North Somerset Multi-Agency Emotional Wellbeing and Mental Health Strategy for Children and Young People Looked After and Care Leavers 2017 - 2019

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Annex 1: Action Plan - Separate Document

Introduction

> Most children become looked after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. For example, almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs.[1]

The primary purpose of bringing children and young people into care is to provide them with safe, stable and loving relationships with trustworthy adults. However, the majority of these children and young people have experienced trauma, neglect or abuse – emotional, physical or sexual – and may also be affected by separation from their birth families. These experiences can have a long lasting impact and may influence the formation of trusting relationships and, therefore, the stability of in-care placements.

North Somerset is committed to helping our children navigate any challenges they may face, building their resilience and developing their full potential. Our aim is to provide the best support available, from health promotion and prevention to intensive interventions when there is an identified clinical need. We also recognise the need to support our staff and carers in the invaluable work that they do, providing them with first class training in attachment and trauma, and looking after their own emotional wellbeing through peer support and clinical supervision.

The *North Somerset Multi-Agency Emotional Wellbeing and Mental Health Strategy for Children and Young People Looked After and Care Leavers*[2] aims to strengthen existing good practice, building on the principles of CYP IAPT (Children and Young People's Improving Access to Psychological Therapies), the Five Ways to Wellbeing and Thrive model of care, extending the evidence base to include the views of children, young people, parents, carers and staff.[3,4,5] We are keen to develop our participation even further, making it 'business as usual' and an integrated part of the system. We

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[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf

[2] In this document children and young people will refer to Children and Young People Looked After and Care Leavers, unless otherwise specified. 'Carers' will refer to foster carers and kinship carers.

[3] CYP IAPT principles: accessibility; evidence–based practice and supervision; routine outcomes monitoring; participation

[4] Five Ways to Wellbeing are a set of evidence-based actions which promote people's wellbeing: (1) Connect (2) Be active (3) Take Notice (4) Keep Learning (5) Give/Be Creative

[5] The Thrive model is split into four quadrants: Getting Advice; Getting Help; Getting More Help and Getting Risk Support. The latter quadrant is for the many children and young people who do not wish to be seen by specialist CAMHS but who may have multiple issues which place them at risk. Although it is likely that certain problems or severities may be more common in some groups, there is no one-to-one relation between severity of type of problem and grouping eg it's not possible to say all cyp with mild depression will be in the getting help group, as they may prefer to get advice about their condition and how to manage it themselves. Groups are organised around the different types of supportive activities provided by children and young people mental health services and are strongly influenced by client choice.

value the feedback that children and young people have given us in writing this document which is also informed by national and local guidance and research.

Education, Social Care and Health services are all part of comprehensive CAMHS and we recognise that specialist CAMHS is not the only, or in many cases the most suitable, source of support. The responsibility needs to be shared across the whole system and include formal and informal methods of support. Building the resilience of our children and young people through a holistic understanding of their wellbeing requires a multi-agency response, focusing on the individual needs of the child or young person, taking into account their wishes and feelings in all decision making.[6] Continuity of care, with stable placements, allows children and young people to form strong, enduring relationships and we will place children's relationships at the heart of all we do. We will listen to children, young people and their families and try to tailor specific interventions to fit their particular circumstances[7].

When a child comes into care, the council becomes the Corporate Parent which means we have collective responsibility – the council, elected members, employees, and partner agencies – for providing the best possible care for children looked after and care leavers. We want to be the best parent we can be to see our children and young people thrive with good physical health, to be safe, happy and resilient, to do well in school and to enjoy good, trusting relationships with the adults in their lives and with their peers. We want them to make the most of their leisure opportunities, their hobbies and interests and to grow towards adulthood fully prepared to lead independent lives, in good accommodation with a sense of purpose and a place in education, employment or training, and financially secure. There is a reciprocal relationship between good mental health and all of these contextual factors.

We endorse the same priorities as those highlighted in *Achieving emotional wellbeing for looked after children*[8]:

1. Embed an emphasis on emotional wellbeing throughout the system
2. Take a proactive and preventative approach
3. Give children and young people voice and influence
4. Support and sustain children's relationships
5. Support care leavers' emotional needs

[6] House of Commons, Education Committee, 2016. Mental health and well-being of looked-after children: Conclusions and recommendations.
[7] NSPCC/Rees
[8] NSPCC/Rees Centre, 2015

National Context

In March 2015 the Department for Education and the Department of Health jointly published new statutory guidance on *Promoting the health and well-being of looked-after children*[9]. The guidance recognised that almost half of children in care have a diagnosable mental health disorder. Under Section 10 of the *Children Act 2004*, local authorities have a duty to co-operate to promote well-being among children.

The House of Commons Education Committee published its report: *Mental health and well-being of looked-after children* in April 2016[10]. In September, as part of the Government's response to this report, an Expert Working Group for Looked After Children was established[11].

Its remit is to consider how to improve the mental health and wellbeing of vulnerable groups, including children looked after; care leavers; children adopted from care; and children leaving care under a Special Guardianship Order or Child Arrangements Order:

> The ambition is for children and young people in care to have access to high-quality services, based on a clear assessment of need, from a range of professionals working across agencies.

The Expert Group will develop:

- **care pathways** –the journey – not necessarily linear - that can be taken by a young person in order to get help from different services. The focus is on accessing support when it is needed and when the person is ready. The care pathway will not go into detail about what interventions/treatments are recommended, and will instead use the blanket term 'appropriate evidence-based intervention'.
- **models of care** – the resources that need to be available, how services should be organised and configured, and the processes that need to be followed to ensure the efficient and accessible provision of interventions of proven clinical and cost effectiveness. This definition reflects the one NICE uses for service guidance. This is distinct from clinical guidance, which advises on what interventions should be provided, for example cognitive behaviour therapy.

[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/413368/Promoting_the_health_and_well-being_of_looked-after_children.pdf
[10] http://www.publications.parliament.uk/pa/cm201516/cmselect/cmeduc/481/481.pdf
[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/552688/Mental_health_response_accessible.pdf

- **quality principles** – concise statements and associated measures that set out markers of high-quality services for children and young people in care, and who is responsible for making sure this is achieved in practice.

The draft care pathways, models of care and quality principles will be available on the SCIE (Social Care Institute for Excellence) website for consultation in spring 2017 and the final report is due in October 2017. North Somerset will submit a response to the consultation and align its strategic objectives with the recommendations of the final report.

Care Leavers

The government's Care Leavers' Strategy, *Keep on caring: Supporting young people from care to independence*, was refreshed in July 2016.[12] One of its five key outcomes is improved access to health support through the Expert Working Group's care pathways, quality standards and models of care; the new Mental Health Services Data Set; and improved accountability regarding the local provision of health services, for example through Care Quality Commission and Joint Targeted Area inspections. To measure the impact of actions:

> The Department for Education (DfE) will continue to publish care leaver outcome data annually and, for the year ending March 2016, will also publish data for 17 and 18 year-old care leavers for the first time (local authority level data will be published in December 2016)[13]. Work will also be undertaken to explore how data can be shared more effectively between relevant government departments. To ensure that care leavers' voices are heard more powerfully in the formulation of government policy, a new national care leaver advisory group will be created and facilitated by the DfE.[14]

The Department for Education has a one-off data sharing with the Ministry of Justice to link pupil level data to prison, probation and police data. A separate agreement is in place with Her Majesty's Revenue and Customs, the Department for Work and Pensions and the Department for Business, Innovation and Skills to explore the link between educational achievement and labour market outcomes. Conditional on the quality of the data match achieved, the Department for Education's aim is to move to a more regular sharing of data and the Department for Education will also consider how best to disseminate the findings.

Training

The Expert Group will review the needs of the Workforce:

[12] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535899/Care-Leaver-Strategy.pdf

[13] See section on Care Leavers on page xx

[14] ibid

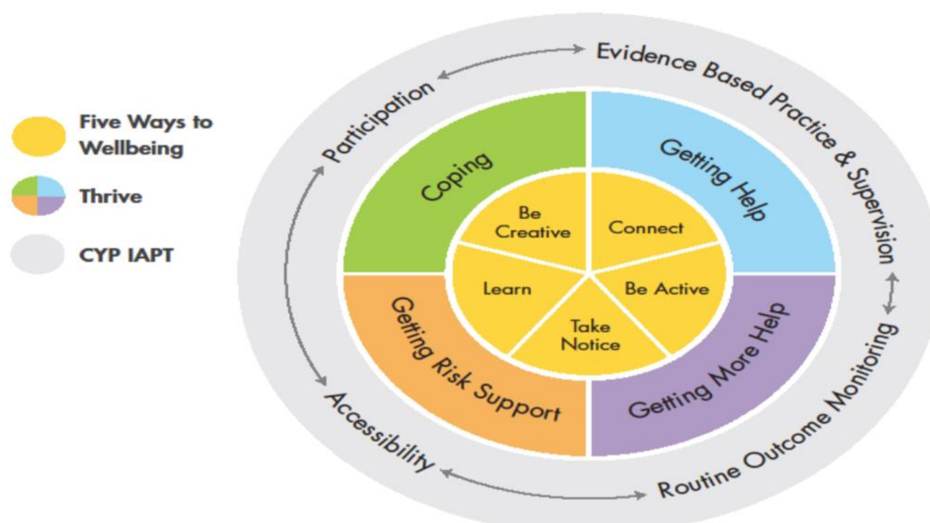
The quality of relationships (not just systems) will make a difference in terms of improving support for the children looked after and care leavers' population. The Expert Group will consider who should be providing particular services, as well as the level of support and type of workforce development required for professionals, including those who refer/commission services and those who deliver services, to enable them to achieve the best for the child during their journey of care. The latter will be primarily explored in relation to how best support the implementation of the guidance this project will be producing[15].

Local Context

This section will report on the current situation and outline the aspirations for the emotional wellbeing and mental health outcomes for children and young people looked after and care leavers.

The Expert Group will use the Thrive Model (details below) developed by the Tavistock and Portman NHS Foundation Trust and the Anna Freud Centre to help it think about the full spectrum of need from universal to intensive services, from 'low self-esteem or problems with bullying to diagnosable mental illnesses.' It proposes a whole system approach moving away from 'access based on diagnostic criteria alone,' and highlights everyone's responsibility including 'support which can be provided at an earlier stage through more informal routes.'

North Somerset will adopt this model but, as a means of measuring how many of our children are 'Thriving', use the Five Ways to Wellbeing as the foundation of good mental health for all of our children.



[15]SCIE (2016) Improving mental health and emotional wellbeing support for children and young people in care Project Scope http://www.scie.org.uk/files/children/care/mental-health/project-scope.pdf?res=true

Five Ways to Wellbeing

Research, including interviews with thousands of children and young people, shows that there are five simple ways to help improve all of our wellbeing; four of them are the same for all age groups:

1. **Connect** – relationships are vital, with family, with friends and with other trusted adults; children and young people want adults to take the time to listen, without judging or trying to find an immediate answer

2. **Be Active** – young people need a range of opportunities to be active whether it's running, walking, skipping, cycling or swimming.

3. **Keep Learning** – learning outside of school is just as important to children and young people as learning in school. Adults can pass on skills to young people – gardening, DIY, sewing – and model other learning activities such as reading.

4. **Take Notice** – it is important to encourage young people to pay attention to their thoughts and feelings as well as their surroundings; listening to music, mindfulness, living in the moment rather than rushing from one thing to the next; encouraging their curiosity

The fifth way to wellbeing is different for adults and young people but important for both:

5. **Giving to Others (Adults**) – doing something for others makes adults feel good but it also improves children and young people's self-confidence and sense of achievement.

5. **Being Creative (Children and Young People**) – children and young people are naturally imaginative and creative – acting, music and crafts, storytelling, collage making. For children there is a big overlap between creativity and play.

We will ensure that all of our children and young people looked after, and our care leavers, have these five elements in place as a foundation to their good emotional wellbeing and mental health.

Thrive

Thrive is a whole system approach, based on the identified needs of children, young people and their families, with the effective use of data to inform delivery and meet needs. It identifies groups of children and young people, the sort of support they need, draws a clear distinction between treatment and support , builds on individual and

community strengths wherever possible, ensures children, young people and their families are active decision makers.

There are five needs-based groups, which are resource homogenous. This means they require similar intensity and types of resource to provide care for them.

Thriving: prevention and promotion in the community (replaced in our model with **Five Ways to Wellbeing**)

Getting Advice and Signposting: signposting, advice and one-off contact; this group would receive community initiatives – health, local authority, social care and third sector - that support the emotional wellbeing and resilience of the whole population.

Getting Help: evidence-informed, outcomes focussed intervention; children and young people who may require temporary support within the community or advice to self-manage long-term conditions for those who choose to do so.

Getting More Help: extensive, longer-term treatment. Some conditions such as psychosis, eating disorders and emerging personality disorders are likely to require this input.

Getting Risk Support: the focus of the intervention is providing risk management; these children and young people are currently unable to benefit from evidence-based treatment eg they have been offered intensive treatments but are not attending appointments and not making progress. They may routinely go into crisis and/or self-harm. The children and young people in this group require close interagency collaboration and clarity on who is responsible. The aim of the support is to develop capacity for self-management and move people into one of the other needs-based groupings.

Thrive groups are not distinguished by severity or type of problem. Although it is likely that certain problems or severities may be more common in some groups, there is no one-to-one relation between severity or type of problem and grouping eg it's not possible to say all children and young people suffering mild depression will be in the 'Getting Help' group, as they may prefer to get advice about their condition and how to manage it themselves. Groups are organised around the different types of supportive activities provided by children and young people mental health services and are strongly influenced by client choice.

There is a recognition that a cultural shift will be required to provide 'whole person' support that considers the context, and includes support which can be provided at an earlier stage through more informal routes.

CYP IAPT Principles

CYP IAPT stands for Children and Young People Improving Access to Psychological Therapies; the aim is to transform children and young people's mental health services. Local Authority and specialist CAMHS staff have trained in CYP IAPT leadership; supervision; and therapeutic modalities.

We have made a commitment to the four main principles which are:

Accessibility – the rapid identification of children and young people in need of emotional wellbeing and mental health services, with seamless links between tiers of need and between partner agencies and the voluntary sector so that children and young people are not subject to repeat assessments and 'bounced' between services.

Evidence based practice and supervision – the embedding of evidence based interventions as common practice; training workers in the most well-evidenced psychological therapies as needed in their day-to-day work; ensuring a robust quality assurance structure, including clinical supervision and continuing professional development.

Routine outcomes monitoring – the regular monitoring of outcomes on a session-by-session basis, with on-going evaluation; children and young people and workers agreeing shared treatment goals, identifying progress and any interventions which are not helping, ensuring the focus is on progress and change; enabling the evaluation of services and the provision of concrete information for commissioners. Providers and service users would jointly agree high-level key quality indicators in line with commissioning intentions.

Participation – participation is at the heart of CYP IAPT, signalling a change from a medical model which views service users as passive recipients of health expertise, towards partnership working which regards service users as active partners – both in their own care and in the design of services.

Our Action Plan (Annex) is built around these four principles.

Current Position and Future Ambition

Workforce

North Somerset has a specialist CAMHS/LD service, an Early Intervention Psychosis Team (for young people aged 14+), a dedicated mental health worker in the Youth Offending Service, Educational Psychologists, school counsellors, Adult Mental Health Services (Positive Step for young people aged 16+ and AWP for those aged over 18), in addition to workers and foster carers in the Resource Service and Community Family Teams, and staff in universal and voluntary services.

CONSULT

A clinical psychologist is embedded within the Fostering and Adoption Service (Resource Service) whose remit is to support the mental health needs of children and young people enabling placement stability. She provides a bridge to specialist CAMHS and is a resource to all staff working with children looked after or adopted children, providing high quality mental health advice when and where needed. She works with the family and social work system and also facilitates groups, particularly around attachment and trauma.

The psychologist's group work is supported by social workers within the team, for example, co-facilitating the ASCEND group for parents/carers with children with social communication difficulties; and by specialist CAMHS, for example, co-facilitating the SAFE group to support parents/carers looking after children with additional needs.

The psychologist is assisted by and supervises a full time social worker, who has completed the CYP IAPT Cognitive Behavioural Therapy programme. He is able to offer individual therapy on anxiety and depression. There is also a part-time Family Support Key Worker in CONSULT who works with individual children on Life Story Work; with groups of young people on social skills, healthy relationships, and coping with adolescence, and also with sibling groups.

In addition, a social worker who has completed the CYP IAPT Systemic Family Practice is released for one day per week to work with families where the young person is experiencing depression or whose behaviour threatens their placement stability.

Training

The majority of children looked after and carer leavers have had early adverse childhood experiences including neglect and abuse; all of them will have experienced significant loss simply by coming into care; and some may have a poor experience of care. The acting out and/or internalising of these complex attachment and trauma-related issues can make understanding and caring for these children and young people demanding.

To add to the complexity, any child or young person who is in care will have several adults in a 'parenting' role ie birth parents, foster carers, social workers, IRO etc. and it is important that the child can see these adults working together in partnership, with a common approach in meeting the child's needs and in supporting the child or young person in fulfilling his or her potential and forming strong, positive relationships.

The training programme reflects this.

All of the staff offering therapeutic work are trained to a minimum of Level 1 in Dyadic Developmental Practice and many are trained in Non Violent Resistance (with its focus on adolescent violence or controlling behaviour towards parents/carers and/or siblings).

A workforce audit to determine mental health training needs was disseminated in December 2016; a training plan will be devised following an analysis of its results. Practitioners and foster carers will have access to role specific and universal training.

Future Ambition

- Review the CONSULT service to ensure the most effective and efficient use is being made of this valuable resource
- Analyse the results of the mental health training audit
- Design an annual training programme based on the audit and in consultation with children, young people and foster carers.
- Embed the use of evidence based practice
- Design a robust quality assurance structure including clinical and/or reflective supervision and continuing cpd
- Regular staff consultations to ensure their knowledge/experience forms part of the evidence base

Data (SDQs)

The Strengths and Difficulties Questionnaire (SDQ) is an internationally validated screening questionnaire for 4-16 year olds which comprises five scales, each with five questions:

1. emotional wellbeing
2. 'conduct' problems
3. hyperactivity/inattention
4. peer relationship problems
5. prosocial behaviour

The scores from scales 1-4 generate the total 'difficulties' score. There are three versions: carer; teacher; child aged 11+.

The Department for Education requires local authorities to submit SDQ data, completed by their foster carer or residential care worker, for children and young people who have been looked after for12 months or more. SDQ scores can be aggregated to help quantify the needs of the local looked after children population and local authorities and CCGs are encouraged to use them as they develop their JHWS [Joint Health & Wellbeing Strategy/ JSNAs].[16]

The NSPCC/Rees Centre University of Oxford report in the Impact and Evidence Series, *What Works in Preventing and Treating Poor Mental Health in Looked-After Children?*, found that 'Use of the Strengths and Difficulties Questionnaire (SDQ) with looked-after children has been shown to provide a good estimate of the prevalence of mental health conditions…'

The total difficulties score for an individual child or young person is in the 'normal' range if below 14, in the 'borderline' range if 14-16 and in the 'cause for concern' range if 17 or above.

North Somerset SDQ data

At the end of March 2015, 115 children and young people looked after by North Somerset were eligible to have their carers' SDQ scores submitted to the DfE.

- 59% of eligible children and young people had an SDQ score submitted.
- The average score was 15.0
- 41% were in the 'normal' range ie their SDQ score was below 14
- 19% were in the 'borderline' range ie their SDQ score was14-16

[16]DfE/DH (2015) Promoting the health & wellbeing of looked after children: Statutory guidance for local authorities, clinical commissioning groups & NHS); Rees Centre/NSPCC (2014) What works in preventing and treating poor mental health in looked after children

- 41% were in the ‘cause for concern’ range ie their SDQ score was 1

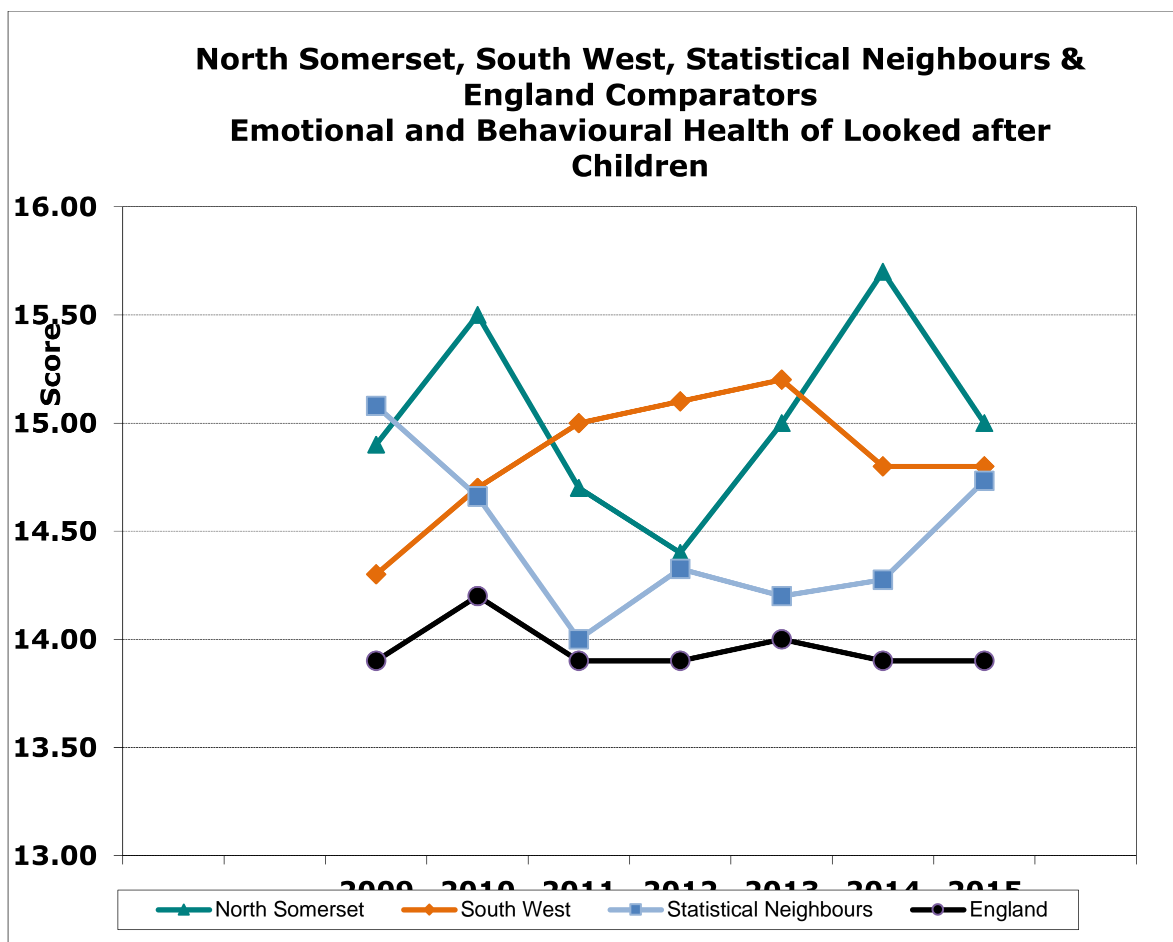
Comparison with the England average

North Somerset is ranked 107/152 local authorities by LAIT for the ‘Emotional and Behavioural Health of Looked after Children’. The DfE table below shows a comparison between the percentage return of all eligible North Somerset children looked after and the England average (in brackets) over 3 years, 2013-2015. The England percentages have remained the same in each range in the last three years while the North Somerset average has been consistently higher.

North Somerset SDQ percentages and scores for 2013, 2014 & 2015 (compared with England)	31 March 2013 (cf England)	31 March 2014	31 March 2015
Percentage return of all North Somerset eligible children and young people (cf England)	69% (71%)	64% (68%)	59% (72%)
Normal range <14	39% (50%)	37% (50%)	41% (50%)
Borderline range 14-16	20% (13%)	17% (13%)	19% (13%)
Cause for concern >17	41% (37%)	45% (37%)	41% (37%)
Average score ie the mean value of the child level SDQ scores for each child or young person aged 4 to 16 who has been looked after for a year.	15 (14)	15.7 (13.9)	15 (13.9)

Comparison with the South West, statistical neighbours and England average

The graph below compares the average 2009 -2015 North Somerset SDQ scores with England, the South West and our statistical neighbours. Since 2010, North Somerset has had higher scores than England and our statistical neighbours. The reasons for this are unknown and warrant further analysis.



Children and young people with a learning disability

North Somerset records show that 14.8% (n=17) of the March 2015 North Somerset returns relate to children and young people with a 'learning disability'. While the numbers are relatively small, there was a much higher return rate from carers of a child or young person with a learning disability (81% cf 59%). There is also a much higher percentage of children and young people with a learning disability in the 'cause for concern' range (53% cf 41%) and 'borderline concern' (23.5% cf 19%).

Data from 31 March 2016

The data for children looked after at 31 March 2016 were published in December 2016. There was a North Somerset SDQ completion rate of 65%, a 6% improvement on 2015 but 10% below the England average (75%). The average score was 15.9. a rise of 0.9 since 2015 and the highest score in the four years analysed (cf an average score of 14 in England):

- 35% in the 'normal' range (cf England 49%)
- 20% in the 'borderline concern' range (cf England 13%)
- 45% in the cause for concern' range (cf England 38%), an increase of 4% on last year's figures

It is unclear whether the relatively low rate of SDQ returns makes a significant statistical difference to the relatively high numbers in the 'borderline concern' range.

There does not appear to be a correlation between the number of years in care and the number of placement moves but, again, this warrants further analysis. A higher proportion of children and young people with a higher number of placements have a disability.

Routine Outcome Measures (ROMs)

The statutory guidance [17] suggests that: 'If the SDQ completed by the carer suggests that the child's total difficulties score is outside the normal range (i.e. a borderline score of 14-16 or a score of 17+, considered as giving cause for concern), the child may benefit from triangulating the scores from the carer's SDQ with those of his or her teacher and (if he or she is aged 4 to 17) the self-evaluation'. However, the Rees/NSPCC report, *What works in preventing and treating poor mental health in looked after children?* suggests that the carers' and teachers' evaluations provide a better indicator of mental health difficulties than the self-evaluation[18].

The statutory guidance further suggests that if triangulation of those scores confirms the carer's score, consideration should be given to using a diagnostic tool to enable an appropriate intervention to be identified.

The NSPCC/Rees Centre report suggests that local authorities could use other tools to supplement the SDQ0. Amongst other assessment tools highlighted in the report are those used in CYP IAPT (Children and Young People's Improving Access to Psychological Therapies):

> The main clinical assessment tools in CYP-IAPT are the SDQ and the **Revised Children's Anxiety and Depression Scale** or RCADS (Chorpita et al, 2000). The RCADS gives information on a range of internalising problems, including depression, separation anxiety, social phobia, generalised anxiety disorder, obsessive compulsive disorder and panic (but not PTSD), and includes cut-off points for normal, raised and high scores by age group for both boys and girls from 8–18 years. [19]
>
> CYP-IAPT stresses the importance of collaborative working and as such places great emphasis on two other types of measure. The first, **Goal-Based Outcomes (GBOs)**, provides user-defined measures of the issues that are important to the young person or to their carer. This is likely to be especially useful for looked after children, because some of the difficulties they target may not fall within the usual diagnostic categories. Secondly, and most usefully for direct work with the child or young person, are the **session-rating measures**,

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[17] DfE/DH (2015) Promoting the health & wellbeing of looked after children: Statutory guidance for local authorities, clinical commissioning groups & NHS

[18] https://www.nspcc.org.uk/globalassets/documents/evaluation-of-services/preventing-treating-mental-health-looked-after-children-report

[19] ibid

which are a way of assessing whether the young person feels involved and engaged with any treatment being offered. [20]

Future Ambition

- Use entry into care SDQ data as baseline
- Develop care pathways for different SDQ scores and SDQ 'at risk' scales ie emotional wellbeing; behaviour; hyperactivity/inattention; peer relationships; prosocial behaviour
- Include Five Ways to Wellbeing as measure of 'thriving'
- Use additional measures (ROMs) when SDQ score is 14+, to be agreed with foster carers and children and young people
- Improve percentage of SDQ returns
- Link the SDQ scores with other outcomes data eg Social Care, Health and Education
- Work in partnership with specialist CAMHS to improve overall data collection and individual records on Social Care and Health systems allowing us to:
- Track emotional wellbeing and mental health interventions and outcomes for each child/young person in care
- Undertake a systemic analysis of emotional wellbeing and mental health offer using the Thrive model

Care Leavers

Young people in care have often had difficult lives but have to start being independent earlier than a lot of their peer group. Research shows that nationally, young people who have been looked after often face difficult social challenges. There is a proportionately higher percentage of care leavers who are homeless; become teenage parents; self-harm in adulthood; have contact with the criminal justice system. There is a significantly higher gap between the educational and employment achievements of care leavers and other young people.

Keep on Caring seeks to enact (ie in the *Children and Social Work Act*[21]) for the first time what is expected from a local authority in its role of a 'good corporate parent':

- creating a new care leaver covenant;
- introducing a new legal duty on local authorities to consult on, and publish information about, services for care leavers; and
- extending existing entitlements so that all care leavers will be able to access support from a local authority Personal Adviser to age 25.

[20] ibid

[21] The Children and Social Work Bill passed its Second Reading on 5 December 2016 http://services.parliament.uk/bills/2016-17/childrenandsocialwork.html

It recommends five key outcomes:

1. Better prepared and supported to live independently
2. Improved access to education, training and employment
3. Experiencing stability and feeling safe and secure
4. Improved access to health support [with a focus on mental health]
5. Achieving financial stability

Historically, the Department for Education has only collected data for Care Leavers aged between 19 and 21; this has now been extended to 17 and 18 year olds, with local authority tables covering this wider age range. The North Somerset data, published in December 2016[22], show that there were 20 care leavers aged 17 and 18 years old of whom 55% were in Education, Employment or Training (cf 61% England), with 40% Not in Education, Employment or Training (NEET) 'for other reasons' (cf 25% England), with less than 5% NEET due to 'illness/disability'.

There were 110 care leavers aged 19, 20 and 21 of whom 46% were in Education, Employment or Training (cf 49% England), with 16% NEET due to illness/disability (cf 10% England), 22% NEET for other reasons (cf 23% England), and 8% NEET due to pregnancy or parenting (cf 7% England).

We know from local data that there are a significant number (n=20) of North Somerset Care Leavers aged between 17 and 21 years old who are Not in Education, Employment or Training (NEET) and have been assessed as not being fit to work due to mental health issues.

According to *Keeping Well,* the Expert Working Group mentioned in an earlier section, will also consider transition to adult mental health services as part of its remit.

Transition

Children and Adolescent Mental Health Services (CAMHS) provide services to young people up to their 18th birthday. All young people with a long term mental health diagnosis are reviewed by a multi-agency group, including a psychiatrist from CAMHS, from the age of fourteen and a half to ensure a smooth transition to adult services. However, young people may not reach the diagnostic threshold for access to adult services and, even if they do, may not be offered regular, individual support.

In February 2016, NICE published: *Transition from children's to adults' services for young people using health or social care services.* NICE guideline NG43.

[22] https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2015-to-2016

The recommendations include the co-production, with young people, of transition policies and strategies; developmentally appropriate transition; strengths-based and person-centred transition support; partnership working between health and social care eg the development of a joint mission statement or vision for transition and jointly agreed and shared transition protocols, information-sharing protocols and approaches to practice.

The associated Quality Standard was published by NICE in December 2016: *Transition from children's to adults' services.* [QS140] It covers all young people (aged up to 25) and includes those 'with mental health problems' and those 'under the care of local authorities'.

Quality statements

1. Young people who will move from children's to adults' services start planning their transition with health and social care practitioners by school year 9 (aged 13 to 14 years), or immediately if they enter children's services after school year 9.
2. Young people who will move from children's to adults' services have an annual meeting to review transition planning.
3. Young people who are moving from children's to adults' services have a named worker to coordinate care and support before, during and after transfer.
4. Young people who will move from children's to adults' services meet a practitioner from each adults' service they will move to before they transfer.
5. Young people who have moved from children's to adults' services but do not attend their first meeting or appointment are contacted by adults' services and given further opportunities to engage.

Future Ambition

- Ensure North Somerset meets the five key outcomes outlined in *Keep on Caring* which all influence mental health but, for the purposes of this strategy, with a special emphasis on Outcome 4.
- Align North Somerset processes with the recommendations of the NICE Guidelines and Quality Standard on Transition.
- Analyse the DfE NEET data for 17–18 year olds and 19, 20 & 21 year olds who are NEET due to mental health issues
- Consult with care leavers about how their emotional wellbeing and mental health needs can be supported through transition
- Reduce the number of care leavers receiving ESA due to mental health needs
- Review the North Somerset Action Plan in the Annex when the *Children and Social Work Bill* is enacted and the Expert Working Group reports on its findings
- Increase PAs confidence in working with mental health issues

Participation

We will consult with care leavers, asking the same questions about North Somerset emotional wellbeing and mental health services as those proposed by the Expert Working Group:

- Where did you first go for help or support when you realised that you needed it?
- Did you experience any barriers getting help? If so – what were they?
- What did you think about the help and support you received?
- What could have been done better or differently?

By asking the same questions at a local level, comparisons with national responses can be made.

We will also consult with foster carers and staff on mental health issues as part of the wider consultation as outlined in the *North Somerset Fostering Strategy September 2016-2018* .

Future Ambition

- Consult with care leavers about their emotional wellbeing and mental health needs
- Consult with foster carers and staff about what would improve emotional wellbeing and mental health services
- Invite care leavers to be involved in design and/or delivery and/or evaluation of training of staff and foster carers to highlight their experience of mental health issues and what would help
- Continue involvement in *Bright Spots*