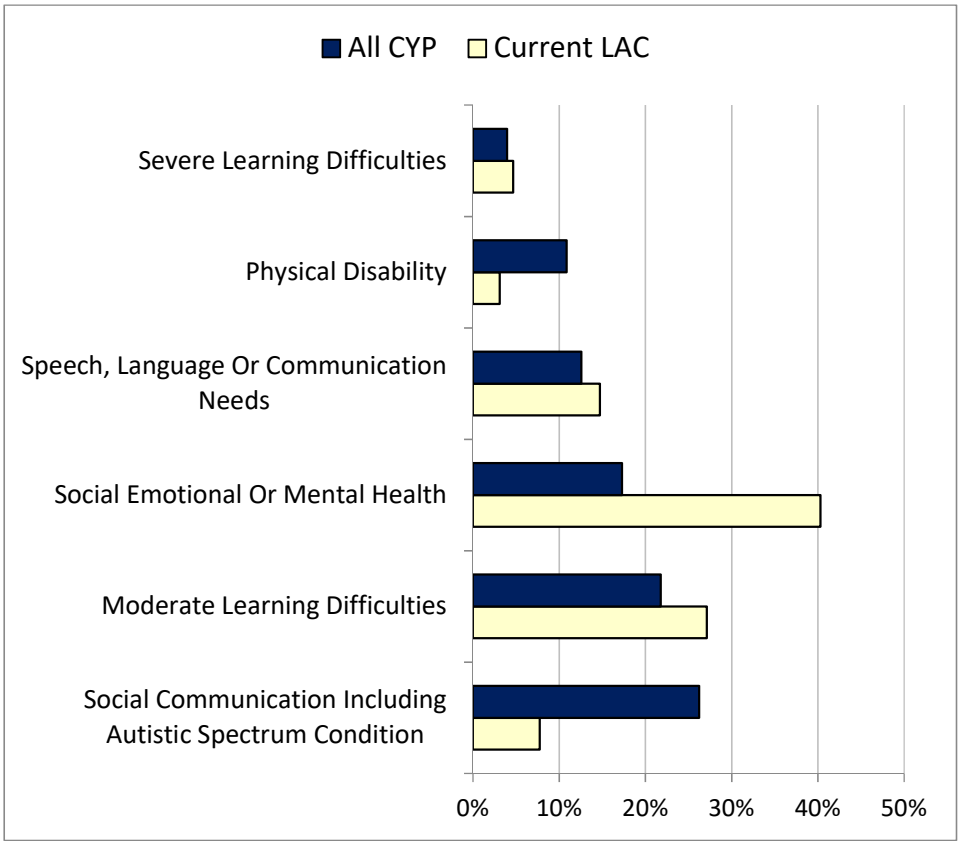
In May 2018 over 3,000 children and young people (0-25 years) in County Durham had an Education, Health and Care (EHC) Plan. These plans provide more support than is available through special educational needs (SEN) support.

In England the most common type of need for pupils with a statement or EHC plan is identified as Autistic Spectrum Disorder with over a quarter of all pupils (26.9%) in January 2017 (Department for Education, 2017) . In County Durham in May 2018, 26% of pupils with EHCP have Social Communication Including Autistic Spectrum Condition as a primary need.

The profile of need for the current cohort of looked after children in County Durham is different. Less than one in ten (8%) current LAC have Social Communication including Autistic Spectrum condition as a primary need. Two out of five (40%) looked after children with an EHC plan have Social Emotional or Mental Health as a primary need compared to less than one in five (17%) for all pupils.

For both population groups, all children and young people (CYP) and current LAC, the second most common primary need in moderate learning difficulties; One in four (22%) for all pupils and one in five (27%) for current LAC.

Table 9: Proportion of Education, health and care (EHC) plans by primary need, comparing all pupils to current looked after children, County Durham. Source: Synergy and SSID.



Prevalence of social, emotional and mental health among looked-after children

Around half of LAC have identified SEND and around one-quarter have an Education, Health and Care Plan (EHCP). It was noted that in line with national trends, a higher proportion of LAC have SEND categorised under "social, emotional and mental health" needs than non-looked after peers.

Bespoke educational psychology is commissioned by the Virtual School which can provide some support, but felt by stakeholders from the Virtual School and Educational Psychology that this could only address some, but not all, of the issues. Understanding the root cause of behaviour and linking into wider services providing mental health and emotional wellbeing support was felt to be important, as was the role of schools in identifying needs and taking appropriate action.

Increased sharing of learning and intelligence between the Virtual School and health services could improve understanding of health needs in the LAC population. The Virtual School have been co-opted as a representative on the recently-established LAC Health Needs Group which is operating across County Durham and Darlington which should help build relationships.

Role of the Virtual School

The Virtual School in County Durham promotes the education of LAC and provides support and guidance to help them achieve the best possible educational outcomes. This includes supporting LAC who have identified SEND. Specific services are commissioned to support those with increased needs, including speech and language therapy, bespoke educational psychology, school counsellors and occupational therapy. Support provided to LAC through the Virtual School was commended in the most recent joint local area SEND inspection in Durham (Ofsted and CQC, 2018) however further development work is required to ensure that children identified with SEND needs within health assessments access these services in a timely manner.

Speech, Language and Communication Needs

In line with the findings of the Barcow Review, County Durham prevalence data has been extrapolated into the following three categories to enable to identify the SLC across the cohort:

- Pervasive speech, language or communication needs
- Significant speech, language or communication needs
- Impoverished speech, language or communication development

These categories and prevalence estimates have been extrapolated to provide a greater understanding of the estimated levels of speech, language and communication difficulties across County Durham. Whilst these figures do need to be taken with a degree of caution, they continue to be acknowledged as a good starting point in relation to understanding the estimated prevalence of Speech, Language and Communication needs across a local authority area (ICAN 2009; Gascoigne (ed) 2012; The Communication Trust 2013; Royal College of Speech and Language Therapists 2018).

Pervasive speech, language or communication needs

Using the findings of the Bercow review; in County Durham numbers of children and young people with pervasive speech, language or communication needs would equate to 60 children across the County per school year or potentially 1,503 children and young people across the 0-25 age range at any one time.

Significant speech, language or communication needs

Applying the estimated national prevalence levels for young people with significant speech, language or communication needs to County Durham would equate to 420 children in County Durham per school year, or potentially 10,500 children and young people across the 0-25 age at any one time.

Impoverished speech, language or communication development

If we apply the estimated national prevalence levels for children with impoverished speech language and communication development to County Durham this would potentially equate to 920 children in County Durham per school year or 23,000 across the 0-25 age range whose speech, language and communication difficulties are not necessarily linked to long term underlying SEND.

The majority of children in care experience conditions of poverty and social disadvantage and so it would appear appropriate to propose that a significant proportion of LAC will have inevitably experienced impoverished speech, language and communication development, which are likely to have been exacerbated by attachment difficulties and any previous abuse, neglect and subsequent trauma.

It should be noted that communication difficulties are often hidden and older children in particular often develop masking techniques for these needs. It is likely that some looked after children communicate through behaviour that may result in school exclusion, anti-social and offending behaviour.

A local audit undertaken in January 2017 by the Durham Youth Offending Service carried in relation to completed AssetPlus assessments found:

- 186 AssetPlus SLCN screens were completed on 186 young people receiving a Youth Caution, Youth Conditional Caution or court conviction between 1 December 2015 - 12 January 2017

- 144 (77.4%) of the 186 had an identified speech, language, communication or neuro-disability need

When considering demand specifically from LAC, it was not possible during this HNA to ascertain the prevalence of speech, language and communication needs across the whole population. Some information is contained within Personal Education Plans (PEPs), some is collated by the Virtual School and some through IHA and RHA. The move to an electronic template for recording the outcomes of RHAs offers an opportunity to identify young people with speech, language and communication needs; In order to fully understand this.

Feedback from Stakeholders

Stakeholders working with LAC, for example social workers and Families First teams, explained that SLCN were typically identified by health visitors during early years or by schools once a young person entered education. The role of other professionals in screening and identifying needs seemed to be less well-understood.

Timely and effective access to generic speech and language therapy (SLT) was noted by a number of stakeholders to be a historic issue. It is somewhat improved by the specifically commissioned SALT from the Virtual School however this was not felt to completely address need. Some stakeholders who had referred young people for SALT highlighted issues of having to "constantly chase" referrals and follow-up appointments with the current service provider.

It is acknowledged that work is currently underway across Durham County Council to review speech, language and communication development provision to streamline pathways and ensure capacity meets demand.

Listening to the voice of the child

Stakeholders from the Virtual School identified the importance of the voice of the child in planning discussions and explained this was an area of ongoing focus to ensure views were incorporated into personal education plans.

Wider Determinants of Health (Care Leavers)

Key points

- **Around 40% of care leavers in England are not in education, employment or training (NEET), however this proportion is lower in County Durham thanks to strong partnership working (29%).**
- **Significant work is ongoing to improve the accommodation offer across County Durham, particularly for those with moderate-high level needs however there is limited information available around accommodation outcomes and user experiences.**
- **Within County Durham a Welfare Rights Officer has been recently reinstated to support care leavers to maximise the financial entitlement of young people and their carer**
- **A number of stakeholders consulted felt that care leavers were at high risk of social isolation and this may be an area that requires dedicated focus in order to support the wellbeing of care leavers and enable them to lead independent, satisfied lives**
- **The implementation of Health Passports in County Durham is acknowledged to have encountered a number of obstacles that mean the overall number issued remains low. A multi-agency task and finish group has been established to review and improve local processes.**

Figure 14 below highlights that the percentage of children leaving care over the age of 16 who remained with the LA until their 18th birthday is higher than the north east average and comparable with the national picture.

Figure 14: Percentage of children leaving care over age of 16 who remained LA until their 18th birthday, County Durham, North East and England, 2009-2017. Source: Department for Education.

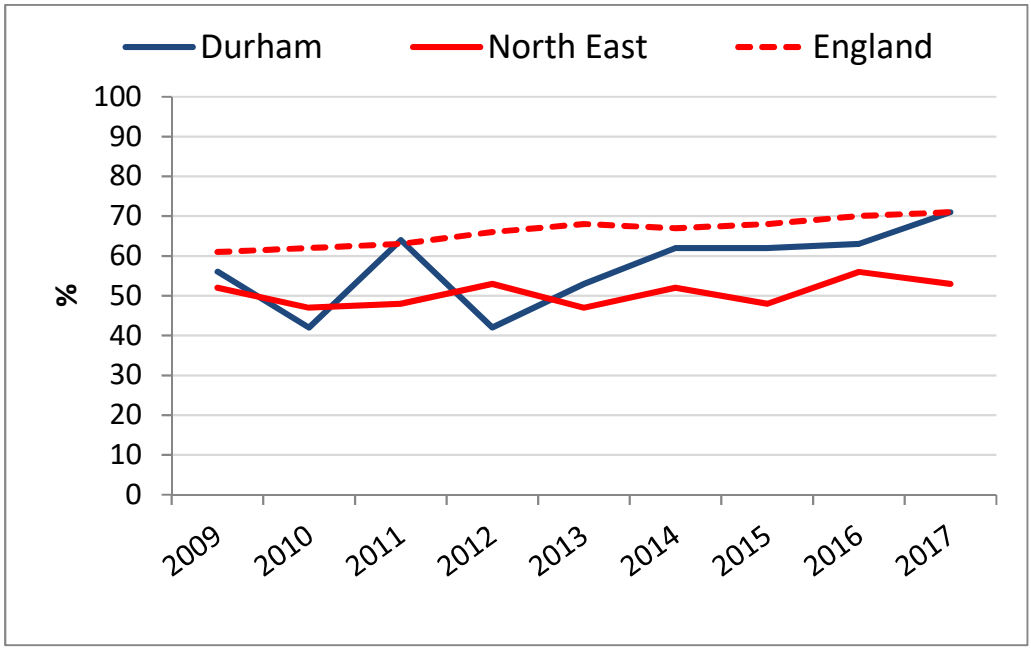
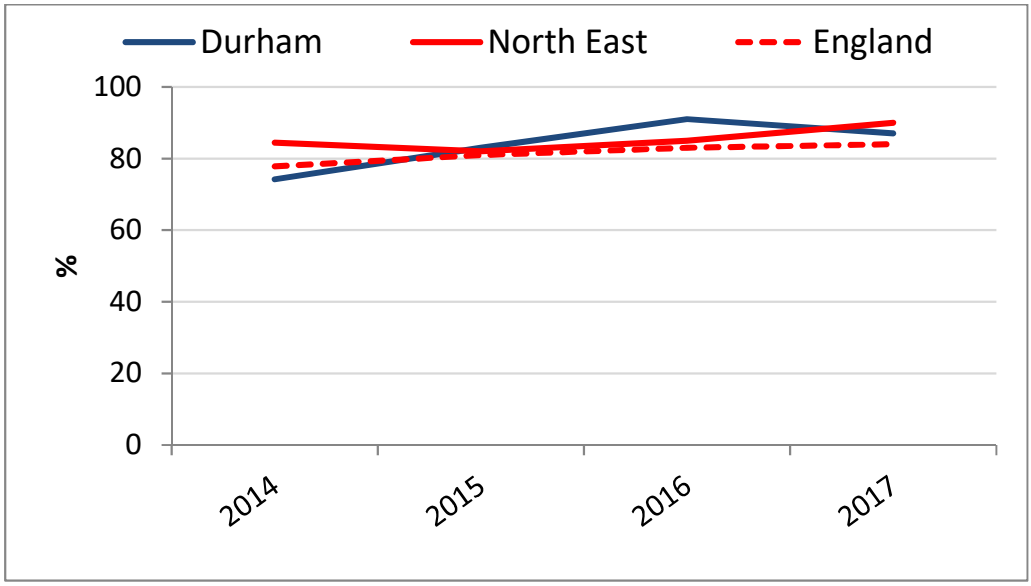


Figure 15 below identifies the percentage of CL in suitable accommodate. Rates are comparable with the north east and national figure. This has remained consistent over time.

Figure 15: Percentage of care leavers in suitable accommodation (previously looked after for at least 13 weeks after 14th birthday including some time after 16th birthday), County Durham, North East and England, 2014-2017. Source: Department for Education.



N.B Data prior to 2014 not comparable due to change in methodology

Figure 16 below shows the percentage of care leavers in higher education. County Durham are higher than the regional and national figures.

Figure 16: Percentage of care leavers in higher education (previously looked after for at least 13 weeks after 14th birthday including some time after 16th birthday), County Durham, North East and England, 2014-2017. Source: Department for Education.

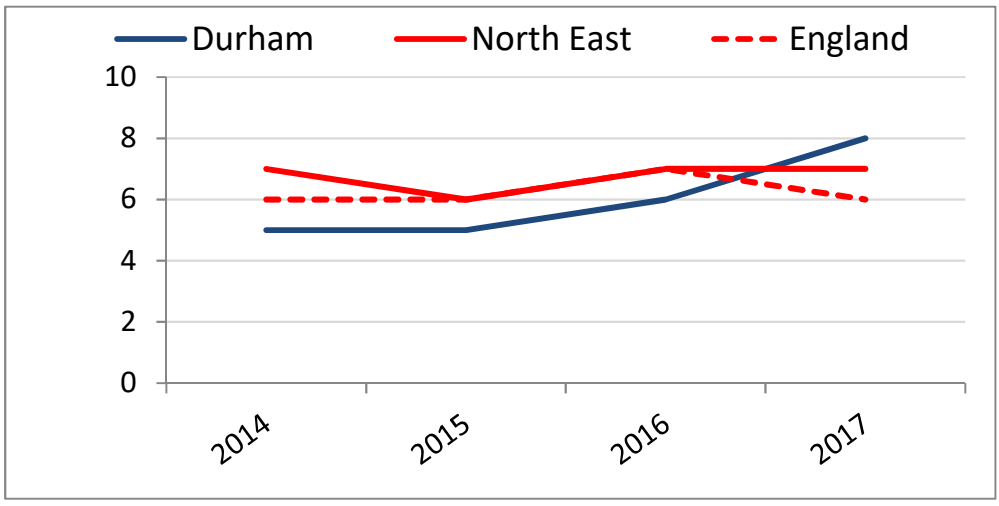
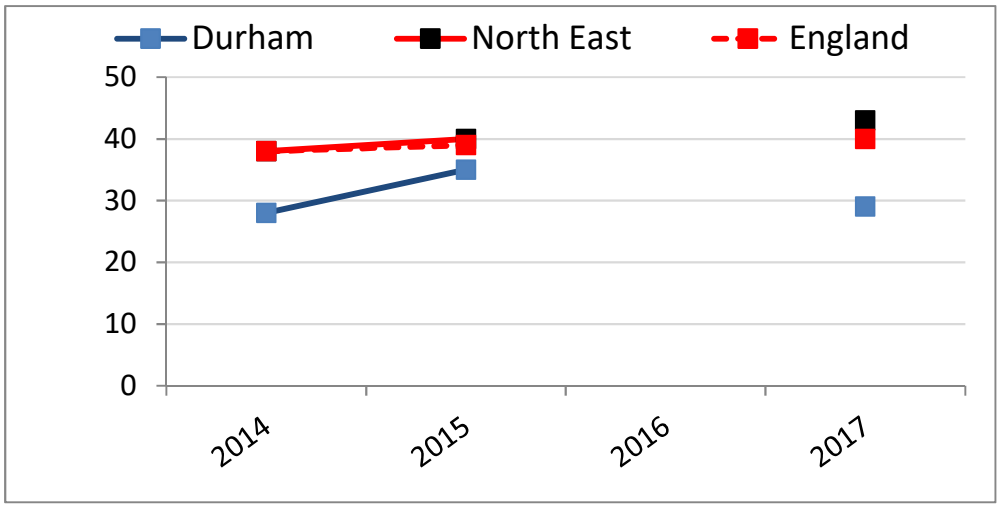


Figure 17 below shows the percentage of CL who are NEET. County Durham figures are lower than regional and national figures.

Figure 17: Percentage of care leavers not in education, training or employment (previously looked after for at least 13 weeks after 14th birthday including some time after 16th birthday), County Durham, North East and England, 2014-2017. Source: Department for Education.



Feedback from Stakeholders

Stakeholders described examples of close partnership working between Children's and Young People's Services, the Virtual School, Improving Progression of Young People's team and Durham Works to support LAC and CL in securing and maintaining EET. It was felt these strong partnerships were reflected in national performance figures for care leavers who are in EET, which is consistently higher in County Durham compared to regional and national averages.

Examples of ongoing work to increase training and employment opportunities were noted by the multi-agency Care Leavers Steering Group. Expanding access to labouring opportunities was noted as a key focus area, for example supporting young people to obtain a Construction Skills Certification Scheme (CSCS) card and increasing access to forklift driving training.

The Care Leavers Steering Group noted some concerns that funding for the Durham Works programme was due for renewal, although partners were actively seeking alternative sources of funding at the time of writing.

Some stakeholders identified that some care leavers struggled to engage in EET as a result of other circumstances in their lives, for example for those with learning difficulties, teenage parents and care leavers experiencing mental health illness.

When considering practical areas for future development, the Care Leavers Steering Group indicated that opening more opportunities for online learning may remove some of the obstacles young people face when trying to develop skills for future employment, for example for those living out of area.

Accommodation

It was noted that a significant amount of focused work had been undertaken to improve accommodation outcomes for care leavers, including the development of a Care Leavers Accommodation and Support Protocol (CLASP) and work beginning to look at how best to meet the accommodation needs of care leavers with moderate to high support needs.

Under this area it was noted that there are multiple accommodation providers and a lack of collated quality outcomes following the termination of the Accommodation Quality Assessment Framework which previously collected and reported outcome data. The voice of the young person was also not systematically collected and it was acknowledged that more could be done to ensure these views are heard and acted upon by services.

Welfare Rights and Managing Finances Independently

Some carers felt that young people leaving care often weren't as prepared as they could be to navigate the welfare system and that they had seen examples of young people being "penalised" (receiving benefit sanctions). A Welfare Rights Officer was recently reinstated to support care leavers (and their carers) in identifying and accessing appropriate support.

Being able to manage finances independently was also raised as an issue from some carers who noted that care leavers often become responsible for budgets much sooner than some of their non-looked-after peers. A range of courses are on offer to support young people, although it wasn't always clear what support was available in a joined-up way.

Social Isolation

Many stakeholders noted that one of the key issues facing young people leaving care was social isolation. After having been surrounded by carers and professionals some stakeholders likened the transition involved in leaving care as "falling off a cliff edge" for some care leavers, even if up to the point of leaving care they had craved independence. Some carers felt this had an impact on the emotional wellbeing and mental health of care leavers and that it would be helpful to have an additional focus on how this could be addressed (in a practical and meaningful way).

Health Passports

Local authority and health partners have a joint responsibility for Health Passports. In 2016 a multi-agency pathway was introduced aimed at supporting a CL's with their future clinical care by providing a concise summary of their medical history. Numbers of Health Passports in County Durham have been low and a number of stakeholders involved (including IROs and Children and Young People's Service) noted that requests had been declined or that there were significant delays. A specific task and finish group was established by the Looked-After Children Health Needs Group which identified issues including the process of LA notifications and capacity within CDDFT; CDDFT reviewed processes in July 2018 in order to address some of the issues raised.

Of the 76 passports requested since September 2017, 56 have been completed. A sample of 10% of Health Passports were peer assessed using the '*Self-Assessed Care Leaver Health Passport Quality Assurance Tool'*. All were assessed to be of a high standard with the exception of the young person's optician's name being omitted from 4 out of the 6 assessed. Out of the 6 Health passports peer assessed none of the Young People wished to have it shared in person by the LAC Nurse, all opted to have it posted.

Chapter 5: Conclusions

The process of completing the HNA highlights both the breadth and complexity of services in place to support looked-after children and care leavers and demonstrates the vast amount of work underway locally to support the health and wellbeing of these vulnerable cohorts. Areas of good practice have been highlighted, as well as a number of areas for development.

Limitations of the HNA

There are some acknowledged limitations to the HNA. Firstly, local data and intelligence was observed to be limited across each of the four priority areas. Population-level local data is important to bring together both findings from the nationally published literature and qualitative findings from stakeholder engagements. It is however anticipated that planned developments, primarily in moving to electronic templates for RHA's, will improve local intelligence in the foreseeable future.

Secondly, difficulties were observed in securing engagement from looked-after children and care leavers themselves. One of the key domains for HNA recommendations is to ensure the voice of the young person is heard as this will be essential in developing and designing services that meet their needs. Whilst it is acknowledged that LAC and CL are a hard-to-reach group it does not mean that engagement shouldn't be done. Identifying effective means of engagement is a key learning point from this work.

Next Steps

- **Report Sign-Off –** report and associated recommendations to be approved by the Integrated Steering Group for Children
- **Dissemination of findings** - Report to be disseminated across key agencies and stakeholders to share learning and recommendations
- **Development of multi-agency action plan –** Recommendations to be translated into multi-agency action plan with SMART (Specific, Measurable, Achievable, Realistic, Timely) objectives
- **Ongoing monitoring of action plan** – Looked-After Children Strategic Partnership Group to provide oversight of the action plan to ensure the

successful delivery of agreed actions and to support the overcoming of obstacles where they may arise.

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http://reescentre.education.ox.ac.uk/wordpress/wp-content/uploads/2015/11/EducationalProgressLookedAfterChildrenOverviewReport_Nov2015.pdf

Appendix 1: Literature Review Search Strategy

- MEDLINE search strategy (conducted February 2018)

1	Looked after child*.mp.
2	Looked after young people.mp.
3	exp Foster Home Care/
4	Child* in care.mp.
5	Young people in care.mp.
6	Youth in care.mp.
7	Adolescent* in care.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
8	Juvenile in care.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
9	teen* in care.mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]
10	girl* in care.mp.
11	boy* in care.mp.
12	"local authority care".tw.
13	"state care".tw.
14	((residential or foster or kinship) adj3 (care or home*) adj5 (kid* or child* or youngster or young person or young people or youth or adolescent* or teen* or girl* or boy* or juvenile*)).tw.
15	(in care adj3 (kid* or child* or youngster or young person or young people or youth or adolescent* or teen* or girl* or boy* or juvenile*)).tw.
16	(looked after adj3 (kid* or child* or youngster or young person or young people or youth or adolescent* or teen* or girl* or boy* or juvenile*)).tw.
17	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16
18	exp ADOLESCENT HEALTH/ or exp CHILD HEALTH/ or exp HEALTH/
19	exp Health Knowledge, Attitudes, Practice/ or Health Behavior/ or exp Health Status/ or exp Attitude to Health/
20	health needs assessment.mp.
21	18 or 19 or 20
22	17 and 21

Search was adapted from a previous HNA conducted by NHS Soctland (Scott, et al., 2013). MEDLINE search was (PsychInfo, Web of Science and Scopus)

- Grey literature – list of websites searched:

UK government (gov.uk) Barnado's (barnados.org.uk)	The Children's Society (childrenssociety.org.uk)

Become (becomecharity.org.uk) Catch 22 (catch-22.org.uk) Children's Commissioner (childrenscommissioner.gov.uk/)	National Society for the Prevention of Cruelty to Children (NSPCC) (nspcc.org.uk) Who Cares Scotland (whocaresscotland.org)