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| **REPORT TO:** | **Corporate Parenting Panel**<br>**7 September 2016** |
| **AGENDA ITEM:** | **6** |
| **SUBJECT:** | **Assessing the health and wellbeing of Croydon's Looked After Children** |
| **LEAD OFFICER:** | **Barbara Peacock,**<br>**Executive Director of People Department** |
| **CABINET MEMBER:** | **Alisa Flemming, Cabinet Member for Children, Young People & Learning** |
| **WARDS:** | **ALL** |

**CORPORATE PRIORITY/POLICY CONTEXT:**

A caring city: Provide safer, high quality, integrated healthcare and social care services close to home with a focus on maternity, children and young people, and mental health services.

Corporate Parenting.

**FINANCIAL IMPACT**

No financial considerations.

**FORWARD PLAN KEY DECISION REFERENCE NO:** N/A

## 1. RECOMMENDATION

1.1 Corporate Parenting Panel to note the report, which is an update on arrangements for improving health outcomes for Croydon's Looked After Children and the needs of Croydon's Looked After Children identified through health assessments and referrals to Croydon's Children and Adolescent Mental Health Services.

## 2. EXECUTIVE SUMMARY

2.1 The corporate parenting responsibilities of local authorities include having 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.

2.2 The report appended is in response to the Panel's request for an update on health assessments for looked after children.

## 3. DETAIL OF YOUR REPORT

3.1 The report on "Assessing the health and wellbeing of Croydon's looked after children" is appended.

## 4. CONSULTATION

4.1 This report has been produced in collaboration between health commissioners and providers on behalf of the Clinical Commissioning Group, the Designated professionals, health provider leads and Council social care managers.

## 5 FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS

5.1 There are no financial considerations arising from this report.

## 6. COMMENTS OF THE COUNCIL SOLICITOR AND MONITORING OFFICER

6.1 There are not legal implications of this report.

## 7. HUMAN RESOURCES IMPACT

7.1 There are not human resources implications of this report.

## 8. EQUALITIES IMPACT

8.1 This report is not proposing a change in policy or service.

## 9. ENVIRONMENTAL IMPACT

9.1 There are no environmental implications of this report.

## 10. CRIME AND DISORDER REDUCTION IMPACT

10.1 There are no crime and disorder implications of this report.

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**CONTACT OFFICER: Amanda Tuke, Joint head of children's integrated commissioning on behalf of Croydon Clinical Commissioning Group and Croydon Council (amanda.tuke@croydon.gov.uk)**

**BACKGROUND DOCUMENTS**
Not applicable

# Assessing the health and wellbeing of Croydon's looked after children

**Report contributors:**
Amanda Tuke – report editor (Joint head of children's integrated commissioning on behalf of Croydon CCG and Croydon Council)
Sandra Richards (Designated LAC nurse, Croydon CCG)
Dr Ian Johnston (Designated LAC doctor – interim, Croydon Health Services)
Sheila O'Brien (Named LAC nurse, Croydon Health Services)
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John Martin (Service manager for Leaving Care service, Croydon Council)
David Butler (Head of school improvement, Croydon Council)
Clare Brutton (CAMHS commissioner, on behalf of Croydon Clinical Commissioning Group and Croydon Council]
Katharine Devlin (LAC CAMHS service, SLAM)
Tiago Brandao (Off the Record/Compass)

## Introduction

1. Improving health outcomes for looked after children is one of the five key priorities in the 2016-17 Children and Families Plan overseen by Croydon's Children and Families Partnership. The CFP recognises that this can only be achieved by effective partnership working between Croydon Council and Croydon foster carers; Croydon Clinical Commissioning Group and Croydon GPs; Croydon Health Services and South London and Maudesley Trust; the Virtual School for Looked After Children and Croydon schools; and relevant voluntary sector organisations.

2. Croydon's looked after children population is unique with around half being unaccompanied asylum-seeking children. Understanding the needs of this population is essential in enabling these health needs to be met and to achieve improved health outcomes. The World Health Organisation defines 'health' as '*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'*. It is acknowledge that the families and most notably the children and young people we serve will have different expectations about what is means to be healthy and how to expect that their needs be met based on their culture and experiences in life so far.

3. The Council's social care teams with foster carers to ensure all looked after children are registered with a GP and that their day to day health needs are met. Social care teams also work with wider health partners who share responsibility for the health outcomes for Croydon's looked after children.

4. Children and young people have a right to have their views taken into account on all issues that affect them. In the future, partners intend to consult with the Children in Care Council (CiCC) and ask them if and how they would like to be involved in offering a view of the services we offer to LAC to support their health. The next meeting of the CiCC is in late October 2016.

5. A half day Looked after Children workshop has been planned to take place in

October 2016. The purpose of the workshop is to promote and raise the profile of the importance of good health for Croydon Looked after Children and Young People. A survey was undertaken in June 2016 by the Designated Nurse for Looked after Children and Young People to gain views, feelings and wishes regarding health topics information and advice YP would welcome during this event. Forty-eight questionnaires were returned. Although the sample size was small, the results were very positive and the workshop has been planned accordingly.

6. This report was produced collaboratively by partners who share responsibility for the health outcomes of Croydon's looked after children and draws on local data for performance indicators in relation to statutory health assessments and specific needs of LAC identified in health assessments.

7. The subsequent sections of this report are set out in the following way:

**Part one – Arrangements for improving health outcomes for Croydon's looked after children**

a) Croydon's performance in relation to arrangements for improving health outcomes for looked after children
b) Commissioning arrangements for statutory health assessments for Croydon's looked after children
c) Arrangements for quality assuring health assessments
d) Performance in relation to health assessment timeliness
e) Monitoring of health plans for looked after children
f) Arrangements for strengths and difficulties questionnaires
g) Commissioning arrangements for children and adolescent mental health services (CAMHS) for looked after children
h) Performance in relation to LAC emotional wellbeing and mental health
i) Arrangements for LAC accessing wider health services
j) Contribution of the Virtual School to improving health outcomes
k) Arrangements for children leaving Croydon's care in relation to health
l) Conclusions to part one

**Part two – Assessment of the health needs of Croydon's looked after children**

a) the findings from an audit of initial and review health assessments
b) the findings from analysis of referrals to LAC CAMHS;
c) analysis of information about LAC with special educational needs and disabilities
d) Conclusions to part two

## Part 1: Arrangements for improving health outcomes for Croydon's looked after children

8. This section describes the arrangements across the partnership of organisations which contribute to improving health outcomes for looked after children and where applicable the performance indicators in relation to those arrangements.

### Croydon's performance in relation to arrangements for improving health outcomes for looked after children

9. The performance dataset in table 1 is drawn from the mandatory annual data return to the Department for Education shows an improvement in relation to a number of measures in relation to the health of Croydon's looked after children. While there have been improvements in a number of performance indicators, the percentage of LAC with up to date dental checks fell from 95.3% in 2015 to 87.0% in 2016 and the percentage of LAC with completed Strengths and Difficulties Questionnaires fell from 83% to 70%.

Table 1: Performance measures for Croydon from SSD 903 return for 2014-15 and 2015-16 with commentary on the objective in relation to each measure and direction of travel.

| | **2015** | **2016** | ***Objective*** | ***Direction of travel*** |
|---|---|---|---|---|
| % LAC with up to date Health Assessments | **76.5** | **85.0** | *Higher is better* | *Improved* |
| % LAC Age 5 and Under with up to date Health Assessments | **72.0** | **93.0** | *Higher is better* | *Improved* |
| % LAC with up to date Dental Checks | **95.3** | **87.0** | *Higher is better* | *Deteriorated* |
| % LAC with up to date Immunisations | **92.5** | **92.4** | *Higher is better* | *Stable* |
| Drugs - % of children looked after identified as having a substance misuse problem during the year | **2.0** | **1.8** | *Lower is better* | *Improved* |
| % LAC with SDQs Recorded | **83.0** | **70.0** | *Higher is better* | *Deteriorated* |
| Average SDQ Score | **11.2** | **10.1** | *Lower is better* | *Improved* |

### Commissioning arrangements for statutory health assessments

*Amanda Tuke (lead commissioner for health assessments on behalf of Croydon Clinical Commissioning Group)*

10. Effective assessment of health needs when a child becomes looked after and at regular intervals while they are in care is an important tool contributing to delivery of improved health outcomes for looked after children.

*Statutory guidance*

11. The guidance covering requirements of health assessments for looked after children is set out in *Promoting the Health and Wellbeing of Looked After Children - Statutory guidance for local authorities, clinical commissioning groups and NHS England (DfE, DH, March 2015).*

12. The local authority is responsible for *"making sure the children in its care receive health assessments"* and "*must ensure that every child it looks after has an up-to-date individual health plan, the development of which should be based on the written report of the health assessment. The health plan forms part of the child's overall care plan."*

13. CCGs and NHS England have *"a duty to cooperate with requests from local authorities to undertake health assessments and help them ensure support and services to looked-after children are provided without undue delay".*

14. The statutory requirements in brief are that all looked after children receive an initial health assessment from a doctor within 20 working days from becoming looked after and the findings are considered in the first looked after child review which must also take place within 20 working days. For children aged under 5, statutory guidance requires that a review health assessment be carried out at 6 monthly intervals. If the child is aged 5 or over, then the review must take place once a year. Review health assessments can be carried out by a nurse.

15. There were 819 children in the care of Croydon Council as of the end of March 2016. Of these 390 were local children, 429 were unaccompanied asylum-seeking children (UASC). On average in 2015-16, 17 local children were brought into care each month and 19 UASC. Similar numbers cease being looked after so the population number remained fairly stable over the year.

16. Based on these numbers, the estimated demand for health assessments in 2016-17 is 36-40 initial health assessments per month and 75 review health assessments per month. Each assessment takes around 60 minutes with the child and results in a report in a format agreed locally including a health plan.

17. The children's integrated commissioning team leads commissioning of LAC health assessments on behalf of Croydon CCG and Council.

*Commissioning arrangements for initial health assessments*

18. The CCG commissions the CHS LAC nursing service to coordinate initial health assessments for local LAC in the CCG/CHS block contract.
    - the CHS community children's medical service currently provides twelve initial health assessments per month for local LAC aged under 12 years as part of the service specification in the CCG/CHS block contract.
    - For further initial health assessments for local LAC placed in Croydon, the CHS LAC nursing service requests that the child's GP carries out the initial health assessment.
    - For initial health assessments for local LAC placed in other areas, the Croydon LAC nursing service requests that the child's GP carries out the initial health assessment.

19. GPs are not mandated to deliver initial health assessments for LAC. A number of GPs have declined to carry out health assessments when these are requested.

20. The local authority is currently commissioning a temporary service arrangement to provide initial health assessments for UASCs. The service was set up initially to manage a backlog of assessments following an increase in the number of UASCs

arriving and because the previous service commissioned privately by the local authority from a CHS community paediatrician ended. The service model proved a very efficient and effective way of delivering a high volume of initial health assessments.

*Commissioning arrangements for review health assessments*

21. In addition to coordinating provision of initial health assessments of local LAC, the LAC nursing service also delivers and "sub-commissions" review health assessments.The service consists of 2.8 whole-time-equivalent nurses.

22. A number of assessments are provided at the child's placement for local LAC (16 per month in 16 half day sessions) and a small number of clinic-based assessments for UASCs (16 per month in 4 half day sessions).

23. The short-fall is currently covered by the LAC nursing "sub-commissioning" around half of review health assessments from:
    a) CHS school nurses (funded by local authority public health)
    b) CHS health visitors (funded by local authority public health)
    c) CHS homeless health team (funded by the CCG)
    d) Other CCGs for children placed outside Croydon.

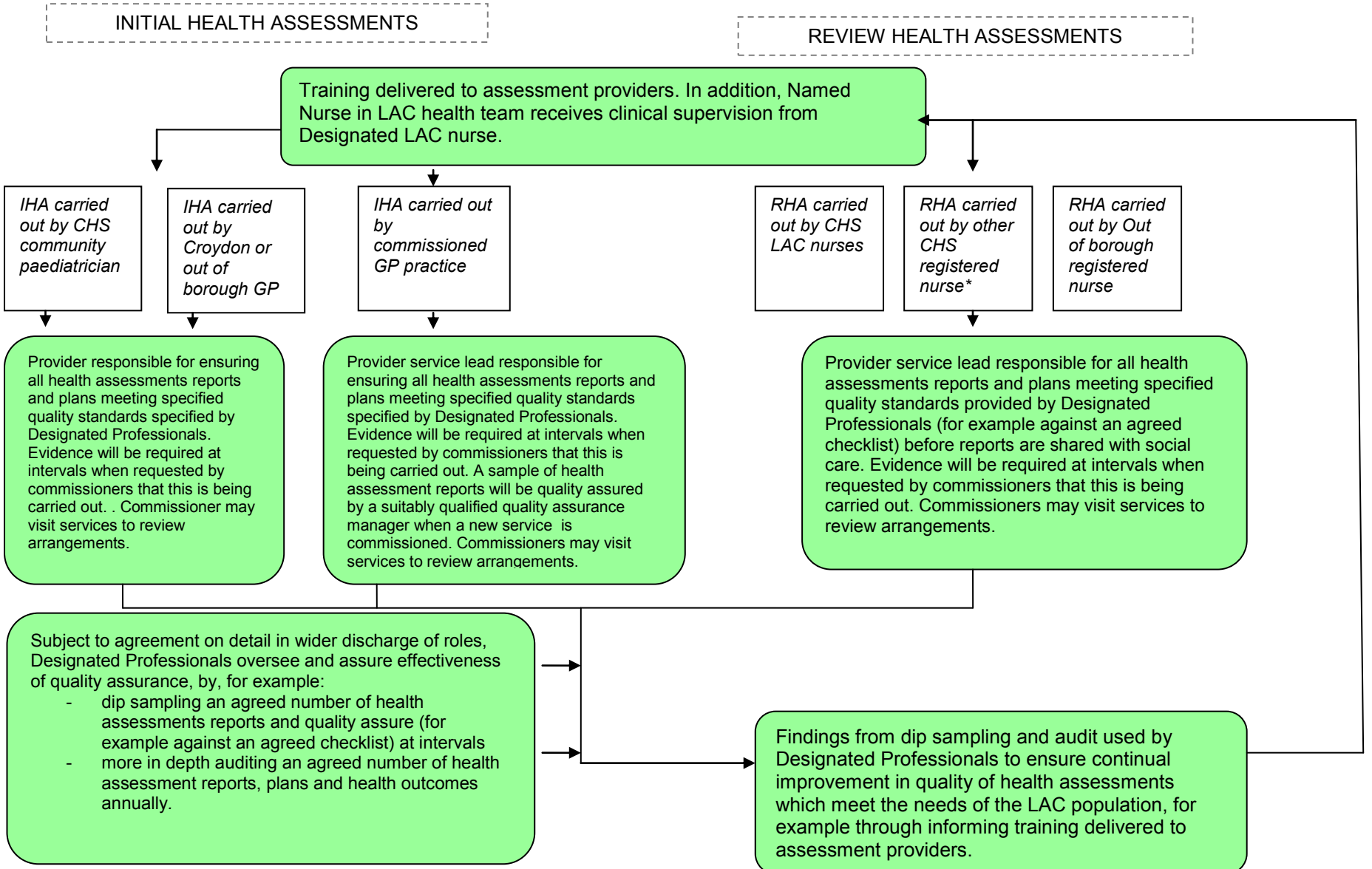
24. As part of the project to increase the timeliness of LAC health assessments (see section on *Performance in relation to health assessment timeliness* below) commissioners are currently working with the Council, Clinical Commissioning Group and Croydon Health Services on increasing the direct delivery of review health assessments by the specialist LAC nursing team and options for increasing commissioned capacity for initial health assessments for local LAC and UASC LAC.

**Arrangements for quality assuring health assessments**
*Dr Ian Johnston (Designated LAC doctor – interim, Croydon Health Services), Sandra Richards (Designated LAC nurse, Croydon Clinical Commissioning Group)*

25. The purpose of health assessment quality assurance process shown in figure 1 is to ensure the best possible quality of health assessments for Croydon's LAC. This process was developed as part of the LAC health assessment timeliness project.

26. The objectives for the quality assurance process for LAC health assessment reports are as follows:
    - To improve the quality of health assessments, health assessment reports and health plans to contribute to improving health outcomes for LAC.
    - To address quality issues in LAC health assessments in a timely way while supporting the timely return of health assessment report for LAC review meetings.
    - To ensure the quality issues of health assessments are fully understood and inform on the needs for training of health assessment providers.
    - To maximise use of quality assurance process to collate information on needs.
    - To provided assurance on the quality of LAC health assessments to the CCG and Croydon Council

**Figure 1. Quality assurance process for Croydon LAC health assessments**



**Performance in relation to health assessment timeliness**
*Amanda Tuke and Wendy Tomlinson (co-chairs of LAC health assessments pathway project board)*

27. Timeliness in carrying out health assessments for Croydon LAC has been historically poor. The latest data for which comparisons with other boroughs is available showed that in March 2015, 77 per cent of Croydon's LAC who had been in care for 12 months had had their statutory health assessment in the previous 12 months in comparison with 90 per cent on average for London. The most recent Croydon data shows that this has improved to 85 per cent but partners agree that further improvement must be made.

28. A review of the the health assessment pathway was carried out by health commissioners in 2015 to gain an understanding of the obstacles to timely health assessments. Following the review, a five month project was jointly funded by Croydon Council and Croydon CCG to take forward the project recommendations with the aim of making sustained improvements to the timeliness of health assessments for LAC before the end of 16-17. The project was overseen by a project board which has representatives from the local authority, Croydon Clinical Commissioning Group and Croydon Health Services. The project was closed at the start of July 2016 and the project deliverables, redesigned elements of the health assessment pathway, will be implemented from July to September 2016. The expectation is that further improvements in timeliness will be seen in the latter part of 2016-17.

29. Key developments from the project are shown in table 2. Partners contributing to the project agreed that the most significant risk to timeliness of LAC health assessments was the insufficient commissioned service capacity for carrying out assessments.

**Table 2: Elements of LAC health assessment timeliness pathway included in the implementation plan for Jul to Sep 2016**

| Project objective | Issues being addressed to improve timeliness |
|---|---|
| 1. Timely notification that IHA/RHA needed | Increase automation of notification of health assessments which are needed.<br>Streamline processes for communicating parental consent for health assessments to NHS. |
| 2. Timely delivery of IHA/RHA | Increase capacity in commissioned service for delivering initial and review health assessments to reduce hand-offs and improve quality of health assessments. |
| 3. Timely return of IHA/RHA to social care | Streamline quality assurance process so that fit for purpose health assessment reports are delivered<br>Simplify processes for health assessments being returned to social care and recorded as completed on social care case management system (CRS) |
| 4. Timely inclusion of health plan in statutory LAC review | Ensure dates for LAC reviews are communicated to LAC nurses so that representations can be prioritised in partnership with social care. |
| Across stages 1-4: Improved pathway performance management and information sharing | Strengthen LAC health pathway performance monitoring and reporting.<br>Update information sharing memorandum of understanding between pathway partners. |
| Post project: Implementation plan for post project | Implement new pathway elements including agreement on future oversight of pathway. |

**Monitoring of health plans for Croydon's looked after children**
*Wendy Tomlinson (Social Care managers, Croydon Council)*
*Oretha Wofford (Manager of Independent Reviewing Officer Service, Croydon Council)*
*Sheila O'Brien (Named LAC nurse, Croydon Health Services)*

30. Social care has a key role in promoting health of looked after children as set out in the statutory guidance which includes:
    "Social workers have an important role in promoting the health and welfare of looked-after children. In particular they should… take action to liaise with relevant health professionals if actions identified in the health plan are not being followed up. Given the impact that poor physical, emotional and mental health can have on learning, they should also ensure the child's virtual school head is involved in resolving any health care needs that impact on the child's education…"

31. Croydon social workers make sure that actions in the health plan are carried out and that these are recorded on the case management system as completed. Unit managers (managers of the social worker teams) are expected to keep this under review through regular supervision.

32. The role of the Council's independent reviewing officers in relation to looked after children's health is also specified in the statutory guidance "The IRO should, as part of the child's case review, note any actions and updates to ensure that the health plan continues to meet the child's needs. The IRO should be proactive in bringing any deficiencies in the quality of the health plan or its delivery to the attention of the appropriate level of management within the local authority, using the local dispute resolution process if necessary. The local authority should, in turn, discuss any concerns with the designated nurse, so that outstanding issues are addressed without unnecessary delay…"

33. Croydon IROs request that health assessment reports are provided to them prior to the statutory LAC review. They use the health section of the review minutes to record any health concerns including delays in obtaining health services Any health concerns flagged in the health assessment will be monitored by the IRO and updates expected at each review.

34. The schedule of monthly LAC reviews is now shared with the LAC health team following the LAC health assessment timeliness project and IROs continue to request that Health is present at reviews where there are ongoing health concerns or health plan actions for updates.

35. Currently the Named Nurse who manages the Looked After Children team in Croydon Health Services supports Croydon Council Social Care with the coordination of the health plans by ensuring that all relevant health professionals are aware of identified health concerns. She has also supported looked after children in accessing health services such as registering with local GP's, dentists, opticians and sexual health clinics.

36. The Named Nurse also currently ensures that a copy of the health action plan with all identified health needs and clear guidance of who is responsible and over what

time frame is sent to the foster carer.

**Arrangements for implementing strengths and difficulties questionnaires (SDQs)**
*Wendy Tomlinson (Head of looked after children service, Croydon Council)*

37. Local authorities are required to use the Strengths and Difficulties Questionnaire (SDQ) to assess the emotional well-being of individual looked-after children. This to helps social workers form a view about the emotional well-being of individual looked-after children.

38. The statutory requirement is that local authorities must ensure that the looked-after child's main carer (a foster carer or residential care worker) completes the two-page questionnaire for parents and carers. This is a simple questionnaire that does not require any training to interpret and can be completed in between five and ten minutes.

39. The social care teams receive weekly data telling them which children and young people have an up to date SDQ and which do not, in order to allow managers and social workers to focus their efforts and ensure their work is recorded. This also supports an understanding of which children need an SDQ according to the counting rules, although it is good practice to have up to date SDQs for all children and this is our endeavour.

40. Local health partners recognise the limitations of SDQ in assessing emotional well-being in the UASC population and addressing this and other aspects relating to the emotional wellbeing and mental health of looked after children is an area of action for the LAC health sub group of the the Children and Families partnership. It is also recognised that there may be challenges for UASC in understanding basic emotional well-being concepts and therefore being unable to express emotional and mental health needs coherently.

**Commissioning arrangements for Children and Adolescent Mental Health services for looked after children**
*Clare Brutton, lead commissioner on behalf of Croydon Clinical Commissioning Group and Croydon Council*
*Katharine Devlin, LAC CAMHS, SLAM*

41. The LAC CAMHS service is commissioned by Croydon Council from the South London and Maudsley Trust who also provide a CAMHS service to the wider population in Croydon commissioned by the Croydon Clinical Commissioning Group (CCG). Off the record/Compass is also commissioned by Croydon Council to provide counselling services for looked after children.

42. The service accepts referrals of looked after children and young people with emotional and mental health difficulties and will assess and offer treatment or advice to social workers and foster carers. An initial consultation is the first step in identifying difficulties and establishing the best way forward.

43. The Croydon CAMHS Looked after Children's Team consists of:
    Charlotte Peacock – Team Leader (Katharine Devlin continuing to offer managerial oversight one day per week)

Dr Anna Bakowski – Clinical Psychologist - part time
Dr Jo Webb- Clinical Psychologist- part time
Dr Simon Wilkinson – Consultant Psychiatrist – part time
Charmaine Robertson-Jones- Systemic Psychotherapist
Dr Aarti Datta – ST4 Psychiatrist- Part time
Clare Killikelly- Trainee Clinical Psychologist- part time
Jo Blankson – Administrator

44. Croydon LAC CAMHS offer various opportunities and events to raise the profile of mental health in looked after children and training to help those in their network to help young people to fulfil their potential. Such activities include:
    - **Consultation Clinics with the Permanence Teams in Social Care.** Fortnightly clinics offering the opportunity for social workers to discuss potential referrals and think systemically around cases.
    - **Consultation Clinics with supervising social workers.** Monthly clinics with supervising social workers based on the model above after positive feedback was received from the permanence teams.
    - **Consultation Clinics with the Virtual School** Monthly clinics have recently been set up with the virtual school based on the model above after positive feedback was received from the permanence teams. The aim of consultation is to improve communication between the two services and increase referrals to the service.
    - **Fostering Changes** Twelve week course which runs twice yearly for foster carers. This course covers the effects of disrupted attachment and trauma on children's emotional well- being as well as providing practical strategies for managing behaviours.

45. The team is also due to present at the General Practice Safeguarding Leads' Workshop to advertise and promote the Looked after Children's service to local GP's with a view to streamline and increase referrals into the service and is due to present at the upcoming LAC health week in October.

46. The CAMHS Referral Form has been circulated to referrers including social workers, GP's and the virtual school. The team hopes this will increase referrals into the service. The team has been working closely with the wider LAC strategic partnership and partner agencies, including the virtual school, Off the Record/Compass and the LAC health team to raise awareness of the service, increase referrals and promote joint working. There are on-going discussions to develop a trauma pathway for young people with a diagnosis of Post-Traumatic Stress Disorder and unaccompanied asylum seeking children.

47. Once children or young people are referred, they are offered a specialist CAMHS assessment, including neuropsychiatry and cognitive assessments and evidence based interventions, such as cognitive behaviour therapy, family therapy, DBT-informed therapy, trauma focussed therapy and narrative exposure therapy.

**Performance in relation to LAC emotional wellbeing and mental health**
*Wendy Tomlinson (Head of looked after children service, Croydon Council)*
*Clare Brutton (CAMHS commissioner)*
*Katherine Devlin (LAC CAMHS lead, SLAM)*

48. Table 1 shows that percentage of LAC with a completed Strengths and Difficulties questionnaire fell from 83% in March 2015 to 70% in March 2016. The local authority has reported back the following reasons for this and actions to be taken to the Department for Education following the annual performance data return:
    a) Croydon has a large number of older UASC within our LAC population, a number which has increased in recent months. This has presented challenges in having SDQs done in a timely manner for all young people.
    b) We noted a reduction in our reported performance on this part of the 903 return and have done some investigative work to establish what has happened and therefore what a suitable remedy might look like.
    c) We note that all young people reported as not having an SDQ, who have not yet reached their 17th birthday this week (w/c 1st Aug) now have an up to date SDQ.
    d) For the young people who are now 17 and 18, we are in regular contact with all of them and can be assured that the emotional and mental health needs of all of them is being understood and addressed as needed.
    e) We are also revisiting guidance and support to managers and social workers in order to improve future performance.

49. The SDQ's scores fell from 11.2 (of 15) on average in March 2015 to 10.1 (of 15) on average in March 2016.

50. Between April 2015 and March 2016 the LAC CAMHS team received 91 direct referrals of young people. Between June 2015 and April 2016 the team has offered a total of 812 appointments, in comparison to 711 appointments during the same reporting period last year. The current median waiting time is around 3 weeks, in comparison to around 8 weeks at the same reporting period last year. From the point of referral the team will see young people more urgently if there are pressing mental health concerns and aim to offer an appointment within 5 weeks.

**Arrangements for LAC accessing wider health services**
*Amanda Tuke (Joint head of children's integrated commissioning)*

51. The role of primary care in relation to the health of looked after children is set out in the statutory guidance as shown below.

    *"NHS England should ensure… looked-after children are always registered with GPs and have access to dentists near to where they are living. This is a shared responsibility with the local authority for the children it looks after… The lead health record for a looked-after child should be the GP-held record. The initial health assessment and health plan, and subsequent review assessments and plans, should be part of that record."*

52. Locally, meeting the health needs of looked after children are a key component of a number of wider community-based health services.

53. Working as part of Croydon Best Start the health visiting service (commissioned by Croydon Council from Croydon Health Services) provide universal services including promotion of attachment and undertaking holistic assessments and developmental reviews of children and families, including for looked after children.

54. Health visitors are expected to be aware of children with an early help assessment, child in need, child protection or Looked After Child plan and as a key part of the Best Start team work with other services, providing assessments and reports as required. All looked after children under 5 years have a health visitor who leads the delivery of the healthy child programme.

55. Health vistors work with other agencies as part of a multi-agency intensive care package for children and families requiring intensive support, including for children who are looked after.

56. The school nursing service (commissioned by Croydon Council from Croydon Health Services) identify children with additional health needs including looked after children and work with the designated school safeguarding lead and local authority services to support those children. Where appropriate and the child or young person is known to the nurse, members of the school nursing team may looked after children reviews when they are the most appropriate health representative and there is a specific outcome to contribute towards.

57. The Children's therapy services (commissioned by Croydon Clinical Commissioning Group and Croydon Council from Croydon Health Services) share electronic medical records for looked after children with the LAC Named Nurse, health visiting and school nursing teams, community and acute paediatricians and any other professional working for CHS. While the therapy services accept referrals according to the referral criteria, children are seen for assessment in a variety of locations.

**Contribution of the Virtual School to improving health outcomes**
*David Butler (Lead for Virtual School, Croydon Council)*

58. The statutory guidance on the health of looked after children requires the following "Given the interrelationship between health and education outcomes, social workers should ensure that the authority's VSH and the designated teacher for looked-after children are aware of information about the child's physical, emotional or mental health that may have an impact on his or her learning and educational progress". *Promoting the Health and Wellbeing of Looked After Children - Statutory guidance for local authorities, clinical commissioning groups and NHS England (DfE, DH, March 2015).*

59. Where there are health conditions which impact on education attendance and/or achievement, the Virtual School will consider this in the 6 monthly review of the child's personal education plan (PEP) and the social worker may be actioned to triangulate information with the LAC health service. Going forward, the Virtual School lead will ensure that where health conditions have impacted on educational progress, there is consideration at the PEP review of how the pupil premium funding (currently £1900 per annum which schools receive for each LAC) can be used to mitigate the impact, for example by funding one to one tuition.

**Arrangements for children leaving Croydon's care in relation to health**
*Wendy Tomlinson (Head of looked after children service, Croydon Council)*
*John Martin (Delivery manager, leaving care service, Croydon council)*

60. The local authority's Leaving Care Service refers young people to GPs, Adult Mental Health and Vulnerable Adults Team, when there are concerns regarding a care leaver's health or emotional well being.

61. All care leavers are:
    a) informed about the services available from Off the Record/Compass, Mind and the Local Helplines for counselling.
    b) advised about the importance of registering with a local GP, dentist and optician and to have check-ups when needed.
    c) advised about the importance of contraceptive measures and information given on local GUM clinics.

62. The young people's pathway plans have the above information and also includes information about advice provided to care leavers to address other issues like smoking, alcohol and drug issues.

**Conclusions for part one**

63. Efforts should continue to improve the timeliness of LAC health assessments through implementing the project developments.

64. The focus in the remainder of 2016-17 should also be on improving percentage of children with update to date dental checks and with completed Strengths and Difficulties questionnaires.

## Part 2: Assessment of the health needs of Croydon's Looked After Children

65. This part reports:
    - the findings from an audit of initial and review health assessments;
    - the findings from analysis of referrals to LAC CAMHS; and
    - analysis of information about LAC with SEN and Disability
    - conclusions from needs assessment

**Findings from audit of initial and review health assessments**
*Sandra Richards (Designated Nurse for looked after children)*
*Dr Ian Johnston (Designated Doctor for looked after children, interim)*

66. Looked After Children (LAC), both local and Unaccompanied Asylum Seeking Children (UASC), share many of the same health risks and problems of their peers, but often to a greater degree. There is extensive research that highlights the vulnerability of Looked after Children related to their physical and emotional health and well-being. A 2002 survey carried out by the Office for National Statistics on behalf of the Department of Health found that allmost half of children placed in care have a mental health issue and two thirds are assessed as having special educational needs. They can have greater challenges arising from disruption and discord within their family of origin, suffer frequent changes of home or school, and lack of access to the support and advice of trusted adults. The importance of the physical and emotional health of children and young people in care cannot be overstated. Many children in care are likely to have had their health needs neglected and, unlike their peers, have not been given the best start in life. Delays in identifying and meeting their emotional and physical health needs can have consequences in all aspects of these children's lives, reducing their educational potential and impacting on their life chances (*The mental health of young people looked after by local authorities in England – Meltzer, H; Gatward, R: Corbin, T.; Goodman, R. and Ford, T* and *Missed opportunities: indicators of neglect – what is ignored, why and what can be done? (2014) Child Wellbeing Research Centre.*

67. The health needs of children and young people in care are very varied. A 2014 study[1] using Department of Health databases found that the prevalence of epilepsy, cystic fibrosis and cerebral palsy, for example, were 4.1, 4.2 and 7.2 times more common among children who were looked after. There is a significant level of unmet need, with health professionals often failing to identify illnesses[2] in looked after children..

*Croydon's looked after children*

68. To look at the levels of physical and emotional health need in the Local LAC and UASC LAC population the Designated Doctor for Looked After Children took a sample of children and young people who had recently presented for their initial or review health assessments. The population included 85 subjects which approximated to 10% of the total local LAC and UASC LAC population. For analysis, the children were categorised by age (0 – 11 years old; over 11 years old) and status (Local LAC or UASC LAC) as shown in table 3.

Table 3: numbers and percentages of Croydon LAC sub groups in the sample used

| | Number | %age |
|---|---|---|
| **Local LAC 0 - 11yo** | 25 | 29% |
| **Local LAC >11yo** | 18 | 21% |
| **UASC LAC** | 42 | 49% |

69. The rates of emotional and physical health needs within the groups are shown in table 4.

Table 4: prevalence of emotional health needs and physical health needs among sample sub groups

| | Emotional health need (n) | Physical health need (n) |
|---|---|---|
| **Local LAC 0 - 11yo** | 10 | 13 |
| **Local LAC >11yo** | 11 | 9 |
| **UASC LAC** | 13 | 29 |
| **total** | 34 (40% of sample) | 51 (60% of sample) |

*Physical health needs*

70. The identified health needs varied considerably among the different age groups and categories. Within the local LAC group, younger children had a higher prevalence of physical disability, developmental delay and poor weight gain. A small number of young children had complex developmental and physical needs including one 4 year old girl who was on home ventilation and a child who had a chromosomal disorder and developmental delay. One child had epilepsy and learning disability. In mid childhood (5 – 10 year olds) the identified needs were relatively minor with skin rashes, dental and visual needs predominating. Older children and young people who were looked after had concerns around weight and diet, sexual health, smoking and substance misuse, bed wetting and, menstrual problems in young women. One young woman was pregnant and had been using alcohol throughout her pregnancy.

71. The highest level of identified physical health need was seen in the UASC LAC population where 29 (69%) had a medical concern. These varied from concerns of a health promotion and illness prevention (smoking and sexual health) nature to dental needs (four required orthodontic procedures), rashes, headaches and weight gain or drop. There were six young people in the UASC LAC group who had a Body Mass Index at or below the 0.4$^{th}$ centile demonstrating they were significantly under weight.

72. All the age and status categories included children and young people whose immunisations were incomplete and those in the UASC group who needed BCG. Figures for BCG requirement were incomplete.

73. Consistent with published research, there were higher than population average numbers of children and young people with neurodevelopmental conditions in the sample. The sample included three young people with autism spectrum disorders, two with attention deficit and hyperactivity disorder (ADHD), a child identified as having epilepsy and learning disability, a profoundly disabled child who has a spinal cord lesion at cervical level requiring ventilation and a child diagnosed with a chromosomal disorder and learning disability. The health assessment forms analysed did not record whether a child or young person has special educational

needs. However, there is a much higher prevalence of neurodevelopmental conditions, at 10%, within the study population. For comparison, the typical population prevalence of neurodevelopmental conditions is approximately 3%.

74. It is proper to ask whether the initial health assessment (which is carried out by a doctor) picks up all important physical health needs. Unfortunately the methodology of the sampling does not allow a direct answer to this question. To comment further these children would need to be followed over their time in foster care. This current analysis is a cross-sectional, observational study that looks at one point in time. Following a child over time would help to identify missed diagnoses.

*Emotional health needs*

75. Children entering the care system have often had extremely turbulent lives from an emotional point of view, where their personal development may have been severely disrupted, and their capacity to trust in other people (adults and children) severely compromised.[3] Young people in care have a five-fold risk of self-harm, increased risk of suicide in adolescence, engage in high risk behaviours (substance and alcohol misuse, sexual risk taking) and run the risk of ending up exploitative relationships[4]. It is estimated that nationally one in five 0-16 years old have a mental health problem, with boys being more at risk than girls. Guidance for the Strengths and Difficulties Questionnaire reports that children of refugees and asylum seekers have been shown to have consistently higher levels of mental ill health, including post-traumatic stress, anxiety and depression. In addition that foster carers frequently report that there are problems associated with emotional wellbeing.

76. There was considerable variation in the presentation of emotional and mental health needs in the study population where an emotional health need was identified in 34 children (40%). The group with the highest rate of emotional health need was the 5 -10 year old local LAC population where 80% of the study group were identified with concerns. Self-harming, binging and restricting diets, sleep difficulties, anger outbursts at school and at home predominate. Children were described as “looking sad” and “withdrawn” or “lacking confidence and self esteem”. Two of the boys had been through school exclusions. Two children had a diagnosis of autism spectrum disorder already established coming into care; the diagnosis was suspected in another who was awaiting assessment. Two children had a diagnosis of ADHD.

77. The older local LAC group (aged over 11 years old) had a similar profile where 60% had an identified emotional or mental health need. Self-harming, anger outbursts, depression, withdrawal, poor socialising and pushing boundaries all featured. A 12 year old boy with mood swings and mutism was undergoing assessment. Two of this group were receiving support for bereavement.

78. The UASC LAC group had their own particular emotional needs. There was a relatively low pick up rate of 13 out of 42 (31%) of the UASC group having identified emotional or mental health needs. A small number spoke of anxiety at living apart from their family of origin and not knowing about the welfare of their family. Themes of trauma were evident in a small subgroup, three of whom were on treatment for depression and complained of poor quality sleep, fears and

worries. One traumatised young man had witnessed his mother and sister being lost at sea. Most, although not all, of the young people from the UASC LAC group whose difficulties were identified were either referred to their GP or CAMHS for support. They were also encouraged to participate in culturally-appropriate friendship groups or were signposted to less formal supports such as *Off the Record.*

79. Again a relevant question is: does the health assessment identify children and young people who have emotional and mental health needs? The frequently quoted figure of one in five of the general child and adolescent population having mental health needs is much increased in Looked After Children where estimates of prevalence of mental health needs vary from 66% to 80%[5]. The evidence from the current analysis would suggest that the identification of emotional needs in the study population, at 40%, is low. When these needs are identified the evidence from the analysis is that the children and young people are being supported and managed well. Many of the young people in the UASC LAC groups rely on informal support networks but it would appear that those with the greatest need are being identified in the initial health assessments. Evidence from the study points to higher rates of identification of emotional need with experienced practitioners. There appears to be a poor level of identification of these needs in assessments done by sessional GPs. There were instances of GPs failing to note self-harming, bereavement and autism spectrum disorder even where this was highlighted in the social work report provided for the assessment.

*Body Mass Index (BMI) and weight concerns*

80. Prevalence rates of overweight (BMI>98$^{th}$ centile) and obesity (BMI>99.8$^{th}$ centile) in the general childhood population are starting to level out nationally with 9.9% of boys and 9.6% girls recorded as obese in reception year and 20.4% boys and 17.3% girls in year 6[6] however obesity levels continue to rise locally in Croydon in Year 6. In school reception year, national figures show that Looked after children are more likely to be overweight and obese compared with standard norms, and there are a number of children (35% of the LAC population) whose BMI increases once in care[7]. Looked after care does not protect a child from the national problem of increasing weight gain and obesity. Refugees commonly experience chronic food shortages in their country of origin that can lead to micronutrient deficiencies and malnutrition[8]. While dietary advice is routinely given to foster carers in their training, these young people may need specialist support through the Dietetic Department at CUH.

81. All the children and young people in the study group had their heights and weights taken at their health assessments but, not all had a calculation done of their BMI. A significant number of children and YP (approximately 40%) with either high or low BMI were missed because the calculation was not done at the time of assessment. The numbers of subjects with BMI above the 99.8$^{th}$ centile (obese) or below the 0.4$^{th}$ centile (underweight) are shown in table 5.

Table 5: Prevalence of obesity and under weight among sample sub groups

| | **BMI <0.4$^{th}$ centile (n)** | **BMI >99.8$^{th}$ centile (n)** |
|---|---|---|
| **LAC 0 – 11yo** | 0 | 1 (4%) |
| **LAC >11yo** | 1 (6 %) | 4 (22%) |
| **UASC** | 6 (14%) | 8 (19%) |

82. The rate of obesity in the younger children (4%) was low compared with the general childhood population. The rates of obesity in the older local LAC group aged over 11 years and the UASC LAC population were more representative of the population norm. While all the children and young people were encouraged to take part in active pastimes and exercise at the health assessment, only 5 out of 13 obese children and young people were given dietitian support. One child who had a pattern of emotional overeating was referred to CAMHS.

83. There was a very high prevalence of young people who were significantly underweight (14%) in the UASC LAC group. Only two of six of these young people had identified emotional or mental health needs. One Albanian refugee had a pattern of skipping meals and eating small portions and an asylum seeker from Afghanistan had multiple fears, poor sleep pattern and anxiety. Both were referred to CAMHS. No apparent cause was identified in the others who had a low BMI, nor was there evidence of any intervention for this.

*Smoking, drugs and alcohol*

84. Screening and assessing young people for substance misuse should be a core part of the care planning for young people in the looked after system as they are likely to have higher rates of prevalence than their peers. There is evidence that looked after young people are four times more likely than those living in private households to smoke, drink and take drugs[9]. Looked after children and young people tend to start using drugs at an earlier age, at higher levels and more regularly than their peers who are not in care, leading to concerns that their drug use may become more established and dangerous[10]. *Promoting the Health of Looked After Children*[11]urges that all young people have substance misuse covered as a key area in their health assessment and all who are identified as having a difficulty with substance or alcohol use, or who may be at risk of developing addictions, should have access to support.

85. In Croydon, looked after children presenting for health assessments are routinely asked about smoking, use of substances and alcohol. The numbers admitting to smoking or substance misuse are given in table 6.

Table 6 Prevalence of smoking among sample sub groups

| | **Local LAC >11yo (n=18)** | **UASC LAC (n=42)** |
|---|---|---|
| **Smoking** | 1 | 2 |
| **Smoking + cannabis** | 0 | 2 |

86. These figures are low and it is impossible to know whether some young people deliberately withheld a disclosure of cigarette and substance misuse. There are difficulties in capturing this type of data in young people. All these young people were offered smoking cessation support.

87. Data on alcohol use is very scarce overall. Of the 60 young people >11yo who would be in the high risk group only 2 admitted to use of alcohol. One of these was a 15yo young woman who was pregnant. This prevalence rate in all certainty does not reflect the use of alcohol in this group of young people. Again, capturing data of this nature is very dependent on the way the question is framed. Asking a categorical question, “Do you drink alcohol?” is easily met with a denial. A more subtle approach[12], “How often do you have a drink containing alcohol?” gives more

useful information. If we don't identify which young people are at risk we are not in a position to help them.

*Sexual Health and Teenage pregnancy*

88. Sexual health is an important concern for looked after young people because of risks of early sexual activity, sexual exploitation and early parenthood. A follow-up study from Sweden looking at teenagers placed in public care found that every third girl placed in a secure residential unit and every fourth girl placed in other residential homes because of behavioural problems became mothers as teenagers[13]. Looked-after teenage girls are 2.5 times more likely to become pregnant than other teenagers[14]. Teenage pregnancy disproportionately affects those who are already disadvantaged and this further increases the likelihood of future social exclusion. The principal risk factors associated with teenage pregnancy, such as socio-economic deprivation; limited involvement in education; low educational attainment; limited access to consistent, positive adult support; being a child of a teenage mother; low self esteem; and experience of sexual abuse, are found more often in the looked after population than among children and young people who are not in care[15]. However, it is not clear what interventions reduce risk-taking behaviours in looked-after young people, particularly early sexual activity, sexual exploitation, smoking, and alcohol and drug use[16].

89. As part of the health promotion aspect of the Croydon LAC health assessment all young people are asked whether they are sexually active. Enquiry is made about sexual risk taking behaviours and, depending on the need, they are given health promotion advice or signposted to specialist services.

90. Of the 60 young people (Local LAC >11yo and UASC LAC) in the sample, 10 (8 male; 2 female) were identified as being sexually active. Three males were identified as engaging in sexual risk taking, all of whom were given advice about condom use. One was offered testing for Chlamydia. Of the two young women, one was using the oral contraceptive pill, the other, a 15 year old, had possibly been sexually exploited and was pregnant. This young woman had a background of self-harming and was drinking alcohol regularly.

91. Again, it is hard to know whether all the data had been captured in relation to sexual activity in the sample population.

*Summary of findings from audit of health assessments*

92. There are high numbers of local Looked After and Unaccompanied Asylum Seeking children and young people in Croydon who have high rates of physical and emotional health needs. The evidence from the study sample is that the physical health needs of these children and young people are being identified and managed. Children and young people are accessing dental care and visiting opticians. There are prevalence rates well above the general population level of children with complex neurodevelopmental conditions in the Looked After population, especially in children under five years of age.

93. The emotional needs of Looked After children and young adults are being identified and for the most part managed appropriately either at general practice or CAMHS level. However findings suggest that only about half of the emotional and

mental health needs of the UASC population are known about or provided for.

94. There is evidence that while practitioners are weighing and measuring all children and young people, they are omitting to calculate a BMI and fail to identify over- and underweight children and young people. There was a surprisingly high number of underweight UAS LAC who were not identified or provided with support.

95. Practitioners are asking about risk-taking behaviours but there appears to be a low general prevalence of these behaviours. It is not possible to say why this is the case. This is a difficult area made all the more so by the relative lack of evidence about what works in intervention.

96. Information on impact of health needs on education and special educational needs is frequently missing from health assessments.

**Findings from analysis of referrals to Looked After Children CAMHS**

*Clare Brutton (Lead Commissioner, on behalf of Croydon Clinical Commissioning Group and Croydon Council)*
*Katherine Devlin (Croydon LAC CAMHS, SLAM)*

97. As described in part one of this report, the numbers of appointments offered by the Croydon LAC CAMHS service increased from 711 in 2014-15 to 812 in 2015-16.

98. Of the 91 referrals made to the service in 2015-16, 66 were accepted (3 out of 4) were accepted. For the same period in the previous year 64 were accepted and 25 declined.

99. Reasons for declining referrals are shown in table 7.

Table 7. Reasons for Croydon LAC CAMHS service declining referrals

| Reason for Decline | 2014-2015 | 2015-2016 |
|---|---|---|
| Not LAC | 2 | 5 |
| Transfer- out of borough | 2 | 5 |
| Transfer- internal | 1 | 5 |
| No contact | 1 | 1 |
| Age | 1 | 2 |
| Redirected to more appropriate service | 12 | 7 |
| Transfer- Tier 4 | 7 | 0 |
| No Social Service Response | 5 | 0 |
| Decline engagement | 2 | 0 |

100. The five out of borough transfers involve referrals to the service for looked after children from local authorities outside of the SLAM boroughs.

101. The five internal transfers involve two Croydon looked after children who were living in foster placement within another SLAM borough and either the young person or their carers requested a transfer to the local services due to difficulties attending appointments in Croydon. Three young people were looked after children

to other SLAM local authorities and their care was transferred to their home borough.

102. Of the two young people who were declined due to age, one was over 18 years of age and already accessing the adult community mental health team. The other young person was due to turn 18 at the point of referral and the CAMHS team attended a network meeting with professionals to offer advice and support to make an appropriate referral.

103. Of the seven young people redirected to more appropriate services, one was not LAC and referred to early help, two declined CAMHS involvement and social care consultation was offered, three were referred to Compass and one was declined at the social workers request due to them accessing play therapy through a private provision at school.

104. The reduction of referrals to Tier 4 services at the point of initial referral may in part be due to the team now offering in house ADOS assessments for Autism Spectrum Disorders

105. Figure 2 below shows the reasons for referrals in this time period and table 8 compares reasons for referrals between 2014-15 and 2015-16. Increases are most notable in post-traumatic stress syndrome (PTSD)/trauma and meeting the needs of unaccompanied asylum seeking children.

106. At the same time, there were reductions in numbers of LAC referred for behavioural disorders, emotional instability and placement instability.

Figure 2. Reasons for referrals to Croydon LAC CAMHS service 2015-16

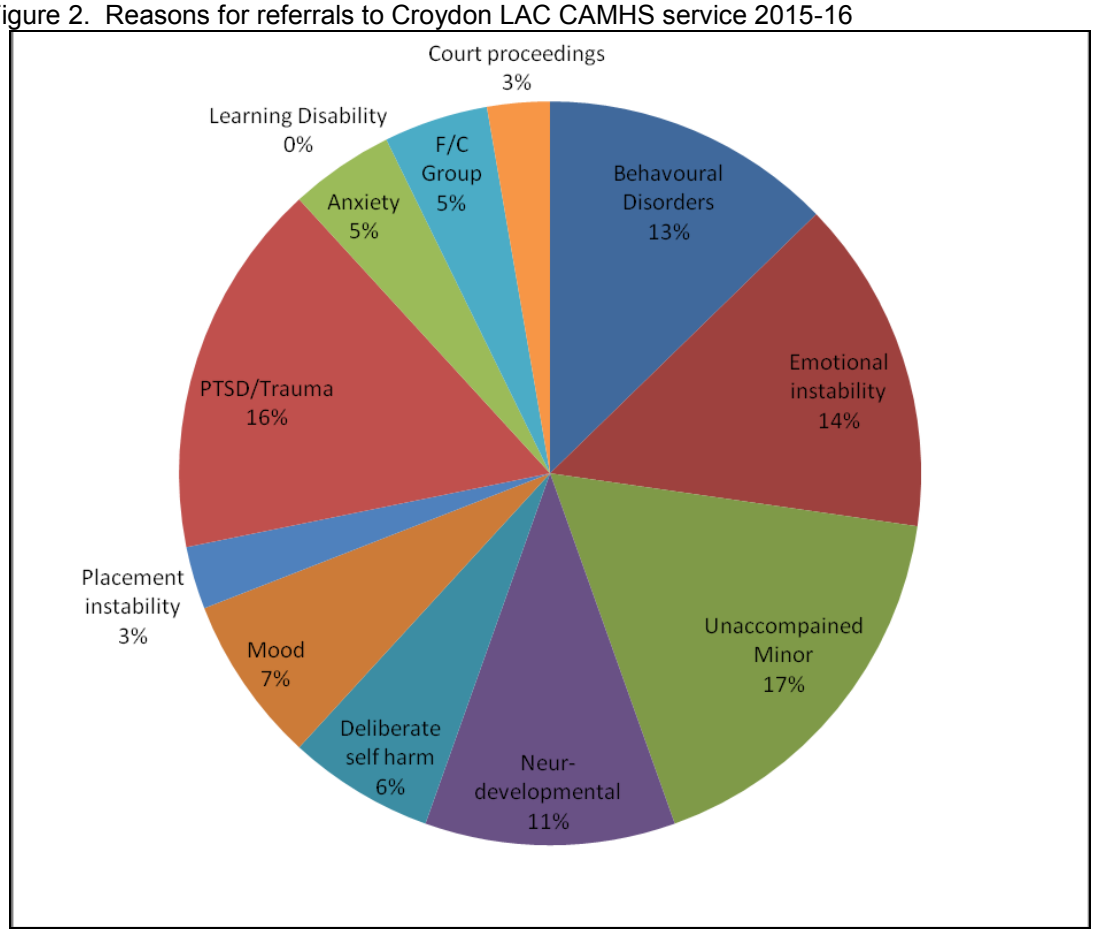


Table 8. Comparison of reasons for referrals to Croydon LAC CAMHS between 2014-15 and 2015-16

| | 2014-2015 | 2015-2016 |
|---|---|---|
| **Behavioural Disorders** | 21 | 14 |
| **Emotional instability** | 20 | 16 |
| **Unaccompanied Minor** | 14 | 19 |
| **Neuro-developmental** | 13 | 12 |
| **Deliberate self-harm** | 8 | 7 |
| **Mood** | 7 | 8 |
| **Placement instability** | 7 | 3 |
| **PTSD/Trauma** | 6 | 18 |
| **Anxiety** | 5 | 5 |
| **Learning Disability** | 4 | 0 |
| **F/C Group** | 5 | 5 |
| **Court proceedings** | 0 | 3 |

107. The case studies below demonstrate the range and effectiveness of the therapeutic approaches offered within the team. Treatment is informed by close work with the young person's network and includes individual therapy, consultation to social workers providing life story work, behavioural work and family therapy.

108. **Case study 1**: J is a 15 year old young person who has been known to mental health services on and off for approximately 7 years and has a number of mental health diagnoses including ADHD and emerging emotionally unstable personality disorder. She is known to have experienced severe intrafamilial abuse. Following an increase of deliberate self-harm J was referred to the National and Specialist Dialectical Behaviour Therapy (DBT) Team at the Maudsley hospital, however following assessment it was felt that J would struggle to access the group element of this service due to her level of vulnerability. J was offered individual DBT-informed therapy at Croydon LAC CAMHS with a DBT trained therapist which successfully allowed her to access this therapeutic modality on a 1:1 basis in spite of previous difficulties engaging J. She and her foster carer and social worker all reported a decrease in deliberate self harm behaviour and increased understanding and vocabulary in emotional regulation.

109. **Case study 2**: Ten sessions of individual Cognitive Behavioural Therapy (CBT) focusing on low mood and increasing self-esteem were provided to a 16 year old female unaccompanied asylum seeking minor, with an extensive sexual and emotional abuse history. She was also experiencing bullying and social isolation at school, increasing her low mood. A school meeting with the network was conducted to address the bullying, leading to the bullying ending and her establishing her own supportive friendship group. CBT sessions conducted through an interpreter supported her to establish a self-care orientated daily routine, to engage in valued activities, to develop skills in assertiveness and positive goals for her future leading to a significant increase in her mood and self-esteem.

110. **Case study 3**: 5 and 8 year old brothers undergoing lengthy care proceedings who were demonstrating multiple emotional and behavioural difficulties were referred to prevent school and foster care placement breakdown. Multiple network meetings were held over 6 months to support the network to understand the children's behaviours within their uncertain context. A comprehensive psychological assessment was completed leading to recommendations for behavioural management plans that were set up within school and foster care, leading to a significant reduction in the emotional and behavioural difficulties observed and school and foster care breakdown being avoided. Consultation was provided to the social worker to provide life story work to the children. Family therapy was provided to support the potential carers to enable them to best support the needs of the children during transition.

111. **Case study 4**: J is a 7 year old boy who has been known to CAMHS for 15 months. J is not currently diagnosed with a mental health condition but it is understood that his emotional and behavioural problems are connected to complex trauma, significant loss, and attachment difficulties. J is cared for under a care order and is resides with foster carers. Due to increased behavioural difficulties within his placement and school setting we worked closely with school, carrying out a school observation , set up a behavioural management plan and worked with him on a fortnightly basis offering narrative/life story work alongside his social worker. Life story work is very challenging for him, therefore the focus of the work has recently changed to emotional literacy and regulation work. J has also been referred to tier 4 CAMHS service for specialist assessment by the conduct adoption and fostering team. Our work in relation to J has been conducted jointly with the professional network – foster carers, school, virtual school, social worker, supervising social worker and when needed the birth family.

**Case studies – looked after children receiving services from Compass/Off the Record (voluntary sector organisation)**

112. **Case Study 5:** E. is an age disputed young asylum seeker originally from Afghanistan. His claimed age is 15 but he has been age assessed as 18 and been placed in independent accommodation. He was referred to Compass by his Personal Advisor and by the Refugee Council due to concerns regarding his ability to self-care, low mood and suicidal ideation. E. was offered an initial session which he did not attend. Discussing his non-attendance with the referrers it was identified that E. struggled with attending appointments due to his poor organisation skills and that he needed to be supported to access the counselling service. In partnership with other voluntary organisations, a caseworker has been allocated to his case who supports E. to attend the counselling sessions as well as other appointments. The sessions have been used as a psychoeducation space that focus on enhancing E.'s coping strategies and emotional self-care skills. The Compass counsellor also works closely with his PA to discuss E's needs and concerns regarding his mental health. In the outcome tools, E has displayed an increase on his resilience and decrease of suicidal thoughts.

113. **Case Study 6:** B. is a 15 year old young asylum seeker originally from Albania. He was sent to the UK by his mother following his father disowning him for being gay. B. was referred to Compass by his foster carer due to concerns regarding to his low mood and sleep difficulties. B. engaged well with counselling and was offered ongoing weekly counselling session. B. has used the safe and confidential

space of the counselling room to speak about his experiences, pre, during and post migration. Gradually as trust between B. and his counsellor grew he was able to speak about his current somatic experiences of insomnia, nightmares, anxiety, unhappiness and hopelessness. Different coping strategies, such as breathing exercises and engagement in social activities were explored which helped B. to manage his emotions and build other positive relationships. B. is still engaged in counselling and is currently exploring his sexuality and the impact in has in his sense of self and in his plans for the future. His outcome tools have shown a considerate reduction of depression and anxiety symptoms and improvement on his overall mood.

**Looked after children with Special Educational Needs and Disabilities (SEND), complex needs and long term conditions**

*George Riley (Service manager, Children with Disabilities service, Croydon Council)*
*Deborah Johnson (SEND service lead, Croydon Council)*

114. While not all children with a disability have health issues, this section considers both LAC with a disability and location of placements and the inter-relationships between Croydon's LAC with a disability and health issues.

115. As of 1st July 2016, 38 looked after children had a registered disability. This is 9% of the local looked after population with no UASC having a recorded disability. Of the 38, 21 children had a severe disability which required specialist support from the 0-25 Special Educational Needs and Disability (SEND) Social Care Service. Five children have diagnosed profound and multiple learning disabilities (PMLD). Sixteen children have a diagnosed severe learning disability with associated challenging behaviour. The remaining looked after children with a registered disability have diagnoses which include, Attention Deficit and Hyperactivity Disorder (ADHD) and mental health issues.

116. Twenty-one (55%) of Croydon's looked after children with a disability are placed within Croydon. Fourteen of these children (36% of the total cohort of looked after children with a disability) are placed with Croydon foster carers. Of the remaining 7 children, 5 are placed with independent foster carers, and 2 in supported or independent living.

117. Six (15%) of looked after children with a disability are placed within other London boroughs. Three are placed with Croydon registered foster carers, one with a member of their Family or Friend, one with an independent foster carer and one in independent living.

118. Seven children (18%) are placed in the areas outside but close to London. Five are inspecialist residential school placements, one with an independent foster carer and one with a Croydon registered foster carer

119. Four children with a disability (10%) are placed at a distance from London: one in a secure unit in Gloucestershire, one in specialist residential care unit in Newcastle, one in a residential school in Yorkshire and one in an independent foster placement in Devon.

120. Of the 38 looked after children with a disability, 28 have an Education, Health

and Care plan (or Statement of Special Educational Needs pending transition to an EHCP), 2 have additional educational needs and 8 have no recorded additional educational needs.

121. In total, one hundred and eleven children in the Croydon LAC population (including the 28 LAC with a disability) have an Education Health and Care Plan (or Statement of Special Educational Needs pending transition to an EHCP). Eighty three children have educational and health needs identified because of emotional, social, behavioural or mental health difficulties.

## Conclusions to part two

122. There are low levels of identification of emotional needs. At best, approximately half of the emotional and mental health morbidity is being identified. Evidence would point to experienced practitioners doing a better job at identifying these and so leading to appropriate management. There is a need for the Designated professionals to address this issue in practitioner training.

123. Physical health needs are being adequately identified. However, the health and developmental needs of these children, especially the under-fives age group, are complex and further underlines the need for experienced or dedicated practitioners to do these assessments which health commissioners should consider in any future commissioning strategy.

124. Unaccompanied asylum seeking children and young people frequently will state they are homesick, lonely and suffering with a low mood and nightmares or terrors. The council should evaluate the service provision and identify better services for this group of young people.

125. Children who are significantly over and underweight are not being identified and directed to appropriate services. The high rate of low BMIs in the UASC LAC group is an unexpected finding and should alert practitioners to address unmet emotional and mental health needs. There is a need for the Designated professionals to address this issue in practitioner training including referral l to dietetics and / or CAMHS.

126. While practitioners ask about risk taking behaviours the identification of these seems to be low. There is a need for the Designated professionals to address this issue in practitioner training.

127. The Health Assessment report template/s should be revised by the LAC Health sub group of the Children and Families Partnership to improve the identification of the emotional and mental health needs of this client group, clarify risk taking behaviours and collect missing data such as Special Educational Needs status.

128. The LAC CAMHS service should continue to work with commissioners to develop a closer working relationship with other services for unaccompanied asylum-seeking children, including Off the Record/Compass, so that there are

clearer and more accessible pathways between services for displaced young people who have been affected by trauma.

129. Currently the LAC CAMHS team does not work with children who are adopted, who are on Special Guardianship Orders or who are Looked After Children from other boroughs. The team should work with commissioners on service developments that would enable it to expand its provision.

130. The numbers of children referred to the team is unlikely to reflect the very high proportion of diagnosable mental health disorders in Looked After Children. The LAC CAMHS team should collaborate with partner agencies including Children's Social Care and Off the Record/Compass in order to increase detection of mental health problems and prompt referral.

131. The Council's 0-65 disability service should strengthen the reporting of health need components of Education, Health and Care plans for looked after children to contribute to future commissioning plans.

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