Profiling the Population of Disabled Care Leavers in Northern Ireland

Berni Kelly, Theresa McShane, Paul Webb, Ciaran Hughes, Gavin Davidson & John Pinkerton

Funded by: HSC R&D Division, Public Health Agency

This report can be cited as: Kelly, B., McShane, T., Webb, P., Hughes, C., Davidson, G., & Pinkerton, J. (2016) *Profiling the population of disabled care leavers in Northern Ireland.* Belfast: Queen's University Belfast.

Contents

List of Figures

1.0 Introduction

Whilst most disabled children and young people live safely with their birth families, disabled children are still over-represented in the population of young people leaving care in NI (DHSSPSNI, 2015; Stalker & McArthur, 2010). However, very few studies have specifically examined the characteristics or experiences of disabled care leavers as they transition from care into their young adult lives. This current study seeks to address this gap in knowledge by investigating transitions and outcomes for the population of disabled care leavers across NI. There are three key stages of the study: (1) a review of policy and research literature on the needs and experiences of disabled care leavers; (2) a survey providing anonymous demographic data on the population of disabled care leavers in NI on 3o September 2013; and (3) case studies of a sample of this population involving reading case files and interviews with young people, carers, birth parents and social workers. Stage 1 of this study is complete and the accompanying reports are available (Kelly et al., 2014 a, b). The present report is based on stage two of the study, describing the aims, methodology and findings of a survey completed by social workers working with disabled care leavers in NI.

2.0 Background to the Study

Before reporting the findings of the survey, it is helpful to consider the service context for disabled care leavers in NI and the data available on the general care leaver population in NI.

2.1 Service Context for Disabled Care Leavers in NI

Health and social care services in NI are delivered though an integrated service model with a commissioning Health and Social Care Board (HSCB) and five Health and Social Care Trusts (HSCTs): Western, Northern, Southern, South-Eastern and Belfast. The geographical spread differs considerably across Trusts, with a mix of urban and rural locations.

The Children (NI) Order 1995 and associated guidance and regulations provides clear definitions of care leavers and specific groups of young people leaving care who are eligible for support. A care leaver is defined as a person who has been ‘looked after’ (in out-of-home care) for at least 13 weeks, since the age of 14, and who is in care on their 16th birthday. The status of care leavers can be further sub-divided into: eligible, relevant, former relevant and qualifying young people. An eligible young person is aged 16 or 17, has been looked after at least 13 weeks since the age of 14 and is currently looked after. A relevant young person must be aged 16 or 17, be eligible and have left care. Former relevant young people are aged 18-21 (or older if they are in further or higher education or training) and, before turning 18, were either eligible and/or relevant young people. Qualifying young people are aged under 21 (under 24 if in education or training) who ceased to be looked after in a variety of other settings, or privately fostered after the age of 16).

As young people leave care, social service support is usually transferred from Looked After Children's (LAC) teams to 16+ (or aftercare) teams. For those who are disabled, there may also be a transfer from Children with Disability (CWD) Teams to adult disability services (which are split by impairment type e.g. Community Learning Disability, Autism or Sensory Impairment teams) or from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS). As a result, disabled care leavers may experience multiple service transitions as they leave care and may have their level of impairment re-assessed to determine eligibility for adult disability or mental health services. Of course, some disabled people do not meet the criteria for child or adult disability/mental health services (for example, those not yet diagnosed or with borderline to moderate levels of impairment) and will only have access to services from 16+ teams.

When disabled young people have left care, their case will be held by their local 16+ team. However, if they successfully move on from child to adult disability or mental health services, their case with 16+ services may close (sometimes following a period of co-working and case handover). Responsibility for disabled care leavers with multiple impairments and/or mental health needs is less clear, and may depend on the main impairment type. The type of team holding a disabled care leaver's case is important because it impacts on young people’s access to a full range of services. For example, staff in 16+ teams will not have access to specialist disability or mental health services. Similarly, staff in disability or mental health teams may not have expert knowledge of issues relevant to leaving care or possible sources of support available for care leavers. Timely and robust transition planning should be undertaken to ensure young people being case managed by adult services continue to access any leaving care entitlements (e.g. assistance with education, training or accommodation).

2.2 Wider Context of the Care Leaver Population in NI

There are two sources of statistical informtation on the care leaver population in NI relevant to the time period of the study. The first is the Departmental statistical bulletin on care leavers in NI for 2013-14 (DHSSPS, 2015). This report is based on OC1 (care leavers aged 16-18) and OC3 (care leavers aged 19 who had been in care for the previous three years) data returns from Health and Social Care Trusts (HSCTs) to the Department, designed to monitor and assess outcomes for care leavers. Whilst this report provides a useful overview of the population of care leavers aged 16-19 years it excludes those in other age groups and those who had been in care for shorter periods.

The second source of data on care leavers is the HSCB’s Delegated Statutory Function (DSF) data return which is collected bi-annually. This data return includes the whole population of care leavers on a given date, including those aged 21 and over. The DSF return on the care leaver population at 30 September 2013 (HSBC, 2013) is the most relevant to the current study as the same data collection point (at 30 September 2013) was adopted for the current study to facilitate identification of young people meeting the study criteria and to allow for comparisons with the overall care leaver population.

The DSF return for that period reported a total of 1339 care leavers in NI, with 49% male and 51% female. The majority were aged 16-17 years (38%), closely followed by those aged 18-19 years (36%). There was a sharp decline in numbers of care leavers in the older age ranges with 18% aged 20 years and only 9% aged 21+ years. Overall, 11% of the care leaver population were parents and almost half of these were lone parents. In addition, 8% of the care leaver population had criminal convictions within the previous year.

The majority of care leavers were reported to be in the ‘former relevant’ category (60%), followed by those in the ‘eligible’ category (35%), with small numbers on the ‘relevant’ and ‘qualifying’ categories. Most ‘eligible’ care leavers were under a Care Order (59%) with a further 38% being voluntarily accommodated. The highest number of care leavers was in the BHSCT (28%) and the lowest was in the SHSCT (14%). Overall, 17% of care leavers did not have access to a personal adviser, 7% did not have a pathway plan and 3% did not have a completed needs assessment.

Most ‘eligible’ care leavers were in foster placement settings (34% non-relative; 21% kinship), followed by children’s residential homes (17%) and being placed at home (12%). The two main accommodation settings for other care leavers were in a tenancy arrangement (34%) or with a former foster carer (GEM) (27%) followed by living at home (16%) or with relatives/friends (9%).

Within the population of ‘eligible’ care leavers, 94% were engaged in education, training or employment, with 4% disengaged and 2% in the ‘other’ category (sick, disabled, parent/carer). These figures change for other categories of care leavers with 71% engaged in education, training or employment, with 22% disengaged and 7% in the ‘other’ category (sick, disabled, parent/carer).

Within the care leaver population, 13% were disabled, with the two main impairment types being ASD (43.6%) and intellectual disability (41.9%) (similarly, the Departmental statistics reported 12% of the cohort were disabled) (DHSSPS, 2015). By comparison, just over 6% of the young people aged 16-18 years in NI have a long-term limiting health condition/disability (DHSSPSNI, 2015:12) and only 5% of those receiving Disability Living Allowance in May 2014 were aged 16-24 years (DSD, 2014). These figures on disabled care leavers, therefore, reveal the over-representation of disabled young people in the care leaver population in NI.

The DSF report also found that 17% of the population of care leavers at 30 September 2013 had mental health needs requiring service intervention and 9% were receiving treatment for self-harm. It is not clear in the DSF report whether there is overlap between these two groups and it is also not known whether or not some of these care leavers with mental health needs also had co-existing disabilities.

3.0 Methodology

This section describes the methodological approach for the survey beginning with an outline of the study’s aims and objectives and the inclusion criteria. The data collection process is then described in detail, including data collection, management and analysis.

3.1 Aim and Objectives of Study

The overall aim of this stage of the study is to profile the population of care leavers with mental health and/or intellectual disabilities across NI. The key objectives were to:

- Examine the characteristics of the population of disabled care leavers in NI;
- Investigate their care leaving experiences and access to services; and
- Establish baseline data on this population to inform practice and further research examining adult pathways and longer-term outcomes in adult life.

3.2 Inclusion Criteria

The study was guided by the definition of disability provided by the UN Convention on the Rights of Persons with Disabilities [UNCRPD] (2006:4): “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.” This definition is in accordance with Section 75 of the Northern Ireland Act (1998) and the principles of critical disability studies by recognising both the experience of impairment and the impact of disabling barriers in society on equality of opportunity. This definition of disability is also inclusive of mental health and/or intellectual disabilities which are the focus of the study. Whilst varying definitions of mental health and/or intellectual disability exist across Trust areas and service boundaries, often linked to eligibility criteria for access to services, the study is focused on care leavers who have been assessed as having:

- An intellectual disability[1] or either awaiting or receiving disability services on the grounds of intellectual disability related needs
- A mental illness or either awaiting or receiving mental health interventions/services
- Autistic spectrum disorder (ASD) or either awaiting or receiving disability or mental health services on the grounds of autism related needs

Mental health and intellectual disability (including ASD) are included because these impairment types are most prevalent in the leaving care population, are often co-existing and relate to the remit of the study's funder (under the Bamford Review). Care leavers with mental health and/or intellectual disability who also have another impairment (e.g. physical/sensory) are included in the sample.

The study also uses the legal definition of care leaver under the Children (NI) Order 1995 and the Leaving Care Act 2002. Under this legislation, care leavers are aged 16-24 and have been in out-of-home care for a period of 13 weeks since the age of 14. 'Eligible' care leavers are aged 16-17, 'relevant' care leavers are aged 16-17 but have left care and 'former relevant' and 'qualifying' care leavers are aged 18 or over (up to age 24 if in education/training) and have left care.

The upper age limit of 25 years also allows for exploration of gradual transitions well into young adult life (Stein and Munro, 2008), acknowledges legal requirements to support care leavers over 21 if they are still engaged in education or training; and recognises that many disabled young people leave care/school at an older age (Priestley et al., 2003; Rabiee et al., 2001).

The study excludes care leavers who are only been looked after due to short breaks usage. This group of care leavers are excluded because: under current regulations

---

[1] This includes mild, moderate or severe levels of intellectual disability.

these young people do not meet the leaving care criteria; they may only be looked after for short periods of time; and they are not classified as looked after children in other UK jurisdictions (Rabiee et al., 2001). The research team consider this to be a unique group who would merit a separate study focused on their particular experiences.

3.3 The Survey Approach

A follow-up survey linked to the Health and Social Care Board's (HSCB) Corporate Parenting data return on care leavers regionally was conducted to profile the characteristics of the total population of care leavers with mental health and/or intellectual disability in NI on 30th September 2013. Prior ethical approval for the study was granted in advance by the Office of Research Ethics Committees NI (ORECNI) and the School of Sociology, Social Policy and Social Work at Queen's University Belfast. Research Governance procedures were then followed in the HSCB and in each Trust, in accordance with the Data Protection Act (1998).

Existing statistical reports, including the HSCB and DHSSPSNI annual reports, provide total numbers but do not account for duplication or allow for cross comparison across disability, needs or circumstances. This follow up survey allows for the collection of data at an individual care leaver level which facilitates disaggregation of data and further analysis.

In order to facilitate the survey, the research team worked with the senior information officer in the HSCB responsible for the DSF return to amend the disability question (and associated guidance) in their bi-annual request for information on care leavers from Trusts to:

a) Include a category for young people with autistic spectrum disorder in the list of disability types,

b) Include care leavers who have been assessed as having a disability but also those who are awaiting/receiving disability services, and

c) Include care leavers with mental health needs who are awaiting/receiving mental health services.

It should be noted that the addition of a separate category to record ASD is a positive impact of the study as it facilitates, for the first time, the identification and recording of care leavers with ASD in the statistical return. Previously, the HSCB were unsure if they had captured this population as they may or may not have been recorded in the ‘other’ or ‘learning disability’ categories. This addition of the ASD category to the DSF return on the care leaver population as a result of this study has been maintained for subsequent data returns.

With the amended disability question and associated guidance in place, the HSCB then asked each of the five Health and Social Care Trusts to hold a list of all care leavers returned under the intellectual disability, ASD and mental health questions in their statistical data return for 30th September 2013 to facilitate the survey. Trusts were asked to compile this list with social care numbers, dates of birth and the named social worker for each care leaver. This list was then checked for accuracy through consultation with Team Leaders from 16+ services who complete HSCB data returns and individual social workers who were then asked to complete a profiling online survey for care leavers on their caseloads.

3.4 Designing the Questionnaire

The online survey was facilitated by the Qualtrics software which was password protected and, once complete, downloaded directly to SPSS software, ensuring a secure and straightforward process. Although social workers were advised that the survey could be made available in hard copy, all of the social workers chose to complete the survey online. Data was held securely on a password-protected computer. Although service related numbers (e.g. health or social care numbers) and dates of birth were collected to facilitate selection of case studies for the third study stage of the project, the research team had no means of identifying young people from the information provided.

The questionnaire design ensured that it gathered comprehensive information whilst also being relatively quick and easy for social workers to complete, without the need for a lengthy period of time to seek additional information or consult case files. Inclusion criteria were checked in the first two sections of the survey with social workers selecting at least one criterion in relation to the young person's leaving care status and impairment type. The layout of the questionnaire was such that sections could be skipped if they were not relevant to the experience of particular children and young people (for example, siblings or short breaks). The questionnaire was piloted by two social workers and two social work managers working in 16+ services. Their feedback confirmed it took between 10-15 minutes to complete and had a user friendly format. A few suggested amendments to layout were suggested and these changes were incorporated into the final version (please see Appendix One).

3.5 Administering the Questionnaire & Response Rate

There were two key stages in the administration of the survey: accessing information on disabled care leavers included in the DSF return; and completion of the survey by individual social workers.

Accessing Trust-level data on care leavers

In order to ensure a clear process for data collection, meetings were held with relevant senior managers in each Trust to clarify the inclusion criteria for the study, and provide full information about the research and survey approach. Although the research team were supported by the HSCB to access the anonymous lists of care leavers based on the 30 September 2013 return, only two of the Trusts were easily able to track further details for young people included in the data return when requested. In other Trusts, gathering this data was an additional task as a retrievable list had not been compiled at the time of the data return. Whilst this required more time, it also offered an opportunity for all Trusts to check their data return for accuracy and identify any inaccurate or missing data. Between October-December 2013, Trusts were asked to check their return and compile lists of care leavers to facilitate the survey. Alongside this process, some Trusts were also finalising their honorary agreements for the research team to undertake the research in their area.

In January 2014, lists were finalised with the access to data commencing by February 2014 (see Table 1 for further details on access to data for each Trust).

TRUST	DATE OF ACCESS TO DATA
WHSCT	February 2014
SHSCT	March 2014
SEHSCT	May 2014
NHSCT	June 2014
BHSCT	July 2014

Table 1: Date of access to data by Trust

Once lists were received from Trusts, they were checked for duplicates and then compared with the DSF return data to identify any categories with a lower than expected return. In such cases, the research team asked the manager in the relevant Trust to check on the accuracy of the return and consult with staff regarding any missing cases. This process of checking the data and providing additional information on missing cases continued in the last Trust (BHSCT) until September 2014. At this stage, surveys were complete in most other Trusts, however, survey completion continued in the BHSCT until December 2014.

Survey Completion

In each Trust, managers informed staff about their involvement in the study and the importance of allocating time for completion of the survey. The researcher also met with teams to demonstrate the online survey and ensure all questions were clearly understood. It was agreed that social workers would be given two weeks to complete surveys unless a longer timescale was required due to leave or particular demands on the team at that time. When the agreed time scale lapsed, the researcher checked the number of returns on the online system and followed up with individual social workers on any missing surveys. Reminders were copied to team leaders and local collaborators if responses were particularly slow, with further assistance from the researcher provided if required. The vast majority of professionals who completed the survey were social workers (92.7%), with 5.1% being senior social workers and 2.2% being the young person’s personal advisor.

Response Rate

A total of 314 completed surveys for disabled care leavers were returned (134 in the disability category and 180 in the mental health category), comprising 23.4% of the total population of care leavers. By comparison, the DSF report for 30 September 2013 identified 179 care leavers in a disability category and 225 with mental health needs (n=404), comprising 30.2% of the total population of care leavers. Based on the total number of care leavers (n=1339) on 30 September 2013, figure 1 compares the percentage of care leavers in both impairment categories in the study and DSF samples. Overall, the 6.8% difference is evenly spread across both the disability and mental health categories.

However, it is important to note that the DSF return does not account for those with co-existing mental health and disability, therefore, some young people are counted twice in the DSF statistics across these categories. In addition, the DSF return includes ADHD within the ASD category (in the study survey this was an additional need) although it is not clear how this was interpreted by those completing the DSF return as the numbers remain low. Given these variations in definition across both datasets, our overall sample of 314 disabled care leavers (including those with disabilities and mental health needs) is a very sound response rate indicating that the survey was successful in capturing the population of disabled care leavers in NI.

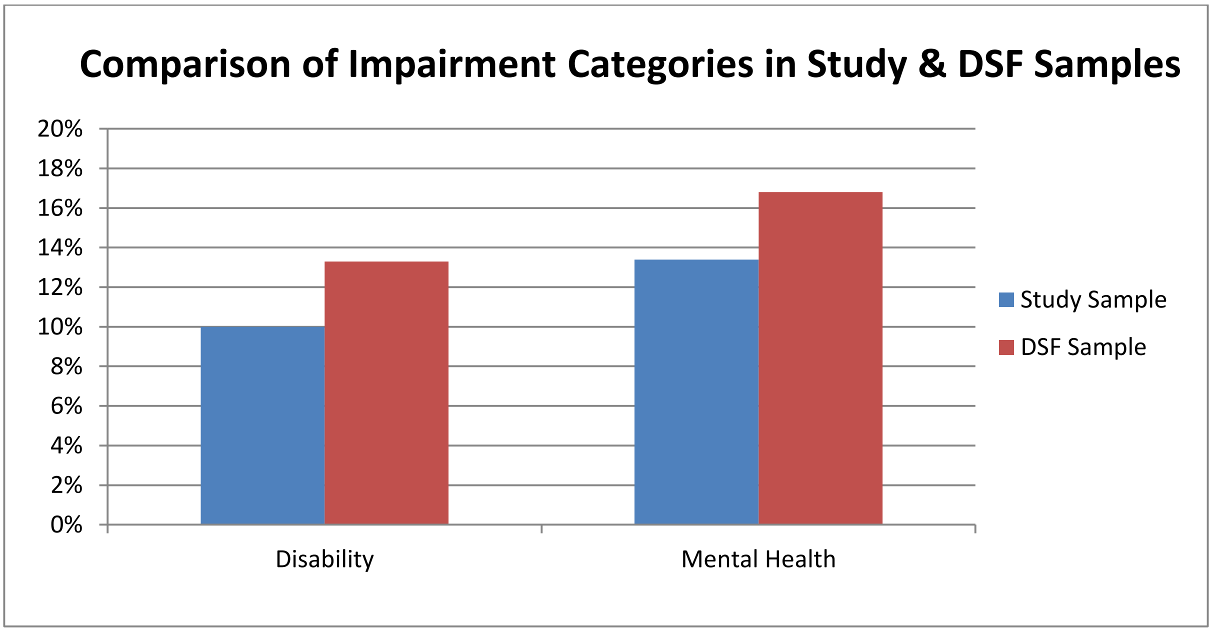

Figure 1: Percentage across impairment categories in study and DSF samples

In terms of response rate by Trust, figure two shows that just over one quarter (25.8%) were in the NHSCT, almost a fifth (19.1%) in the BHSCT, WHSCT and SHSCTs and a smaller number (16.9%) in the SHSCT. Figure 1 also shows that there were similar proportional returns across Trusts in the DSF sample, with the exception of higher numbers reported in the BHSCT (30% compared with 19% in the study sample) and lower numbers in the NHSCT (21% compared with 26% in the study sample).

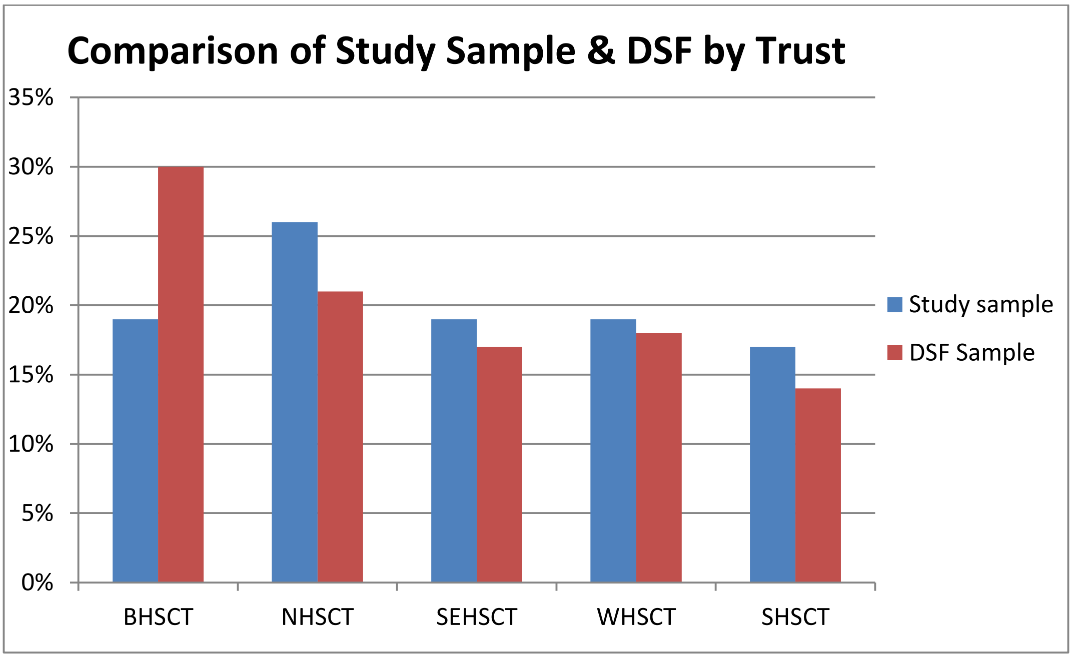

Figure 2: Returns of disabled care leavers across Trusts in study and DSF samples

Figure 3 compares the number of care leavers in disability and mental health categories across Trusts in the study and DSF samples. Similar trends can be observed across both datasets with the number of those with mental health needs exceeding those in the disability category in all but one Trust (BHSCT). Lower numbers of care leavers within the BHSCT reflect the lower rate of survey returns in that Trust, particularly for those in the mental health category. Interestingly, there are variances in the proportion of young people in both impairment categories in the NHSCT and SEHSCT. For example, although there were only four more young people in the NHSCT in the DSF return compared with the study sample, the proportions in impairment categories differed (23.5% in the disability category in study sample compared with 40% in the DSF sample). This is likely to reflect the time taken to quality check returns for the study and the high level of co-existing disability and mental health needs amongst the study population. However, the challenges for some Trusts in accessing accurate data on the population of care leavers indicates a need for a more robust method for collating and maintaining records on this population.

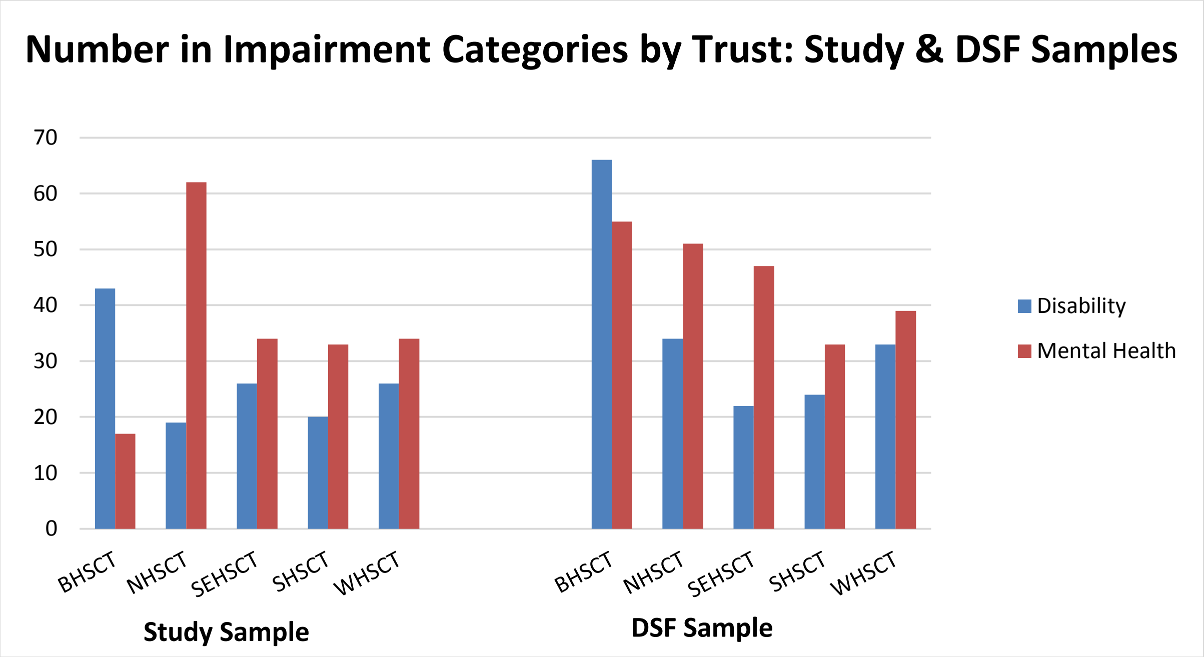

Figure 3: Number in impairment categories by Trust in study and DSF samples

3.6 Limitations

Although every effort was made to ensure completion of surveys, it is possible that some young people eligible for the study were not included in the data return from Trusts. However, the number of completed surveys indicates a strong rate of response. It is important to note, however, that the study only captures care leavers who were known to Trusts at 30 September 2013. Whilst young people whose cases had closed between 30 September 2013 and the time of survey completion are still included, those who had already ended contact with services by 30 September 2013 could not be included. These young people may be some of the most vulnerable care leavers who are hardest to reach.

3.7 Data Analysis

Before data analysis commenced, the researcher undertook a methodical process of checking for missing or contradictory data in survey returns. This involved follow up phone calls and emails to individual social workers across the region which required more time but ensured further data was captured or inaccurate responses were corrected. It was also necessary to undertake data cleansing which involved sorting labelling systems and collapsing variables, where appropriate, to facilitate data analysis. Data analysis began by running frequencies and cross-tabulations to identify findings relevant to the full range of questions. Relationships between different sub-groups of disabled care leavers were identified by conducting cross-tabulation of combinations of variables; for example, impairment and care leaver status and testing for significance and odds ratios.

4.0 The Profile of Disabled Care Leavers in NI

This section presents the profile of disabled care leavers in NI based on the findings of the survey completed by social workers, including their demographic characteristics, their family background and level of contact with birth family members and the range of impairment experience in the care leaver population in NI. The section then reports on the legal status of disabled care leavers and their access to social work, leaving care and other relevant services. Issues relating to safeguarding and risk-taking behaviours are also explored. Finally, living circumstances, income levels, engagement in education, training or employment and unmet needs are considered. Throughout the report, where relevant, the findings will be compared with population data (NISRA, 2014) and data from the DSF statistical return on all care leavers for the same period (at 30 September 2013) (HSBC, 2013).

4.1 Demographic Profile

Just over half (52.2%) of the study sample are male, with 47.8% being female. These figures are similar to census data on the gender of the population aged 16-25 years in NI, with 50.7% male and 49.3% female (NISRA, 2011). Interesingly, this is reversed in the DSF return for the overall care leaver population which reported 49% male and 51% female, although the gender divide across all three sources of data is minimal.

Figure 4 shows that, in the study population, ages range from 16 to 22 years, with a mean age of 18. Just over one fifth (21.3%) are aged 16 and almost half (47.8%) are aged 17-18 years, over one quarter (28.7%) aged 19-20 years and a very small proportion (2.2%) aged 21+ years.

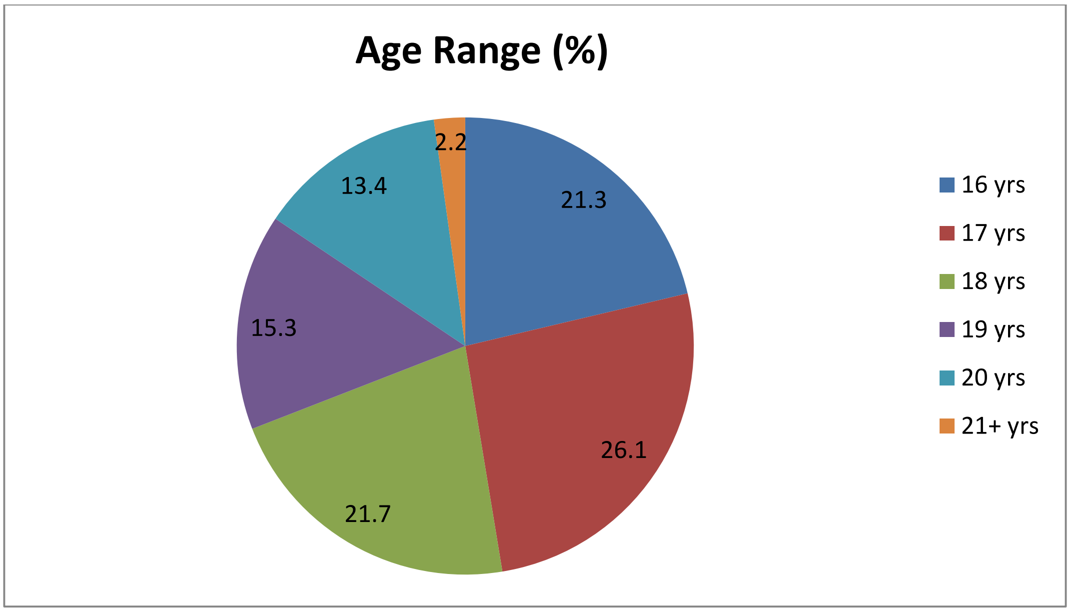

Figure 4: Age range in study sample

Figure 5 compares the age range in the study sample with that of the overall care leaver population in the DSF return, showing a small increase in numbers of those aged 16, 17 or 18 years in the study sample (an increase of 3.7%, 6.2% and 3% respectively) and a decrease in the numbers aged 19, 20 or 21+ years (a decrease of 2.2%, 4.4% and 6.3% respectively). In both datasets, the age of care leavers peaks at 17 years, however, the notable decrease in numbers of disabled care leavers in the 21+ age range indicates that some disabled care leavers may be exiting leaving care services by the age of 20. The census data on the NI population aged 16-25 years reports relatively even numbers of young people across each year age group (NISRA., 2011). The smaller numbers of those aged 21+ indicates an ongoing focus on services for care leavers aged under 21 years and a gap in provision for vulnerable care leavers over 21 who have continuing needs and require extended care leaver services.

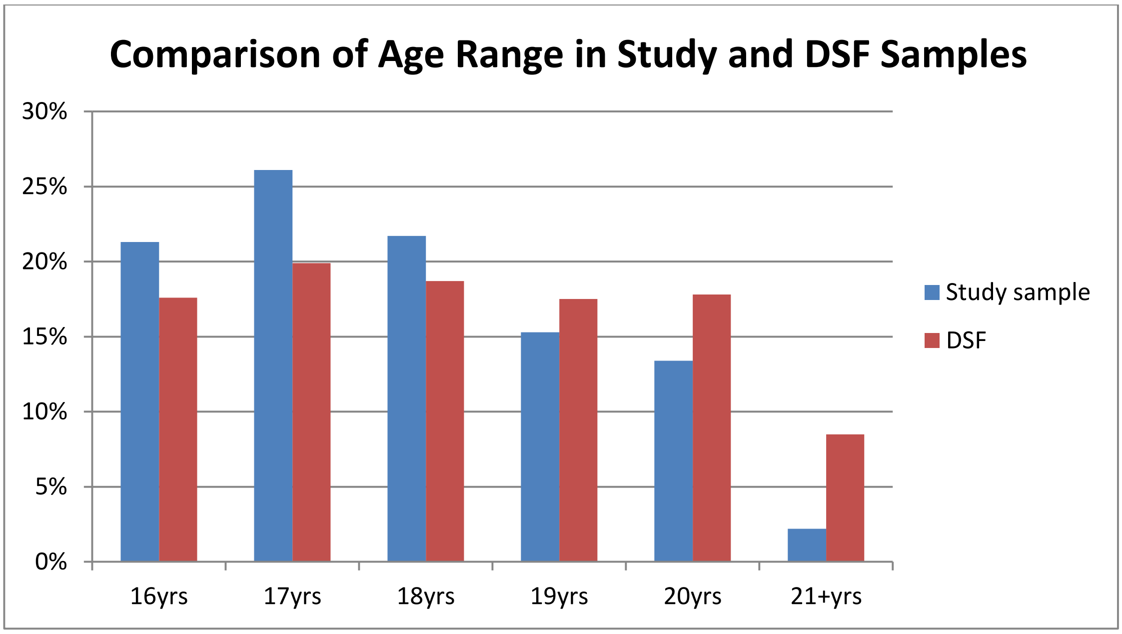

Figure 5: Comparison of age range in study and DSF samples

The majority of young people are either Protestant (47.8%) or Catholic (45.2%), and a smaller proportion having no religious faith (4.8%) (see figure 6). The small number of remaining young people had ‘other’ religious affiliations, including Muslim, Seventh Day Adventist and Jehovah Witness. Religious affiliation was unknown for two young people. Data on the religious background of care leavers is not provided in the DSF report however the Department figures report a higher number of Catholics (49%) than Protestants (41%) in the care leaver population. There are also more Catholics in the general youth population (45% compared with 38% Protestant aged 15-19yrs; 43% compared with 35% Protestant aged 20-24yrs) (NISRA, 2011), although Protestants slightly outnumber Catholics in the overall NI population of disabled people (23% compared with 20% Catholics).

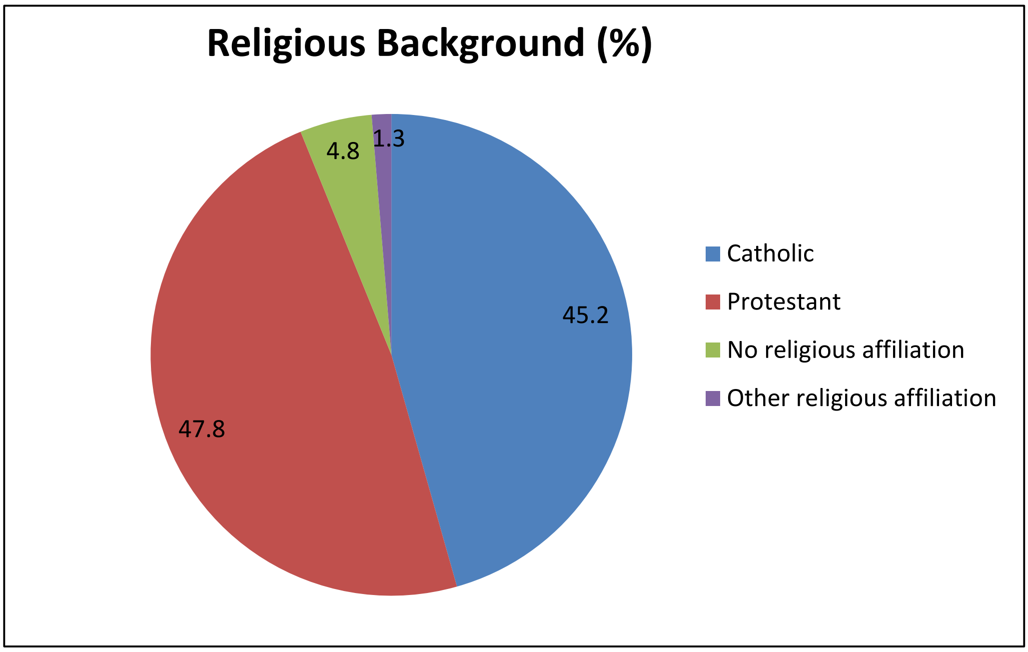

Figure 6: Religious background of young people in study sample

As there is no comparative data on religious groupings of care leavers at Trust level, figure 7 compares the two dominant religious groups within the study sample of disabled care leavers with the overall population of children still in care across the five HSCTs. There are some differences in the representation of religion in the study sample compared with the overall care population in some Trust areas (HSCB, 2013). For example, in the study sample, the number of Protestant disabled care leavers more than doubled in the BHSCT and almost doubled in the SHSCT and WHSCT.

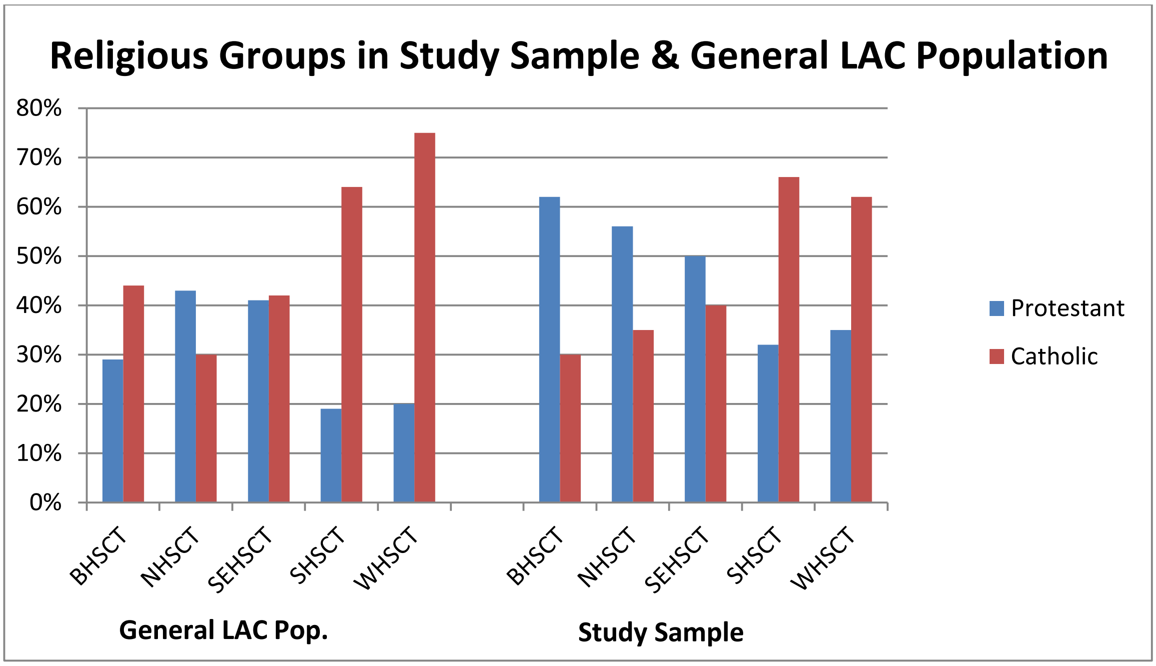

Figure 7: Comparison of dominant religious groups in study and LAC population

In relation to ethnicity, the vast majority of the study sample are white Northern Irish or white other. There are a small proportion of young people from Black (1.6%), Asian (1%) or Irish traveller community (1%) backgrounds. The majority (81.2%) of young people were born within Northern Ireland, with a smaller proportion being born in the wider UK (6.3%) or Southern Ireland (3.5%). The majority have parents who were born within NI (68.2% of mothers and 62.1% of fathers). Data on birthplace is not known for 7% of young people, 18.2% of mothers and 27.7% of fathers.

Only 12.1% (n=38) of the study population are parents (similar to the prevalence of parenting in the wider leaving care population, 11%), while 5.1% (n=16) were pregnant at the time of data collection. The vast majority (81.6%) of parents have one child, six parents have two children and one has three. The majority (63.2%) of those who are parents are female and 40.7% of those who are parents/pregnant are under the age of 18 (at the time of the survey). Less than half (47.4%) of parents are living with their children.

Summary

The age of disabled care leavers peaks at 17 years, however, there is a notable decrease in numbers in the older age ranges indicating that some disabled care leavers may be exiting leaving care services by the age of 20. There are similar rates of parenting compared to the wider leaving care population with less than half of those who are parents living with their children.

At Trust level, there are some variations in the prevalence of the two dominant religious groups in NI within the study sample. For example, there are more Protestant disabled care leavers in the BHSCT and more Catholic disabled care leavers in the SHSCT. However, the study population does not differ from the wider care leaver population in terms of ethnicity, with the majority being white Northern Irish.

4.2 Range of Impairment Experience

As noted earlier in the report (see figure 1), the total number of care leavers in the study sample is 314 (23.4% of the total population of care leavers), with more than half of these in the mental health category (57.3%) and 42.7% in a disability category. Figure 8 provides a more detailed breakdown of impairment type. Those with intellectual disability (including specific diagnoses, such as Down's syndrome, and less specific diagnoses, such as global developmental delay) form the largest group within the disability category, at just over a fifth (21%) of the overall study sample. The other main impairment type within the disability category is ASD (including Asperger's syndrome), forming 12.1% of overall study sample. Smaller numbers are reported in the 'other' impairment category (which includes physical and sensory impairments), 3.8% of the overall study sample; and multiple impairment category (those with three or more impairment types), 5.7% of the overall study sample.

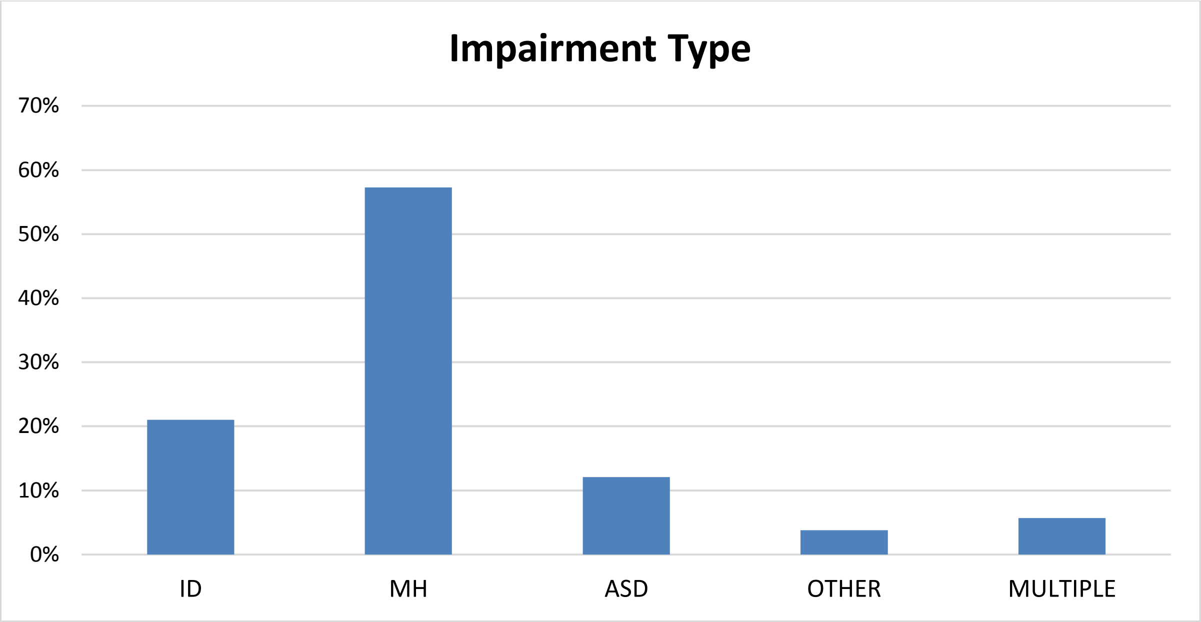

Figure 8: Impairment type in study sample

In addition to those with multiple impairments (5.7%, n=18), it is important to note that 27.3% (n=18) of those in the intellectual disability category also have a mental health need. In addition, almost two thirds of young people in the ASD category (60.5%, n=23) also have intellectual disability and/or mental health needs. Overall, almost one fifth of the study sample (18.8%, n=59) have more than one impairment type across the disability and mental health categories. As the DSF return does not allow for the identification of co-existing mental health and disability, these findings are particularly important as they highlight the previously unknown complexity of need amongst the group of disabled care leavers.

Figure 9 compares impairment types in the study sample with the DSF return data, showing similar trends in prevalence overall. There are fewer numbers in the ASD and other impairment categories in the study sample, however, this is likely to be due to variance in definitions across the datasets with the DSF including ADD/ADHD in their definition of ASD and not recording multiple impairments.

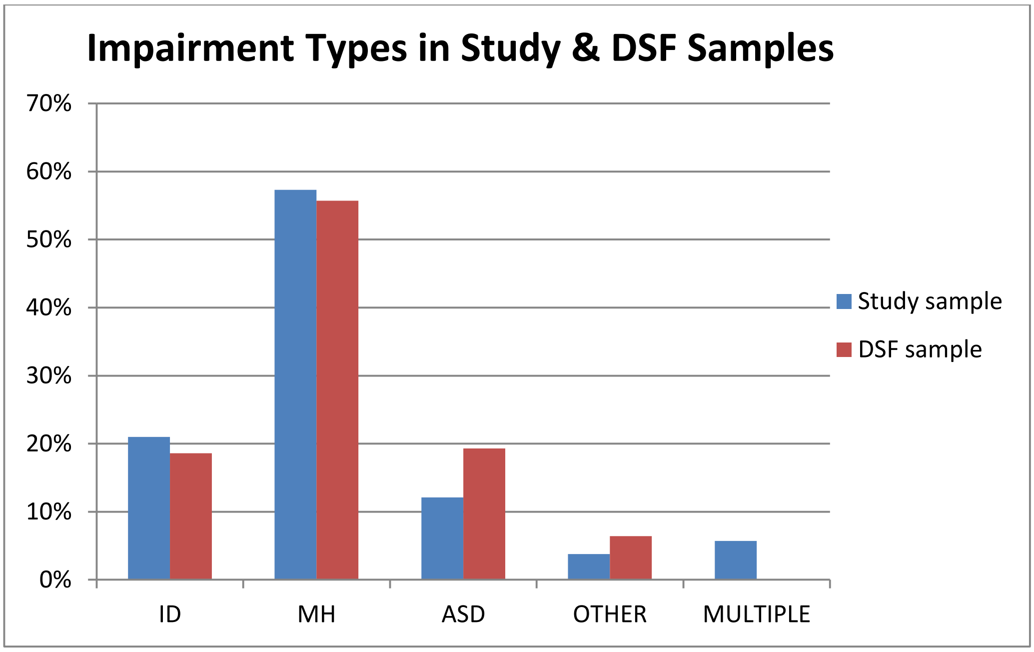

Figure 9: Types of impairment across study and DSF samples

Figure 10 shows that there are more females in the mental health (55%) and 'other' impairment categories (58.3%). In contrast, the large majority of those with ASD are male (86.8%) and there are also more males with multiple impairments (55.6%) and intellectual disability (53%). A Chi-Square test of independence was performed to examine the relationship between gender and impairment type. The relationship between the variables was statistically significant with a moderate effect size $\chi^2(4, N = 314) = 22.650$, $p < 0.001$, $\varphi_c = 0.27$). Females are two times more likely than males to have a mental health impairment (OR = 1.99). Similarly, males are two times more likely than females to have intellectual disability, ASD or multiple impairments (OR = 2.18). These figures reflect statistics on children in need in NI where 80% of those with autism are reported to be male, and more males are reported across all disability categories (20% of males having a disability compared with 12% of females in the children in need population) (DHSSPSNI, 2014a: 10). Similarly, Departmental figures on the prevalence of autism in school age children in 2013/14 show that autism was almost five times more prevalent in the male population than the female population (DHSSPSNI, 2014b: 6).

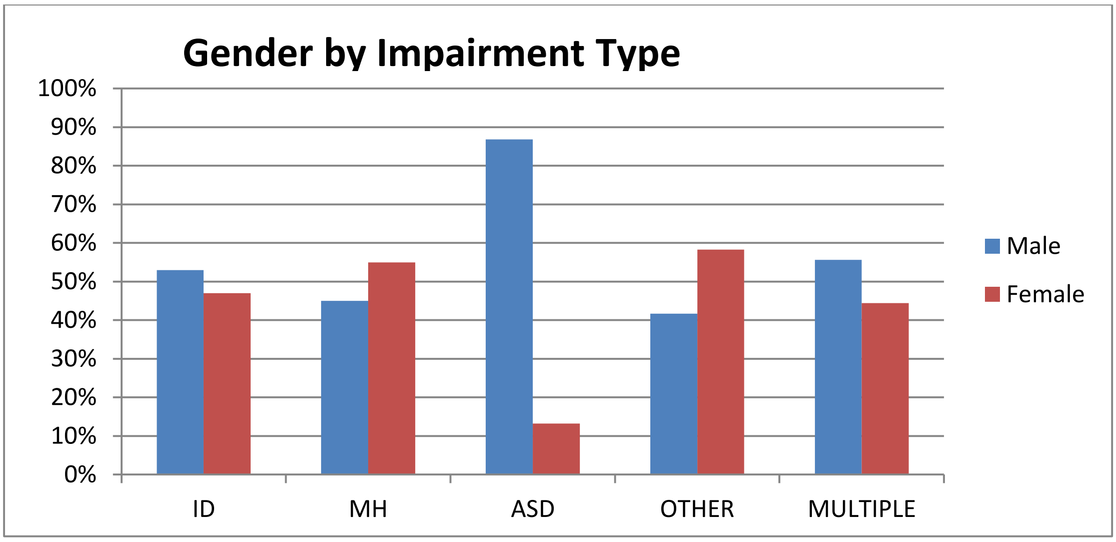

Figure 10: Gender by impairment type

Figure 11 shows that age peaks at 17 years across all impairment types, however, it is matched by those aged 16 or 18 years in multiple and other impairment categories respectively. In contrast to other impairment categories, there is a peak at age 20 for those with an intellectual disability, whilst the minority of those with ASD and none of those with multiple impairments are aged 20 years. Those aged 21+ years are not shown on the graph because of their small number. There are only five young people aged 21 years (two with mental health needs, two with multiple impairments and one with ASD) and two aged 22 years (across intellectual disability and ASD categories).

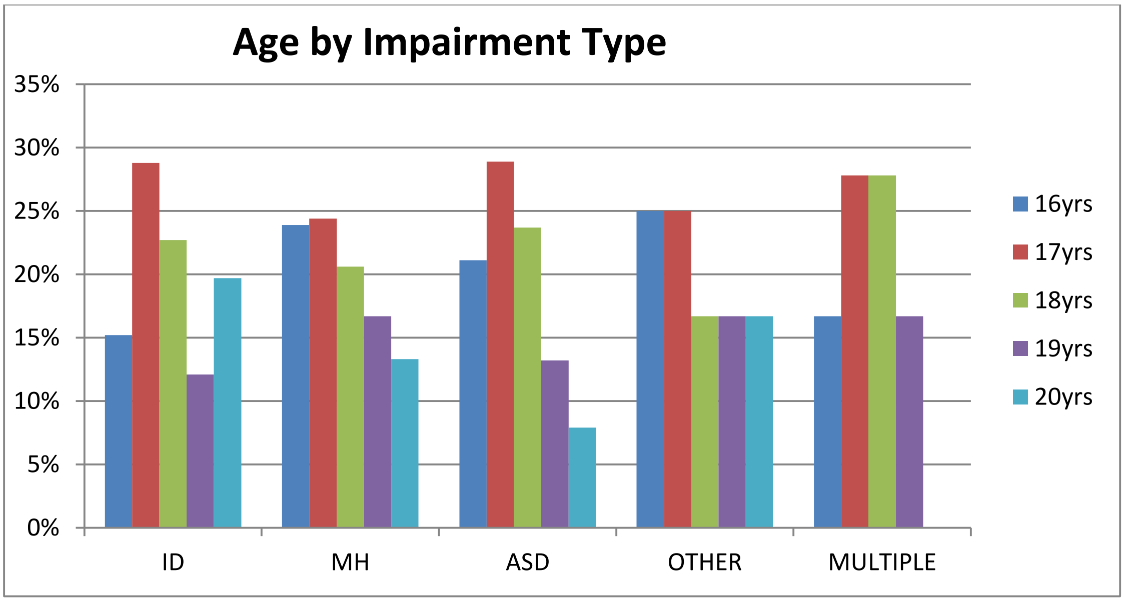

Figure 11: Age by impairment type

A comparison of impairment categories by Trust area shows that the highest number of care leavers with intellectual disabilities are in the BHSCT and the same trend prevails for those with ASD (see figure 12). The lowest number of care leavers with intellectual disabilities are in the NHSCT and the lowest number of those with ASD are in the WHSCT. The highest numbers of those with mental health needs are in the NHSCT and the same trend can be observed for those in the ‘other’ impairment category, although the total numbers in this category are small (n=12). The lowest number of care leavers with mental health needs are in the BHSCT. The highest numbers of those with multiple impairments are in the WHSCT and BHSCT, with the lowest numbers in the SEHSCT, however, these total numbers are also small (n=18).

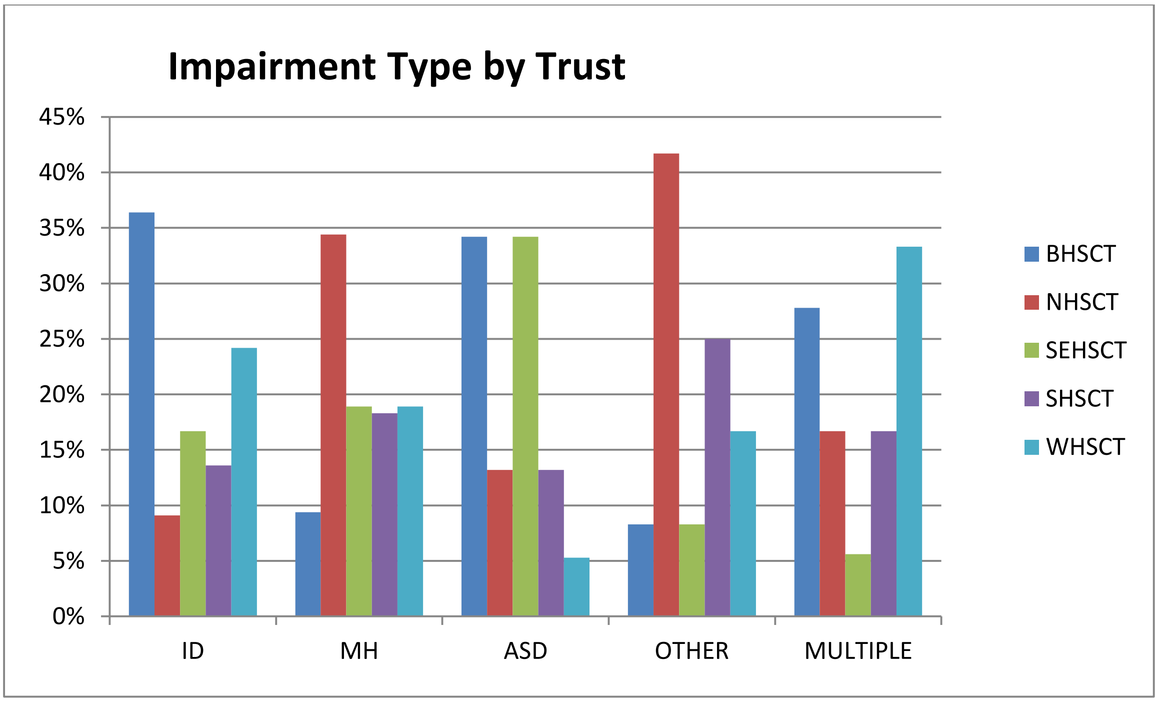

Figure 12: Trust by impairment type

A total of 180 young people are included in the survey because they have an assessed mental illness or they are receiving/awaiting mental health services (57.3% of study sample). Of these, 37.8% (n=68) have an assessed mental illness and 62.2% (n=112) are receiving or awaiting mental health services. It is notable that, of those who have been diagnosed with a mental illness (21.7%, n=68), more than a quarter (27.9%, n=19) have co-existing impairments, most commonly intellectual disability followed by ASD.

Of those with an assessed mental illness, 36.9% were assessed as having a mental illness before becoming LAC and 44.6% after becoming LAC.[2] The majority are diagnosed with depression (n=25), followed by anxiety (n=11), personality disorder (n=7), PTSD (n=5) and schizophrenia (n=4). Smaller numbers of other mental illnesses are also reported including psychosis, dissociative personality disorder, bipolar disorder and compulsive disorder.

Almost a fifth (19.5%, n=61) of care leavers in the study sample require personal care or a high level of supervision. Within impairment groups, two thirds (66.7%) of those with multiple impairments require personal care/high level supervision, almost one third of those with ASD (29.7%), a quarter of those with intellectual disability (25.8%) and 11.1% of those with mental health needs. A Chi-Square test of independence was performed to examine whether there was an association between young people requiring personal care assistance or a high level of supervision and impairment type. The relationship between the variables was statistically significant with a medium effect size χ^2 (4, N = 313) = 38.663, $p < 0.001$, $\varphi_c = 0.35$). Young people who did not require personal assistance/high level of supervision were 3 times more likely to have a mental health need than those young people who did require personal assistance (OR=3.56)

A range of other health conditions/needs are also reported for care leavers in the study sample. The three main additional needs are challenging behaviours (32.5%), anxiety (30.5%) and ADD/ADHD (17.5%). In addition, 23.6% are reported to have 'other' conditions, including foetal alcohol syndrome and rare health conditions. Smaller numbers are also reported for specific conditions such as epilepsy or asthma.

Within impairment groups, over a third of those with ASD (36.8%) and those with mental health needs (35%) are displaying challenging behaviour, closely followed by almost a third of those with an intellectual disability (30.3%). The majority are male (60.8%) and two thirds are in the lowest age ranges of 16-17 years. As expected, three quarters of those with anxiety are also in the mental health category (74.7%).

---

[2] A further 18.5% of social workers stated ‘don’t know’.

Within impairment groups, around one quarter or those with ASD (26.3%), intellectual disability (25.8%) or ‘other’ impairments (25%) are reported to have ADD/ADHD. This reduces to only 12.2% of those with mental health needs presenting with ADD/ADHD. The majority of those with ADD/ADHD are male (65.5%). In contrast, the majority of those with anxiety are female (55.8%). Half (50.9%) of those with ADD/ADHD are aged 16-17 years with the numbers steadily decreasing as young people age (38.2% aged 18-19; 10.9% aged 20). In contrast, the numbers of those with anxiety are more evenly spread across the younger age ranges (39.9% aged 16-17; and 43.1% aged 18-19) however, there is a similar decrease in the older ages with 16.8% aged 20. None of those aged 21+ are recorded under additional health needs as having ADD/ADHD, challenging behaviours or anxiety, however, there are very low numbers of young people in these age ranges (n=7) in the study sample.

Summary

Over half of the study sample are in the mental health category (57.3%); with 21.7% having an assessed mental illness (mostly depression or anxiety), and 35.6% receiving/awaiting mental health services. Just over one fifth (21%) have an intellectual disability and 12.1% have ASD. Interestingly, almost one fifth of the study sample (18.7%) have more than one impairment type across the disability and mental health categories and almost a fifth of the study sample require personal care or a high level of supervision.

The number of care leavers in the mental health category is highest in the NHSCT and lowest in the BHSCT. These trends are reversed for the disability categories with the BHSCT having the highest number of care leavers in disability categories and the NHSCT having the lowest. The lowest number of those with ASD are in the WHSCT. The highest numbers of those with multiple impairments are in the WHSCT and BHSCT, with the lowest numbers in the SEHSCT, however, these total numbers are small. These findings may indicate varying approaches to case ownership across Trusts, for example, in the NHSCT disability teams have lead responsibility for LAC services for disabled young people however, in contrast, in other Trusts LAC and 16+ teams lead on these cases. Differences in prevalence of disability and mental health may also reflect variation in definitions of mental health and disability (e.g. only those with a formal diagnosis or also including those with an assessed need) which impacts on identification and reporting of mental health and disability for care leavers across Trusts.

Males outnumber females across impairment categories including ASD, intellectual disability and multiple impairments. In contrast, there are more females in the mental health category and the 'other' impairment category.

Whilst there is a steady decline in age for those with mental health needs, ASD or multiple impairments, there is an increase in age for those with intellectual disability post-18. These findings may indicate that most young people cease use of support services as they age out of children's services, whilst those with intellectual disabilities continue to be engaged with support services.

The three main additional health needs identified are challenging behaviours, anxiety and ADD/ADHD. In addition, just over one fifth are reported to have 'other' conditions, including foetal alcohol syndrome and rare health conditions. Almost a third of young people are displaying challenging behaviour, mostly males in the lowest age ranges of 16-17 years. The majority of those with ADD/ADHD are also younger males, however, the majority of those with anxiety are female and more evenly spread across the 16-19 age ranges.

4.3 Family Background and Contact

This section of the report presents findings in relation to birth parent impairment status and level of contact between disabled care leavers and their birth families.

Almost one fifth of the study sample (17.2%) have a disabled mother and 7% a disabled father (however, impairment status was unknown for 30.6% of mothers and 50.6% of fathers). Of those young people who have a disabled parent, the most common impairment type is intellectual disability for both mothers and fathers, followed by physical impairment. In addition, the mothers of almost half (47.8%) of young people have a mental health need, and 16.9% of fathers of those with a mental health need.

The vast majority (80.6%) of young people have contact with their mother, though a smaller proportion (57.3%) have paternal contact (see figure 13). Of those with siblings, 89.4% are in contact with their siblings. Grandparents also play an important role with 70.7% in contact with a grandparent. In addition, a small proportion (5.1%) have contact with an aunt or uncle.

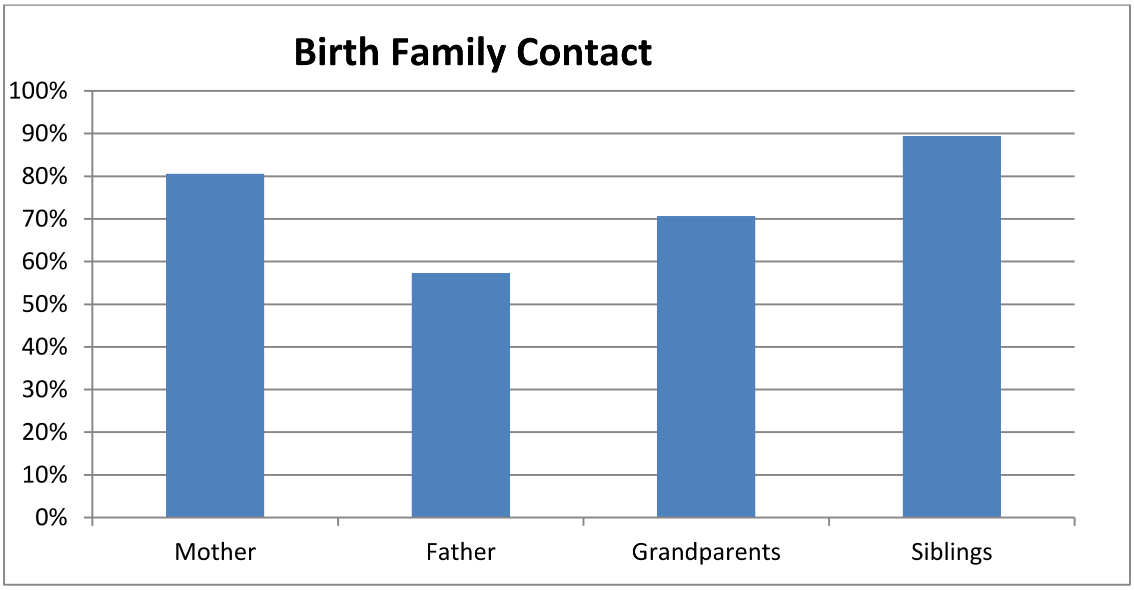

Figure 13: Birth family contact

Overall, 14.6% of young people have supervised contact and 30.6% have supported contact. Social workers reported a range of reasons for why contact was be supervised, most commonly to support the young person or promote positive family relationships (particularly for sibling contact). Other reasons given are ‘parent’s negative behaviour’, which could include substance misuse, absconding with the young person, seeking information from young person and sharing inappropriate information. Social workers also stated that contact could be supervised when there was negative behaviour on the part of the young person, such as drug misuse, absconding, aggression or a history of assault. A range of significant people in the young person's life are reported to support contact with birth family, most commonly field social workers, foster carers and residential staff. The types of support provided included: arranging contact and providing a venue; providing financial support or travel to contact; encouraging family contact and positive family relationships; and providing emotional support for the young person or family members.

Summary

Almost one fifth of the study sample have a disabled mother and 7% a disabled father, most commonly intellectual disability. In addition, almost half of mothers of young people in the study sample have a mental health need, and 16.9% of fathers.

The large majority of young people have contact with their siblings and mother, though a smaller proportion (57.3%) has contact with their father. A large number also have contact with grandparents (70.7%) indicating the importance of extended family support.

Almost one third have supported contact with their birth family and 14.6% have their contact supervised, most commonly to support the young person or promote positive family relationships. Practical and emotional support for contact is most commonly provided by field social workers, foster carers and residential staff.

4.4 Legal Status

Figure 14 shows that two thirds of young people in the study sample are *Former Relevant* (over 18 and have been eligible and/or relevant young people). More than a quarter (26.8%) are in the *Eligible* category (aged 16-17 and are still looked after) and, of these, 63.1% are under a Care Order and 28.6% are voluntarily accommodated. Only 3.8% are in the *Relevant* category (aged 16-17, are eligible and have left care) and a smaller percentage (2.9%) are *Qualifying* young people (under 21 (or 24 if in education or training) and leave alternative/private foster care after the age of 16). These findings on care leaver status for the study sample reflect those for the general population of care leavers in the DSF report for the same period where the majority are also in the ‘former relevant’ category (60%), followed by those in the ‘eligible’ category (35%). Similarly, most ‘eligible’ care leavers are under a Care Order (59%) with a further 38% being voluntarily accommodated.

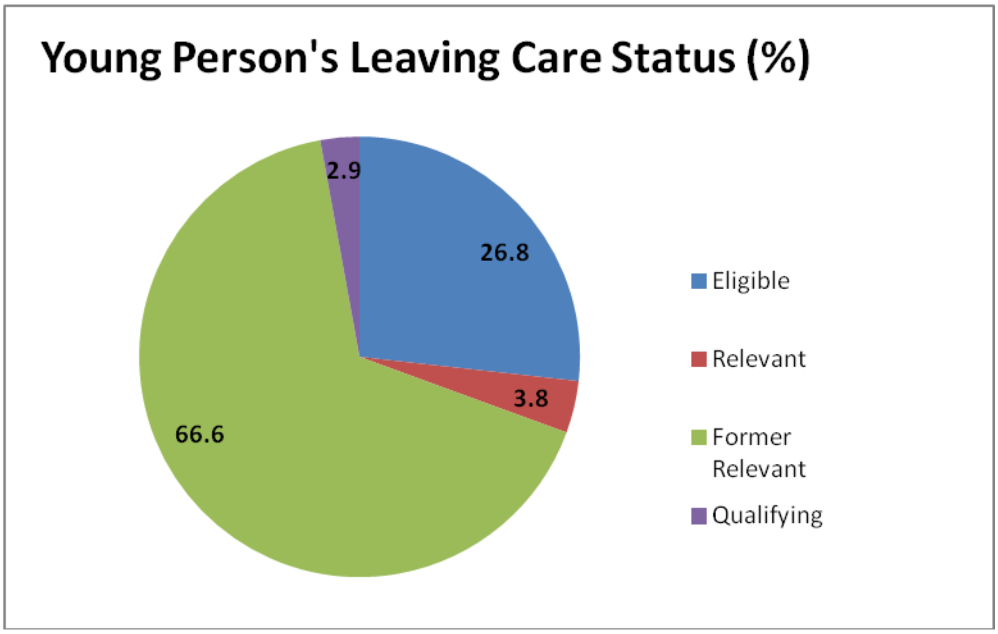

Figure 14: Care leaver status

Social workers reported all reasons for entry to care so young people are counted more than once as they feature across the categories in figure 15. The most commonly cited reasons for entry to care for the study sample are neglect (57.6%), followed closely by parents not coping (46.2%) and emotional abuse (41.4%) (see figure 15). Smaller numbers of disabled care leavers had been in care due to physical (17.5%) or sexual abuse (10.8%). The other category (13.4%) in the figure below includes very small numbers in care for other reasons such as being an unaccompanied minor or relinquished into care.

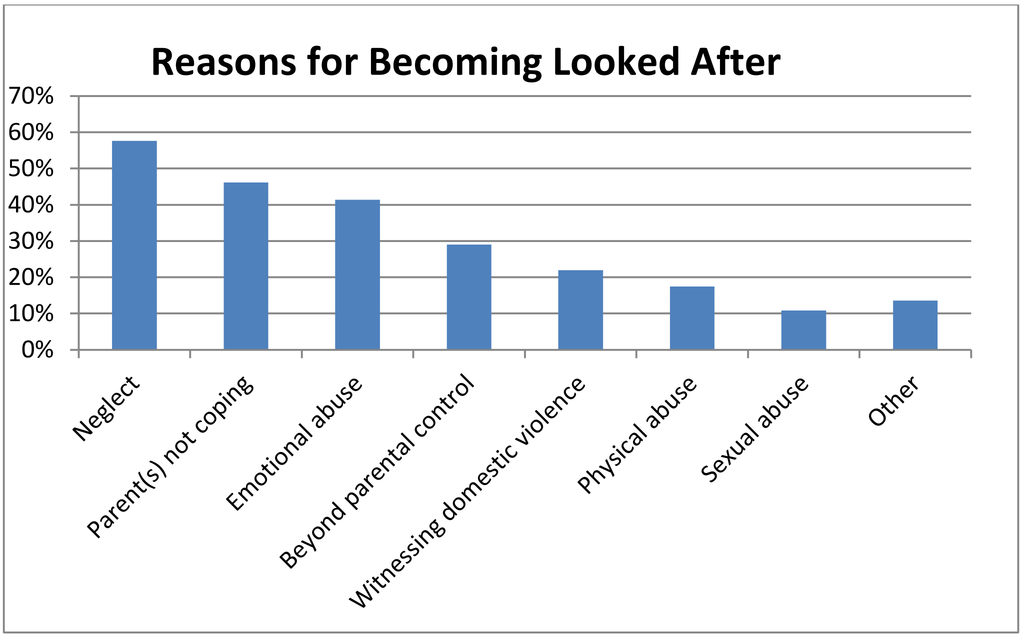

Figure 15: Reasons for becoming looked after

Variances in reasons for being admitted to care can be observed across the two dominant impairment categories of mental health and intellectual disability. Figure 16 shows that whilst neglect is the main reason for those in both impairment categories, this reason is more common for those with intellectual disability (78.8%) than those with mental health needs (51.1%). Indeed, young people with intellectual disabilities are 3.5 times more likely than people with mental health needs to have been taken into care because of neglect (χ^2 (1, N = 246) = 14.122, $p < 0.001$, φ = - 0.25, OR = 3.55). Emotional abuse is also more prevalent amongst those with an intellectual disability (54.5% compared with 39.4% for those with mental health needs) with young people with intellectual disabilities being 1.8 times more likely than young people with mental health needs to have been taken into care because of emotional abuse (χ^2 (1, N = 246) = 3.888, $p < 0.05$, φ = - 1.4, OR = 1.84). Moreover, young people with intellectual disabilities are two times more likely than young people with mental health needs to have been taken into care because of sexual abuse although the result is not statistically significant (χ^2 (1, N = 246) = 2.755, $p > 0.05$, φ = - 0.12, OR = 2.13). In contrast, those with mental health needs are three times more likely than young people with intellectual disabilities to have been taken into care because they were beyond parental control (χ^2 (1, N = 246) = 9.937, $p < 0.005$, φ = 0.21, OR = 3.32).

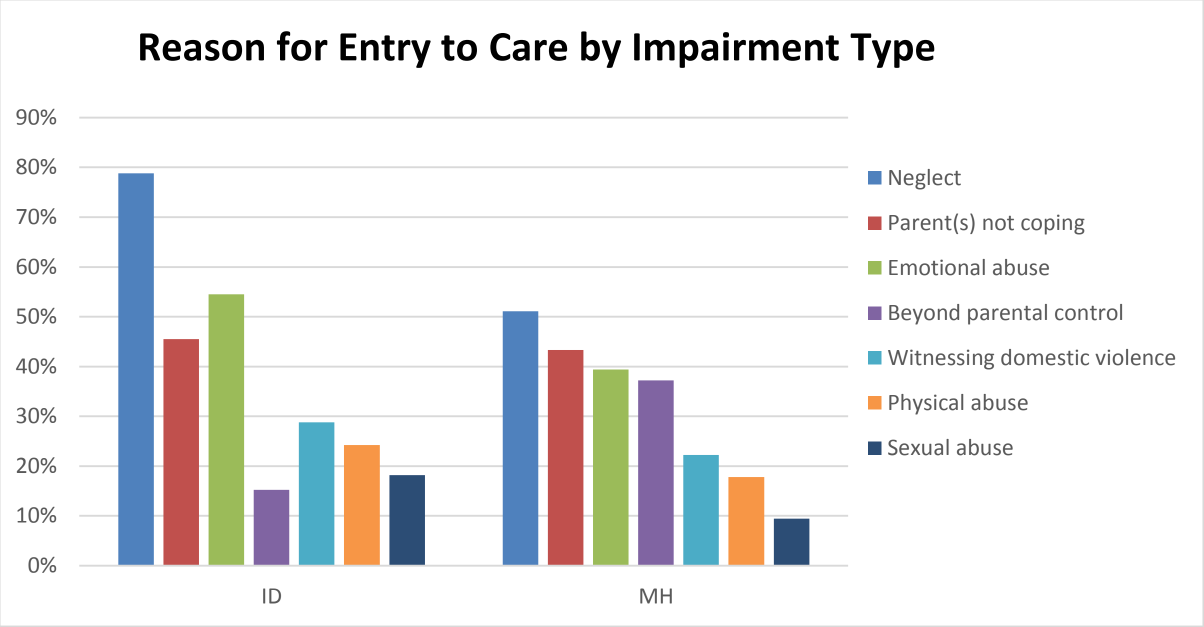

Figure 16: Reasons for becoming looked after by impairment type

The numbers of young people in the other three impairment categories do not feature in figure 16 as the numbers are small (ASD, n=38; other, n=12; multiple, n=18). However, some similar trends are apparent for these impairment categories. Reflecting the findings for those with intellectual disability, those with multiple impairments are most likely to feature in the neglect category (88.9%), followed by emotional abuse (61.1%) and sexual abuse (11.1%). Those with other impairments are spread across the categories of reasons for entry to care. Interestingly, parents not coping is the main reason for entry to care for those with ASD (55.3%) rather than neglect which was the second main reason (39.5%). Only one young person with ASD features in the physical or sexual abuse categories.

Almost half of the study sample (46.2%) have experienced significant placement changes during their time in care with three or more placement moves. Figure 17 shows that only 17.9% had no placement change whilst almost a third (35.9%) had one to two placement changes.

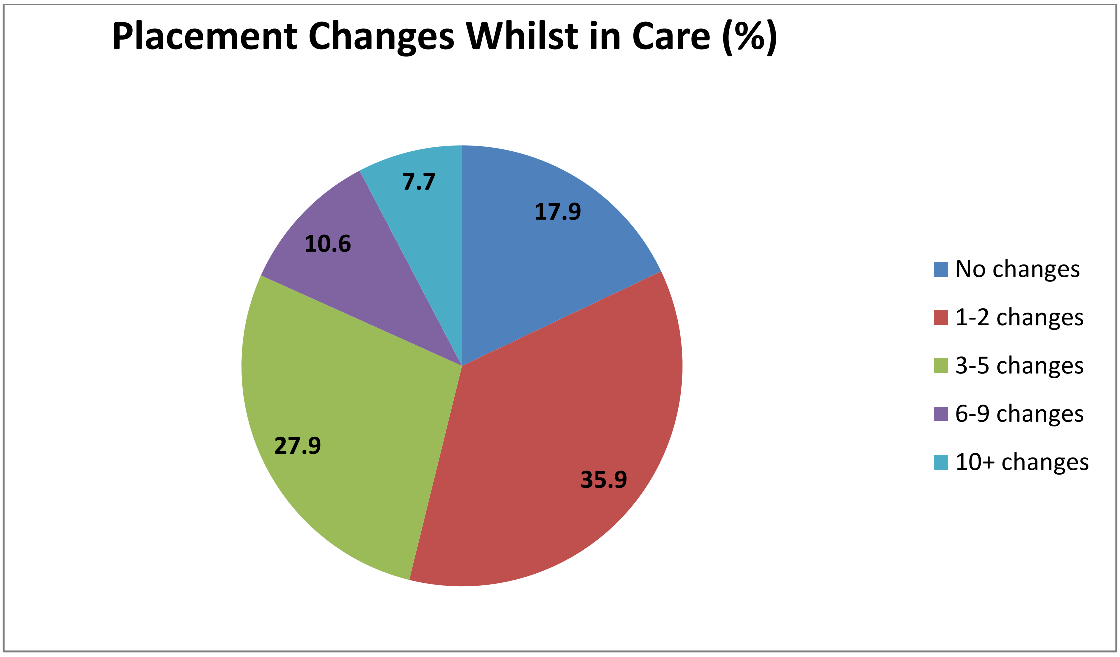

Figure 17: Placement change whilst in care

Figure 18 compares experience of placement change by impairment type, showing that those with multiple impairments or ASD are most likely to have no placement changes. Young people with ASD are three times more likely than young people with all other impairments to have experienced no placement changes whilst in care χ^2 (3, N = 312) = 15.454, $p < 0.005$, $\varphi_c = 0.22$, OR = 3.38) whilst those with multiple impairments are four times more likely than young people with all other impairments to have experienced no placement changes whilst in care χ^2 (3, N = 312) = 9.147, $p < 0.05$, $\varphi_c = 0.17$, OR = 4.1). Young people with mental health needs are three times more likely than young people with all other impairments to have six or more placement changes (OR = 3.38) (χ^2 (3, N = 312) = 24.606, $p < 0.001$, $\varphi_c = 0.28$). Indeed, the majority of those experiencing 10+ placement changes (n=24) have mental health needs (70.8%) or intellectual disabilities (20.8%), with the remaining two young people having multiple impairments.

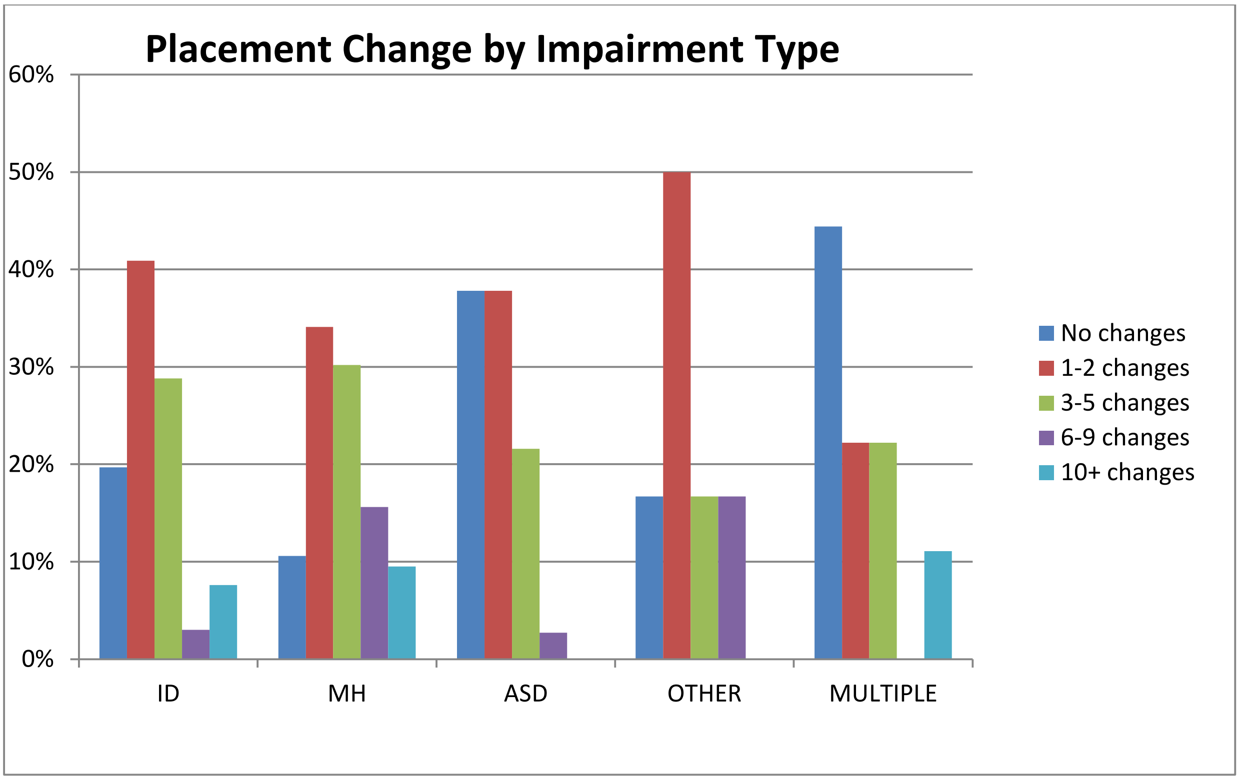

Figure 18: Placement change by impairment type

Figure 19 shows that the majority of the study sample have been in care for over five years (51%), or 3-5 years (25%), followed by 17.6% being in care for 1-2 years and smaller numbers in care for less than a year. Most of those in care for less than one year are in the mental health category (80%) and aged 17-18 (65%). These findings highlight that some care leavers are late care entrants which brings an added complexity of issues at the point of coming into care.

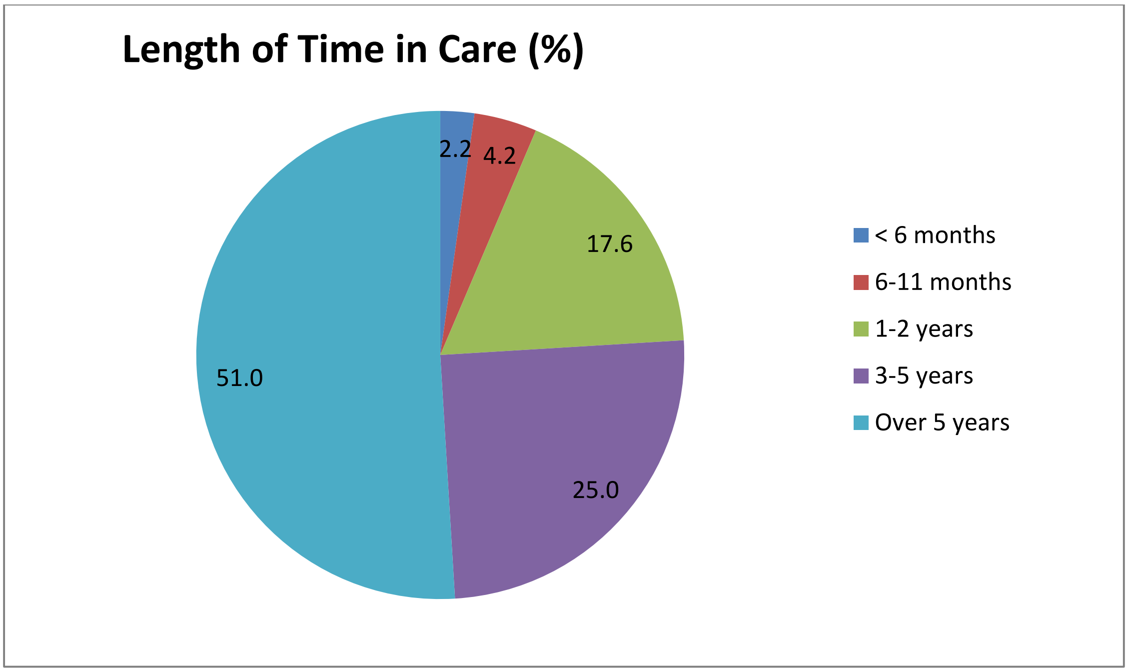

Figure 19: Length of time in care

Of those who have left care (see figure 20), 29.3% left care within the past year whilst 50.9% have been out of care for between one to two years and almost a fifth (19.2%) for three to five years[3].

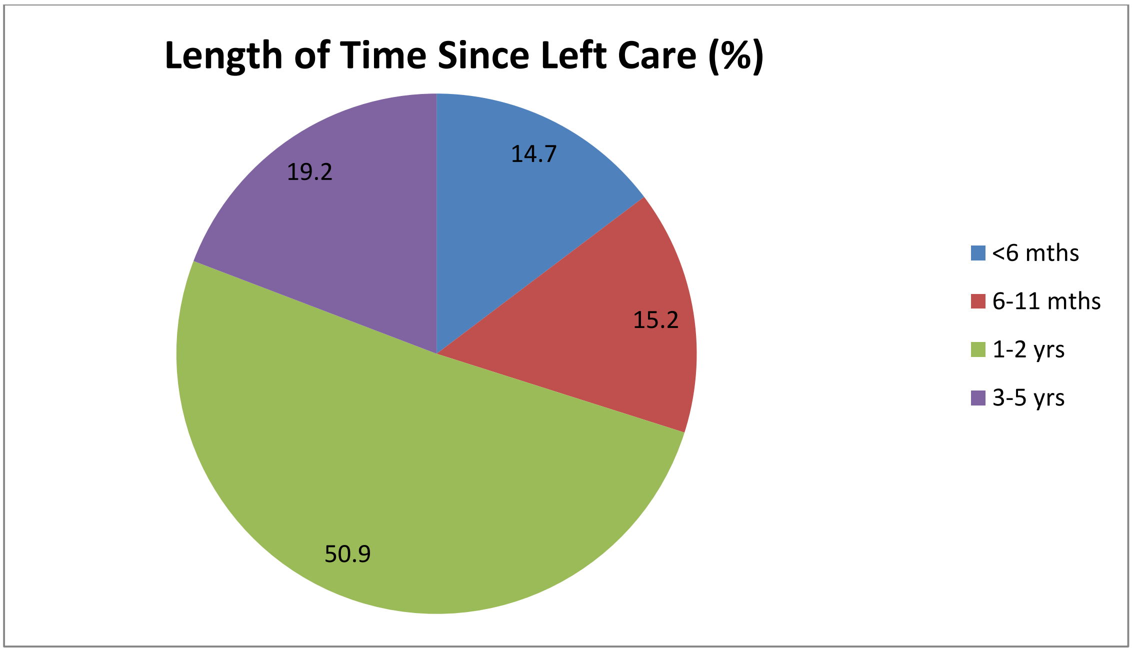

Figure 20: Length of time since left care

---

[3] Data for this survey question was missing for 28.6% of the study sample.

Summary

Reflecting the pattern of care leaver status for the general population of care leavers in the DSF report, two thirds of the study sample are *Former Relevant* care leavers, just over a quarter are *Eligible,* only 3.8% are *Relevant* and 2.9% are *Qualifying* young people. The most commonly cited reasons for entry to care for the study sample are neglect (57.6%), followed closely by parents not coping (46.2%) and emotional abuse (41.4%). Smaller numbers have been in care due to physical or sexual abuse. Neglect is the main reason for entry to care for those in the two dominant impairment types, particularly intellectual disability, but not for those with ASD where parents not coping is the main reason. Emotional abuse and sexual abuse are more prevalent amongst those with an intellectual disability. Those with mental health needs are three times more likely to have been beyond parental control compared with those with intellectual disabilities.

Almost half of the study sample have experienced significant placement changes during their time in care with three or more placement moves. Those with ASD or multiple impairments are least likely to experience placement change. Those with mental health needs and/or intellectual disabilities are most likely to have multiple placement changes, particularly those with mental health needs.

Just over half of the study sample have been in care for over five years and a quarter for 3-5 years. Smaller numbers of those in care for less than a year are mostly in the mental health category and aged 17-18. Of those who have left care, the majority have been out of care for more than one year.

4.5 Living Arrangements

Reflecting similar trends in the DSF return for the general population of those who have left care (relevant, former relevant or qualifying), the most common living arrangements are tenancy with or without housing support[4] (38.3%), at home with birth parent (17.4%), former foster care (GEM) placement (10%). and jointly commissioned supported accommodation (8.7%). The 'other' accommodation

---

[4] There are a range of possible reasons for young people not receiving support with housing including: refusal to engage with services, living independently or managing well on own without additional support.

category (15.5%) includes B&B, hostel, unregulated placements, parenting assessment units and university accommodation.

Figure 21 compares living arrangements for the study population with statistics on the general care leaver population from the DSF report. The number in former foster care (GEM) placements (10%) starkly compares with the 27% of the general care leaver population in the same category. However, in the study sample, a further 2.2% are in kinship care and 5.2% are still in non-relative foster care (not shown in figure as comparative DSF figures are not available). It is also notable that fewer in the study sample are living informally with relatives/friends compared to those in the general care leaver population (3.9% in the study sample compared with 9% in the DSF return).

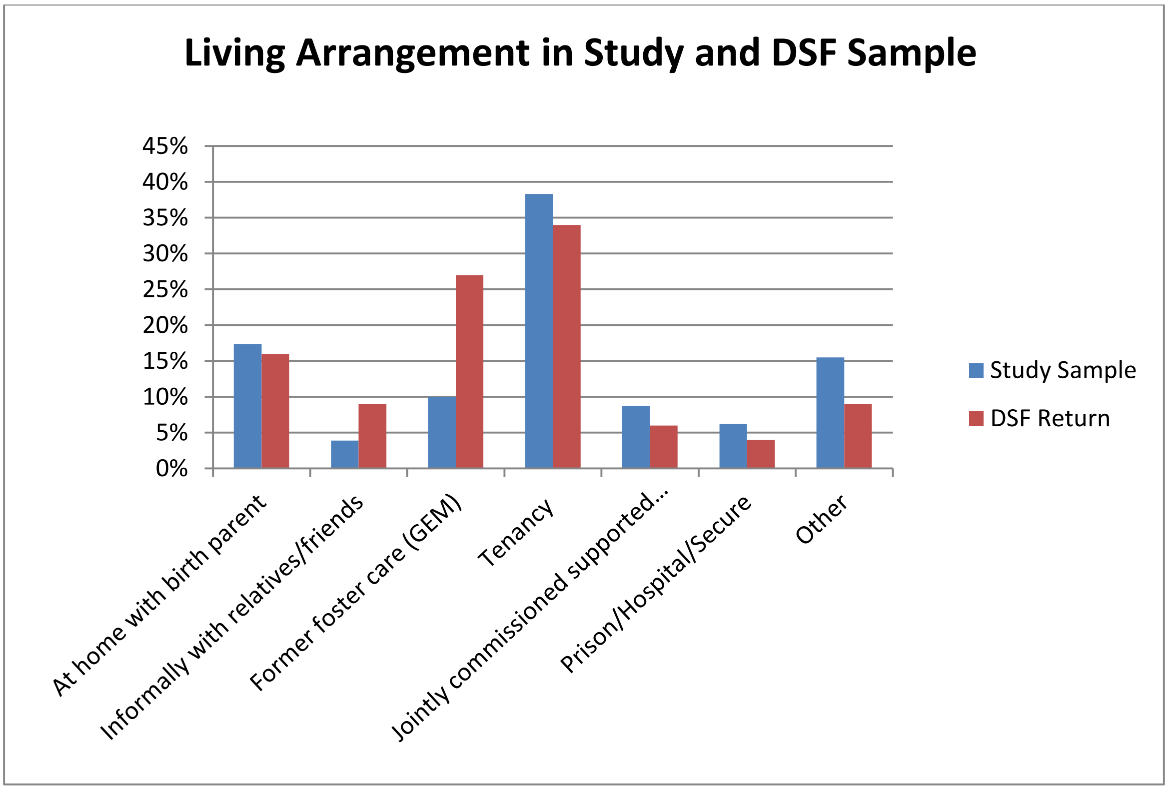

Figure 21: Comparison of living arrangement in study and DSF sample

Figure 22 shows the living arrangements for young people (relevant, former relevant or qualifying) across the three main impairment types. Within the category of intellectual disability, young people are most likely to have returned home (26.4%), have remained in foster care (17% GEM and 7.5% non-relative foster care) or have moved to jointly commissioned supported accommodation (13.2%); and are least likely to be living in tenancy without support (5.7%). In contrast, those with mental health needs are most likely to be living in tenancy without support (28%), followed by tenancy with support (18.2%) and living at home with a birth parent (15.9%). Overall, young people with intellectual disabilities are two times more likely than young people with mental health needs to have returned home (OR = 1.90). Conversely, young people with mental health needs are six times more likely than young people with intellectual disabilities to be in a tenancy without supports (OR = 6.49). Young people with mental health needs who have left care are least likely to be in foster care (4.5% GEM, 3.8% non-relative foster care) or with relatives/friends (3%). Conversely, young people with multiple impairments are eight times more likely than young people with mental health needs to be in former foster care (GEM) (OR = 7.88). Reflecting trends for those with mental health needs, young people with ASD are most likely to be in tenancy without support (32.0%) and are eight times more likely than young people with intellectual disabilities to be in a tenancy without support (OR = 7.84). None of those with ASD are in jointly commissioned supported living placements. However, following trends for those with intellectual disability, a significant number of young people with ASD are also living in GEM placements (16%).

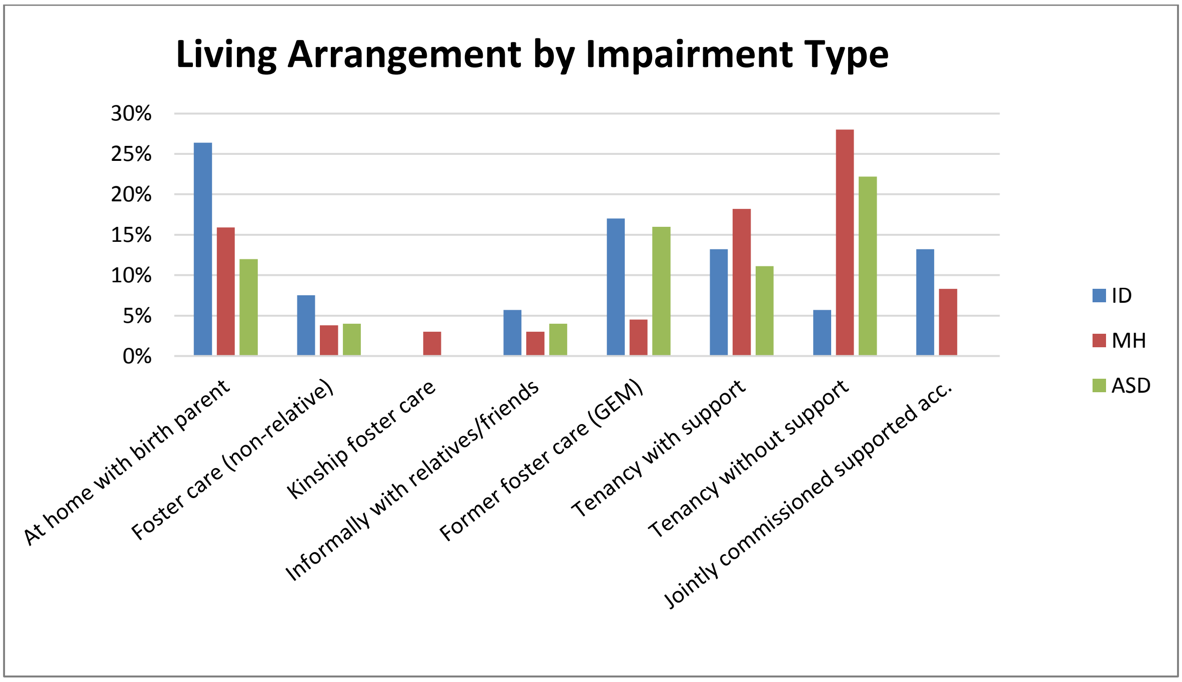

Figure 22: Living arrangement and impairment type

Figure 23 shows the gender differences across living arrangements with males being much more likely to return home to a birth parent (60%) and females featuring most prominently in foster care (66.7% non-relative) and tenancy with support (62.2%). Indeed, males are 1.6 times more likely than females to return home to their birth parent (OR = 1.67). In contrast, females are two times more likely than males to be in non-relative foster care (OR = 2.04) and 1.7 times more likely than males to be in a tenancy with support (OR = 1.77). There are minimal gender differences in GEM foster care placements, tenancy without support and jointly commissioned supported living.

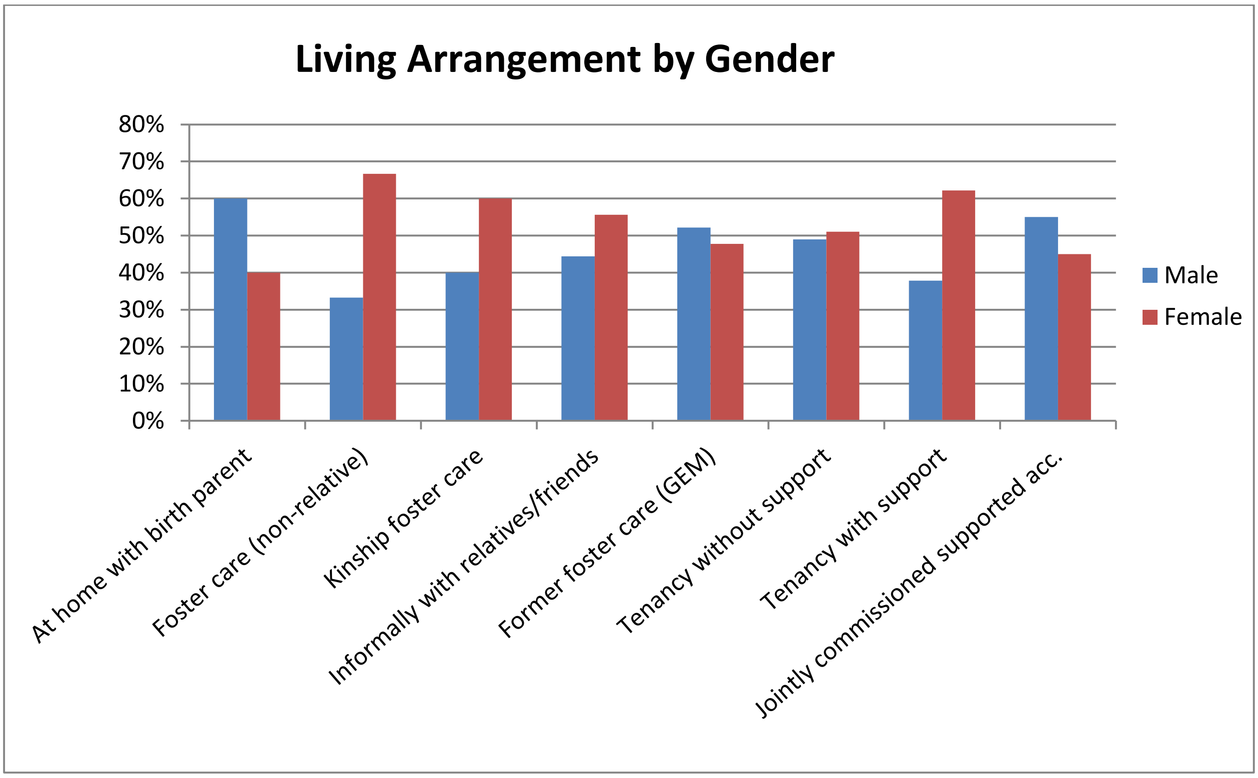

Figure 23: Living arrangement and gender

Some living arrangement categories are not shown in the figures above as the numbers are too small. Of all the young people in the study sample (also including eligible care leavers), twelve are detained in a juvenile justice centre or prison and one in secure care. This is the category with the largest gender difference where ten of these thirteen young people are male. The majority of these young people (11 out of 13) have mental health needs.

Overall, 5.4% of young people are living in specialist accommodation. Seven young people (four male and three female from BHSCT, SEHSCT and NHSCT) are living in hospital with three aged 16-17yrs and four aged 18-21yrs. Six of these young people have mental health needs, co-existing with intellectual disability in two cases, and one with ASD and intellectual disability.

Three young people (all male) are living in a residential school (all with intellectual disability, two with co-existing ASD); and six (three males and three females) in a specialist residential placement (three with mental health and/or intellectual disability, two with multiple impairments and one with intellectual disability and ASD). Two of those in the latter category are placed out of jurisdiction in England as no placements are available in NI to meet their complex needs. Another two of these young people are placed in a residential home for adults with intellectual disabilities; one in an assessment and treatment centre for young people with intellectual disabilities; and one in a supported living setting for people with autism. Living arrangements are less stable for two males with no fixed abode (both with mental health needs and aged 18-19 years) and two young people for whom living arrangements unknown.

As expected, those in University accommodation and in a former foster care placement (GEM) are former relevant care leavers. This former relevant category also dominates for those living at home with a birth parent, those in a tenancy arrangement with or without housing support, those in jointly commissioned supported living and those in prison/juvenile justice settings. Unsurprisingly, the majority of those still in foster care (non-relative and kinship), children's residential care or secure care are eligible care leavers. Qualifying care leavers feature only in placement at home with a birth parent and tenancy arrangements. Relevant care leavers are mostly living at home with a birth parent or in kinship arrangements.

Over three quarters of the study sample (76.4%) are reported to be receiving assistance with accommodation and maintenance from 16+ services. Within impairment categories, those with multiple impairments or mental health needs are most likely to receive assistance with accommodation and maintenance from 16+ services (all but one of those with multiple impairments and 78.9% of those with mental health needs), followed closely by three quarters of those with 'other' impairments and 71.1% of those with ASD. Of those with an intellectual disability, 68.2% are receiving assistance with accommodation and maintenance from 16+ services.

Most of those receiving assistance with accommodation and maintenance from 16+ services are living in tenancy arrangements (28.8%), followed by foster care (17.6%), at home with a birth parent (12.9%), jointly commissioned supported living (10.8%) or other accommodation (8.3%). Overall, 15.9% of the study sample have access to a floating support worker, with the vast majority (74%) of these in the mental health category. Most of these young people are in tenancy arrangements (60%) or other accommodation settings (12%).

Summary

Young people who had left care (relevant, former relevant or qualifying) were mostly living in tenancy arrangements followed by living at home with a birth parent. Placements with former foster carers and jointly commissioned supported accommodation are also prevalent, however, in comparison with trends in the wider care leaver population, fewer young people in the study sample (15.2% compared with 27% in general care leaver population) are in former foster care (10% GEM; 5.2% non-relative foster care) or living informally with relatives/friends (3.9% compared with 9% in the DSF return).

Those with intellectual disabilities are most likely to return home, remain in foster care and be in jointly commissioned support living. Those with mental health needs or ASD are more likely to be in tenancy arrangements without support. Males are much more likely to return home to a birth parent and females are more likely to remain in foster care or move to a tenancy without support. Males, mostly with mental health needs, far outnumber females in the juvenile justice/ prison settings and all those in residential schools are male, with intellectual disability). A small number living in specialist care settings, such as hospital or specialist residential care, have multiple and complex needs. Two young people are placed out of jurisdiction in England as no placements are available in NI to meet their complex needs. The majority of the study sample are receiving assistance with accommodation and maintenance from 16+ services, mostly those with multiple impairments or mental health needs and those living in tenancy arrangements. Similarly, those accessing floating support (15.9%) are mostly in the mental health category and in tenancy arrangements. Those with an intellectual disability are least likely to receive assistance with accommodation and maintenance from 16+ services, with almost a third of young people with an intellectual disability (31.8%) not receiving these services.

4.6 Leaving Care Support

Just over two thirds of young people (67.2%) are in receipt of 16+ social work services, with over half being male (54%) and 46% female. Most have contact with their named social worker on a monthly (36.9%) or fortnightly (21.5%) basis. The main reasons reported for young people not having a 16+ social worker are: young person aged out of service; adult services now leading; or young person's refusal to engage.

Figure 24 shows that those with multiple impairments (83.3%) or mental health needs (70.6%) are most likely to have access to 16+ social work services. Young people with mental health needs are almost two times more likely to have access to 16+ social work services than young people with intellectual disabilities (χ^2 (1, N = 246) = 3.937, $p < 0.05$, $\varphi = 0.14$, OR = 1.88). Whilst all of those with multiple impairments have access to 16+ social work services, just over half of those with ASD (52.6%) and 56.2% of those with an intellectual disability are accessing 16+ services (χ^2 (N = 314) = 16.276, $p < 0.005$, $\varphi_c = 0.23$).

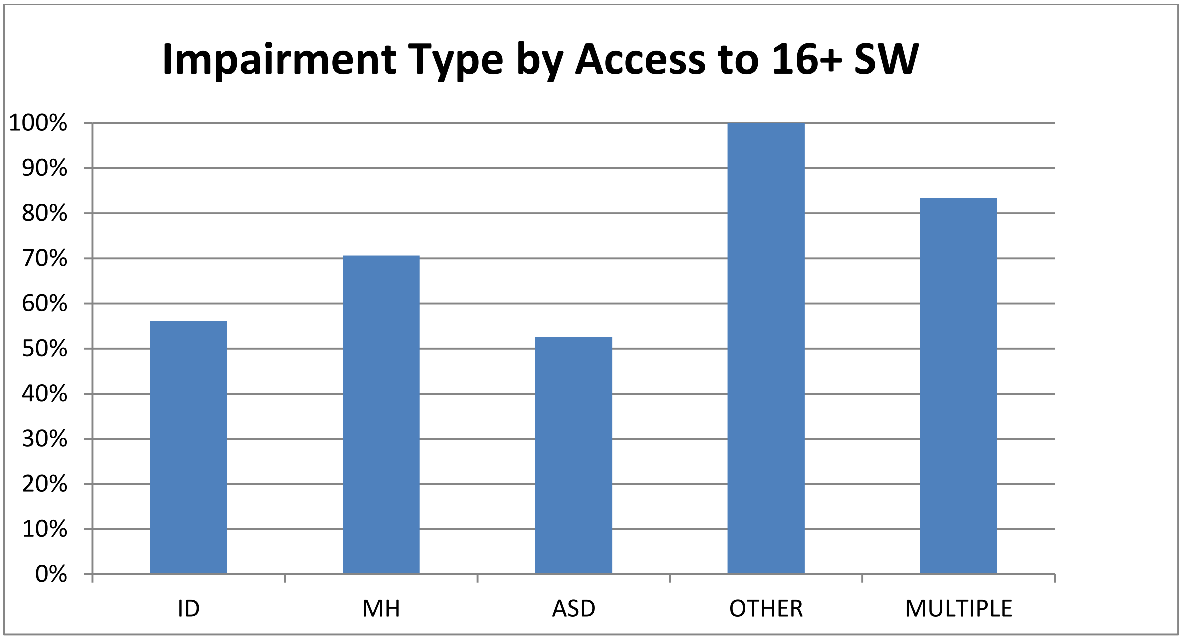

Figure 24: Impairment type by access to 16+ social work services

All but one of those in the relevant care leaver category are accessing 16+ social work services and around two thirds of those in the eligible (65.5%) and former relevant categories (67%). This figure reduces to 55.6% of those in the qualifying category. Following this trend, the majority of those accessing 16+ social work services are aged 17 years (28.9%), followed closely by those aged 16 (21.3%), 18 years (21.3%) and 19 years (19%).

Figure 25 shows the proportions of young people in each age who are accessing 16+ social work services. A third of those aged 16 (32.8%) and 18 (33.8%) and a quarter of those aged 17 (25.6%) are not accessing 16+ social work services. This gap widens for those in the older ages with more than half of those aged 20 (57.1%), 60% of those aged 21 and none of those aged 22 accessing 16+ social work services. These findings indicate that case closure in 16+ teams across Trusts dramatically increases when young people reach the age of 20.

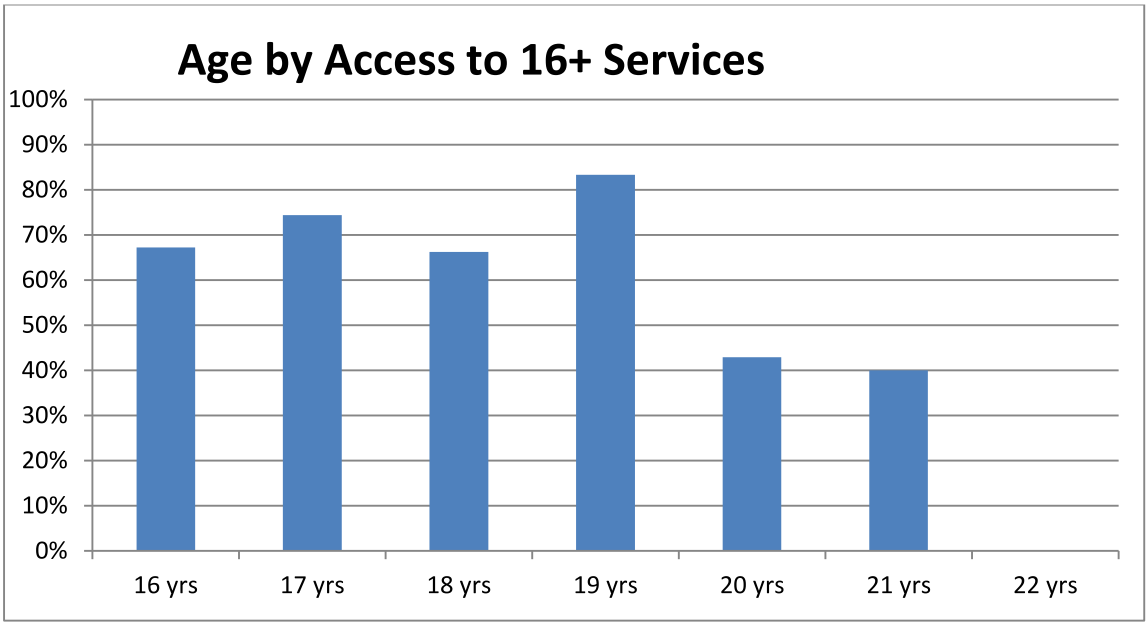

Figure 25: Age by access to 16+ social work services

In terms of leaving care support, figure 26 shows that the vast majority of young people (96.5%) have a completed needs assessment and a pathway plan (94.9%) (see figure 26). Similarly, for the general care leaver population in the DSF return, 97.5% have a completed needs assessment and 83.4% have a pathway plan. In the study sample, the majority also keep in touch with their social worker or personal advisor (94.3%) and have general assistance (93.9%). A smaller proportion of young people have assistance with employment (66.9%). The main reasons for not having assistance with employment are: assistance not required (n=23), still at school (n=21) or refused to engage (n=15).

However, variations in access to assistance with employment across impairment categories can be noted. Almost three quarters (73.4%) of those with mental health needs access assistance with employment and, similarly, 66.7% of those in the 'other' impairment category and 63.2% of those with ASD. However, only 57.6% of those with an intellectual disability are accessing assistance with employment and 38.9% of those with multiple impairments.

Just over a quarter have a befriender (27.7%). Most of those accessing a befriender have mental health needs (65.6%, n=21) with much lower numbers reported for those with intellectual disability (n=5), multiple impairments (n=4), ASD (n=1) or other impairment (n=1). In contrast to the other categories, there are two main reasons reported to explain the high number of young people not accessing a befriender: not required (n=114) and young person does not want a befriender (n=54).

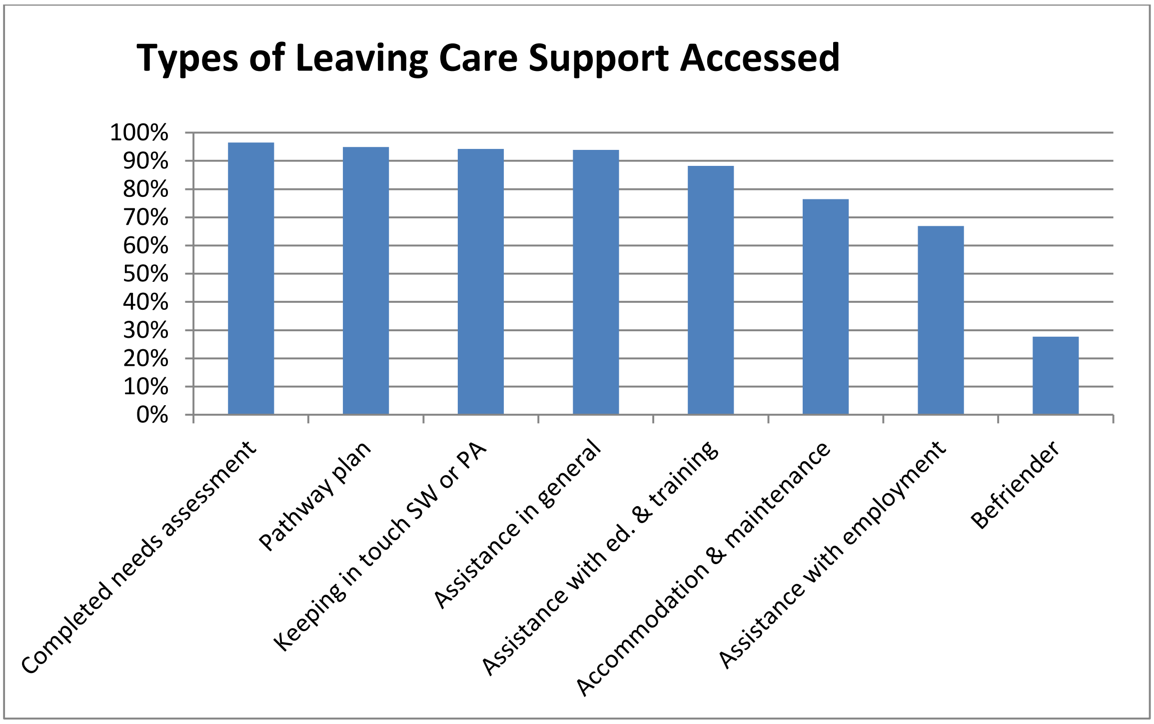

Figure 26: Types of leaving care support accessed

In addition, 82.8% accessed support from a personal advisor. Similarly, 83.4% of the general care leaver population in the DSF return accessed a personal advisor. Of those who do not access PA support, the main reasons given are refusal to engage (n=18) or service not required (n=13), followed by being on a waiting list for the service (n=5) or ageing out of the service at 21 years (n=4). However, there are some notable trends in the impairment type of those not accessing PA support. Over a fifth of those with intellectual disability (22.7%) and over a quarter of those with ASD (28.9%) or multiple impairments (27.8%) are not accessing PA support. By comparison, only 11.7% of those in the mental health category and 16.7% f those in the other impairment category are not accessing a PA. A Chi-Square test of independence was performed to examine the relationship between accessing support from a personal advisor and impairment type. The relationship between the variables was statistically significant with a small effect size χ^2 (4, N = 314) = 10.386,

$p < 0.05$, $\varphi_c = 0.18$). Those accessing support from a personal advisor are 2.5 times more likely to have mental health needs than those who did not access a personal advisor (OR = 2.47). Conversely, young people who did not access the support of a personal advisor are 1.6 times more likely to have intellectual disability than those who did access support from a personal advisor (OR = 1.57). Most of those who do have a PA have contact with them on a monthly (33%) or fortnightly (18.3%) basis, however, 19.9% do not have contact with their PA. The main reasons for no contact are: PA not required, refusal to engage or case not yet allocated/newly allocated.

Summary

Just over two thirds of young people are in receipt of 16+ social work services, with most having contact with their named social worker on a monthly or fortnightly basis. In addition, 82.8% accessed support from a personal advisor with most having monthly or fortnightly contact, however, a fifth do not have contact with their PA. Those with mental health needs or multiple/other impairments are most likely to have access to 16+ services. Levels of access to 16+ services are reported to be much lower for those with ASD or intellectual disability. Similarly, those in the qualifying care leaver category are least likely to be accessing 16+ social work services. There is a reduction in access to 16+ social work services as care leavers aged with half of those accessing these services aged 16-17 years (50.2%), and 40.3% aged 18-19. Social workers report very high levels of completed needs assessments and pathway plans but much lower levels of access to a befriender. The main reasons given for those who do not access the range of 16+ services are: refusal to engage, case is new/closed; or service is not required.

4.7 Support from Disability or Mental Health Services

In relation to mental health services, figure 27 shows that 20.7% are accessing AMHS; 15.3% CAMHS; 7.6% LAC Specialist Therapeutic Services; and 12.4% early intervention services (including those provided by voluntary/community services).

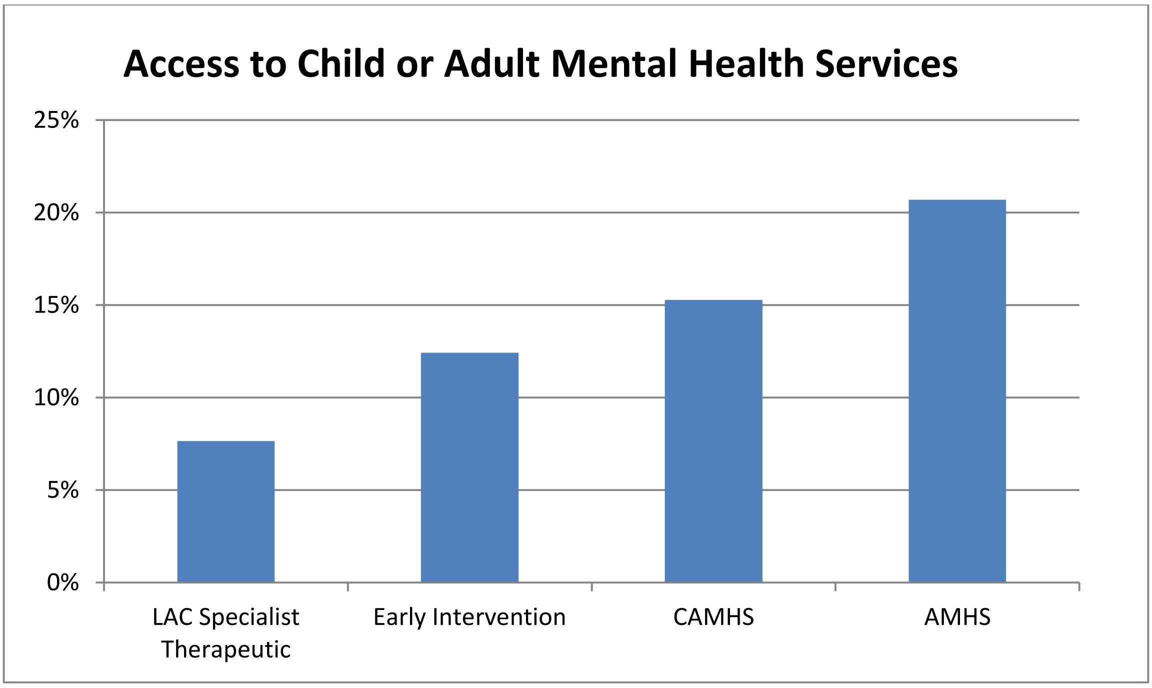

Figure 27: Access to mental health services

As expected, the majority of young people accessing these mental health services are in the mental health category (22.2% of those with mental health needs are accessing CAMHS and 27.2% accessing AMHS). However, almost half (47.1%) of those with an assessed mental illness are not receiving child or adult mental health services. Despite high levels of co-existing mental health and intellectual disability/ASD, very low levels of engagement in mental health services are reported for those with an intellectual disability (n=3 in CAMHS; n=8 AMHS) or ASD (n=2 in CAMHS; n=4 AMHS). Interestingly, however, these figures increase for those with ASD in relation to access to early intervention services with 30.8% of those receiving these services in the ASD category (46.2% in the mental health category).

Equal proportions of males and females (50% each) are accessing CAMHS, however, females outnumber males in all other mental health services (58.3% in LAC Specialist Therapeutic services; 60% in AMHS and 53.8% in early intervention services). As expected, the large majority of those accessing CAMHS (95.9%) and LAC Specialist Therapeutic services (83.3%) are aged under 18; and most of those accessing AMHS are aged 18+ (72.3%). Those accessing early intervention services have a broader spread of ages with 43.6% under 18 and 33.3% aged 18-19 years.

A very small proportion of the study sample are accessing children's disability services (5.1%). Of those who are, most are male (68.8%) and under 18 years (87.5%). Most of those accessing children's disability services have ASD (37.5%) intellectual disability (25%) or multiple impairments (25%), although numbers are small.

In terms of access to adult disability services, the numbers remain relatively small (13.1%), with 68.2% aged 18 or over and 26.8% aged 17; and a more even gender balance (51.2% male; 48.8% female). The majority of those accessing adult disability services have an intellectual disability (70.7%), followed by multiple impairments (17.1%), although numbers are small. Only two young people with ASD (co-existing with intellectual disability) are accessing adult disability services. Interestingly, qualitative comments from social workers indicated that three young people could not access adult learning disability services until they were 18 years and, in contrast, two young people had their learning disability diagnosis removed when they were re-assessed for eligibility for adult learning disability services.

For almost four fifths (79.1%) of those receiving CAMHS, social workers were able to specify a service related need. The most common service related need was depression (n=8), followed by the monitoring of medication (n=6) and behavioural issues (n=5). Four young people were receiving CAMHS due to concerns about suicide.

Social workers specified a service related need for 16 of the young people in receipt of specialist therapeutic LAC. Eight young people access these services for therapeutic support and counselling, four for emotional needs and a smaller number for behavioural support, anxiety or life story work.

Social workers specified a service related need for just over half of those young people in receipt of AMHS. The most common service related needs were depression (n=8) or regular self-harm (n=5). A smaller number of young people are in receipt of AMHS for substance misuse, suicide concerns or eating disorders. Some social workers indicated that a number of young people are also in receipt of other mental health services from a range of providers. For example, therapeutic counselling (n=7), community addiction services (n=4) and trauma centre services (n=3).

Overall, 9.8% of the study sample (n=31) are in receipt of multiple child or adult mental health services, most commonly Specialist Therapeutic LAC services in addition to CAMHS/AMHS or another service (54.8% of those receiving more than one mental health service). Five young people are in receipt of CAMHS and AMHS, and nine young people are in receipt of CAMHS/AMHS alongside another mental health service (from a range of providers). In addition, 46.2% have previously accessed CAMHS, 7.3% Specialist Therapeutic LAC services and 13.4% have previously been in receipt of AMHS. Across all disability and mental health services, the most common reasons for the service ending were that the young person had disengaged, the young person had aged-out of the service or the service aim had been achieved.

Summary

Low levels of engagement in mental health and disability services are reported. Only one fifth are accessing AMHS, with fewer accessing CAMHS or early intervention services. In addition, just over half of those with an assessed mental illness are in receipt of child or adult mental health services. Despite levels of co-existing mental health and impairment, very low levels of engagement in mental health services are reported for those with an intellectual disability or ASD, with the exception of those with ASD accessing more early intervention services. Equal proportions of males and females (50% each) are accessing CAMHS, however, females outnumber males in all other mental health services. Services are provided to meet a range of mental health needs including depression, behaviour, self-harm, suicide concerns and anxiety.

Smaller numbers are reported to have access to children's disability services (5.1%) or adult disability services (13.1%). Although numbers are small, it is interesting to note that the numbers of young people with intellectual disability accessing disability services increased significantly from child to adult disability services (4 in children's disability and 29 in adult disability services), the reverse was the case for those with ASD (6 in children's disability and 2 in adult disability services).

4.8 Access to Other Support Services

Social workers reported a range of other support services that young people accessed as they left care. These included short breaks, summer or leisure opportunities and input from a range of other professionals.

Short breaks

Almost one in ten (9.9% / n=31) young people use short breaks, most commonly short break placements in a non-relative foster care (35.5%), specialist foster care (12.9%) or specialist residential care (12.9%). There is considerable variation in the length and number of short break stays with some young people accessing block usage (for example, weekly blocks in residential settings during the summer) and others only spending parts of the day/evening at short breaks (no overnights). Some young people are also accessing a mix of short breaks, for example, one young person availed of 44 days of short breaks split between a residential short break facility and an adult foster care placement.

Figure 28 shows that almost a third of young people accessing short breaks are in the NHSCT (32.3%), followed by a quarter in the WHSCT (25.8%). A much lower number of young people are accessing short breaks in the SEHSCT (6.5%). This variance in numbers accessing short break may reflect different levels of availability of short break services across the region.

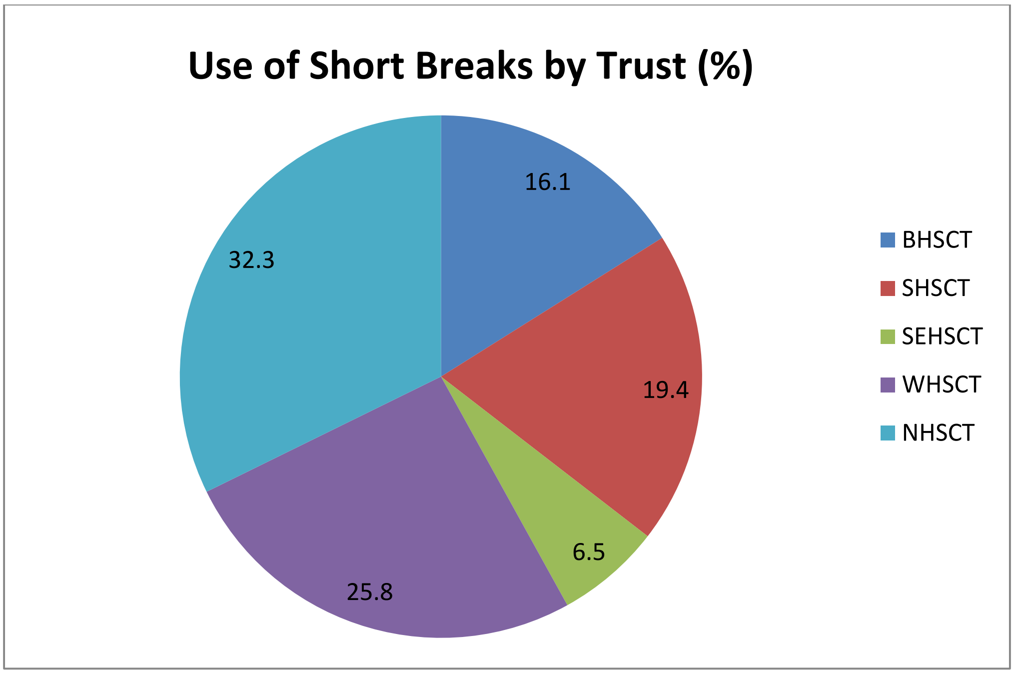

Figure 28: Use of short breaks by Trust

In relation to the gender of short break users, almost equal numbers are reported (51.6% male and 48.4 female). The majority of short break users are in the mental health category (48.4%), followed by multiple impairments (25.8%) and intellectual disability (16.1%). The association between being in the mental health or intellectual disability impairment category and being a short break user is not statistically significant. Young people with mental health impairments are no more likely to be short break users than those with intellectual disabilities (χ^2 (1, N = 246) = 0.037, $p > 0.05$, OR = 1.11). However, young people with multiple impairments are almost nine times more likely to be short break users than young people in the mental health category (although the numbers in the multiple impairment category are small, n = 18) ($p < 0.001$, Fisher's Exact Test, OR = 8.8). The majority are aged 16-17 years (74.1%) with a quarter aged 18+ years. Reflecting this trend in ages, most (64.5%) are eligible care leavers, followed by 29% in the former relevant category.

Of those young people using short breaks, more than half (51.6%) use short breaks as a planned break for a parent or caregiver or to support a current care placement (see figure 29). An additional 12.9% have experienced unplanned short break placement in response to a crisis. It is notable that only 38.7% use short breaks as a social opportunity for the young person. Five social workers specified 'other' reasons for short break usage which are: to support foster carers to continue with role (n=3), to maintain attachment with carers (n=1) or at request of young person (n=1).

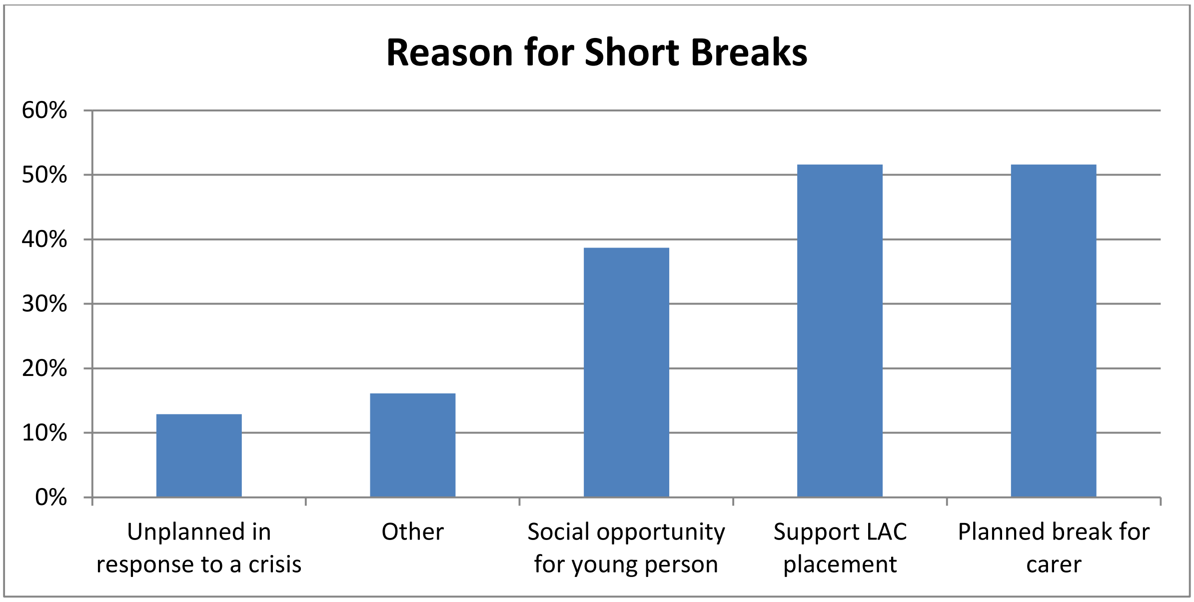

Figure 29: Reason for use of short breaks

Summer or Leisure Opportunities

Relatively small numbers of young people in the study sample are recorded to access summer or leisure opportunities (see figure 30). Only 1.9% are accessing Special Olympics activities, with a further 7% accessing specialist summer/leisure opportunities and 5.1% accessing holiday provision. Slightly higher numbers of young people are reported to access summer schemes (11.5%) which could be available as part of the package of support from 16+ services or from their specialist school or placement provider. In addition, 11.8% access other social activities. Some of these young people are independently availing of social activities, such as, a local gym, football team, choir or band. Others access additional social opportunities as part of a wider support programme for care leavers through mentoring, personal development or employment programmes such as, VOYPIC schemes; Include Youth's 'Give and Take' programme; well2 project (SEHSCT with Action Mental Health and the Cedar Foundation); Prince's Trust activities; Autism Initiatives; or the Barnardo's 'Safer Choices' programme.

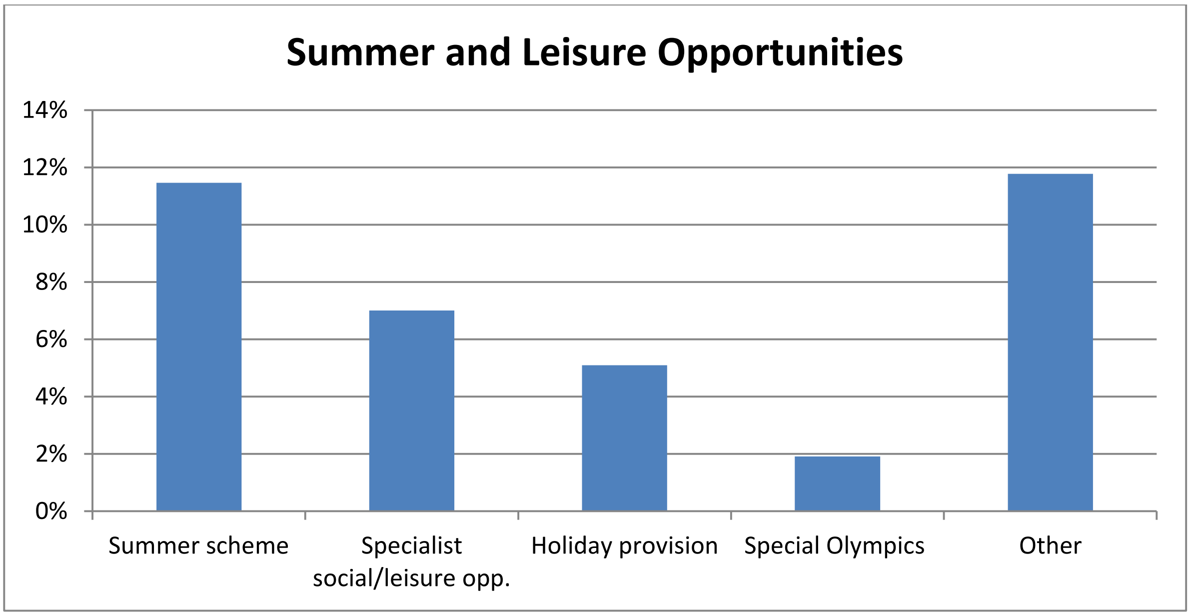

Figure 30: Use of summer or leisure services

Direct payments

Only 4.5% (n=14) are reported to use direct payments, mostly living in the BHSCT (35.7%), NHSCT (35.7%) or SHSCT (14.3%). Half of those using direct payments are in the mental health category, followed by three with an intellectual disability, two with ASD and two with multiple impairments. Just over half (n=8) are aged 16-17 years. This finding indicates a low uptake of direct payments for care leavers and a possible area for further service development, including raising awareness of the possible use of direct payments among 16+ social work teams and care leavers themselves.

Other statutory and voluntary/community sector services

Almost one fifth (19.1%) of the study sample are accessing transition support from the education sector and 85% of these young people are aged 16-18 years. Services from the education sector include transition planning, careers officer support, work placements and transitional college classes.

Overall, 43% are using other statutory or voluntary/community services including disability related organisations (for example, Mencap, Praxis Care, Triangle, Autism

Initiatives) and care leaver/youth related organisations (for example, VOYPIC, Action for Children, Include Youth, Extern, Macs, Belfast Central Mission, Barnardo's, Simon Community and NIACRO). Types of services include floating support/accommodation support, programmes related to personal development and relationships, counselling, drug/alcohol treatment and diversionary activities. Other statutory services include employability or university/college support.

The majority (67.4%) of care leavers accessing these other services are in the mental health category and 70.5% are aged 16-18 years. A further 17.8% are aged 19 years and 10.4% aged 20 years (1.5% aged 21 years) suggesting these services may also be targeted at the younger age ranges, social workers are not informed about the contact those in the older age ranges have with other services, or older care leavers disengage from services.

Other professional support

Figure 31 shows the range of other professionals involved in the lives of care leavers. The highest number relates to access to a dentist, however, this remains relatively low (44.3%). There are also higher numbers accessing psychiatry (21.3%), psychology (19.1%) and a solicitor (21%). Lower numbers are reported for access to floating support (15.9%), support workers (13.4%), employment officers (12.7%) or counsellors (10.8%). Access to nursing care is reported to be even lower (4.8% in-patient nursing and 5.1% community psychiatric nursing). In addition, it is concerning that only 8.9% are reported to have access to a mentor and 5.7% an independent advocate. Just over a third of young people (34.1%) are reported to have access to 'other' professionals not listed in the survey including education professionals, GPs, family support/gateway social workers, family nurses, psychotherapists, and addiction-related professionals.

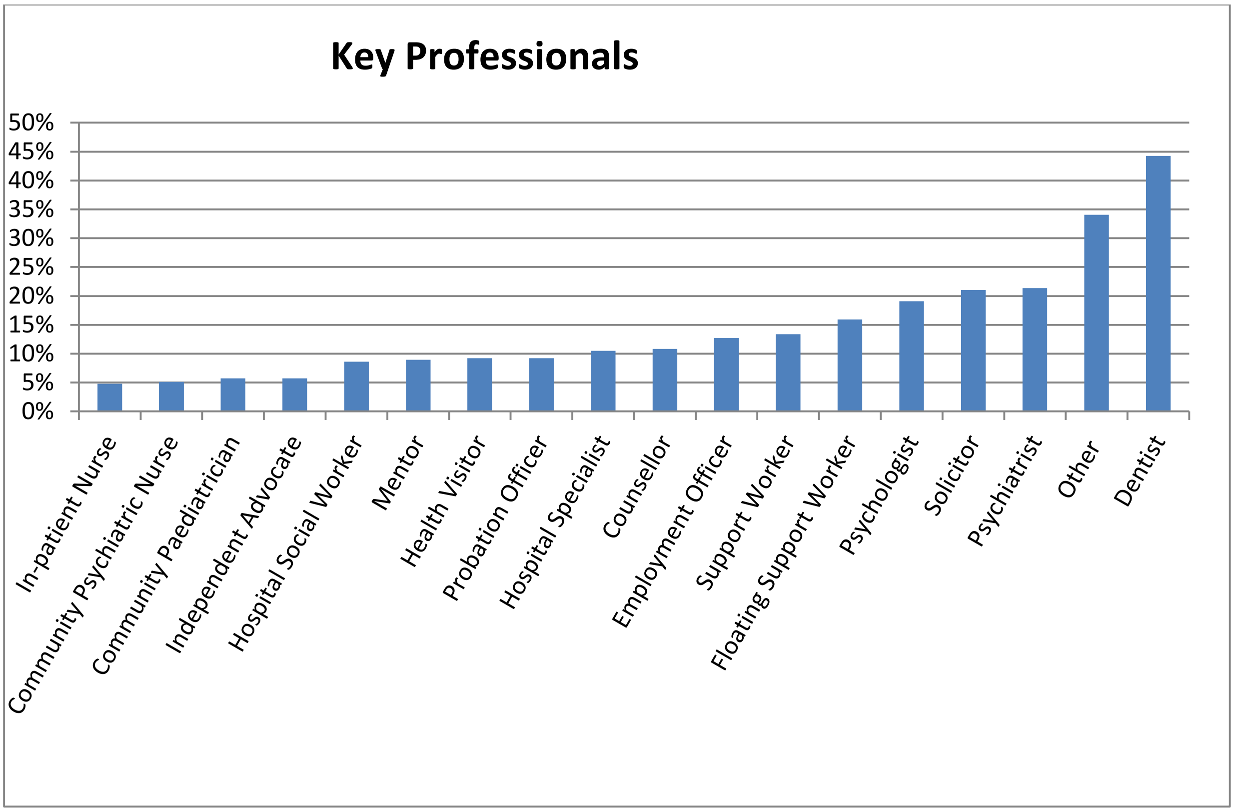

Figure 31: Access to key professionals

A range of other professionals are not shown on the graph given the low numbers of young people accessing their services (less than 5%). For example, youth justice workers (n=12) and independent visitors (n=7). In addition, a concerning low number of young people are accessing a transition coordinator (n=9) and a range of other disability-related professionals: speech therapist (n=8), community learning disability nurse (n=10), physiotherapist (n=10) and occupational therapist (n=14). Very low numbers of disabled care leavers accessing these professionals is concerning, particularly those related to transition to adult life and ongoing disability related needs.

Summary

Almost one in ten young people use short breaks, most commonly in a non-relative foster care setting with varying length and number of short break stays and evidence that availability of short breaks is variable across Trusts. There are no major differences in the gender of short break users however, most are aged 16-17 years and in the mental health category. For more than half of those availing of short breaks, the service is provided as a planned break for a parent/carer or to support a current care placement. Just over a third report short breaks to be a social opportunity for the young person. In addition, small numbers of young people in the study sample are recorded to access summer or leisure opportunities. Similarly, low levels of uptake of direct payments are reported indicating a need to raise awareness of the possible use of direct payments among care leavers and staff in 16+ teams.

Almost one fifth are accessing transition support from the education sector, mostly aged 16-18 years, and 43% are using other statutory or voluntary/community services including disability and care leaver/youth related organisations. The majority of care leavers accessing these services are in the mental health category and aged 16-18 years. These findings may indicate that services are often targeted at younger care leavers or that older care leavers disengage from services.

A range of other professionals are also supporting care leavers including mainstream health professionals (e.g. dentist) and disability/mental health professionals (psychiatrist/psychologist). However, it is concerning that very low levels of support from mentors, independent advocates and transition coordinators are reported.

4.9 Safeguarding and Risk-taking Behaviours

More than one in five (21.3%) of the study sample have attempted suicide in the preceding 12 months, with similar proportions of females (22.7%) and males (20.1%). Of those who have attempted suicide, 43.4% have attempted suicide more than once and more than a fifth (22.4%) are aged 16 (at the time of the survey). Just over one quarter (28.4%) of these young people are in receipt of CAMHS and almost one third (32.8%) are receiving AMHS, with 9% receiving LAC specialist therapeutic services.

In terms of risk taking behaviours, 28.3% of young people are reported to be at high to medium risk of engaging in risky sexual behaviour. More than two fifths (22.6%) of young people are reported to be at high to medium risk of suicide, and 36.9% are at high to medium risk of substance abuse. Figure 32 shows almost equal numbers in the high (14%) and medium (14.3%) levels of risky sexual behaviours; whilst more young people at medium (14.6%) than high (8%) levels of suicide. In contrast, many more young people are at high level of risk of substance misuse (22.6% compared with 14.3% at medium risk level).

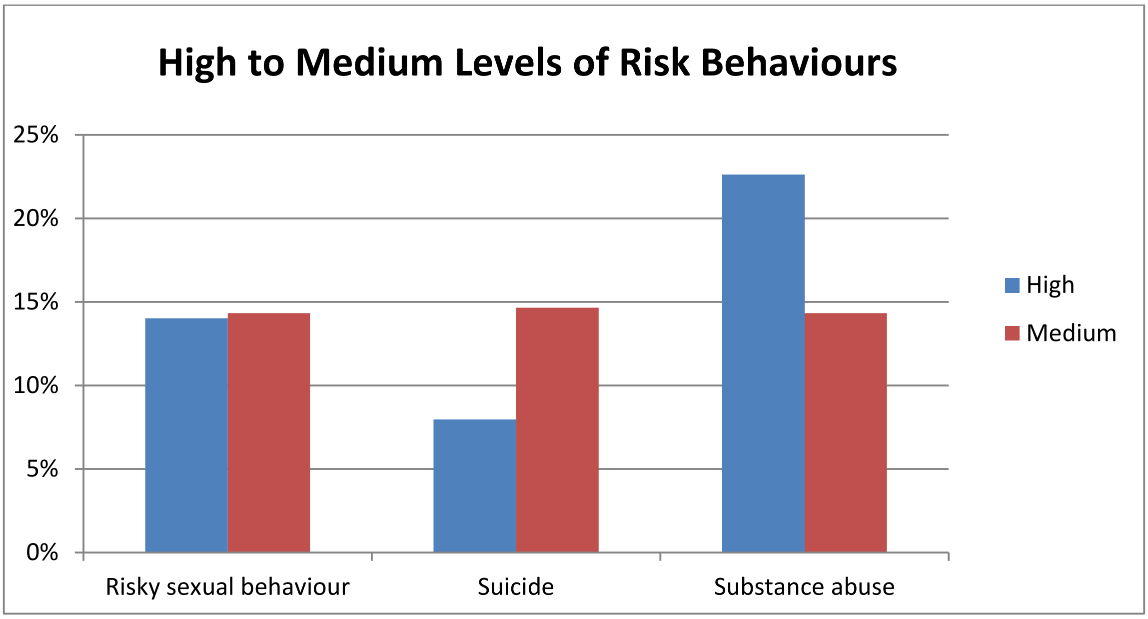

Figure 32: Levels for risk

Three quarters (75%) of young people at risk of exploitative or other high risk sexual behaviours are receiving services and a further 18.2% have been referred to services for risky sexual behaviour (see figure 33). Similarly, 80% of those with a high risk of suicide are receiving services and a further 16% referred to services. Of those at high risk of substance misuse, less than two thirds (60.6%) are in receipt of services and more than a quarter (28.2%) have been referred to services. Social workers also specified a number of other risks including self-harm, absconding, financial exploitation and gambling.

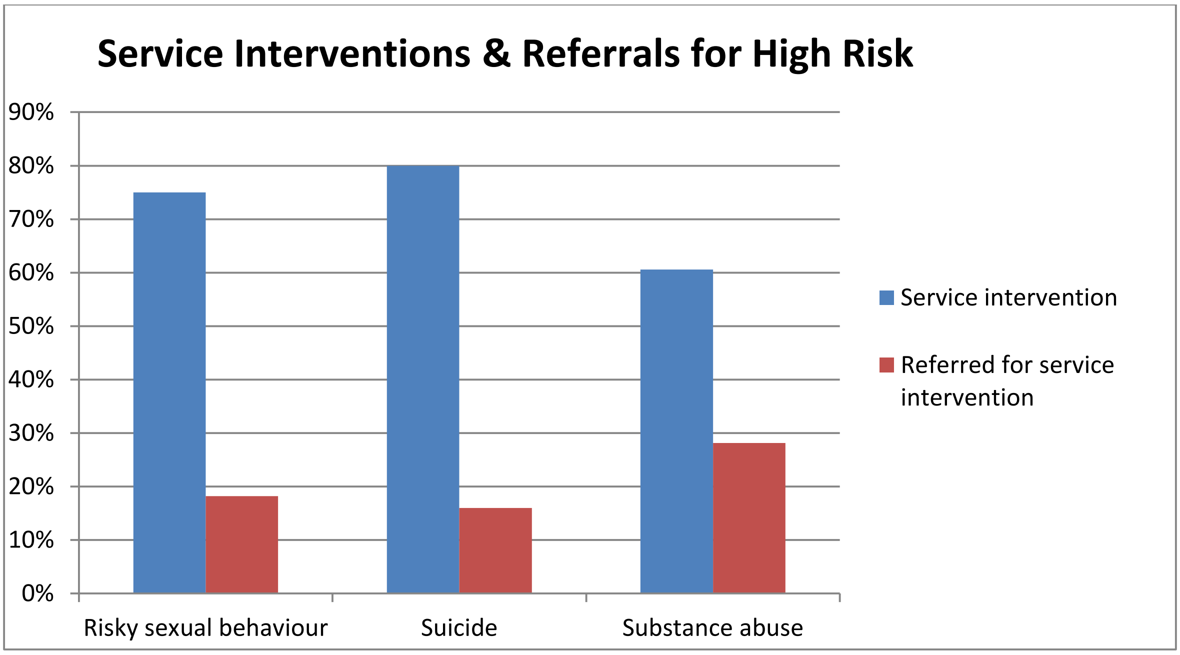

Figure 33: Service intervention and high level risk

Figure 34 shows gender differences across types and levels of risk. Overall, almost one third (32.6%) of all females are at high/medium levels of risky sexual behaviour and almost a quarter of all males (24.4%). In addition, 41.5% of all males are at high/medium levels of risk of substance misuse and almost a third of all females (32%).

At the high level of risk, there are slightly more females in the categories of risky sexual behaviour category and risk of suicide (52% in both), however, more males (67.6%) at high risk of substance misuse. Overall, males are two times more likely than females to be at high risk of substance abuse (χ^2 (1, N = 314) = 7.916, p = 0.005, φ = - 0.167, OR = 2.28).

At the medium level of risk, there are more females in the categories of risky sexual behaviour (57.8%) (χ^2 (1, N = 314) = 1.666, p > 0.05) and substance misuse (55.6%) (χ^2 (1, N = 314) = 0.938, p > 0.05) although more males are at medium risk of suicide (58.7%) (χ^2 (1, N = 314) = 0.625, p > 0.05).

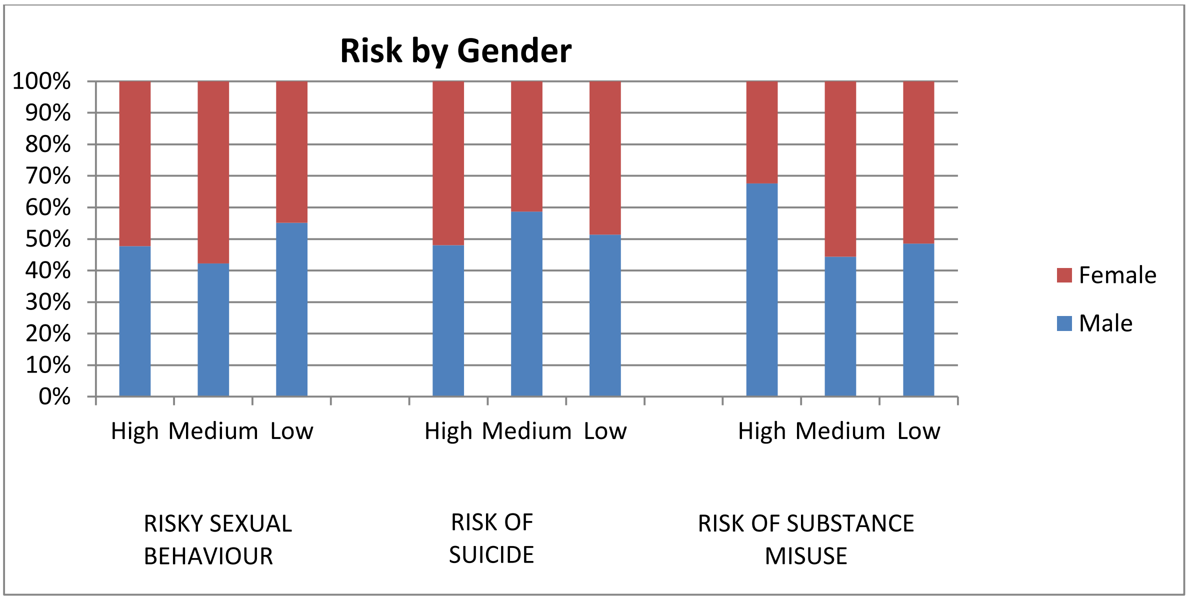

Figure 34: Gender by level of risk

Figure 35 below shows that those aged 17 are at the highest levels of risk, followed by 16 and 18 years olds.

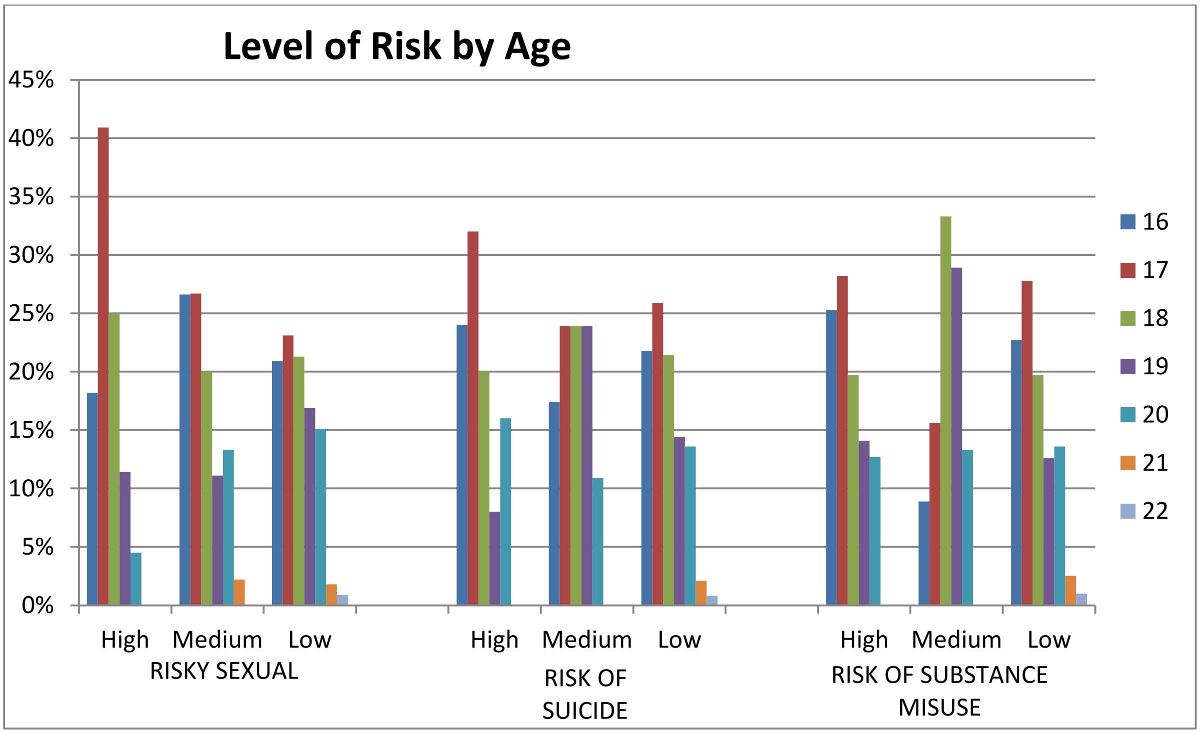

Figure 35: Age by levels of risk

Of those at the high level of risky sexual behaviour, the majority are living in tenancy without housing support (15.9%) followed by those living at home with a birth parent (13.6%). However, young people at the high level of risky sexual behaviour are no more likely to live in a tenancy without housing support than young people who are not at the high level of risky sexual behaviour (OR = 0.95). At the medium level of risky sexual behaviour, the majority are at home with a birth parent (24.4%), followed by those in 'other' accommodation (11.1%). Young people at the medium level of risky sexual behaviour are two times more likely to be living at home with a birth parent than those young people who are not at the medium level of risky sexual behaviour (OR = 2.16).

Of those at high risk of suicide, the majority are living at home with a birth parent (24%), followed by those living in tenancy without housing support (16%) or in hospital (16%). Young people at high risk of suicide are two times more likely to be living at home with a birth parent than those young people who are not at high risk of suicide (OR = 1.97). At the medium level of risk of suicide, the majority are living in tenancy without housing support (28.3%), followed by tenancy with housing support (17.4%). Young people at medium risk of suicide are two times more likely to be living in a tenancy without housing support than those young people who are not at medium risk of suicide (OR = 2.31).

Of those at high risk of substance misuse, the majority are living at home with a birth parent (19.7%), followed by living in tenancy without housing support (15.5%). Young people at high risk of substance misuse are 1.6 times more likely to be living at home with a birth parent than young people who are not at high risk of substance misuse (OR = 1.62). At the medium level of risk of substance misuse the majority are at home living in tenancy without housing support (28.9%), followed by tenancy with housing support (17.8%). Young people at medium risk of substance misuse are 2.4 times more likely to be living in a tenancy without housing support than young people who are not at medium risk of substance misuse (OR = 2.40).

In relation to impairment type, figure 36 shows that those with intellectual disability are at the highest level of risky sexual behaviour (34.8% of young people with intellectual disability) and lowest risk of suicide (9.1%), with just over one fifth at high/medium risk of substance misuse (21.2%). In contrast, high levels of risk of suicide (32.8%) and substance misuse (51.7%) are reported for those in the mental health category, with just over one quarter (26.3%) reported at high/medium level of risky sexual behaviour. Lowest levels of risks across categories are reported for those with ASD, other or multiple impairments with the exception of risky sexual behaviour where over a quarter of those with ASD (26.3%) and multiple impairments (27.8%) are also reported at high/medium level of risk.

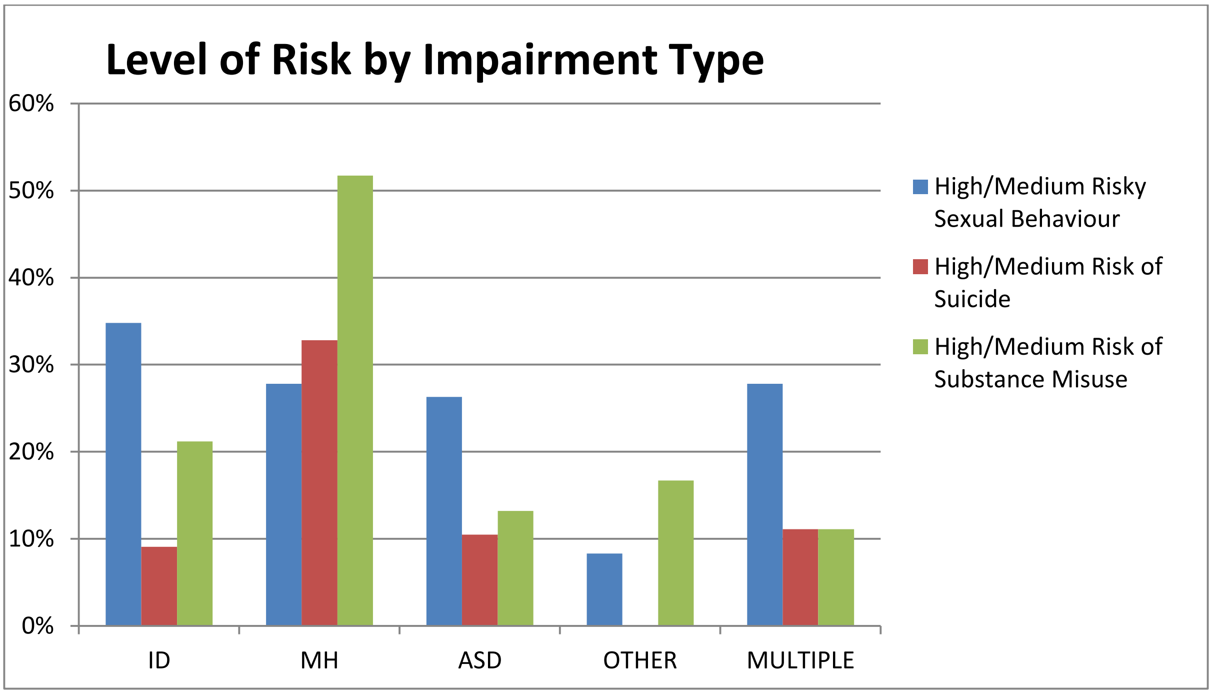

Figure 36: Impairment by levels for risk

Cautions and Convictions

A considerable number of young people have received a police caution (40.8%) (see figure 37). Information on the number of police cautions was provided for over half (55.6%) of these young people. The majority have been cautioned once or twice (40.3%), however, 11% have been cautioned more than 10 times, with 7% cautioned more than twenty times. In addition, 40.3% have been cautioned multiple times for an unspecified number of cautions and, for some of these, social workers recorded 'too many to count'. In relation to gender, 45.1% of males have received a caution in comparison to just over a third (36%) of females although the association between gender and receiving a caution was not statistically significant (χ^2 (1, N = 314) = 2.335, $p > 0.05$, $\varphi = 0.093$).

Almost one fifth (19.5%) of young people with a police caution live at home with a birth parent which is more than half (54.3%) of all those in this living arrangement. Young people with a caution are almost twice as likely to live at home with a birth parent when compared to young people without a police caution (OR = 1.91). Similarly, over half of those in residential child care (53.3%) have had a police caution, followed by 45% of those in 'other' accommodation settings, 43.6% of those in tenancy arrangements with no housing support, 42.9% of those in jointly commissioned supported living, and 42.3% of those in tenancy arrangements with housing support.

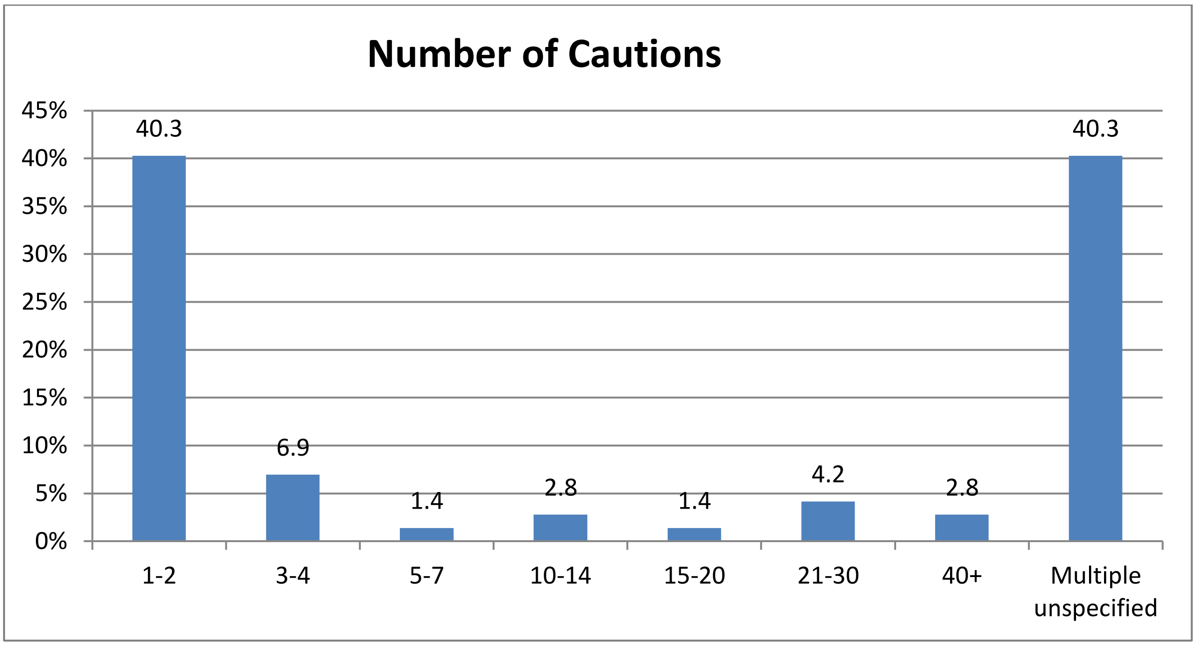

Figure 37: Number of police cautions

Figure 38 shows that the majority of young people (66.1%) have been cautioned after coming into care, although almost a quarter (23.6%) receive cautions both before and after becoming LAC.

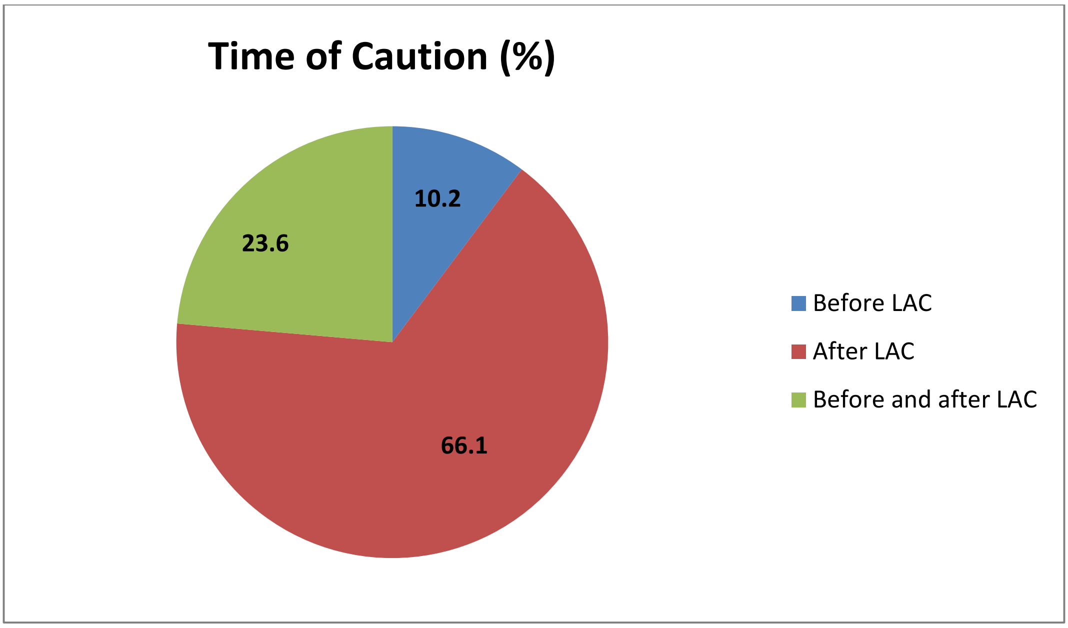

Figure 38: LAC stage by police cautions

Figure 39 shows that almost a third (30.6%) of the study sample have received a conviction. Of those who have been convicted, 37.8% are male and 22.7% are female. Moreover, males are two times more likely to have received a conviction than women (OR = 2.07) and the association between gender and convictions is statistically significant (χ^2 (1, N = 314) = 7.760, $p < 0.01$, $\varphi = 0.16$).

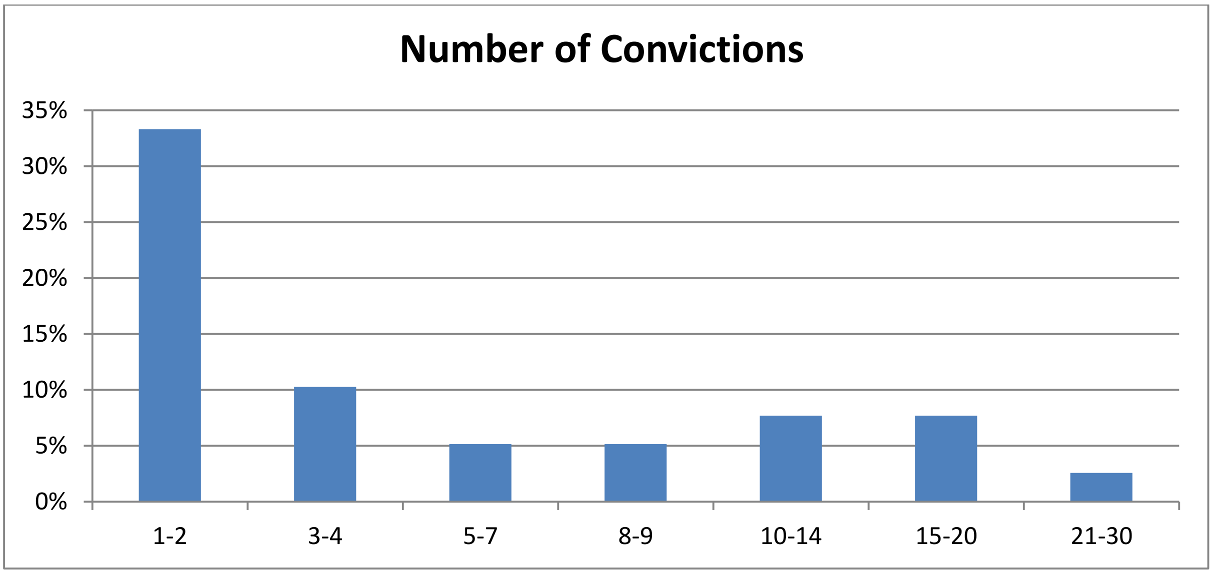

Figure 39: Number of convictions

The majority of young people have been convicted after coming into care (see figure 40), although a significant proportion of young people receive convictions both before and after becoming LAC.

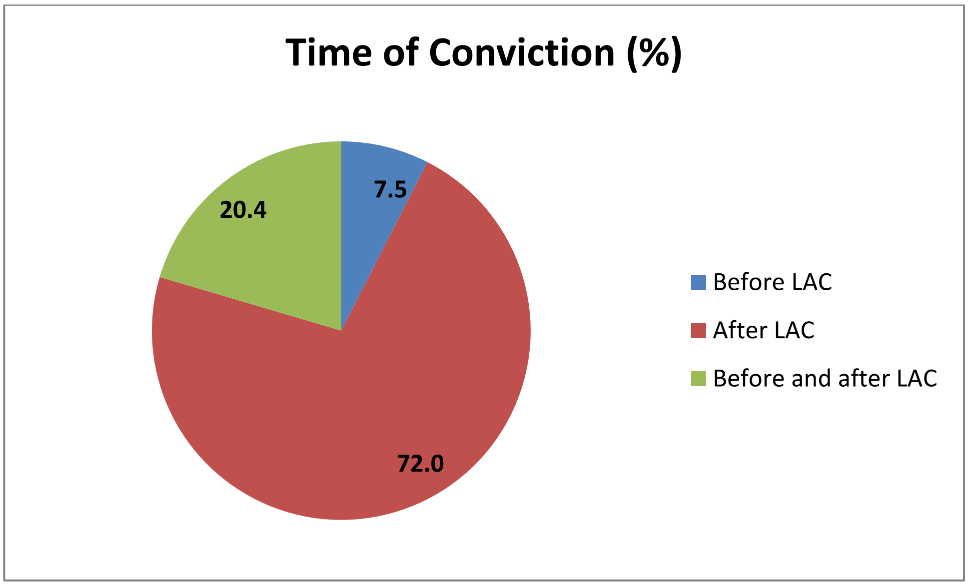

Figure 40: LAC stage by convictions

Almost one fifth (19.8%) of those convicted are living at home with a birth parent which is 41.3% of all those in this living arrangement. Young people with a conviction were 1.7 times more likely to live at home with a birth parent when compared to young people without a conviction (OR = 1.75). Overall, 40% of those in residential child care and 40% of those in 'other' accommodation settings have a conviction, followed by, 35.9% of those in tenancy arrangements with housing support, 30.8% of those in tenancy arrangements with no housing support and 28.6% of those in jointly commissioned supported living.

Figure 41 shows that a higher proportion of those who are cautioned are 17-18 years old (52%). Moreover, almost half of young people with a conviction are 17-18 years old (48.9%). There is very little difference for those aged 16 (17.1% cautioned compared to 18,8% convicted) and low numbers aged 21+ reflect the lower numbers in this age range within the study sample.

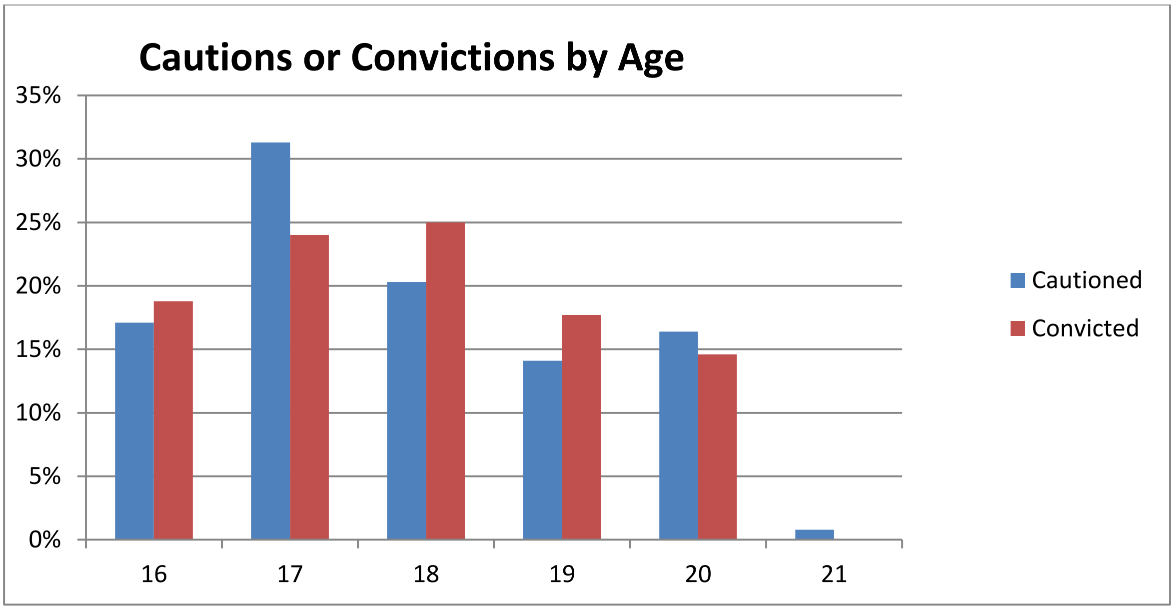

Figure 41: Police cautions or convictions by age

Figure 42 shows the percentage of cautions and convictions within each impairment category. Those with mental health needs, followed by those with an intellectual disability are most likely to have cautions and convictions: half of those with mental health needs have been cautioned and 41.7% convicted; whilst almost one third of those with an intellectual disability (30.3%) have been cautioned and just over one fifth convicted (21.2%). Whilst similar numbers of those with ASD have been cautioned (28.9%), in contrast, only 13.2% had been convicted. Even lower rates of conviction are reports for those with other (8.3%) and multiple impairments (5.6%). A Chi-Square test of independence was performed to examine whether or not there is an association between being cautioned and impairment type. The relationship between the variables was statistically significant with a small effect size χ^2 (4, N = 314) = 15.345, $p < 0.005$, $\varphi_c = 0.22$). Young people who have been cautioned are 2.5 times more likely to have mental health needs than those who have not been cautioned (OR = 2.52). Similarly, a Chi-Square test of independence to examine associations between receiving a conviction and impairment type showed a statistically significant relationship with a medium effect size χ^2 (4, N = 314) = 26.694, $p < 0.001$, $\varphi_c = 0.29$). Young people who have received a conviction are 3.8 times more likely to have mental health needs than those who had not received a conviction (OR = 3.84).

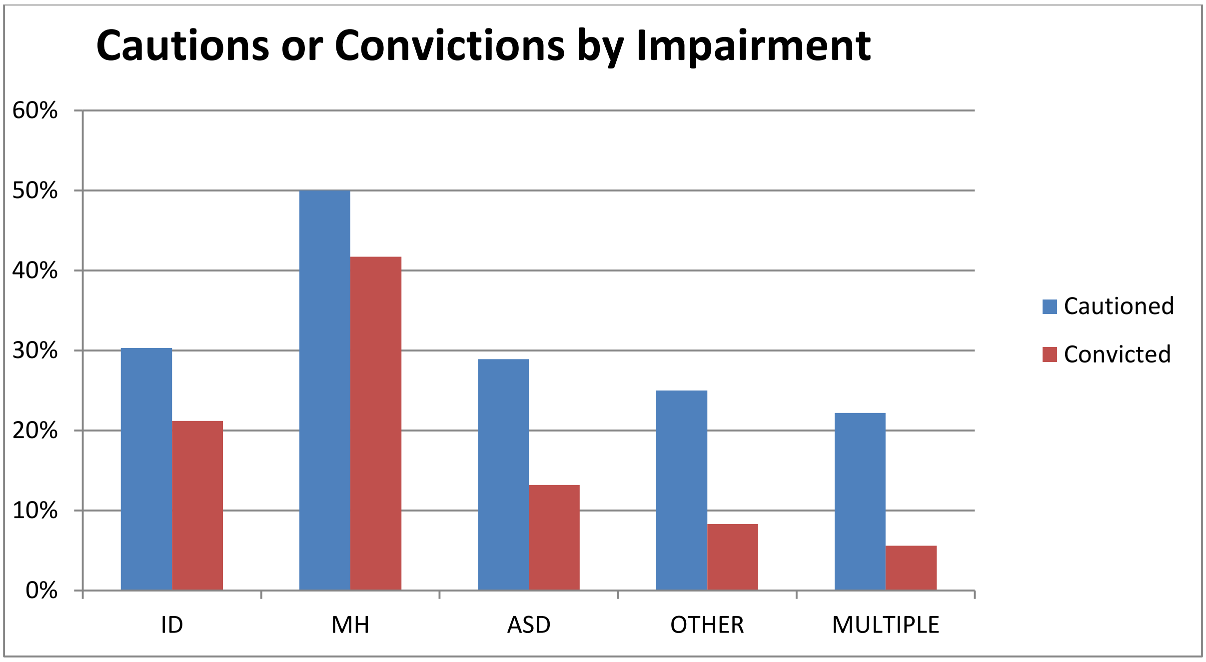

Figure 42: Police cautions or convictions by impairment type

For 21 young people, social workers provided information on the outcome of the conviction. Figure 43 shows that the majority received a Youth Conference Order (38.1%), however, almost a fifth (19%) received a custodial sentence.

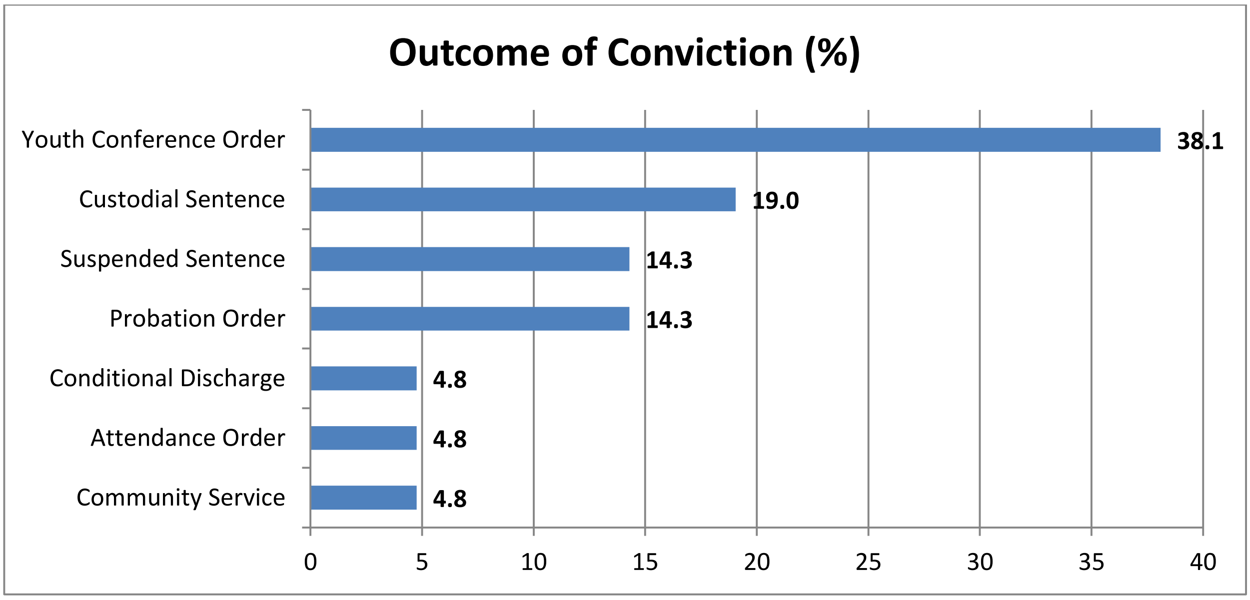

Figure 43: Outcome of conviction

Summary

More than one in five of the study sample have attempted suicide in the previous year with no major differences in gender. Of those who have attempted suicide, 43.4% have attempted suicide more than once and more than a fifth are aged 16 (at the time of the survey). Whilst just over one quarter of these young people are in receipt of CAMHS and almost one third receiving AMHS, social workers report that the majority of those with a high risk of suicide are receiving services.

High levels of risk are reported in relation to substance misuse, however, more than a third of young people at high risk of substance misuse are not receiving services to address these risks. In contrast, three quarters of young people at risk of exploitative or other high risk sexual behaviours are receiving services. At the high level of risk, there are slightly more females in the categories of risky sexual behaviour category and risk of suicide, however, more males are at high risk of substance misuse. Those at higher levels of risk are living in tenancy arrangements or at home with a birth parent. Young people with intellectual disability, ASD and multiple impairments are at higher levels of risky sexual behaviour. In contrast, high levels of risk of suicide and substance misuse are reported for those in the mental health category.

A considerable number of young people have received a police caution (40.8%), mostly after they came into care. Of these, 11% have been cautioned more than 10 times and a further 40.3% multiple times for an unspecified number of cautions. More males than females have been cautioned and more than half of those living at home with a birth parent or in residential care have been cautioned, followed closely by those in 'other' accommodation settings, tenancy arrangements or jointly commissioned supported living.

Almost a third of the study sample have received a conviction, mostly after coming into care, and almost two thirds of these are male. Many of these young people are living at home with a birth parent, in residential child care or 'other' accommodation settings, followed by those in tenancy arrangements or jointly commissioned supported living. Higher rates of cautions and convictions are reported for 17 and 18 year olds. Half of those with mental health needs have been cautioned and 41.7% convicted; whilst almost one third of those with an intellectual disability have been cautioned and just over one fifth convicted. The majority received a Youth Conference Order however almost a fifth received a custodial sentence.

4.10 Care Leaver Income

Figure 44 shows that over a third of young people (33.8%) are in receipt of Disability Living Allowance and a quarter (25.2%) in receipt of housing benefit. More than a fifth of the study sample (23.9%), are not in receipt of any benefits. Of those not receiving benefits, 17.3% are Not in Education, Employment or Training (NEET); 12% are at a training centre, 6.7% are pre-vocational, 14.7% are in paid employment, and 5.3% are at university and 17.3% are in mainstream education. Almost two thirds of those not in receipt of any benefits are male (61.3%) and in the mental health category (65.3%), and almost three quarters (73.3%) are aged 16-17 years.

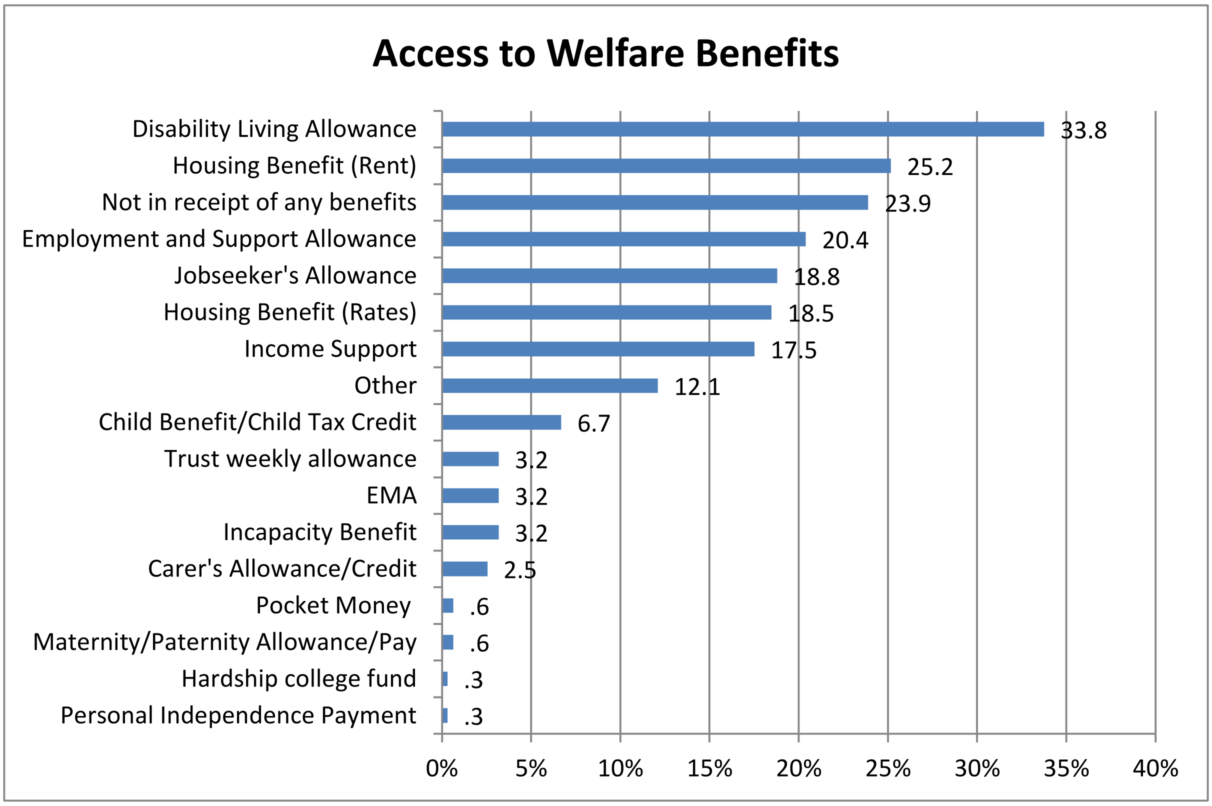

Figure 44: Access to welfare benefits

Social workers completing surveys were asked to provide an approximate estimate of each young person's current weekly income. This data was missing for almost one fifth (20.4%) of the sample. From the data provided, figure 45 shows that 44.4% are living on £51-100 per week, followed by £1-£50 per week (17.1%). Just over one quarter (27%) receive over £100 per week and only 15.7% receive over £150 per week.

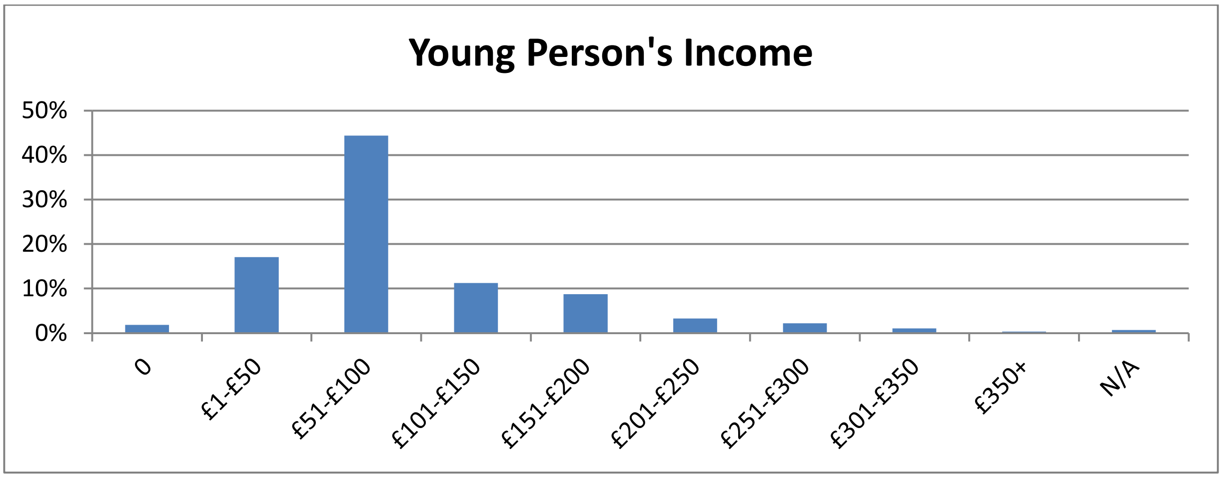

Figure 45: Income levels

Summary

Almost one quarter of young people are not in receipt of any benefits and, of these, 17.3% are Not in Education, Employment or Training (NEET). Almost two thirds of those not in receipt of any benefits are male and in the mental health category and almost three quarters are aged 16-17 years. Some care leavers may be entitled to receive maintenance and accommodation monies from Trusts, however, from the data available on income, the majority of care leavers (61.5%) are living on less than £100 per week.

4.11 Education, Employment and Training

Figure 46 shows that 10.5% of the study sample are engaged in employment, similar to the 8% of those in the general care leaver population in the DSF return. However, only half of those in the study population engaged in employment (5.7%) are in paid employment (3.2% are in supported employment and 1.6% are volunteering). A further 19% are still in school (mainstream or specialist), which is slightly higher than the figure reported in the DSF return for the general care leaver population (14.4%). A further 12.7% are attending a training centre and 11.5% are attending further education colleges (lower than 19.5% for the general population attending further education colleges reported in the DSF return). Only 1.6% are studying at University, compared to 4.9% for the general population in the DSF return. Four out of these five young people attending University in the study sample are male, and all of these young people are in the mental health or ASD impairment categories. A further 8.4% are considered to be pre-vocational with some of these young people attending employability programmes and courses offered by Give and Take or Connections programmes. This is similar to the figure (9.2%) for the general population in the DSF return. A small number of young people (3.5%) are in other arrangements such as, education provided in prison/juvenile justice centre, in a women's centre or as part of a service for asylum seekers. Overall, 34.1% have a statement of special educational needs.

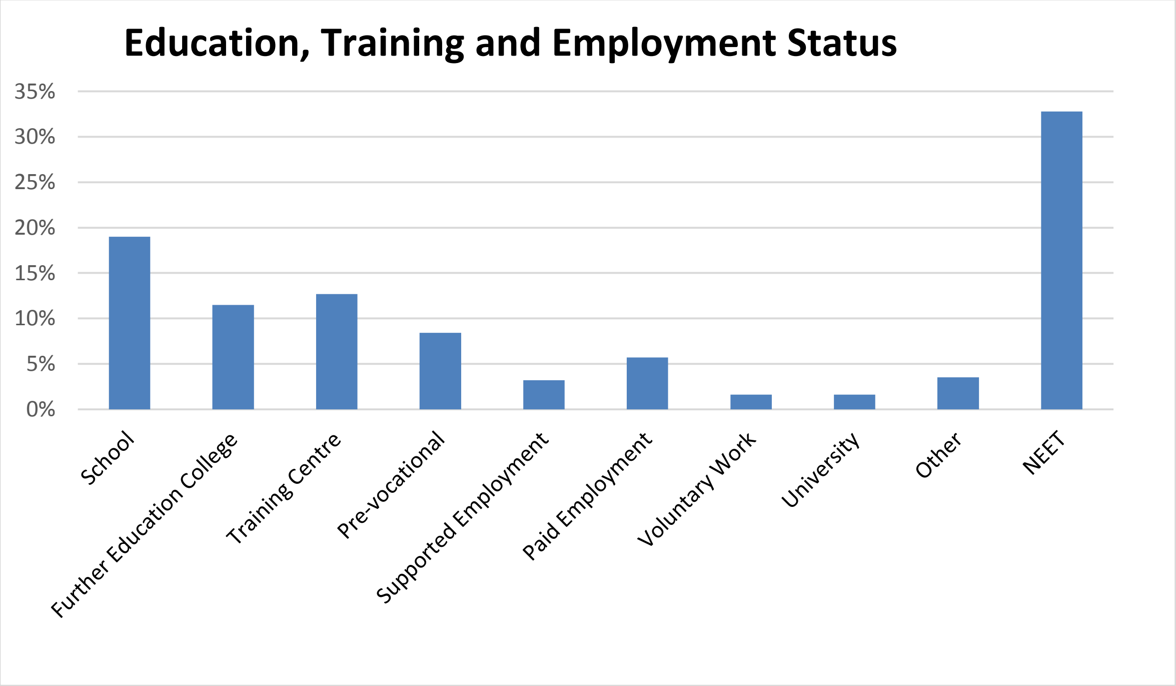

Figure 46: Education, training and employment status

Whilst most of the study sample experienced no or few school changes, (43.9% had none; 42% had 1-2 school changes), more than one in ten (11.8%) had between three and nine school changes (see figure 47), perhaps reflecting placement change reported earlier in the report. The majority of these young people have mental health needs (62.2%), with 18.9% having an intellectual disability and much smaller numbers reported for other impairment types. Although the association between impairment type and the number of school changes is not statistically significant, this level of school change is likely to have a significant impact on their educational experience and performance (χ^2 (4, N = 307) = 2.292, $p > 0.05$, $\varphi_c = 0.06$).

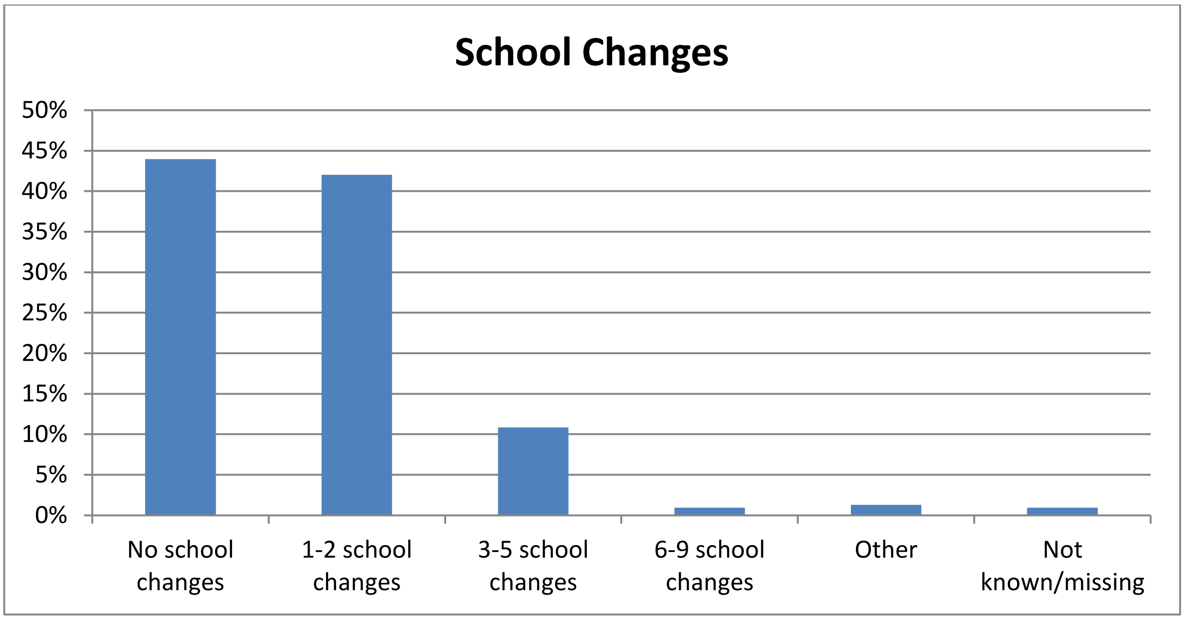

Figure 47: Experience of significant school change

Of those in paid employment, the majority (55.6%) are employed in permanent or temporary full-time work (see figure 48). A smaller proportion of those in paid employment are employed on a casual (5.6%), part-time temporary (22.2%) or part-time permanent (16.7%) basis.

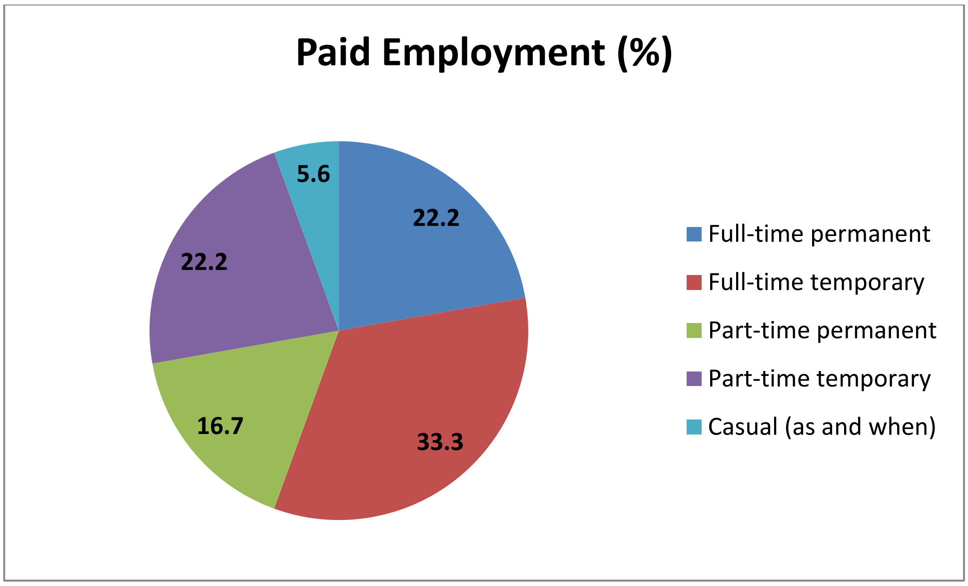

Figure 48: Paid employment status

Two thirds of those in paid employment are male and half of those in paid employment are aged 18-19 years. The majority of those in paid employment are in the mental health category (61.1%), followed by equal proportions of those with an intellectual disability or ASD (16.7% in both of these impairment categories). A third of those in paid employment are in tenancy arrangements without housing support, 22.2% are living at home with a birth parent, 16.7% are informally staying with friends/relatives, followed by equal proportions of those in GEM former foster care (11.1%) and non-relative foster care (11.1%).

Figure 49 shows that almost a third (32.8%, n=103) of the study sample are not in education, training or employment (NEET). This is a higher figure than that for the general care leaver population in the DSF return (21%). Social workers provided the main reason for NEET for 89 of these young people indicating that for almost half of these cases, social workers reported that the young person does not want to engage (50.5%). Other main reasons for NEET are pregnancy or parent/carer roles (14.6%), sickness (10.5%), addiction (4.5%) waiting for education training or employment opportunities to commence (9%), or being in prison/out on bail (7.9%).

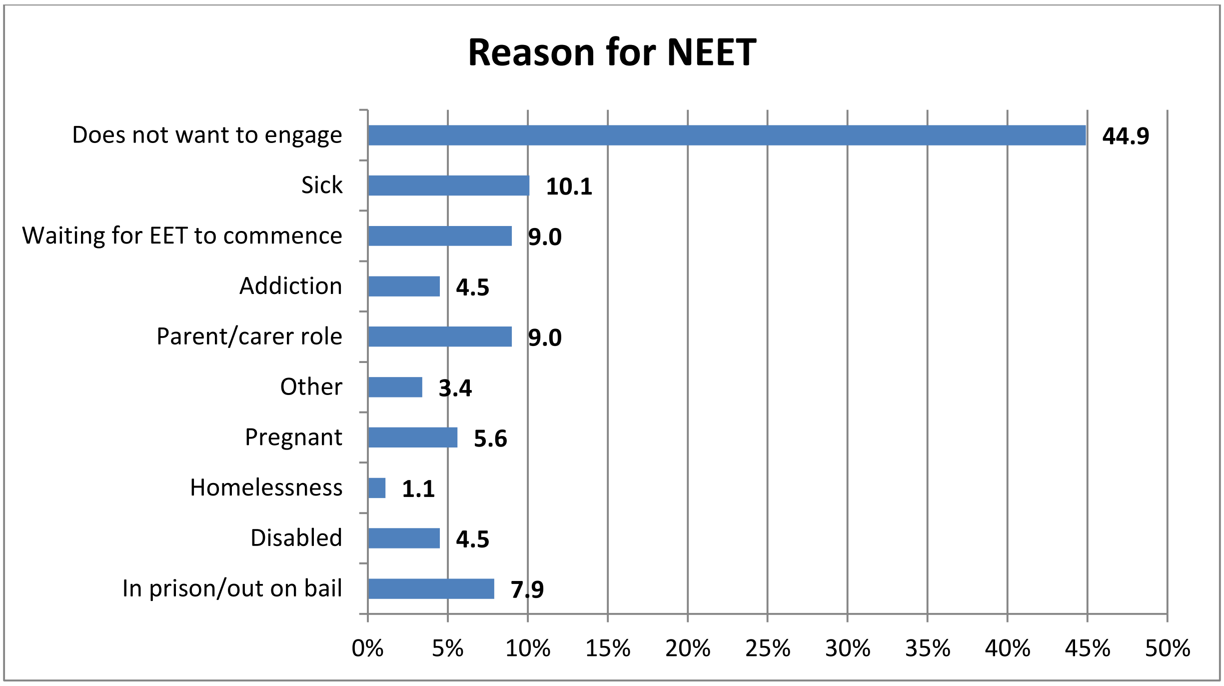

Figure 49: Reason for NEET

Almost a third of those NEET are aged 18 (30.9%), followed by 22.7 % aged 17 and 22.7% aged 20 (see figure 50). There were no major differences in gender for those in the NEET group, however, those at home with birth parent (22.7%) and in tenancy without housing support (26.8%) are most likely to be NEET, followed by those in tenancy with housing support (16.5%). Over two thirds (68%) are in the mental health category, with 17.5% having an intellectual disability and 10.3% ASD.

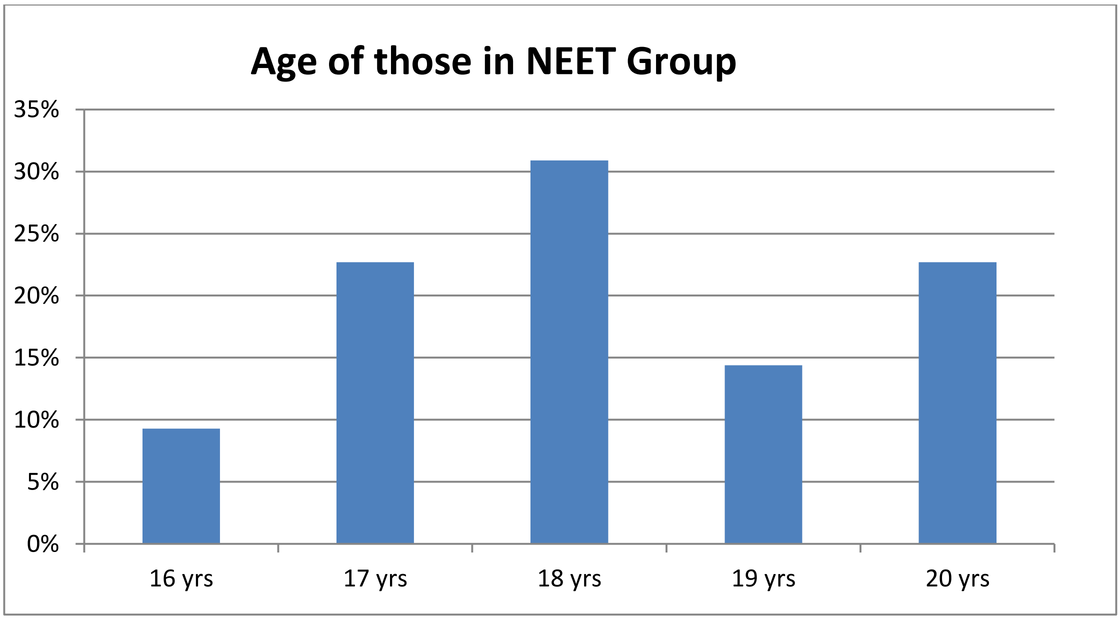

Figure 50: Age by NEET

Most young people are receiving assistance with education and training (88.2%) or employment (66.9%). Those who are not availing of such assistance are mainly reported to be refusing to engage or not requiring assistance for a range of reasons (e.g. already in education, training or employment or living in custody/detained). However, there are notable trends in assistance with education or employment across impairment type. Figure 51 shows that there is a marked drop in assistance with employment for those with multiple impairments (from 94.4% to 38.9%) or intellectual disability (from 84.8% to 57.6%). This reduction may indicate that young people in these impairment categories are least likely to engage in employment, however, this finding may also indicate lower employment expectations for young people with these impairment types.

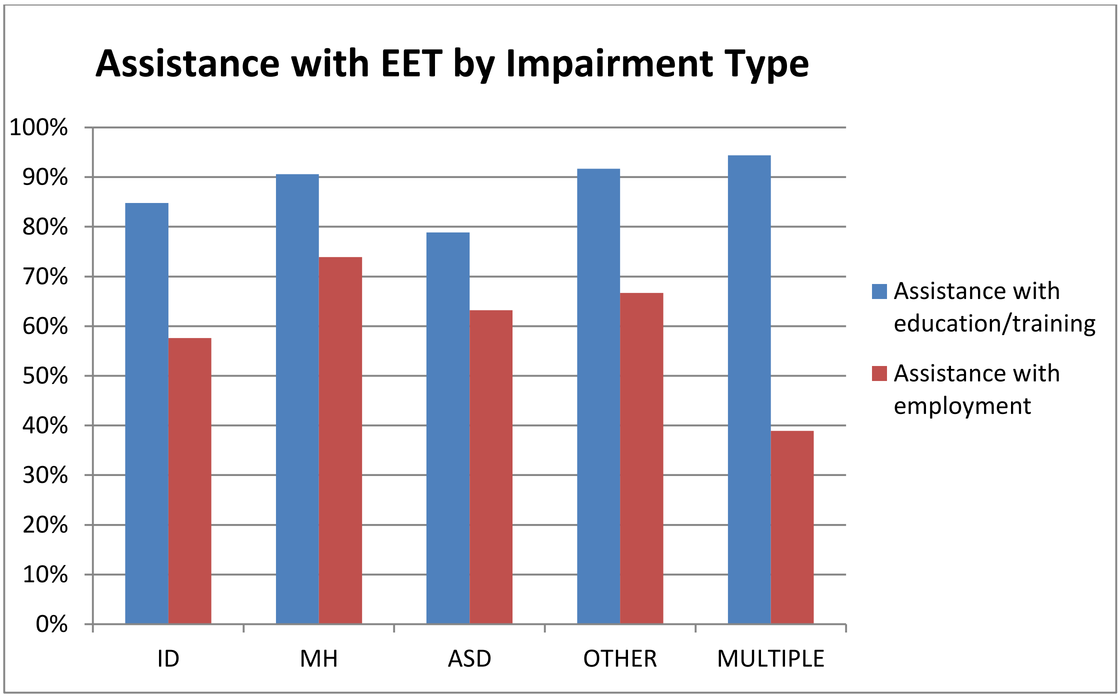

Figure 51: Assistance with EET by impairment type

Summary

Almost one fifth of the sample are still in school. Only one in ten of the study sample are engaged in employment and only half of these are in paid employment. Of those in paid employment, the majority are male and in the mental health category.

Almost a third of the study sample are not in education, training or employment (NEET) and for almost half of these cases social workers reported that the young person does not want to engage. There were no major differences in gender for those in the NEET group, however, over two thirds are in the mental health category and mostly living at home with birth parent or in tenancy without housing support.

Other young people are attending training/pre-vocational or further/higher education courses. Just over one third have a statement of special educational needs. Interestingly, more than one in ten (11.8%) have experienced multiple school changes, mostly those with mental health needs, which is likely to have a significant impact on their educational experience and performance.

The majority of young people are receiving assistance with education and training or employment. However, there is a drop in assistance with employment for those with multiple impairments or intellectual disability, reflecting lower employment expectations and attainment for young people in these impairment groups.

4.12 Unmet Needs

Social workers used the space provided at the end of the survey to record qualitative comments about particular areas of concern for disabled care leavers.

Firstly, social workers expressed concerns regarding transitions to adult services and barriers to accessing adult disability or mental health services. Social workers reported gaps in services for those aged 18-21 years who are not yet accessing adult services or are on waiting lists for diagnostic assessments. There are also concerns about the re-assessment of young people transitioning to adult services, especially when their former diagnosis is removed as they age out of children's services and young people who met the criteria for children's disability/mental health services but do not meet the eligibility criteria for adult services, despite ongoing high levels of vulnerability in the community and low levels of independent living skills. In addition, a few social workers identified young people who are vulnerable in the community due to sectarian or paramilitary threat, with two young people moving jurisdiction for their own safety. These issues will be further explored in the case studies undertaken as part of the third stage of this study.

Reflecting earlier reports on young people disengaging from services, social workers commented on their concerns for young people who refuse assessment or support from disability / mental health services. In some cases, 16+ staff sought advice from experts in these services to guide their own work with these young people. Following earlier survey findings on lower levels of services provided in response to risks of substance misuse, a number of social workers expressed concerns for young people with substance misuse problems who found it difficult to maintain contact with therapeutic support services. Many services also refused access for young people engaging in ongoing drug or alcohol use or criminal behaviour (e.g. hostels). Whilst some care leavers may well wish to disengage from services in general, these findings raise questions for service providers about how accessible, age appropriate and responsive services are to the presenting needs of care leavers.

Secondly, social workers highlighted the need to revert to out of jurisdiction due to the lack of specialist and in-patient care available within NI and the impact this has on birth family contact and transitions from care. As one social worker stated:

> *"This young person was placed outside NI as there was no suitable placement to meet her complex needs. It is unlikely an adult placement will be found in Ireland which means this young person will remain in England. If a place was available a shared care arrangement could be in place with former foster mother and placement. The young person's mother has not seen her daughter in almost two years due to her own health needs is unable to travel."*

Thirdly, limited supported accommodation options and adult foster placements are reported by social workers who referred to cases where some young people are missing out on daily care and support they require. Lack of appropriate adult placements also impacts on young people's vulnerability in the community and engagement in education, training or employment, as one social worker explained:

> *"This young man found his unplanned transition from foster care to independent living very difficult. He moved through a number of private rent accommodations... Engagement in EET was then difficult to maintain due to the difficulties in adjusting to independent living. His previous GEM foster carers still visit and keep in touch, but unfortunately could not maintain the placement. He presents as very vulnerable and has also since been cautioned for assaulting PSNI."*

In some cases, social workers are struggling to identify suitable accommodation and support for young people transitioning from care:

> *"There is no appropriate supported accommodation for this young person who is very vulnerable and has complex needs but doesn't fit under categories of learning disability and mental health or funding for supported housing. We have great difficulty in sourcing an appropriate move on option."*

Finally, the age when leaving care support services cease was highlighted. Generally, social workers indicate that cases close when young people turn 21 years old even though some young people are still in a stage of transition at this age, often awaiting assessment from adult services or planning to leave former care arrangements (e.g. birth family or former foster care). Ceasing leaving care support services at this time can be very challenging, particularly for those who experience anxiety or who require a stable daily routine. Social workers also indicate that the cessation of leaving care services may also result in the withdrawal of funding for services from the voluntary/community sector that young people rely on for additional support.

Summary

Social workers reported a number of key areas where they have ongoing concerns about disabled care leavers' unmet needs. These are: barriers to accessing adult disability or mental health services, including changing eligibility criteria and waiting lists; lack of specialist and in-patient care available within NI; and an inadequate range of supported accommodation options and adult foster placements. Difficulties associated with finding suitable adult placements also impacts on young people's vulnerability in the community and engagement in education, training or employment. Overall, social workers indicate that leaving care services cease too early when young people turn 21 years old but are still in a stage of transition from care and from child to adult services. Finally, social workers were concerned for young people who refuse assessment or support services, particularly those who have substance misuse problems or are engaged in criminal behaviour.

5.0 Conclusion and Recommendations

This report has presented the findings of the survey stage of the study which has profiled the population of disabled care leavers in NI at 30 September 2013. For the first time, this survey has captured the characteristics and experiences of this sub-group of care leavers. Based on the findings reported, it is possible to identify key trends and areas requiring service improvement to address unmet need or poorer outcomes for care leavers with mental health needs, intellectual disabilities or ASD. The points presented below are the key areas that should be addressed by policy makers and service planners, commissioners and providers to more effectively address the needs of disabled care leavers:

1. **Identification and monitoring of disability amongst the care leaver population.** One of the key findings from the survey data is the need to recognise care leavers with mental health and/or intellectual disabilities as distinct groups with unique experiences of services and post-care outcomes. Indeed, the data suggests that there are differences in the experiences of those with mental health needs and those with other impairment types, indicating a need to raise awareness of the diverse needs within the population of care leavers. There are also variances in the characteristics of these two impairment groups. For example, there are more females with mental health needs and more males in the intellectual disability, ASD or multiple impairment categories. In addition, there are different trends in the prevalence of impairment types in the care leaver population across Trusts. Given these findings, it is crucial that Trusts review and improve systems for identifying, collating and maintaining records of impairment type within the care leaver population and that the HSCB ensures quality checks are in place to monitor the accuracy of statistics on disabled care leavers in statutory data returns. The HSCB should play an important role in ensuring such developments in data collection and monitoring systems are implemented consistently at a regional level. It would also be helpful if the DSF return could separate ADD/ADHD from the current ASD category in the bi-annual returns for care leavers to improve the accuracy of returns for those with ASD. Developing a comprehensive database on the care leaver population that accurately records impairment type would help to facilitate improved services for disabled care leavers, many of whom will require ongoing aftercare and adult support services. Enhancing the data available on disabled care leavers would also provide further opportunity for audit, evaluation and research to

build our understanding of how well we are meeting their distinct needs as they transition from care.

2. **Co-existing impairments.** As current statistical reports on care leavers do not allow for the identification of co-existing impairments, it is important to note that almost one fifth of the study sample (18.8%) have more than one impairment type. These findings on the multiple impairment experiences of disabled care leavers are important as they highlight the previously unknown range and complexity of need amongst the population of disabled care leavers in NI. Clear pathways to services that address varying impairment related needs are essential, including transparent and inclusive eligibility criteria for access to disability and/or mental health services, as required. For example, a care leaver with mental health and intellectual disabilities who is known to the disability service should not be excluded from access to specialist mental health services that may more effectively meet their presenting needs at the time of leaving care.
3. **Reasons for being in care and vulnerability to abuse, neglect or family breakdown.** Variances in reasons for being admitted to care are notable across the two main impairment categories: mental health and intellectual disability. Young people with intellectual disabilities are 3.5 times more likely than those with mental health needs to have been taken into care because of neglect and 1.8 times more likely to be in care due to emotional abuse. Moreover, young people with intellectual disabilities are more likely than young people with mental health needs to have been taken into care because of sexual abuse (although numbers are small). In contrast, those with mental health needs are three times more likely than young people with intellectual disabilities to come into care because they are beyond parental control. The survey does not provide information on the direction of causality, for example, whether a young person's mental health needs impact on parental ability to maintain control or poor parental control leads to the development of mental health needs for young people. However, the findings do provide insight into potential risks of abuse, neglect and family breakdown for disabled care leavers with different types of impairments. Professionals working with disabled children and young people should be aware of these differing risk experiences to ensure signs of abuse or neglect are identified early and

interventions are tailored to the presenting needs of different sub-groups of disabled children and young people.

4. **Placement and school disruption whilst in care.** The survey found that almost half of the population of disabled care leavers have experienced significant placement changes during their time in care, particularly young people with mental health needs who are at greater risk of multiple placement changes. Such placement disruption is likely to have a detrimental impact on opportunities for permanence, social inclusion, birth family contact and schooling. Indeed, more than one in ten of the sample had between three and nine school changes. Efforts should be made to reduce this level of disruption for disabled care leavers through greater understanding of the reasons for placement breakdown and school change and targeted care planning to promote permanence.
5. **Parenting status.** The numbers of disabled care leavers in the study sample who are parents reflect those for the wider leaving care population. The majority of those who are parents are female and many are under 18 and not living with their children. These findings highlight the importance of including disabled young people in educational programmes about sexual and personal relationships and effective parenting, ensuring such programmes are accessible and disability aware.
6. **Living arrangements.** In comparison with trends in the wider care leaver population, the survey found that disabled care leavers are less likely to have the opportunity to stay with former foster carers under the GEM scheme. There is a trend towards those with mental health needs moving on to tenancy arrangements without housing support. Whilst some care leavers with mental health needs may cope very well in such living arrangements, there are increased risks of poorer outcomes for those living in tenancy without support. In contrast, care leavers with intellectual disabilities are more likely to return home, which may reflect the lack of suitable supported housing or adult residential placements for these young people (reported in qualitative comments from social workers). Whilst returning home reduces the risk of moving into supported tenancy arrangements, there are also inherent risks in returning to the birth family home if original safeguarding issues have not been addressed. In addition, the survey findings show that outcomes for those

returning home are poorer. For example, those who live at home with a birth parent or in tenancy without housing support are most likely to be NEET and are at high levels of risk of suicide or substance misuse. Interestingly, those with an intellectual disability are reported to be least likely to receive assistance with accommodation and maintenance from 16+ services, with almost a third of these young people not receiving these services. Whilst this may be due to an assumption that they are receiving support from disability services or birth families, it is clear that further support with accommodation should be provided to care leavers with intellectual disabilities, including assessment of risks associated with returning home potentially as a vulnerable adult.

7. **Access to 16+ social work and personal advisor (PA) services.** The majority of those with mental health needs have access to 16+ social work services compared with just over half of those with ASD or intellectual disabilities. Similarly, over a fifth of those with intellectual disability and over a quarter of those with ASD are not accessing PA support; compared with only 11.7% of those in the mental health category not accessing PA services. These findings indicate that 16+ services are more likely to include care leavers with mental health needs and less likely to be inclusive of those with other impairment types, despite their care leaver status. As the findings also show low uptake of child or adult disability services, it cannot be assumed that their needs are being met by other disability-related service providers. Service planners and commissioners, therefore, should review access to 16+ services for those with intellectual disabilities and ASD to ensure they have equal access to the full range of leaving care services they are entitled to. There should be a clearer pathway to services to ensure needs and entitlements are fully met through children’s services and into adult services. Most of those who have a PA have regular contact with them, however, a fifth have no contact with their PA. Social workers indicated that this was due to the young person's disengagement or because the case was newly allocated, however, this level of limited or no contact requires further attention, particularly in cases where social workers are reliant on a PA to maintain support for young people.

8. **Reduced access to employment assistance.** Similarly, whilst almost three quarters of those with mental health needs access assistance with employment, over a third of those with ASD and 42.4% of those with an intellectual disability are not accessing such assistance. These findings may indicate a reliance on schools or other disability-related organisations to provide employment assistance for these care leavers or lower expectations for those with ASD or intellectual disabilities in terms of progressing to employment. Whatever the reason, it is essential that care leavers with ASD and intellectual disabilities have access to services targeted at assisting them with efforts to secure employment.
9. **Low levels of access to disability or mental health services.** Despite high levels of co-existing mental health and intellectual disability/ASD, very low levels of engagement in CAMHS and AMHS are reported for those with intellectual disabilities or ASD. Similarly, numbers remain relatively small in relation to access to child or adult disability services, particularly for those with ASD. It is unsurprising, then, that low levels of contact with a range of other professionals are reported, including nurses, transition coordinators and professionals allied to medical services. Very low numbers of disabled care leavers accessing some of these professionals is concerning, particularly those who could provide important specialist support during the transition to adult life. Qualitative comments from social workers indicate barriers to accessing disability and mental health services due to lengthy waiting lists and high eligibility thresholds. These findings indicate a need to review eligibility criteria for access to child/adult disability and mental health services and prioritise the needs of disabled care leavers.
10. **Access to a befriender or advocate.** Almost three quarters of the study sample do not have access to a befriender. The majority of those who do, are in the mental health category with only five young people with intellectual disability and one with ASD accessing these services. In addition, it is concerning that less than one in ten are reported to have access to a mentor and only 5.7% have an independent advocate. These are core services that should be further developed to ensure disabled care leavers have access to peer support and independent advocacy. Whilst there is a regionally commissioned mentoring and advocacy service for all looked after and care

experienced young people, these very low levels of access to befriending and advocacy services indicate that future commissioning of advocacy and mentoring support should target disabled care leavers.

11. **Variation in short break usage.** Less than one in ten of the study sample use short breaks, with particularly low levels of short break usage for older care leavers and in some Trust areas. In addition, those with multiple impairments are much more likely to be accessing short breaks than those with other impairment types. The variance in numbers accessing short breaks across Trusts is likely to reflect different levels of availability of adult short break placements across NI and indicates a need to review and develop the extent of these services regionally.
12. **Low levels of uptake of direct payments.** The low levels of direct payment usage indicates a need to raise awareness amongst care leavers and staff in 16+ teams of the opportunity to access direct payments. Given the current policy emphasis on personalisation, it is important that disabled care leavers have information about direct payments and support and advice on how to manage direct payments. Increased use of direct payments may also provide an opportunity for more creative and personally meaningful ways to increase the low levels of social activity reported for the study sample.
13. **Risky behaviours.** Those with intellectual disability are at the highest level of risky sexual behaviour and lowest risk of suicide, with just over one fifth at high/medium risk of substance misuse. In contrast, high levels of risk of suicide and substance misuse are reported for those in the mental health category, with just over one quarter at high/medium level of risky sexual behaviour. Unfortunately, of those at high risk of substance misuse, more than a third are not in receipt of services to address these needs. Indeed, qualitative comments from social workers illustrate their concern for young people with substance misuse problems who experience barriers to accessing required services. Lower levels of risks are reported for those with ASD, with the exception of risky sexual behaviour where over a quarter of those with ASD are at high/medium level of risk. These findings on risky behaviours should help service planners and commissioners to target services at particular sub-groups of disabled care leavers. As mentioned earlier, professionals should develop their awareness of the increased level of risky

sexual behaviours for those with ASD and intellectual disabilities, and educational programmes should be provided for these young people aimed at raising awareness of personal safety and positive personal relationships. Whilst many of those at higher risk of suicide are receiving services, those with substance misuse problems seem to be more disengaged from services. An audit of services targeted at care leavers with substance misuse problems would be helpful to develop our understanding of why young people disengage and how services could be enhanced to more effectively address substance misuse related issues for care leavers.

14. **Low income levels and financial hardship.** From the data available in the survey, almost two thirds of the study sample are living on less than £100 per week. This indicates a severe risk of financial hardship for care leavers at a time when they are only learning how to manage their finances. A review of welfare benefit usage amongst disabled care leavers would help to elucidate some of the barriers to financial support and develop ideas on how best to support disabled care leavers economically as they transition from care.
15. **Withdrawal of leaving care services.** The survey findings indicate that leaving care services are targeted at younger care leavers and tend to cease as young people age out of children's services, with 90.5% of those in the study sample being aged 19 or under. Whilst it could be argued that this withdrawal of leaving care services is appropriate as young people move on to more independent post-care lives, there is much concern among social workers that older disabled care leavers have unmet needs and require more extended care leaver supports as they experience further change and transition well into their twenties. There is also a need to examine the types of ongoing support required with a combined focus on the leaving care service model alongside enhanced skills and knowledge for supporting disabled care leavers across child to adult services.

As outlined above, many of the survey findings require targeted policy and practice developments. In addition, as this is the first survey that aimed to capture a regional perspective on the profile of disabled care leavers, we need further research to develop our understanding of the needs and experiences of this population of care leavers. It is hoped that the next qualitative phase of this study will address some of these issues further through case file review and qualitative interviews with care leavers, parents/carers and social workers.

References

Department for Social Development (2014) *Northern Ireland Benefits Statistics Summary, May 2014.* Belfast: DSD. Accessed 5/8/15 at: http://www.dsdni.gov.uk/index/stats_and_research/benefit_publications.htm

DHSSPSNI (2014a) *Children's Social Care Statistics NI 2013/14.* Belfast: DHSSPSNI.

DHSSPSNI (2014b) *Prevalence of Autism (including Aspergers syndrome) amongst school aged children in Northern Ireland*. Belfast: DHSSPSNI.

DHSSPSNI (2015) *Children's Social Care Statistics NI 2014/15.* Belfast: DHSSPSNI.

Health and Social Care Board (2013) *Corporate Parenting Statistical Report: 30th September 2013*. Belfast: HSCB.

Kelly, B., McShane, T., Davidson, G. & Pinkerton, J. (2014a) *A Review of Literature on Disabled Care Leavers and Care Leavers with Mental Health Needs.* Belfast: Queen's University Belfast.

Kelly, B., Hanna-Trainor, L., Davidson, G. & Pinkerton, J. (2014b) *A Review of Policy and Legislation Relating to Care Leavers with Learning Disabilities and/or Mental Health Needs in Northern Ireland.* Belfast: Queen's University Belfast.

APPENDIX 1: Survey Profiling Disabled Care Leavers

PRELIMINARY INFORMATION: CARE LEAVING

QA. Name of Trust	

QB. Please tick the relevant statement to indicate the young person's leaving care status:			
Eligible (16-17 looked after at least 13wks since age of 14 and still looked after)		**Former Relevant** (18-21 who were eligible and/or relevant or 21+ and still being helped by the Trust with education /training)	
Relevant (16-17 who are eligible and have left care)		**Qualifying** (under 21 (under 24 if in education or training) who ceases to be LAC/accommodated in other settings after age of 16)	

QC. Please indicate current living arrangement			
At home with birth parent		Hospital	
Foster care (non-relative)		Residential school	
Formal kinship foster care		Secure care	
Informally staying with relatives/friends		Prison	
Former foster care (GEM)		Supported board and lodgings	
Specialist foster care		Juvenile justice centre	
Children's residential home		Unregulated placement	
Tenancy without support (NIHE, Housing Assoc., private)		Other accommodation (B&B, hostel, Foyer)	
Tenancy with support (NIHE, Housing Assoc., private)		Specialist residential in NI/ out of jurisdiction (specify)	
Jointly commissioned supported accommodation project		Other (please specify)	

QD. Please indicate the young person's LAC status and placement type:			
Voluntarily accommodated		Emergency Protection Order	
Care Order		Interim Care Order	
Police protection in Trust accommodation		Juvenile Justice Order	
Assessment Order		Secure Accommodation Order	
Other (please specify):		The young person is no longer looked after	

QE. Details of the young person's main social worker who will complete this form	
Name	
Email	
Phone	
Name of SW team	
Current role in relation to young person	

QF. Please indicate other social work support currently being provided for the young person (please tick all that apply)

	Please tick all that apply	Please tick to indicate how long they have been receiving this support?		
		Less than 6 months	6 - 12 months	More than one year
LAC field SW				
Placement SW (e.g. fostering)				
Children's disability SW				
Children's mental health SW				
Adult disability SW				
Adult mental health SW				
16+ SW				
Other(please specify)				

QG. Young person's SOSCARE no.		**QH. Young person's Health & Social Care no.**	

QI. Please tick to indicate young person's gender	**Male**		**Female**	

PRELIMINARY INFORMATION: DISABILITY AND/OR MENTAL HEALTH NEEDS

QJ. Does the young person have a disability? (please tick)	Yes		No		**If no is selected, please go to QN.**

QK. Young person's disability type (please tick all that apply and specify, working from left column to the right column)			
	Disability type (please tick all that apply)	Please specify name of disability if known (e.g. Down's syndrome, Asperger's, Cerebral Palsy, or Deaf)	If multiple disabilities, tick one to indicate main disability type
Learning disability			
Physical disability			
Sensory impairment			
Autistic spectrum disorder			
Other			

QL. If the young person has a disability, please indicate if it is …					
Mild		Moderate		Severe	

QM. Does the young person use a wheelchair?			
Yes		No	

QN. If the young person is currently receiving child or adult mental health services, please indicate type of service (please tick all that apply and specify)		
Mental Health Service	Tick	Please specify service related need
Child and Adolescent Mental Health Services		
Specialist Therapeutic LAC		
Adult Mental Health Services		
Other (e.g. Early Intervention / voluntary or community services)		

QO. Please indicate if the young person previously received child or adult mental health services which have now ceased (Please tick all that apply and specify)		
	Tick all that apply	Please state reason service ceased
Child and Adolescent Mental Health Services		
Specialist Therapeutic LAC		
Adult Mental Health Services		
Other (e.g. early intervention/voluntary or community services)		

QP. Has the young person attempted suicide in past 12 months?	Yes		No	
	If yes, please state how many attempts:			

QQ. Has the young person been assessed as having a mental illness? (please tick)				
Yes		No		If yes, please provide further details:

QR. Was young person's disability/mental health need identified before/after they became LAC?	Before		After	

QS. Please indicate which, if any, of the following conditions/disorders the young person has? (tick all that apply)					
Acquired brain injury		Dental problems		Glue ear/ grommets	
ADD/ADHD		Diabetes		High level medical intervention (e.g. tubefed)	
Anxiety		Dyslexia		Kidney/urinary tract problems	
Asthma		Dyspraxia		Migraine/severe headaches	
Cancer		Eating disorder (e.g. anorexia)		Obesity	
Challenging behaviours		Eczema		Obsessive Compulsive Disorder	
Chest infection (e.g. bronchitis)		Encopresis/soiling		Speech/language problems	
Chronic fatigue syndrome / ME		Enuresis		Stomach digestive problems	
Cystic fibrosis		Epilepsy		Other (specify):	
No other conditions/disorders					

QT. Does the young person require personal care assistance or a high level of supervision?	Yes		No	

QU. Please indicate if any of the following risks apply to the young person (tick all that apply)	Risk				Service Intervention		
	High	Med	Low		Yes	Referred	No
Risky sexual behaviour (e.g. exploitation)							
Suicide							
Substance misuse							
Other (please specify)							

QV. Is the young person a parent? (Please tick)	Yes		Pregnant		No		**If no, go to Q1**

QW. Please state number of children:		**QX. Is young person living with the child(ren)?**	

CARE LEAVER AND BIRTH FAMILY BACKGROUND

Q1. Do/did the young person's birth parents have a disability? (please tick)	**Mother**	Yes		No		Don't know		**If you answered no/don't know for both father AND mother skip to Q3**
	Father	Yes		No		Don't know		

Q2. Please specify the young person's birth parent(s)' disability?						
	Learning disability	Autistic spectrum disorder	Physical disability	Sensory impairment	Don't know	Other (please specify)
Mother						
Father						

Q3. Do/did the young person's birth parents have mental health needs? (please tick)	Mother	Yes		No		Don't know	
	Father	Yes		No		Don't know	

Q4. LAC status of siblings - please tick the statement which applies:		
Sibling(s) are LAC and reside(d) in the same placement to child with a disability/mental health need		Further comments
Sibling(s) are LAC and reside(d) in a different placement to child with a disability/mental health need		
Sibling(s) are not LAC		
No siblings		

Q5. Please specify country of birth (if known)	Mother		Father		Young person	

Q6. Please indicate young person's religious background (please select one)	
Roman Catholic	
Protestant	
Hindu	
Muslim	
Sikh	
Buddhist	
Jewish	
Any other religion (specify)	
No religious affiliation	

Q7. Please indicate child/young person's ethnicity (please select one)	
White Northern Irish or White other	
Black Northern Irish, Caribbean, African or other	
Asian Northern Irish, Indian, Pakistani, Bangladeshi or other	
Chinese/Chinese Northern Irish	
Irish Traveller	
Any other group (please specify)	

Q8. Please select all that apply to indicate current access to welfare benefits					
Carer's Allowance / Credit		Housing Benefit (Rent)		Personal Independence Payment	
Child Benefit / Child Tax Credit		Incapacity Benefit		Statutory Sick Pay	
Disability Living Allowance		Income Support		Working Tax Credit	
ESA		Jobseeker’s Allowance		Other (please specify)	
Housing Benefit (Rates)		Maternity/Paternity Allowance/Pay		Not in receipt of any benefits	
Q9. Please provide an approximate estimate of the young person’s current weekly income				**£**	

Q10a. Has the young person ever received a police caution? (please tick)				**Yes**	**No**	
Q10b. If yes, was the caution(s) before or after they became LAC? ***Please provide further details, including number of cautions:***	Before		After		Before & After	

Q11a. Has the young person ever received a conviction? (please tick)				**Yes**	**No**	
Q11b. If yes, was the conviction(s) before or after they became LAC? ***Please provide further details, including number of cautions:***	Before		After		Before & After	

LAC EXPERIENCE

Q12. For how long has/was the young person looked after?									
Under 6 months		6-11 months		1-2 years		3-5 years		Over 5 years	

Q13. Please indicate the reason the young person first became LAC (please select all that apply)			
Neglect		Parent(s) not coping	
Emotional abuse		Family illness/death	
Physical abuse		Child beyond parental control	
Sexual abuse		Other (please specify)	
Witnessing domestic violence			

Q14. Please indicate if there have been significant placement changes since the young person became looked after									
No change		1-2 changes		3-5 changes		6-9 changes		10+ changes	
If there have been no changes, please skip to Q16									

Q15. If there have been placement changes, please indicate previous LAC placement types (please select all that apply)			
At home with birth parent		Hospital	
Foster care (non-relative)		Residential school	
Foster care (kinship/relative)		Secure care	
Juvenile justice centre		Specialist residential placement in NI/out of jurisdiction (please specify)	
Other (please specify)			

Q16. Has the young person left care (ceased to be looked after)?	Yes		No		**If no, please go to Q17**			
Q17. Please indicate how long since the young person left care	Under 6 mths		6-11 mths		1-2 yrs		3-5 yrs	

Q18. Please indicate who the young person *currently* has regular contact with and how often (tick all that apply)								
	Daily	Weekly	Fortnightly	Monthly	Biannually	Annually	Irregularly (no fixed pattern)	No contact
Mother								
Father								
Sibling(s)								
Grandparent(s)								
Other (please specify)								

Q19. Have there been changes in contact with any of the people listed below since the young person became LAC? (please tick all that apply)				
	Less often	More often	Ceased	No change
Mother				
Father				
Sibling(s)				
Grandparent(s)				
Other (please specify)				

Q20. If the young person has contact, is it supervised?	Yes		No	
If yes, please state with whom and give reason				
Q21. If the young person has contact, is it supported?	Yes		No	
Yes, please state with whom and give reason				

EXPERIENCE OF SHORT BREAKS (previously referred to as respite care)

Q22. Does the young person use short breaks?	Yes		No	**If no, please skip to Q25**

Q23. Please indicate reason for use of short breaks (please select all that apply)			
Planned break for parent/carer		To prevent the young person becoming fully LAC/removal	
Social opportunity for young person		To support current LAC placement	
Unplanned break in response to a crisis		Other (please specify)	

Q24. Please indicate types and frequency of short breaks used

	Tick to indicate type of short break	Please complete relevant options below to indicate the regularity of short break usage					
		No of days/evenings per week (no overnight)	No of days/evenings per month (no overnight)	No. nights per week	No of nights per month	Block usage (e.g. full week/fortnight/summer) Please specify	No particular pattern 'NPP'
Foster placement (kinship/relative)							
Foster placement (non-relative)							
Specialist foster placement							
Mainstream residential children's home							
Short break facility for disabled young people							
Short break facility for young people with mental health needs							
Hospital							
Specialist residential placement							
Day activity (non-residential) (please specify)							
Other (please specify)							

Q25. Please indicate if there have been significant changes in short break provision since the young person became looked after

No changes		1-2 changes		3-5 changes		6-9 changes		10+ changes	

Q26. Please indicate any formal summer/leisure opportunities regularly accessed by the young person (select all that apply)

Summer scheme / camp		Specialist social / leisure programme	
Holiday provision		Special Olympics related activities	
Other (please specify)			
No opportunities regularly accessed			

ACCESS TO LEAVING CARE AND TRANSITION SERVICES

Q27. Please indicate the young person's access to leaving care support (please select all that apply) and if, 'no', please indicate the reason

	YES	NO	IF NO, please specify reason (e.g. not required or not available) and if waiting for a service, the waiting time
Personal adviser			
Pathway plan			
Completed Needs Assessment			
Accommodation and maintenance			
Keeping in touch with social worker or personal adviser			
Assistance with employment			
Assistance with education and training			
Assistance in general			
Befriender			
Any leaving care support			

Q28. How often does the young person have contact with named social worker?

More than Once a Week		Every 3 Months	
Once a Week		Every 6 Months	
Fortnightly		Once a Year	
Monthly		No contact (state reason)	
		Other (please specify)	

Q29. How often does the young person have contact with personal adviser?

More than once per week		Every 3 months	
Once per week		Every 6 months	
Fortnightly		Once a year	
Monthly		No contact (state reason):	
		Other (please specify):	

ACCESS TO CHILD OR ADULT DISABILITY SERVICES

Q30. Please select the relevant box below to indicate the young person's access to disability related assessment and support (please select all that apply)

	YES	DON'T KNOW	NO	IF NO, please specify reason (e.g. not required / not available)
A completed needs assessment from a disability service				
A completed care plan from a disability service				
Accommodation and maintenance (including floating support)				
Keeping in touch with disability social worker				
Assistance with employment				
Assistance with education and training				
Assistance with transport				
Assistance in general				

Q31. Is the young person currently receiving child or adult disability services? (Please tick all that apply and specify)

	Please select all that apply	Please specify service(s) or reason for non-receipt
Child disability services		
Adult disability services		
Not in receipt of child or adult disability services		

Q32. Has the young person previously received child/adult disability services which have ceased?	Yes		No	
(If yes, please state type of support and reason service ceased)				

ACCESS TO TRANSITION SUPPORT

Q33. Is the young person currently receiving transition services from any of the following service sectors?

	Please select all that apply	Please specify services accessed
Education		
Social services		
Voluntary organisation		

Q34. Has the young person previously received transition services which have now ceased?	Yes		No	
Yes (If yes, please state type of support and reason service ceased)				

OTHER SERVICES ACCESSED

Q35. Does the young person use direct payments?	Yes		No	
If yes, please specify the services being accessed using direct payments				
Q36. Does the young person receive any other services from the statutory or voluntary sector?	Yes		No	
If yes, please specify the services being accessed				

Q37. Please select all that apply to indicate key professionals in the young person's life in the last 12 months			
Adult Disability Social Worker		Hospital Specialist (e.g. audiologist, neurologist, heart specialist, ophthalmologist)	
Adult Mental Health Social Worker		Hospital Social Worker	
Appropriate Adult		Independent Advocate	
Befriender		Independent Visitor	
Children’s Disability Social Worker		In-patient Nurse	
CAMHS Social Worker		LAC Field Social Worker	
16 + Social Worker		Mentor	
Community Paediatrician		Occupational Therapist	
Community Learning Disability Nurse		Physiotherapist	
Community Psychiatric Nurse		Probation Officer	
Counsellor		Psychologist	
Dentist		Psychiatrist	
Domiciliary Worker		Residential Social Worker	
Employment Officer		Respite Carer	
Family Therapist		Solicitor	
Floating Support Worker		Speech Therapist	
Foster Care Social Worker		Support Worker	
Guardian ad Litem		Transition Coordinator	
Health Visitor		No other key professionals involved	
		Other (please specify)	

Q38. Please complete the table below to indicate if this young person has unmet needs for interventions/services	
Please state intervention(s)/service(s) needed	Please state reason action not taken (e.g. service unavailable/waiting list/not eligible)

NETE EXPERIENCE

Q39. Please indicate the young person’s Education, Training and Employment Status (please tick all that apply)			
Mainstream secondary level school		Pre-vocational	
Unit within secondary level school		Paid employment	
Special school		University	
Residential school		Voluntary work	
Further education college		Supported employment	
Training centre		Not in Education, Training and Employment	
Other (please specify)			

Q40. If in paid employment, please indicate employment status	
Full-time permanent	
Full-time temporary	
Part-time permanent	
Part-time temporary	
Part of training course	

Casual (as and when)	
Other (please specify)	

Q41. If NOT in Education, Training and Employment (NETE), please indicate all reasons below and indicate main reason

	Please tick all relevant options to indicate all reasons	Please tick one option to indicate main reason
Sick		
Disabled		
Parent/carer role		
Pregnant		
Does not want to engage		
Addiction		
Homelessness		
Gap year		
In prison/out on bail		
In secure accommodation		
Waiting for education, training / employment to commence		
Other (please specify)		

Q42. Does/did the young person have a Statement of Educational Needs?	Yes		No		Don't know	

Q43. Please indicate if there have been significant school changes since the young person became looked after

No school changes		6-9 school changes	
1-2 school changes		10+ school changes	
3-5 school changes		Other (please specify)	

Q44. Please use this space to add any further comments relevant to the study or the young person's circumstances

THANK YOU FOR TAKING TIME TO COMPLETE THIS SURVEY