

THE UNIVERSITY OF HULL

Assessment of Mental Health for Looked After Children

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By

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Overview

The portfolio has three parts:

Part One: A systematic literature review, in which the literature relating to the assessment and identification of mental health problems in looked after children is reviewed.

Part Two: A mixed methods empirical research study which qualitatively explores foster carer's perceptions of screening measures used with looked after children and the ability of these to capture need. Clinicians' views regarding the same issue are also explored both quantitatively and qualitatively.

Part Three: Appendices including all relevant documents related to the systematic literature review and empirical papers and a reflective statement from the researcher on the process of completing the portfolio.

Total word count: 23,241 (excluding references and appendices)

Part One: Systematic Literature Review

**The Assessment and Identification of Mental Health Problems in Looked After
Children: A Systematic Literature Review**

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This paper is written in the format for submission to Child and Youth Services Review.

Please see Appendix A for the Guidelines for Authors.

Total word count: 11,222 (excluding references and appendices)

Abstract

Appropriate assessment and early identification of mental health difficulties for looked after children (LAC) are vital for interventions to help improve wellbeing and outcomes in this vulnerable population. However, the literature relating to this has not been reviewed. The present study aimed to synthesise the literature to date on the assessment and identification of mental health difficulties specifically for LAC. A systematic search of nine databases revealed sixteen studies which met the inclusion criteria and were included in the review. The Strengths and Difficulties Questionnaire (SDQ) was the most commonly used measure across the studies and the evidence suggested it was a suitable screening measure for mental health for LAC although there was some variability in methodological quality. Furthermore, cautions against using the SDQ alone and the importance of holistic assessment were highlighted. There were also a number of factors to consider in the assessment of LAC including: gaining multiple perspectives and including LAC in the process. The need for interventions and multi-agency working with these young people was emphasised to improve the wellbeing and outcomes for LAC.

Keywords: Assessment; identification; mental health; looked after children and systematic literature review.

Introduction

The early identification of mental health difficulties in children and adolescents is vital for assessment and intervention and thus future wellbeing and outcomes (Albers, Kratochwill, & Glover, 2007). Research has demonstrated that behavioural and emotional difficulties during childhood and adolescence impact on education, family and relationships; these effects can continue into adulthood (Catalano, Haggerty, Osterle, Fleming, & Hawkins, 2004; Reef, Diamantopoulou, Van Meurs, Verhulst & Van Der Ende, 2009 and Suldo, Thalji & Ferron, 2011). Early intervention has positive effects on outcomes for children and adolescents both in the short and long term (Kieling et al., 2011). Identifying difficulties early allows for interventions to be implemented before issues become more problematic, the effectiveness of intervention is increased as well as decreasing the chances of re-occurrence and secondary difficulties (de Girolamo, Dagani, Purcell, Cocchi & McGorry, 2012).

Early intervention has been embedded within Government policy and legislation. Every Child Matters (Department for Children, Schools and Families (DCSF), 2003) and The Children Act 2004 emphasised early identification and intervention for children and families to help promote health (both mental and physical health), enjoyment and achievement, to make a positive contribution to society, achieve full potential in life and stay safe. In addition, schools have enhanced the emotional wellbeing of children with various programmes such as the Targeted Mental Health in Schools (TaMHS; DCSF, 2008), which constituted a change to the way mental health services were delivered to children. Therefore early identification and intervention are key National priorities.

Identifying risk factors for the development of mental health difficulties can be difficult, especially when they co-occur. The Family Life Cycle model considers risk factors chronologically with various age related risk factors for difficulties with physical,

mental and emotional health existing at different stages. (Carter, & McGoldrick, 1999 and Kieling et al., 2011). For example, during early years a nurturing and caring environment are important for development, during childhood school and peer relationships are critical and in adolescence changing relationships with family and peers and new risks emerge, such as substance use (Kieling et al., 2011). The patterns that children have experienced often then repeat themselves in adulthood and with offspring of their own (MacMillan, 2010).

This picture is even more complex for children who are looked after by the state. Higher rates of physical and mental health problems and emotional and behavioural difficulties have consistently been found in looked after children (LAC; Meltzer, Corbin, Gatward, Goodman, & Ford, 2003; Minnis, Everett, Pelosi, Dunn & Knapp, 2006; McCann, James, Wilson, & Dunn, 1996 and Sempik, Ward, & Darker, 2008). Moreover, due to early adverse experiences additional difficulties have been found amongst LAC including attachment difficulties, trauma, sexualised behaviour and difficulties with food and or eating (Minnis et al., 2006; Tarren-Sweeney, 2007 and Turney and Tanner, 2003).

These difficulties pose multiple problems. Not only do they affect the child's mental health and wellbeing, but they can also affect the stability of their placement.

Behavioural and emotional difficulties have been associated with placement breakdown (Arrons et al., 2010 and Fisher, Stoolmiller, Mannering, Takahashi, & Chamberlain, 2011). The breakdown of placements can have a detrimental effect on a child's ability to form attachments and relationships and thus affect their emotional and mental health further (Leathers, 2002).

Furthermore, once LAC reach adulthood, they are at greater risk of poorer psychosocial outcomes, higher levels of employment difficulty and criminality, and more likely to have physical health problems, mental health difficulties and substance misuse problems (Dixon, 2008; Ford, Vostanis, Meltzer, & Goodman, 2007 and Viner and Taylor, 2005). It is therefore vital that children in care who experience emotional difficulties or mental health problems receive the support they need as early as possible, and that support and mental health is monitored to reduce the risk or severity of problems encountered in adulthood.

LAC often experience internalised and externalised problems (Kaufman, & Charney, 2001; Tarren-Sweeney, & Hazell, 2006 and Toth, Manly, & Cicchetti, 1992).

Externalised problems for LAC are more readily identified and reported by carers, whereas internalised difficulties may be harder to identify by others, and thus may be neglected (Beck, 2006 and Mount, Lister & Bennun, 2004). This means that LAC may be experiencing difficulties which go unnoticed, resulting in unmet need. Discrepancies have been found between the level of need for LAC and the level of support received or accessed (Minnis et al., 2006; Phillips, 1997 and Stanley, Riordan & Alaszewski, 2005). When LAC are identified as needing help and support with their emotional and mental health, it is often at the point of extreme and enduring difficulties or when a placement is in jeopardy of breakdown (McCann et al., 1996 and Dimigen et al., 1999).

Interventions tend to be longer term and more intensive. Timely, accurate and early assessment and identification are therefore vital for LAC to allow for intervention to promote their current and future mental health, wellbeing and outcomes.

In the UK it is a requirement that all LAC receive a holistic health assessment upon entry to the care system (DCSF, 2009). In addition to physical health, the emotional and mental health of LAC should be assessed. In England, health assessments should be

completed twice a year for children under five and annually for children over five. The policy for England has also specified that the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) be completed by the carer of LAC to assess emotional and mental health of LAC aged between four and sixteen (DCSF, 2009). It is also recommended where the SDQ highlights difficulties, the child's teacher should complete the SDQ and children over 11 complete the self-report. However, it is also noted that the SDQ should not be solely relied upon as a measure of the emotional and mental health of LAC. If required LAC should then be referred for further assessment and support to specialist mental health services such as Child and Adolescent Mental Health Service (CAMHS). CAMHS are then required to assess emotional and mental health and offer individualised support with an emphasis on early identification and intervention (Department of Health, 2008).

Focusing on the early identification and intervention for LAC would impact on their emotional and mental health, relationships, social functioning, school performance and future wellbeing. A number of studies have looked at the identification and assessment of mental health problems and wellbeing in LAC, including looking at the use of specific measures for this process. However, there is no systematic review to synthesise the research relating to the identification and assessment of mental health problems for LAC. Given the importance of early identification and the risks for this vulnerable group, a systematic review is overdue in this area. This would allow conclusions to be drawn about the identification and assessment of mental health problems, which could be used to inform future policies and service delivery for LAC. Therefore the aims of the current systematic review include:

- To synthesise and evaluate the research on the identification and assessment of mental health problems for children in all types of out of home care worldwide.
- To draw conclusions regarding the identification and assessment of mental health problems for LAC.
- To identify areas for future research.

Following on from the aims, the specific research questions for the review included:

- What do we know about the identification and assessment for mental health problems in LAC?
- What questionnaires/measures/tools are used in the identification and assessment of LAC?
- Are the current ways of identifying mental health problems in LAC effective?
- What factors are important to consider in the identification and assessment of mental health problems for LAC?

Method

Search Terms

PsycInfo, PsycArticles, CINAHL, Academic Search Premier, ERIC, Medline, Education Research, Web of Science and Scopus were searched in March 2014. The search terms were chosen after initial searches and reading of titles and abstracts identified key words used within the literature in the area. The search terms used included:

“foster care*” or “temporary care*” or “out of home care” or “foster placement*” or “residential care” or “residential placement*” or “looked after” or “looked after children” or “child welfare system” or “looked after children and young pe*” or “LAC”

or “LACY” or “looked after young people” or “child* without permanent parents” or “non relative care” or “non-relative care” or “kinship care” or “state care” or “welfare care” or “local authority care”

AND

Screen* or measur* or assess* or identif* or outcome or questionnaire* or tool* or checklist* or inventor* or SDQ or “strength* and difficult* questionnaire*” or CBCL or “child behavior checklist” or ACC or “assessment checklist for children” or BAC or “brief assessment checklist” or BAC-C or “brief assessment checklist for children” or BAC-A or “brief assessment checklist for adolescents” or “ages and stages questionnaire” or ASQ or “ages and stages questionnaire social emotional” or ASQ-SE or CORC or “CAMHS Outcomes Research Consortium”

AND

“Mental health” or “mental illness*” or “well being” or emotion* or “psychiatric disorder*” or psycholog* or behavior

Also, the references of the sixteen included articles were hand searched for any additional relevant articles that met the inclusion criteria. It was difficult to determine an appropriate start date given worldwide research was included and the aim was to explore the research in this area. Therefore no limit was set on the date for searching.

Inclusion criteria

To ensure the highest possible quality of papers the following inclusion criteria were applied:

- Peer reviewed studies
- Written in English language

- The aim of the study was the identification or assessment of mental health in LAC
- Data reported should be primary rather than secondary data
- Studies carried out with the general LAC population

Exclusion criteria

The following exclusion criteria were applied:

- Case studies
- Dissertations
- Reviews
- Books
- Studies written in a language other than English
- Children and families who were in contact with child welfare/social services and were not LAC
- Studies where the aim was to determine the prevalence of mental health problems in LAC
- Longitudinal design
- Assessment of one specific domain (for example, trauma)
- Secondary data or case file audit as the only source
- Development and validation of a new measure
- Sub populations of LAC such as young people with epilepsy or learning disability
- Pre-school children (there could be additional factors such as developmental delay which may impact on the measures for mental health for this population (Jee et al., 2010))

Article selection

The initial searches resulted in 2,348 results. Applying the limiter of peer review reduced the results to 2,007. The titles of the articles were screened for relevance and after the removal of duplicates, 61 articles remained. The inclusion and exclusion criteria were then applied to the remaining abstracts and then full texts. A total of 16 articles were identified for inclusion. A flowchart depicting the process of the article selection is outlined in Figure 1.

Studies were excluded if they were based on: secondary data (N=2), descriptions of services (N=2), pre-school children (N=1), contact with child welfare rather than being looked after (N=1), prevalence of mental health problems and service use (N=1) and validation of a new measure (N=1). A list of the excluded studies can be found in Appendix B.

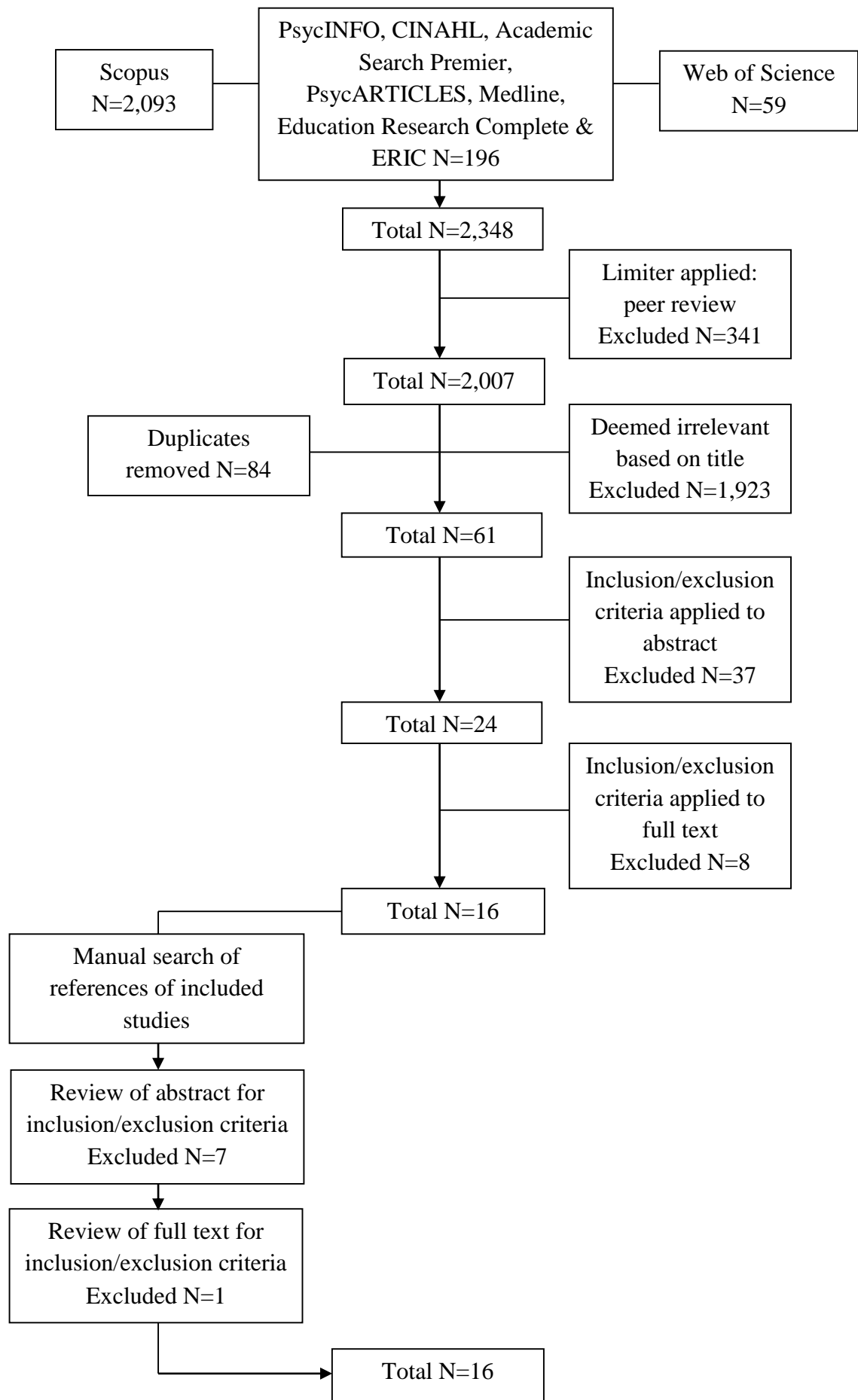


Figure 1. Flowchart of the article selection process.

Quality assessment

Due to the variability of the methods and designs of the studies, no one single quality assessment tool was found to be suitable. Therefore to assess the methodological quality of the studies a quality assessment checklist was developed from items on the Mixed Methods Appraisal Tool (MMAT; Pluye et al., 2011) and Strengthening the Reporting of Observational Studies in Epidemiology (STROBE; Von Elm et al., 2007). Together the items on these tools cover a range of methodologies to reflect the diversity of the studies and capture the characteristics of them (Appendix C).

The quality scores were then converted to a percentage and a sample of papers from the lowest, middle and highest quality score were chosen and blindly quality scored by an independent rater. Inter-rater reliability assessment was completed and Cohen's Kappa was .56 ($p < .001$). This would be classed as moderate agreement (Landis & Koch, 1977). Any discrepancies were discussed and a consensus was reached.

Data analysis

With the heterogeneous nature of the methods of the included studies, a qualitative narrative synthesis was chosen to analyse the results. This allowed for both qualitative and quantitative results to be integrated, a description of the range of the research, the assessment of the strength of the evidence and identifying areas for future research (Dixon-Woods et al., 2006 and Lucas, Baird, Arai, Law & Roberts, 2007).

Data extraction

A data extraction tool was developed to collect relevant information from each study (Appendix D). This included the authors, aims, participant characteristics, method of assessment, the type of measures used, findings and conclusions. The themes and quality score for each study were also noted.

Results

Characteristics of included studies

Type of care

Ten of the sixteen studies included a mix of children in different types of care. These included: foster and residential care (Mount et al., 2004; Goodman et al., 2004; Marquis & Flynn, 2009 and McCrystal & McAloney, 2010), foster care, residential school and children's home (Blower et al., 2004), kinship, foster and residential care (Goodman & Goodman, 2012), residential, non-kinship and kinship care (Cousins et al., 2010), foster care, residential and other not specified (Fleming et al., 2005), foster, residential, kinship care and secure accommodation (Rees, 2013) and kinship and non-kinship care (Shore et al., 2002). Jee et al. (2011a, 2011b) and Bernedo et al. (2012) focused on foster children and Altshuler and Poertner (2003) on non-kinship care. Two studies did not specify the type of care: one stated the sample was children in the care of social services in an inner London Borough (Newlove-Delgado et al., 2012) and the other was children looked after by the local authority in Essex (Richards et al., 2006).

Participants

LAC were the focus with no comparisons for six of the studies (Mount et al., 2004; Blower et al., 2004; Jee et al., 2011a, 2011b; Fleming et al., 2005 and Shore et al., 2002). Seven studies included comparisons to general population norms (Newlove-Delgado et al., 2012; Richards et al., 2006; Altshuler & Poertner, 2003; Goodman & Goodman, 2012; Marquis & Flynn, 2009; Cousins et al., 2010 and Rees, 2013), one to children living with one or two biological parents (McCrystal & McAloney, 2010), one to children living in private households (Goodman et al., 2004) and a control group (and Bernedo et al., 2012).

Blower et al. (2004), McCrystal & McAloney (2010) and Altshuler & Poertner (2003) included only young people in the assessment of mental health. The remaining studies incorporated young people and carers (Mount et al., 2004 and Jee et al., 2011a, 2011b), young people, carers and teachers (Newlove-Delgado et al., 2012; Richards et al., 2006; Goodman et al., 2004 and Rees, 2013), young people, carers, parents and social workers (Fleming et al., 2005), carer and teacher (Shore et al., 2002), carers only (Goodman & Goodman, 2012 and Marquis & Flynn, 2009), teacher only (Bernedo et al., 2012) and social worker only (Cousins et al., 2010).

Recruitment

The recruitment of participants fell within four main categories: those in care in an area, part of a new screening protocol, part of a study/project and from databases. One of these methods included inviting LAC from one particular local authority (Mount et al., 2004; Blower et al., 2004 and Richards et al., 2006), all of those children in care at a particular time or area (Rees, 2013 and Bernedo et al., 2012) and random sampling from an area or department (Altshuler & Poertner, 2003 and Fleming et al., 2005). Some of the studies had implemented a new protocol for screening LAC for mental health problems and so all LAC after the implementation took part (Jee et al., 2011a, 2011b and Newlove-Delgado et al., 2012). Some participants were recruited through their engagement in particular studies/projects (McCrystal & McAloney, 2010; Marquis & Flynn, 2009 and Shore et al., 2002). Finally, databases of LAC were also used to identify participants on a particular date (Goodman et al., 2004), randomly (Goodman & Goodman, 2012) and a purposive sample (Cousins et al., 2010).

Six studies were conducted in England (Mount et al., 2004; Newlove-Delgado et al., 2012; Richards et al., 2006; Goodman & Goodman, 2012; Goodman et al., 2004 and Rees, 2013). Four studies: Jee et al. (2011a, 2011b), Altshuler & Poertner (2003) and

Shore et al. (2002) were all completed in America. Three studies were undertaken in Ireland (McCrystal & McAloney, 2010; Cousins et al., 2010 and Fleming et al., 2005). There was one study from Scotland (Blower et al., 2004), one from Canada (Marquis & Flynn, 2009) and one from Spain (Bernedo et al., 2012).

Design

All of the studies employed quantitative methods except Blower et al. (2004) and Fleming et al. (2005) who employed mixed method designs with both qualitative and quantitative methods. Both of these studies used semi-structured interviews and focus groups and Blower et al. (2004) also incorporated 6 psychometric measures.

Measures

A description of the measures used in the studies can be found in Table 1. Within the quantitative studies four utilised measures and a diagnostic interview. Newlove-Delgado et al. (2012), Goodman and Goodman (2012) and Goodman et al. (2004) used the DAWBA, whilst Jee et al. (2011b) used the ChIPS. Mount et al. (2004) also combined measures with a semi-structured interview but this did not follow a specified assessment protocol and was focused on intuitive judgements of mental health problems. There were three studies which used psychometric measures only: McCrystal and McAloney (2010) used the SDQ, Altshuler and Poertner (2003) the CHIP-AE and Shore et al. (2002) the CBCL and TFR.

Four studies also collected additional information about LAC participants. Richards et al. (2006), Cousins et al. (2010) and Rees (2013) completed case file reviews and Bernedo et al. (2012) used a data collection log to collect demographic details about LAC's history. Marquis & Flynn (2009) had the SDQ embedded within other measures to form an Assessment and Action Record (AAR-C2; Flynn, Ghazal & Legault, 2006). Finally, Jee et al. (2011a) completed a medical chart review.

Table 1. Details of the measures used in the articles.

| Measure, Author and Study | Description |
|---|---|
| Strengths and Difficulties Questionnaire (SDQ; Goodman et al., 1997) (Mount et al., 2004; Jee et al., 2011a, 2011b; Newlove-Delgado et al., 2012; McCrystal & McAloney, 2010; Richards et al., 2006; Goodman & Goodman, 2012; Goodman et al., 2004; Marquis & Flynn, 2009; Cousins et al., 2010 and Rees, 2013) | 25 item screening tool which assesses behavioural and emotional difficulties for children aged 4-11 years old. There are parent and teacher versions and a self-report version for over 11 year olds. |
| The Child Behaviour Checklist (CBCL; Achenbach, 1991) Youth Self Report version (YSR) (Blower et al., 2004) Teacher Report Form (TRF) (Bernedo et al., 2012 and Shore et al., 2002) | Measures children's behaviour, emotions and social functioning from ages 6-16 year old. There is also a Self-Report version (YSR) and a teacher version (TRF). |
| Development and Well-Being Assessment (DAWBA; Goodman, Ford, Richards, Gatward & Meltzer, 2000) (Newlove-Delgado et al. (2012), Goodman and Goodman (2012) and Goodman et al. (2004) | A structured psychiatric assessment interview designed to assess for mental health diagnoses for children aged 5-16 years old. |
| Kiddie Schedule for Affective Disorder and Schizophrenia-Present and Lifetime Version (K-SADS-PL; Kaufman et al., | Semi-structured interview to assess for psychiatric diagnoses in children aged 7-18 years old. |

1997)

(Blower et al., 2004)

Children's Interview for Psychiatric Syndromes (ChIPS; Weller, Weller, Fristad, Rooney, & Schecter, 2000)

Structured clinical interview tool to assign a mental health diagnosis.

(Jee et al., 2011b)

Child Health Illness Profile-Adolescent Edition (CHIP-AE; Starfield et al., 1995)

Self-administered instrument which assesses six domains (satisfaction, discomfort, resilience, risk, achievement and disorders).

(Altshuler & Poertner, 2003)

Mood and Feelings Questionnaire (MFQ; Costello & Angold, 1988)

32 item self-report measure of mood over the previous two weeks.

(Blower et al., 2004)

Trauma Symptom Checklist for Children (TSCC; Briere, 1996)

Self-report measure of trauma symptoms for children aged 8-16 years old.

(Blower et al., 2004)

Modified Harter Self-Esteem Questionnaire (Hoare, Elton, Greer & Kerley, 1993)

Measures self-esteem and self-regard in children aged 8-15 years old.

(Blower et al., 2004)

Children's Global Assessment Scale (CGAS; Shaffer et al., 1983)

Clinician rated single score to determine psychosocial functioning.

(Blower et al., 2004)

The Adolescent Well-being Scale (AWS; Birleson, 1981)

18 item measure for assessing depression.

(Mount et al., 2004)

| | |
|--|--|
| The Eyberg Child Behaviour Inventory (ECBI; Eyberg, 1992) (Mount et al., 2004) | 36 item behavioural rating scale for children aged 2-16 years old. Allows ratings of frequency and degree troublesome. |
| Assessment and Action Record (AAR-C2; Flynn, Ghazal & Legault, 2006) (Marquis & Flynn, 2009) | Canadian tool to assess and monitor LAC's needs and inform care plans. It measures health, education, identity, family/social relationships, self-care and behavioural and emotional health. |
| Emotional Literacy: Assessment and Intervention Inventory (ELAII; Faupel, 2003) (Rees, 2013) | Measure of emotional literacy for 7-16 year olds. Child, parent and teacher versions are available. |

Methodological quality

The studies were assessed using an adapted checklist from MMAT and STROBE and ranged in methodological quality from 55% to 86% with an average of 69% (see Appendix E). Two studies used mixed methods, with an average quality score of 64% and the remaining quantitative studies scored an average of 70%. Overall the studies presented a clear and balanced abstract, background and rationale, summary of the key results and interpretation of the results. All of the studies with the exception of Fleming et al. (2005) used a measure. These measures were appropriate, standardised and had been validated and therefore all studies scored maximum points for this.

However, there were some areas which were consistently neglected across the studies. Most studies failed to present an explicit theoretical framework on which the research

was based. The exceptions were Newlove-Delgado et al. (2012) who discussed test theory in relation to assessment and screening measures, McCrystal and McAloney (2010) discussed attachment theory in relation to difficulties in LAC and Fleming et al. (2005) presented a model of interdisciplinary practice.

Mount et al. (2004), Richards et al. (2006) and Marquis and Flynn (2009) were the only studies to include hypotheses. The sampling strategy was generally appropriate.

However, problems with generalisability emerged in some studies. Altshuler & Poertner (2003) used a sample of less than 1% of the total population of children in non-kinship care under the Illinois Department of Children and Family Services. Therefore it may be difficult to draw conclusions from this study and make any generalisations. Mount et al. (2004) and Blower et al. (2004) recruited participants from one city and local authority respectively and so caution is needed generalising the results beyond this and considering the representativeness of the sample. For a few studies it was difficult to determine the response rate due to missing information, such as the original population size the participants were drawn from (Mount et al. 2004; McCrystal & McAloney, 2010 and Marquis and Flynn, 2009).

Most of the studies did not explore limitations (Altshuler & Poertner, 2003; Goodman & Goodman, 2012; Goodman et al., 2004; Fleming et al., 2005 and Shore et al., 2002). Some studies reported limitations but did not discuss the direction or magnitude of potential bias (Mount et al., 2004; Blower et al., 2004; Newlove-Delgado et al., 2012; McCrystal and McAloney, 2010; Marquis and Flynn, 2009; Rees, 2013 and Bernedo et al., 2012). Similarly, generalisability was either not mentioned or very briefly mentioned by Blower et al. (2004), Jee et al. (2011a, 2011b), Altshuler and Poertner (2003), Rees (2013) and Bernedo et al. (2012). None of the studies scored maximum points for generalisability.

For the two mixed method studies, neither explored the context in which the data was collected, the influence of the researcher on the findings and research process, or the limitations of integrating the methods.

The main details of the study including the aims, methodology, main findings and conclusions are presented in Table 2.

Table 2. Summary of the main characteristics of the included studies.

| Authors, data, country of origin | Study aims | Participant characteristics | Method of assessment (Including measures) | Main findings | Conclusions (Quality score) |
|---|--|---|--|--|---|
| Mount et al. (2004) UK | To explore the utility of a mental health screen. Hypothesis: Young people and carers would more accurately identify mental health needs of LAC with tools than the present routes to CAMHS | Looked after young people N=50 Aged 10-18 years old Average=14.24 years (SD=1.84) Males N= 23 (46%) Females N=27 (54) Non-white ethnic group N=11 (22%) Carers N=50 | Semi- structured interview SDQ AWS ECBI | <i>Young people:</i> 9% believed they had mental health problems and 62% believed they did not have any difficulties. These were both supported by the SDQ results. 18% believed they had mental health needs and 11% did not believe they had any problems. These were not confirmed by the results of the SDQ. | As predicted, the results provide evidence of suitability of a routine mental health screen and the SDQ would be useful for this purpose. (68%) |

referral which
rely upon carer
intuitive
judgements of
need.

Carers:

65% intuitively recognised
mental health needs in LAC

19% of carers believed mental
health problems were present
for the LAC and 33% of carers
believed there were no
problems. The SDQ results did
not support either of these
views.

Carers were four times more
likely to perceive mental health
needs and rated higher needs
than young people themselves.

| | | | | | |
|-----------------------|---|--|------------------|---|---|
| Jee et al. (2011b) | To assess the effectiveness of social emotional screening for youths in foster care | Total sample N=138 Male=66 (48%) Female=72 (52%) African American N=83 (60%) White N=32 (23%) Hispanic N=12 (9%) Other N=11 (8%) Age range 11-17.8 years with average of 14.5 years (<i>SD</i> =1.8) 11-14 years old N=75 (54%) 15-17 years N=63 (46%) | SDQ ChIPS | <i>Objective one: Reported strengths and difficulties</i> Parents rated difficulties higher than youth. 78% had prosocial behaviours and 70% had SDQ identified problems in the abnormal range. 42% had problems in two or more domains <i>Objective two: agreement between youth and carers</i> Foster parents were 11.3 times more likely to report a problem, 4.5 times more likely to report | The SDQ offers an efficient and valid tool for screening for social-emotional problems for LAC to identify those who need a full mental health evaluation. This however should not replace or override clinical judgement. Both self and carer report should be used. Identifies strengths as well as difficulties which should be recognised. |
|-----------------------|---|--|------------------|---|---|

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|--------------------|---|
| ChIPS sample | hyperactivity/inattention and 3.4 (86%) |
| N=50 | times more likely to report |
| Male=30 (60%) | social-emotional problems than |
| Female=20 (40%) | youths. |
| African American | |
| N=32 (64%) | <i>Objective three: accuracy of</i> |
| White N=9 (18%) | <i>SDQ</i> |
| Hispanic N=6 (12%) | Sensitivity for the SDQ: young |
| Other N=3 (6%) | people=54%; |
| Age | carers=71%; |
| 11-14 years old | combining young people and |
| N=35 (70%) | carers=93% |
| 15-17 years | |
| N=15 (30%) | |

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|--------------------------------------|--|---|--|--|---|
| Newlove- Delgado et al. (2012) | To evaluate the feasibility of a screening test for LAC to identify undetected psychiatric disorders | N=18 Males N=15 Mean age=11.1 years (SD=3.5) Black or Asian=74% | SDQ to young people, carers and teachers DAWBA Questionnaire for Social workers (same wording as the impact supplement of SDQ) | Significantly more severe difficulties according to all three informants compared to the general population. 5/7 children interviewed who received a diagnosis had difficulties according to their social worker. | Low levels of refusal and high uptake support the use of the SDQ for screening to identify those for more comprehensive mental health assessments and for some CAMHS a single brief screen might be sufficient. The DAWBA is now part of the assessment in the service. There needs to be a plan for support and intervention before screening (70%) |
|--------------------------------------|--|---|--|--|---|

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|-----------------------------|---|---|-----------------|---|---|
| McCrystal & McAloney (2010) | To show the value of the SDQ as a screening tools for mental health issues with young people entering care. | <p>N= approximately 4000 at each stage</p> <p><i>Year One</i></p> <p>Age=11/12 years old</p> <p>In-care: Males=78%</p> <p>Females=22%</p> <p>School sample:</p> <p>Male=54%</p> <p>Females=46%</p> <p><i>Year Four</i></p> <p>Age=14/15 years old</p> <p>In-care: Males=62%</p> <p>Female=38%</p> <p>School sample:</p> <p>Male=47%</p> <p>Female=53%</p> | SDQ self-report | <p>At both Year One and Four the in-care sample was more likely to score within the borderline or abnormal behaviour difficulties range of the SDQ.</p> <p>The in-care sample reported significantly higher mean difficulty scores and for individual subscales of the SDQ than those in the school sample living with at least one biological parent.</p> <p>The results were consistent at both data collection points.</p> | <p>Suggests the use of the SDQ as a general mental health screener for LAC to detect problems and highlight those potentially at risk.</p> <p>The inclusion of young people's views is consistent with the drive for holistic assessment upon entry to care outlined in national policies.</p> <p>(55%)</p> |
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| Richards, Wood & Ruiz- Calzada (2006) UK | To identify the mental health needs of LAC in a permanent placement social work team and to identify a suitable screening tool for the early identification of mental health need. Expected mental health needs for LAC. | 41 LAC between 4-16 years old Mean age=10.4 years (SD=3.9) Under 11 N=21 (males =14, females=7) 11-16 years old N=20 (males=11, females=9) Main carer or Keyworker N=41 Teacher N=41 Over 11 years old N=20 | SDQ self, parent and teacher versions Case files and discussions with social workers | Identified needs on the SDQ were higher for LAC than comparison group. Self-reporters consistently cited lower difficulties than carers and teachers. Significantly positive correlations between self, carer and teacher rated SDQ total scores | Young people consistently report lower levels of difficulties than do their carer/teacher. Significant agreement between self, carer and teacher ratings indicating the total SDQ scores have good inter-subject reliability. Experiences of LAC are unique and need early identification, intervention and co-ordinated multi- agency working. (80%) |
|---|--|---|---|---|--|

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|--------------------------|---|--|--------------|--|--|
| Goodman & Goodman (2012) | To examine whether the parent SDQ is a genuinely dimensional measure of child mental health | N=1,391 Females=595 Age range 5-16 years | SDQ DAWBA | Each one point difference in SDQ score generally corresponded to an increased prevalence of clinical disorder. | The parent SDQ provides a genuinely dimensional measure of mental health in LAC. |
| UK | Whether the parent SDQ prevalence estimator equation is accurate | 1999 and 2004 British Child and Adolescent Mental Health surveys N=18,205 Females=8,967 Aged 5-16 years old | | LAC with higher mean SDQ scores also had a higher prevalence of disorder and the SDQ prevalence estimators provided good approximate estimates of these. | The findings support the use of the SDQ to compare local authorities and monitor trends over time and also the British Government's use of the SDQ to monitor the mental health of LAC. (55%) |
| Goodman et al. (2004) | To examine whether the SDQ | N=1,029 children and adolescents | SDQ | Sensitivity=84.8% Specificity=80.1% | Screening with the SDQ (carer and teacher versions) |

| | | | | | |
|------------------------|---|--|--------------------------|--|---|
| UK | could be a suitable screening tool for LAC | <p><i>Any data set (at least one SDQ completed 99.9%)</i></p> <p>Mean age=12.5 years old (SD=3.5)</p> <p>Male=57.4%</p> <p><i>Full data set (Carer, teacher and self-report SDQ 52.4%)</i></p> <p>Mean age=11.3 years old (SD=3.4)</p> <p>Male=54.4%</p> | DAWBA | <p>Self, carer and teacher reports have the greatest sensitivity. If only two raters available, then carer and teacher were best and equal value. Self-report was least sensitive.</p> | <p>could improve the detection and treatment or behavioural, emotional and concentration problems among LAC.</p> <p>(68%)</p> |
| Marquis & Flynn (2009) | To compare the SDQ for an Ontario sample of | <p>N=492 LAC</p> <p>Age=11-15 years old</p> <p>Mean=13.18</p> | <p>SDQ</p> <p>AAR-C2</p> | <p>As predicted, a higher proportion of LAC scored in the high risk range than the British</p> | <p>The SDQ is useful in screening, referral and outcome monitoring for</p> |

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| Canada | LAC with the British general population norms | (SD=1.44) Male=57% Female=43% | | general population. | LAC. (65%) |
| | Higher prevalence rates of behavioural difficulties in LAC expected | | | | |
| Cousin et al. (2010) | To examine the mental health needs of young people aged 10-15 years old living in state care in Northern Ireland | N=165 Males=86 (52.1%) Mean age=12.8 years (SD=1.6) Females=79 (47.9%) Mean age=12.4 years (SD=1.7) | SDQ teacher version completed by social workers Analysis of social work | 70.3% of LAC were purported by their social workers to potentially have mental health difficulties but rated 92% of their overall health “as good as” or “better than” other young people their age. | Possible under-reporting of sensitive issues by professionals. Future studies should utilise more comprehensive psychiatric assessments, and |

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| | | Caucasian N=162 (98.2%) | case files | | incorporate the voices of the young people. |
| | | Afro-Caribbean N=1 (0.6%) | Questionnaire for social | | (65%) |
| | | Asian N=1 (0.6%) | workers on the | | |
| | | Mixed race N=1 (0.6%) | outcomes at the end of the year for LAC | | |
| Rees (2013) | Presents data | N=193 | SDQ | Statistically significant lower | Multifaceted difficulties for |
| | from a multi- | Aged 7-15 years old, | | performance for LAC on all but | LAC. |
| UK | dimensional, | median=10 years and | ELAII | the Emotional literacy social | |
| | multiple rater | 5 months | | skills teacher subscale. | Evidence of positive |
| | (child, carer and | Males=101 (52.3%) | | | exceptions; cautions against |
| | teacher) | Females=92 (47.7%) | | 16% met positive exception | overgeneralisation of |
| | population-based | White British=99% | | criteria. | findings for LAC. |
| | study of LAC | | | | (80%) |

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|-------------------------|---|---|---|---|---|
| Blower et al. (2004) | To describe the needs assessment phase for LAC. | <i>Stage 1 Psychological screening</i> N=48 Males=29 Females=19 Mean age=12.87 (SD=2.38) | <i>Stage 1 Psychological screening</i> CBCL YSR MFQ TSCC | <i>Stage 1 Psychological screening</i> 27/48 of the first stage participants displayed significant psychological morbidity. | Difficulties were generally well recognised by carers. |
| UK (Scotland) | | <i>Stage 2 Psychiatric diagnostic interview</i> N=22 Males=16 Females=6 Mean age=13.23 (SD=2.20) | Harter Self-Esteem Questionnaire <i>Stage 2 Psychiatric diagnostic interview</i> K-SADS-PL CGAS | 21/22 young people interviewed met criteria for a diagnosis. | It is not appropriate to offer formal psychological screening to every looked after child but some assessment of emotional well-being would be essential. |
| | | | | | The need is not improved identification of mental health problems for LAC but improved and more effective interventions. (67%) |

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| Bernedo et al. (2012) | To analyse the severity of behaviour problems in foster children | Foster children N=97 Males=54 Females=43 Mean age=10.94 years (SD=3.2) Control group N=97 Same age, gender and social class background as the foster children | TRF Data collection log (details about history of LAC) | Small percentage of foster children were rated within the clinical range on the TRF total score. | Most foster children were within the normal range on the TRF as rated by teachers. (80%) |
| Shore et al. (2002) | To compare youths in kinship and non-kinship care on behavioural assessments | N=122 Caucasian=41.8% Native American/Alaskan Native=25.4% African | TRF CBCL | Teacher perceptions did not differ between kinship and non-kinship care. Elevated rates on only a few subscales of TRF. | Teacher ratings of behaviour of children in care are similar to teacher ratings in a normative sample. Important to incorporate |

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|-----------------------------|--|--|---|--|--|
| | completed by teachers | American=11.5% Hispanic=12.3% Polynesian/Pacific Islander=9% | | Slightly higher agreement between foster parent and teacher ratings for kinship than non-kinship care. | different informants for a comprehensive assessment. (65%) |
| Altshuler & Poertner (2003) | To assess the levels of wellbeing for youth in non-kinship foster families | N=49 adolescents Age range = 12-19 years old Mean=16 years Male=15 (30%) Female=34 (70%) African American=76.5% White=15.7% Latino/Hispanic=3.9 % | Child Health and Illness Profile – Adolescent Edition (CHIP-AE) | Youth in non-kinship care reported a higher level of satisfaction with health and fewer limitations on activities than a normed reference group. | Supports potential use of CHIP-AE as a tool for assessing health and well-being of youth in non-kinship care in six domains. |
| USA | To obtain the perception of the youth themselves of their own well-being | | | Youth in the study group reported significantly lower levels of achievement in the work performance arena. | It targets specific strengths and needs and aids practitioners in designing interventions specific to needs. (59%) |

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| Fleming et al. (2005) | To identify issues in the health of young people from the perspective of primary carers and young people | <p><i>Focus groups</i></p> <p>Focus group 1: one male and four female residential social workers</p> <p>Focus group 2: three male and two female foster carers</p> <p><i>Semi-structured interviews</i></p> <p>Five parents and eight young people (five females and three males in residential and foster care)</p> | <p>Focus groups</p> <p>Semi-structured interviews</p> <p>Case file analysis</p> | <p><i>Case file analysis</i></p> <p>44% described as having “poor” or ongoing mental health problems;</p> <p>60% described as having “significant behaviour difficulties”;</p> <p>56% had undergone statutory medical assessments and 52% of these revealed no problems.</p> <p><i>Focus group themes</i></p> <p>Foster carer/residential social worker were seen in a health promoter role</p> | <p>Young people had positive views of their health and felt their health was valued in their placement. They were content with arrangements for addressing health.</p> <p>Low uptake of statutory medical assessments and few issues arose during medicals which questions the value of medical assessments.</p> <p>Broader health needs beyond basic physical requirements are often not adequately</p> |
|-----------------------|--|--|---|---|--|

Semi-structured interviews with young people addressed, especially with regard to psychological and emotional wellbeing.

Positive perceptions of health

(62%)

Main Findings of the Review

Measures and methods of assessment

Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997)

The most frequently used measure was the SDQ which was used in eleven of the sixteen studies (Mount et al., 2004; Jee et al., 2011a, 2011b; Newlove-Delgado et al., 2012; McCrystal & McAloney, 2010; Richards et al., 2006; Goodman & Goodman, 2012; Goodman et al., 2004; Marquis & Flynn, 2009; Cousins et al., 2010 and Rees, 2013). There was some variation in the informant versions used. Four of the studies utilised all three informant versions of the SDQ with self, parent and teacher (Newlove-Delgado et al., 2012; Richards, et al., 2006; Goodman et al., 2004 and Rees, 2013). Using the self-report and parent version was the next common combination with three studies employing these (Mount et al., 2004 and Jee et al., 2011a, 2011b). Goodman and Goodman (2012) and Marquis and Flynn (2009) used only the parent version SDQ. McCrystal and McAloney (2010) focused only on the self-report SDQ. Finally, Cousins et al. (2010) used the teacher version of the SDQ completed by social workers.

Focus of the studies

Four studies compared the ability of the SDQ to capture mental health difficulties in comparison to a clinical interview which was regarded as the “gold standard”. The DAWBA was used in three studies for this purpose (Newlove-Delgado et al., 2012; Goodman & Goodman, 2012 and Goodman et al., 2004). Together these studies found that the SDQ was able to detect previously unidentified mental health need, and that the parent SDQ was a genuine measure of mental health need in LAC. The SDQ was found to have a sensitivity of 85% and specificity of 80% for multi-informant versions (self, carer and teacher). Likewise, Jee et al. (2011b) compared the ChIPS to the SDQ and

found a higher rate of sensitivity for detecting mental health problems when using youth and carer reports of 93%.

Mount et al. (2004) also compared initiative judgements of mental health problems to the SDQ. Although carers were generally found to be intuitively accurate in identifying mental health need in LAC, 23% failed to identify need which was picked up by screening using the SDQ. Similarly, Jee et al. (2011a) found that the use of the SDQ improved the rate of detection of mental health problems from 27% to 54%.

A different comparison using social worker ratings and views of mental health in LAC was undertaken by Cousins et al. (2010). Based on SDQ ratings 70% of a sample of LAC were considered to have mental health needs requiring further assessment. However, through discussions with social workers, 92% rated the LAC's health "as good as" or "better than" other children their age.

The remaining studies using the SDQ compared the results to the general population to determine whether the SDQ would be a viable measure for mental health screening in LAC (McCrystal & McAloney, 2010; Richards et al., 2006 and Marquis & Flynn, 2009). The results showed higher rates of mental health problems for LAC compared to the general population. The findings from Rees (2013) also supported statistically significant higher SDQ scores for LAC compared with norm group scores. As the SDQ discriminated between care and non-care samples the studies concluded that the SDQ would be a suitable screening tool.

Jee et al. (2011a) examined the feasibility of the SDQ as a screening tool for LAC. It was found to take less than five minutes to complete and high completion rates of 92% were noted, suggesting it was a feasible option. Newlove-Delgado et al. (2012) also found high completion rates of 78%, albeit with a small sample.

Child Behaviour Checklist (CBCL; Achenbach, 1991)

The CBCL was less commonly used, in only two studies (Blower et al., 2004 and Shore et al., 2002) and the TRF of the CBCL was used by Bernedo et al. (2012). Blower et al. (2004) used the CBCL, YSR, MFQ and TSCC with a diagnostic interview, the KSADS-PL. Those cases highlighted by the CBCL and YSR as being above the clinical threshold also scored in the abnormal range on the MFQ and TSCC. From the 22 LAC who completed the KSAD-PL, 21 met the criteria for diagnosis for at least one psychiatric disorder, which would support the use of these screening tools for capturing mental health difficulties. However, in contrast to the findings of significant differences of mental health difficulties between LAC and the general population, Shore et al. (2004) and Bernedo et al. (2012) found little difference between the two groups when rated by teachers.

Other measures/methods

One study examined the use of the CHIP-AE for the assessment of well-being in non-kinship care (Altshuler and Poertner, 2003). They concluded that the CHIP-AE could be a suitable tool for assessing health and well-being across the six domains. However, this study was in the lower range for methodological quality and so the conclusions from this are limited. Mount et al. (2004) also used the AWS and the ECBI for the assessment of mental health in LAC, but this was for identifying prevalence of difficulties only and the SDQ was focused on as a potential tool for identifying mental health needs in LAC.

One study did not use any measures and qualitatively explored the health and well-being of LAC along with a case file review (Fleming et al., 2005). Despite a case file review indicating reports of poor mental health for 44% and significant behavioural

difficulties for 60% of the sample, young people had positive views about their health and well-being.

Themes across the studies

There were a number of themes across the studies relating to factors that were important considerations in the identification and assessment of mental health of LAC. These involved factors related to the informant (type, number and agreement), the views of LAC themselves, the need for interventions and multi-agency working.

Multiple informants

The SDQ allows self, parent and teacher informants which provides information from different people, perspectives, situations and context. When the SDQ self-report was used alone LAC reported higher mean difficulty scores compared to children living with biological parents (McCrystal & McAloney, 2010). This approach of involving the views of young people was consistent with the policies in Ireland and supported the use of the SDQ for highlighting mental health problem in LAC.

Carer report alone has distinguished between care and non-care samples (Marquis & Flynn, 2009). The scores carers assigned on the SDQ were also found to reflect the level of mental health and well-being when compared to a clinical interview (Goodman & Goodman, 2012).

When young people's reports are compared to carers, research has consistently shown that carers rate difficulties higher than young people. Foster carers were found to be eleven times more likely to report a problem, three times more likely to report hyperactivity/inattention and three times more likely to report social-emotional problems compared to young people (Jee et al., 2011b). In contrast, a similar pattern of carers being four times more likely to perceive mental health difficulties and report

higher needs for young people was also found by Mount et al. (2004) but this difference was not found to be statistically significant.

Combining young people and carer reports could improve the sensitivity of the SDQ from 54% and 71% respectively to 93% for both together (Jee et al., 2011b). When a teacher rating is added to self and carer reports, self-rating of total difficulties score was lower than carers' scores, which in turn were lower than teachers' ratings (Newlove-Delgado et al., 2012 and Rees, 2013). However, it is unknown whether these were significant as statistical analysis of these differences were not completed. Similarly, self-reporters consistently reported lower difficulties compared to carers and teachers, but there was a significant positive relationship between the three raters, suggesting agreement (Richards et al., 2006). Combining self, carer and teacher reports has been found to have the greatest level of sensitivity for mental health difficulties (85%; Goodman et al., 2004). Carer and teacher reports were found to have similar value individually and together they provided the next highest level of sensitivity after all three informants. Self-report alone was found to have the least sensitivity at just 16%.

Social workers have been found to rate difficulties for LAC similar to carers and teachers and higher than young people (53%, 56%, 56% and 16% respectively) when using the impact supplement of the SDQ (Newlove-Delgado et al., 2012). Furthermore, of seven LAC who social workers identified concerns for regarding mental health, five were considered by the DAWBA to have a diagnosis of a mental health problem. When social workers completed the teacher SDQ, they rated 70% of the sample of LAC as being in a range where further assessment would be required (Cousins et al., 2010). This contrasted with the general view of social workers on the health of LAC gained through discussion when 92% felt the health of LAC was good. Therefore the view of social workers differed whether a standardised screening tool or discussion was used.

The CBCL also allows multiple informants with a self-report (YSR) and teacher version (TRF). Evidence from teacher reports for the assessment of mental health of LAC is similar to that of the general population with only a few subscales of the TRF being within the elevated range (Shore et al., 2002). Similarly, Bernedo et al. (2012) found that teachers rated most of a sample of LAC within the normal range and only a small proportion were rated within the clinical range. When teacher and carer reports were compared, carers rated difficulties higher than teachers (Shore et al., 2002). There were significant positive correlations between the ratings although these were modest. These results contrast with those of the teacher SDQ which generally found similar ratings and agreement between carers and teachers (Richards et al., 2006 and Goodman et al., 2004). Richards et al. (2006) and Goodman et al. (2004) had higher methodological quality compared to Shore et al. (2002) and so their results could be given greater weighting.

Views of LAC

Goodman et al. (2004) found the sensitivity of self-report to be 16%. Other studies have also suggested the lower levels of reports from young people (Richards et al., 2006). However, a higher methodological quality study by Jee et al. (2011b) found combining the SDQ from young people and carers increases the sensitivity, suggesting the role of self-reports despite differences of opinions.

Many studies emphasised the importance of involving young people and their views. Blower et al. (2004) concluded that difficulties were generally well recognised by young people and carers and instead of adding further screening tools, it would be more relevant to make the process more sensitive to the views of young people. Similarly, when using only social worker ratings it was concluded that there was possible under-reporting, and more comprehensive assessment was required which incorporates the

views of young people (Cousins et al., 2010). Likewise, to ensure a holistic assessment consistent with policies, young people should be encouraged to participate in the process (McCrystal & McAloney, 2010 and Richards et al., 2006).

This is something which Fleming et al. (2005) focused on by exploring health and wellbeing with LAC. Young people were found to be attuned to their health needs, thus suggesting they should be involved in health related matters and the identification of such. However, there were discrepancies between the positive view portrayed by the young people and the case file notes. It also seems that youth report alone is not used often and only two of the sixteen studies relied upon this, with many incorporating assessment from other people and perspectives as well.

The need for interventions

It has been suggested that the need for LAC is not for improved identification of mental health problems but instead improvement in the provision of interventions (Blower et al., 2004). Others have also argued that work needs to be focused on support and interventions and that it is unethical to screen for or identify need without the provision in place for support (Newlove-Delgado et al., 2012; Goodman et al., 2004 and Marquis & Flynn, 2009).

Multi-agency working

Multi-agency working was highlighted as an area to build upon to help mental health and wellbeing interventions and support for LAC (Richards et al., 2006 and Marquis & Flynn, 2009). Furthermore, the need for closer working between child welfare and mental health services was also highlighted from carers and social workers themselves (Fleming et al., 2005).

Discussion

Overview of the findings

This review has synthesised the available literature surrounding the assessment of mental health difficulties in LAC. The review examined measures and methods of assessment used for identification, along with important factors such as the type and number of informants, the views of LAC, the need for interventions and multi-agency working.

A few studies focused on the introduction of a screening process for LAC, which suggests that early identification - key for outcomes and embedded in legislation - is being addressed (Kieling et al., 2011 and The Children Act 2004). The SDQ was the most frequently used measure for LAC, with evidence suggesting that it is a good measure of mental health when compared to clinical interviews. The fact that it discriminates between care and non-care samples has been interpreted as evidence for its suitability as a screening tool for LAC. Some studies have suggested that a single screening tool may suffice. However, despite demonstrating the feasibility and use of the SDQ as a screening tool, after a pilot one service later introduced the DAWBA which they felt provided a more holistic assessment (Newlove-Delgado et al., 2012). Furthermore, screening measures only provide a snapshot in time, to be used as part of a holistic assessment process, and not override clinical judgement (Richards et al., 2006 and Jee et al., 2011b).

In all studies that incorporated young people's views, lower levels of mental health difficulties compared to other informants were consistently reported. This could be because young people do not perceive themselves to have mental health difficulties. Alternatively they may underreport their difficulties to avoid the label and stigma of mental health, something which LAC themselves have identified as being present

(Stanley, 2007). It is also possible that the experiences and label of being “looked after” may make young people feel different to others, leading to a desire to be “normal” and fit in with their peers (Ellermann, 2007). It is also possible that feelings of anxiety and behaviours result from frightening and risky environments in life so far and have become “normal” for them (Bernedo et al., 2012). This calls into question whether the cut off scores for the SDQ should be lowered for LAC (Mount et al., 2004).

Although there may be difficulties with self-report, young people’s views should be captured to help them feel empowered and included rather than being passive to the agendas of adults (McLeod, 2007 and Woods, 2006). Moreover LAC report wanting to be included in decisions about their care and interventions (Davies & Wright, 2008) but they often feel left out of such decisions (Wigley, Preston-Shoot, McMurray, & Connolly, 2012). LAC do have valuable views to share and time should be taken to gather these which may first require the development of a trusting relationship (Bell, 2002 and Winter, 2010).

There is some evidence that behaviours can be perceived differently across settings which may affect identification of mental health problems. The importance of different people in a child’s life bringing a different view was highlighted by Shore et al. (2002) and Bernedo et al. (2012) in relation to teachers. They rated a sample of LAC as similar to the general population when using the TRF of the CBCL. Is it possible that the school environment provides the interaction, relationships, structure and stability which helps the young person’s sense of continuity (Stanley, Riordan, & Alaszewski, 2005).

However, patterns of teachers rating external behaviours more highly than internal problems for LAC have been documented (Fernandez, 2008). Therefore it is possible that teachers focus more on external behaviours that may cause class disruptions, rather than on internalised difficulties (Dubowitz & Sawyer, 1994). This would account for the

lower ratings by teachers and comparable rates to the general population. It may also mean that internalised behaviours are missed, rather than not present. This emphasises the importance of multiple informants to capture more holistic information.

Social workers are key people in LAC's lives and also contribute valid information about the LAC they work with. Young people were found to seek out social workers to discuss sensitive matters that could not be discussed with carers and social workers had justifiable levels of concern regarding the mental health of LAC (Fleming et al., 2005 and Newlove-Delgado et al., 2012). The development of meaningful relationships between LAC and social workers has been the aim of proposals in social work (Le Grand, 2007). However, the development of trusting relationships is likely to take time and with reported high turnover rates of social workers this may be difficult for many LAC (Weaver, Chang, Clark, & Rhee, 2007). Therefore the findings from Fleming et al. (2005) with a comparatively low methodological quality may not be representative of LAC and social worker's relationships. Although, it would be suggested that more weighting be given to Newlove-Delgado et al. (2012) suggesting social workers contribute valid information, therefore their views would be useful to capture.

Some studies examined the level of agreement between raters. However, different people will inevitably have different views and perspectives and some research suggests low levels of agreement between different informants, which can also differ according to the domain being assessed (Brookman-Frazee, Haine, & Garland, 2006). Social constructionist theory would argue that we all see things through a "lens" which is shaped by our experience of and interaction with the world (Hoffman, 1990).

Furthermore, what constitutes good mental health and positive outcomes also differs between people (Perkins, 2001). Therefore, regardless of the level of agreement,

multiple perspectives are important to be gained and failure to do so may result in biases depending on the informant (Brann, 2010).

The CBCL was less commonly used, but captured mental health problems, along with the YSR when compared to a clinical interview. The higher prevalence of the use of the SDQ over the CBCL may reflect that the SDQ is much shorter (25 questions compared to over 100 for the CBCL) which makes it more appealing for people to complete and for services to score and interpret. Goodman and Scott (1999) compared the use of the SDQ and CBCL and found mothers completing them were twice as likely to prefer the SDQ. Jee et al. (2011a) concluded that the SDQ was a feasible measure, had high completion rates and was quick to complete. Although measures need to be easy to complete this is not their main aim and the quickness of completion is not the most important aspect of screening. The information they capture is the most important and this needs to be comprehensive and cover relevant domains (Brann, 2010).

Only one study reviewed used the CHIP-AE for assessing the well-being of LAC. However this study was methodologically relatively weak, drawing on a small sample, so therefore it is difficult to draw generalisable conclusions. Although, considering the potential difficulties with self-report, if used it would need to be used in conjunction with other assessments. Exploratory interviews and qualitative data regarding the mental health of LAC seems the best holistic option (Fleming et al., 2005). However, the integration of different perspectives and informants would need to be considered and the inclusion of a standardised assessment tool would be desirable to ensure all necessary details are explored (Cousins et al., 2010).

Implications of the quality of the studies

The studies that were methodologically most robust and therefore may be given the most weighting, were Jee et al.'s studies (2011a, 2011b). They found that the SDQ

could improve the detection of mental health problems, was a feasible measure, performed well compared to a clinical interview and was most accurate when self-report and carer report are combined. Three other studies also had a high methodological quality: Richards et al. (2006) further supported the use of the SDQ as a screening tool for LAC. However, it was also concluded to be cautious with using the SDQ alone and using it instead as part of a holistic assessment. Rees (2013) found positive exceptions for LAC and cautioned against overgeneralisations for this population. Finally, Bernedo et al. (2012) found teachers may provide a different perspective. Therefore the assessment for LAC needs to be holistic, individualised and not reliant on one screening measure.

Far less robust research by McCrystal and McAloney (2010) and Goodman and Goodman (2012) examined the use of the SDQ for identifying mental health problems for LAC and concluded it was a suitable screening tool. Although this corroborates the Jee (2011a, 2011b) studies, the brevity and methodological weakness of the Goodman research means that its implications are less impactful.

Strengths and limitations of the review

Consideration should be given to the limitation of the review when interpreting the findings. A large proportion of the initial search results had to be excluded due to the focus on prevalence of mental health problems in LAC rather than focussing on optimising assessment processes. Obviously, with the use of different inclusion/exclusion criteria, other findings may have arisen related to the assessment of mental health problems in LAC. The current review is also limited to the currently published available research. Research difficulties with the LAC population, such as gaining consent and access, are well documented (Heptinstall, 2000), and this may account for the lack of good quality research in this area.

Researcher bias may have been present in selecting the articles for inclusion, despite an inter-rater reliability assessment. Furthermore, the adapted quality checklist (based on MMAT and STROBE) may also have been subject to researcher bias, despite its scrutiny in development during supervision.

Despite these limitations, the review has provided an overview and evaluation of the international literature relating to the assessment of mental health for LAC. Factors for consideration in this process in clinical work and for future policies are highlighted along with areas for future research.

Clinical implications

There is a need to review the policies regarding the assessment of mental health in LAC to ensure clear protocols are in place for early identification and intervention. In particular the UK Government policy needs reviewing, as it states that the parent version of the SDQ is used annually with all carers of LAC (DCSF, 2009). Questions need to be asked about whether this one measure alone is an adequate indicator of needs, especially considering the variety of methodological quality of the research supporting this. The results of the current review support the collection of information from multiple sources, for example, the self-report version for young people over 11 and the teacher forms which are currently only recommendations in addition to the parent report (DCSF, 2009). This would enable inclusion of the young people's view, which would be consistent with current policies and allow for holistic assessments including functioning at school to be captured (DCSF, 2009). Combined with the carer report these were found to be the most sensitive.

Internalised difficulties are often under-reported compared to externalised difficulties (Arcelus, Bellerby & Vostanis, 1999). However, this may not reflect a true picture and it may be that internalised difficulties are not recognised or reported by young people

themselves, or other people around them. Furthermore, emotional difficulties can be masked by externalised behaviours (Maughan, Rowe, Messer, Goodman, & Meltzer, 2004 and Sayal, Goodman, & Ford, 2006). Therefore this under-reporting may represent unmet need for LAC which carers and professionals should be aware of. Attempts could be made to improve recognition of these difficulties.

A great deal of work has been done to ensure mental health needs of LAC are identified early. The guidelines for England recommend that the SDQ be completed on an annual basis at the child's statutory annual health assessment (DCSF, 2009). This would suggest that LAC have some time to settle into their new placement and allow time for carers to get to know the child enough to be able to answer the questions but still identify potential difficulties early enough to begin intervention as soon as possible. Despite this, high rates of mental health difficulties and poorer outcomes in adulthood persist. Perhaps the issue now is no longer the identification of difficulties, but interventions for this group of young people (Blower et al., 2004). This will be particularly challenging given the current economic climate and the cuts to services, including mental health services and CAMHS (Young Minds, 2013). There also remains the issue of the gap between those who have been identified as having needs and their access to services (Stanley et al., 2005).

Multi-agency and closer working between child welfare and mental health services was highlighted as an area to build upon to improve support for LAC (Richards et al., 2006 and Marquis & Flynn, 2009). It is known that inter-organisational relationships between child welfare and mental health services have a positive impact on mental health service access and outcomes (Bai, Wells, & Hillemeier, 2009). In England dedicated LAC teams within CAMHS (Street, & Davies, 2002) and clinical psychologists and family

therapists working within social care teams within a systemic model, the so-called Hackney model, are being implemented (Trowler & Goodman, 2008).

An important factor for all carers and professionals to remember is that LAC also have strengths as well as difficulties (Jee et al., 2011b and Rees, 2013). Often research and attention is focused on difficulties, promoting a deficit model of LAC, and there is a danger that the strengths of these young people are being overlooked. This is a neglected area of work worthy of further exploration. It may be helpful to begin this type of research involving the young people who receive LAC services, to ensure planning and implementation of research and findings are meaningful to this population.

Future research

Social workers offered information about the health and well-being of LAC that other people were unaware of. However, this needs to be done in a standardised way and this finding was based on social workers completing the teacher version of the SDQ. Therefore, exploring ways of gathering this information from social workers may be a useful avenue for future research.

The current review suggests that mental health difficulties are identified for LAC using various tools and measures. However, this is based mainly on combing the results and comparing scores to the general population. As McCann et al. (1996) and Richards et al. (2006) point out, LAC often experience multiple problems which cannot be identified from a single cause but more probably are caused by an interaction of complex factors from their pre and post care experiences. Therefore it is not clear whether the measures used with LAC are measuring relevant aspects of their life and functioning which are important to LAC given their often more complex early experiences than the general population. Future research could address whether LAC, and their carers and professionals, feel the current use of measures are capturing important and relevant

aspects of their functioning to examine the acceptability of the measure amongst people using them.

More specific measures designed for LAC are beginning to emerge, for example, the Assessment Checklist for Children and Adolescents (ACC and ACA; Tarren-Sweeney, 2007) and the Brief Assessment Checklist (BAC; Tarren-Sweeney, 2013). Future research could examine the use of these measures further and compare the commonly used existing measures.

Conclusions

In the assessment of young people's mental health it is important for young people to feel included in the process and to ensure holistic information is gathered. However, reliance on LAC's views alone may result in needs being missed and thus remaining unmet. Therefore, assessment of LAC from multiple perspectives is paramount. Self, carer and teacher reports would provide the best holistic assessment of LAC. Social worker views are also valuable sources of information, but this information would need to be collected in a standardised manner, rather than through discussions. Although clinical interviews with multiple sources would be a holistic assessment, it is not realistic, feasible or practical to implement this regularly for all LAC. Compromise is needed between ensuring needs are identified within the limits of services and their resources in today's climate, hence the use of screening measures to identify children for further assessment where necessary. At the moment the SDQ is commonly used for this purpose, however firm conclusions about its efficacy are difficult given the variability in the methodological quality of the research. Although the SDQ is a useful tool for LAC, assessments must be holistic, individualised and not reliant on one measure or source to ensure optimum practice. New research could focus on LAC

specific measures and interventions to help ensure the holistic needs of this population are identified and met.

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Part Two: Empirical Paper

**Foster Carer's and Clinicians' Perceptions of Screening Measures used with
Looked After Children**

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Please see Appendix A for the Guidelines for Authors.

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Abstract

Looked after children (LAC) often have negative early experiences which leave them vulnerable to an increased risk of mental health difficulties. Despite such a complex picture, screening measures not designed for this population are commonly used with LAC. It is also a Government requirement that the Strengths and Difficulties Questionnaire (SDQ) is completed annually for all LAC. More specialist screening measures for LAC are starting to emerge, such as the Brief Assessment Checklist (Tarren-Sweeney, 2013). The present study employed a mixed methods design to explore foster carer and clinician perceptions of the ability of the SDQ and the BAC to capture need for LAC. Six foster carers participated in semi-structured interviews which were analysed using thematic analysis. Seventy-six mental health clinicians from across the UK participated in an online survey and their responses were analysed using descriptive statistics, Wilcoxon tests and thematic analysis. For foster carers and clinicians, the BAC was favoured for capturing LAC specific difficulties. Foster carers felt the SDQ captured relevant externalised behaviours, whereas clinicians felt these aspects overshadowed and neglected internalised and LAC specific difficulties. Some foster carers and clinicians felt that together the measures may provide an appropriate screening process but the importance of having multiple informants was highlighted by both. Clinicians also raised clinical assessment as being essential. Therefore the Government requirement for the mandatory, annual screening of LAC using the SDQ alone is not considered sufficient to capture the mental health needs of LAC. As a minimum, a self-report and teacher report should also be introduced, preferably along with measures relevant to LAC such as the BAC.

Keywords: Looked After Children; Screening; Mental Health; SDQ; BAC

Introduction

“Looked after children” (LAC) refers to the placement of a child into public care in accordance with the Children Act 1989. This can be a voluntary, short term and planned arrangement for respite, or from a court order. Children can be placed in different types of care including foster care with family (kinship care) or with strangers (non-kinship care) and residential care. Research has highlighted high levels of mental health problems and poorer psychosocial outcomes in adulthood for this population (Meltzer, Gatward, Corbin, Goodman & Ford, 2003 and Viner & Taylor, 2005). Attention has focused on the need for early identification of mental health problems for LAC and since 2009 it has been a Government requirement that the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) is completed annually for every child in care to monitor wellbeing. The SDQ is a commonly used brief 25 item screening tool to detect child psychological difficulties. However, despite this monitoring, LAC have continued to experience difficulties with mental health problems and outcomes in later life. Discrepancies have also been found between level of need and support from Child and Adolescent Mental Health Services (CAMHS) highlighting unmet need for LAC (Mount, Lister & Bennun, 2004). Therefore, this remains an important area of research.

Entry into care

There are numerous situations which may result in becoming looked after including neglect, abuse, breakdown in family relationships, behaviour, illness, imprisonment and homelessness (SCIE, 2009). Some studies estimate that 62% of LAC have experienced abuse and/or neglect prior to entering the care system (McAuley and Davis, 2009). The effects of abuse and neglect can impact on development and regulation of emotion, attachment, self-efficacy, sense of self and relationships (Turney and Tanner, 2003).

Furthermore, the care system itself can bring with it a number of additional challenges and vulnerabilities, for example, being parted from biological siblings, integrating into

an existing family and high rates of placement breakdowns and changes (Farmer, Moyers & Lipscombe, 2004 and Oosterman, Schuengel, Slot, Bullens, & Doreleijers, 2007). These can be influenced by or have an impact on mental health.

Mental health

Children who become looked after are at increased risk of experiencing mental health problems, behavioural problems (Lawrence, Carlson & Egeland, 2006 and Roy, Rutter & Pickles, 2000), poorer academic performance, absenteeism and developmental delay (Zima et al., 2000) neurodevelopmental disorders and conduct and peer relation problems (Millward, Kennedy, Towlson & Minnis, 2006) compared to the general population (Ford, Vostanis, Meltzer & Goodman, 2007). Additional difficulties commonly reported for LAC include attachment difficulties, age inappropriate sexual behaviour, interpersonal problems, self-harm and unusual behaviour with food (Tarren-Sweeney, 2007, 2008 and Turney and Tanner, 2003).

Relevant theories

Attachment theory suggests infant are born with a genetic instinct to seek attachments with care givers to provide comfort and safety and is an important aspect in emotional and social development (Bowlby, 1969). Internal working models of how to relate with other people and the world are developed through these attachments. The ability to develop relationships with other people is a critical task during early school years and has been found to be associated with adjustment in adolescence and adulthood (Bagwell, Newcomb & Bukowski, 1998). Disruptions in early attachments and frequent placement changes can impact on relationship formation (Oosterman et al., 2007). This can affect a child's experience of involvement in the systemic/family environment which has been described as a sense of belonging (Hagerty, Lynch-Sauer, Patusky, Bouwsema, & Collier, 1992). Maslow (1943) described belonging and relationships as

basic human needs and research has suggested it is closely related to social and psychological functioning. A lower sense of belonging has been found to be associated with loneliness, depression and anxiety (Hagerty, Williams, Coyne & Early, 1996).

Many LAC are affected by complex trauma, which has a known impact on neurodevelopment (Cook et al., 2005; Mills et al., 2010 and Perry, 2005). Experiencing maltreatment, neglect and abuse can impact on a child's ability to form attachments, interactions with others, the development of self-regulation, self-concept and self-esteem, numerous behaviours including problems with sleeping, eating and managing emotions, neurological development including motor, language, social and emotional functioning and cognitive development. Neurodevelopmental perspectives such as Sunderland (2008) and Gerhardt (2004) take account of the effect of early experiences on a child's developing brain and suggest this can be hindered by a lack of emotional security and uncomforted distress.

Research has shown that neglected and abused children are at risk of social difficulties, peer relation problems, peer rejection, and high rates of aggression, externalising difficulties and have lower self-esteem (Dolan, Peasgood, & White, 1998; Gross & Keller, 1992; Jaffee, Caspi, Moffitt, & Taylor, 2004; Millward, Kennedy, Towlson & Minnis, 2006 and Price & Glad, 2003). Therefore assessment for LAC needs to take account of attachment, trauma and neurodevelopmental factors.

Relevant models

In an attempt to provide a framework to conceptualise the needs of LAC to allow for holistic assessment of their needs, Coman and Devaney (2011) suggested an ecological model. This model incorporated multiple factors including those related to the young

person, their birth family, placement, care system, social services, inter-agency, commissioning and societal. Similarly, Fleming, Bamford and McCaughley (2005) developed a model of interdisciplinary practice which incorporates LAC, psychosocial, physical, spiritual, social and environmental factors along with the people and professionals involved in their life. Broad (1999) also suggested a holistic model for viewing the health of LAC to include social, personal and emotional elements and the interaction between those elements.

These models have similarities to Bronfenbrenner's Ecological Systems (1979) with the various systems and influences on their everyday lives including carers, foster family, biological family, social workers, social services, education, policies and Government legislation. There are also similarities to Engel's (1977) Bio-psycho-social model which acknowledges the importance of all three aspects and the way they influence each other. Models around LAC are therefore predominantly systemic, in that they view the child as part of the broader system, with different levels impacting on the child's world and experience.

Assessment of LAC

Given the elevated levels of difficulties for this vulnerable group, the accurate, holistic and timely assessment of their mental health is therefore vital to allow monitoring, interventions and improved outcomes. In 2009 the Government introduced annual screening of LAC using the SDQ parent report version completed by carers. The SDQ explores five domains; emotional symptoms, conduct problems, hyperactivity, peer problems and prosocial behaviour, and also calculates an impact and overall difficulties score. The SDQ is commonly used in CAMHS and research has supported the validity and reliability across numerous populations in different countries and cultures

(Goodman, 1997; Goodman, Meltzer & Bailey, 1998; Goodman, Renfrew & Mullick, 2000 and Muris, Meesters & van den Berg, 2003).

Various studies have examined the use of the SDQ with LAC and found it discriminates between children in care and the general population (Newlove-Delgado, Murphy & Ford, 2012; McCrystal & McAloney, 2010; Richards, Wood & Rulz-Calzada, 2006 and Marquis & Flynn, 2009). Mount, Lister and Bennum (2004), Goodman and Goodman (2012) and Jee et al. (2011) found the SDQ was accurate at identifying mental health problems when compared with a clinical interview. Goodman, Ford, Corbin and Meltzer (2004) examined the SDQ as a screening tool for detection of mental health problems in LAC and found a sensitivity of 85% and a specificity of 80%. Similarly, Jee et al. (2011) found a sensitivity of up to 93% when self-report and carer report of the SDQ were used.

However, it has been noted that the SDQ does not provide a holistic assessment for LAC and its use alone should not be relied upon (Richards et al., 2006). Additionally, the SDQ was not developed for the LAC population and so may miss specific difficulties they experience and result in unidentified and unmet need. Similarly, if used by clinicians as an outcome tool assessing the effectiveness of an intervention, there are aspects that cannot be captured and it is difficult to detect change in specific domains.

More recently specific measures for LAC have been developed. For example, Tarren-Sweeney (2007) developed the Assessment Checklist for Children (ACC) and Assessment Checklist for Adolescents (ACA) which are 120 item carer report rating instruments focused on behaviours, emotions, traits and manners of relating to others common in children in care. Tarren-Sweeney compared the ACC to the Child

Behaviour Checklist (CBCL) in a New Zealand population of children in care. The results indicated that the ACC had good content, construct and criterion related validity.

Tarren-Sweeney (2013) then developed shortened versions of the ACC: the Brief Assessment Checklist for children (BAC-C) and the Brief Assessment Checklist for Adolescents (BAC-A). These contain 20 items derived from items on the ACC and the format is comparable to the SDQ. Both the BAC-C and BAC-A had internal consistencies of 0.89 and 0.87 and a high level of accuracy was found for screening for the clinical range on the ACC and ACA and CBCL.

Service user involvement

Over recent years there has been an emphasis on service user involvement in decision making and development of services. The Health in Partnership Programme found patient involvement increased patient satisfaction, confidence, trust and relationships with professionals (Department of Health, 2004a). The National Service Framework for Children, Young People and Maternity Services also emphasise the importance of increasing information, power and choice for children and their families and including them in the development of services (Department of Health, 2004b). This focus has remained at the forefront of more recent legislation which aims to increase the information, choice and control of individuals to personalise and tailor support to their needs to ensure the best quality care (Department of Health, 2010). Specific guidance for LAC has also echoed the importance of person centred services and the inclusion of LAC in shaping services (Department for Children, Schools and Families (DCSF), 2009).

However, whilst measures are routinely used in services there has been little involvement of service users in this process (Lelliott et al., 2001). This is an important

omission as Lelliott et al. (2001) highlight the importance of service user involvement in outcome measures to ensure the measures capture elements important to service users. Moran, Kelesidi, Guglani, Davidson and Ford (2012) found children and families had important and useful views about screening and outcome measures and raised important aspects to consider. This information is vital in the development of measures and services to ensure care and support are focused on appropriate areas that will most benefit children and families.

Despite policies and legislation putting LAC at the heart of services, a screening tool not designed for LAC has become mandatory. Although there is evidence to suggest the SDQ is sensitive, specific and valid with LAC, their acceptability by the people using them is not known and more specific measures for LAC are beginning to emerge, such as the BAC. There is currently a gap in the literature regarding the views of carers who complete measures and whether they are deemed useful at capturing aspects of functioning which are relevant. Carers have been found to be highly accurate in identifying mental health problems for LAC so are therefore important informants (Mount et al., 2004). The views of clinicians working with LAC are also not documented. It has been suggested that identifying key areas for measures by collaboration with researchers, clinicians and service users is required to ensure measures are meaningful (Brookman-Frazee, Haine & Garland, 2006).

Aims of the current study

The absence of carer and clinician views means that potentially important information regarding the usefulness of measures to capture relevant aspects for LAC is missing. Carer and clinician views would provide vital insight into whether measures are assessing relevant and important aspects for LAC and could contribute to the development of more specific measures in the future. Also, to address the call for more

mixed method research in mental health, the current study used a mixed methods approach to explore foster carer and clinician views about screening measures used with LAC (Palinkas et al., 2011). This focused on the SDQ due to its mandatory use and the BAC as a new specific measure for LAC that is comparable in format to the SDQ. Broad's (1999) holistic model of health of LAC, Maslow's (1947) Hierarchy of Needs, Bronfenbrenner's Ecological Systems (1979), Fleming et al.'s (2005) model of interdisciplinary practice and research on difficulties encountered by LAC were drawn upon to form the basis of the questions to explore with foster carers and clinicians.

In particular the aims of the foster carer study included:

- What are foster carers' perceptions of the SDQ and BAC?
- Do foster carers identify needs for their foster child that are captured well by the SDQ and BAC?
- Do foster carers identify needs for their foster child that are not captured well by the SDQ and BAC?
- How do the SDQ and BAC compare in terms of their ability to capture need in LAC from foster carers' perspective?
- Are there any differences between foster carer and clinician perceptions about the SDQ and BAC?

The hypotheses made for the clinician study included:

- Clinicians may highlight some aspects that the SDQ does not capture for LAC.
- Clinicians may identify different aspects that are captured well and not captured by the SDQ and BAC.
- Clinicians may find the BAC more clinically useful for capturing difficulties for LAC than the SDQ.

Method (Foster carer study)

Design

A qualitative approach was employed with foster carers to explore their views and opinions of the ability of the SDQ and BAC to capture need and functioning for LAC. Semi-structured interviews were used and the data was analysed using thematic analysis (Braun & Clarke, 2006). The epistemological statement outlines the rationale for the method of analysis (Appendix F).

Recruitment

Once ethical approval was received, (Appendix G) the local fostering team was contacted to recruit participants. The research was discussed with the service manager and research information sheets (Appendix H) were sent out by the team via email to foster carers. The research information sheets contained the contact details of the researcher for those who wanted to participate.

After two months no participants had come forward so the researcher attended a foster carer meeting facilitated by the fostering team. A short research presentation was delivered to ten foster carers and all present were given research information sheets. Of those present four consented to participate and a date, time and location was arranged to conduct the interview. The same method was followed at a second foster carer meeting. Nineteen different foster carers were present and two consented to participate.

Participants

A total of six foster carers met the inclusion criteria and consented to participate in the study. The first two participants were a married couple who participated together. The inclusion criteria specified that foster carers should currently have a foster child in their care for at least six months, who was aged between 4-16 years old. The demographic information of these participants is presented in Table 1.

Table 1. Demographic information of foster carer participants.

| Participant (pseudonym) | Gender | Age | Length of time fostering | Total number of children fostered | Number of current foster children | Completed the SDQ previously? | Completed the BAC previously? | Age of foster child | Gender of foster child |
|----------------------------|--------|-----|--------------------------------|---|---|-------------------------------------|-------------------------------------|---------------------------|------------------------------|
| 1 (Kate) | Female | 42 | 1 year | 2 | 2 | Yes | No | 12 | Male |
| 2 (Ben) | Male | 44 | 1 year | 2 | 2 | Yes | No | 12 | Male |
| 3 (Sally) | Female | 56 | 20 years | 20+ | 1 | Yes | No | 5 | Male |
| 4 (Mary) | Female | 58 | 28 years | 100 | 2 | Yes | No | 7 | Female |
| 5 (Laura) | Female | 38 | 3 years | 3 | 1 | Yes | No | 16 | Female |
| 6 (Jane) | Female | 50 | 10 years | 40+ | 3 | Yes | No | 14 | Female |

Measures

At the start of the interview foster carers were asked to look at the SDQ and BAC, focused on one of their current foster child. This was done to familiarise foster carers with both of the measures before starting the interview. A semi-structured interview then took place which allowed foster carers to express their views about the SDQ and BAC.

Procedure

The six foster carers chose to be interviewed in their home. Participants completed a consent form (Appendix I), demographics form (Appendix J) and looked at the SDQ (Appendix K) and BAC (Appendix L) before the interview. The length of the interviews ranged from 25 minutes to one hour and were recorded on a digital Dictaphone. A semi-structured approach was used which included an interview schedule (Appendix M and N) to guide questioning and any further interesting points raised by the participants were explored.

Analysis

Each interview was transcribed verbatim and analysed using thematic analysis, as described by Braun and Clarke (2006; see Appendix F for Epistemological statement and research assumptions). The first stage of analysis involved familiarisation with the data. This was achieved by listening to the recording, transcribing and reading through the transcripts and also checking the accuracy of the transcripts. Whilst doing this, notes were made with initial ideas. After re-reading the transcripts and developing the initial ideas further, these points were coded along with the relevant data to support them. The codes were gathered to form themes and develop a thematic map. The themes were then reviewed, refined and clearly named and defined. Sections of the transcript with analytic notes can be found in Appendix O. A thematic map can be found in Appendix P.

Quality control

Sections of transcripts and selections of quotes were reviewed by three colleagues, one of whom was experienced in qualitative analysis. The themes were also discussed to support the final grouping.

Method (Clinician study)

The clinician study took the form of an online survey and aimed to elicit professionals' views on the clinical utility of the BAC and SDQ.

Design

A mixed method was used for the online survey with clinicians. The quantitative element required clinicians to provide five point scale responses to reflect how well they felt the SDQ and BAC captured a range of aspects. The Likert type scale responses were statistically analysed to examine the responses from clinicians.

Clinicians also had the option to respond to two open questions to add anything about either the SDQ or BAC. This qualitative data was analysed using thematic analysis (Braun & Clarke, 2006).

Recruitment

Emails containing a short description of the research and a link to the online survey were circulated to child mental health teams and looked after children services in the UK, whose contact details were online. Clinical psychologists, play therapists, drama therapists, art therapists and psychotherapists were also emailed directly using contact details found on specific therapists' websites (such as the British Psychological Society, the British Association of Play Therapists, the British Association of Drama Therapists, the British Association of Art Therapists and the UK Council for Psychotherapy).

Participants

Altogether seventy-six clinicians participated in the online survey. The inclusion criteria were clinicians who had experience of working with Looked After Children, for at least 6 months.

Measures

Electronic links to the SDQ and BAC were provided at the start of the survey for clinicians to familiarise themselves with the measures before beginning the survey.

Questions on the survey were focused on behaviour, emotion, well-being and functioning. Likert type scale responses were used to measure how well clinicians felt the SDQ and BAC captured these aspects. The questions were generated from research highlighting indicators of psychological functioning and specific LAC difficulties (see appendix Q for the questions).

Procedure

When clinicians accessed the survey online they were presented with a short explanation of the study and could then begin. Participants were aware that they were consenting to participate by completing the survey, that the survey was anonymous, that they could withdraw at any time and that only the data from completed surveys would be recorded.

Analysis

Quantitative data from the online clinician survey was entered into a Microsoft Excel spreadsheet and into SPSS Version 20. The five point Likert type scale responses were converted to a score (Very well = 5, well = 4, neutral = 3, not well = 2 and not very well = 1). There were no missing values in the data as the survey only saved the results for the participants who completed every question. Descriptive statistics and bar charts were created in to begin the analysis. To examine statistical differences between

participants' ratings of the SDQ compared to the BAC, the Wilcoxon signed ranks test was used to compare mean ranks. The data was ordinal level as the level of differences between the scores is not known and may not be equal. Also, the scores appeared to be clustered around one end of the scale and did not represent a normal distribution. Therefore, non-parametric statistics were required due to the data violating the assumption of normal distribution so rather than using t-tests, the Wilcoxon test was employed.

For the qualitative data from the survey, thematic analysis was used to analyse and present the data. This followed the same process as outlined for the foster carer study. A thematic map can be found in Appendix R.

Quality control

All of the qualitative data from the clinician survey was reviewed with the research supervisor and a colleague with experience of qualitative analysis. The themes were also discussed to support the final grouping.

Results (Foster carer study)

Thematic analysis was used to analyse the data from foster carers. Four themes were identified each with a number of subthemes and are presented in Table 2 below:

Table 2. Themes and subthemes from foster carers.

| Theme | Subtheme |
|--|-------------------------------------|
| Theme 1: Completion of the screening measures | <i>Ease of completion</i> |
| | <i>Interpretation of questions</i> |
| | <i>Tick box options</i> |
| | <i>Need for multiple informants</i> |

| | |
|--|--|
| | <i>Relevance</i> |
| Theme 2: Usefulness | <i>Feedback and acknowledgement</i> <i>Paperwork</i> <i>Additions</i> |
| Theme 3: Services and support | <i>Long term placements</i> <i>Matching response to need</i> |
| Theme 4: The ability of the measures to capture functioning | <i>Areas of functioning that were captured well</i> <i>Comparison of the measures for capturing functioning</i> |

Theme 1: Completion of the screening measures

Ease of completion

Participants discussed the ease of completion of the forms.

“They’re both equally easy” (Mary)

“No problem at all...it’s quite easy to do...very easy to quickly go through these forms because it is all non specific, they don’t want a statement, they don’t want a particular date...it’s quite general isn’t it...these forms aren’t difficult to do like I say if you know the children” (Jane)

Mary highlighted how the ease of completion depended on the child currently in their care.

“The more complex the child, you need to think about it more. If you’ve got a child that’s showing no....behavioural problems...it’s going to be far easier” (Mary)

Both the SDQ and BAC ask respondents to consider behaviour in the previous 4-6 months. This was something some participants were able to do but some found it difficult.

“We’re quite good at that...we wouldn’t do it on an event...we are quite good at stretching it out and looking at the whole thing” (Ben)

“You try don’t you but if you had some a major thing then that’s the foremost in your mind int it? So if it happened yesterday it would be very difficult to fill it in and think about how he was 6 months ago.” (Sally)

There was also a mix between participants who only spent a few minutes completing such measures and those who took more time to complete them.

“We would give it the time it needed, we wouldn’t rush anything like that” (Ben)

“Oh only a couple of minutes” (Sally)

Some differences emerged between the SDQ and BAC in relation to completion. The SDQ was found to be harder and longer to complete while the BAC was quicker, easier and shorter.

“We found it (SDQ) harder to do didn’t we last time...it took me a long time to answer (SDQ) whereas the other one I knew straight away what they were (BAC)” (Jane)

Interpretation of questions

Sometimes participants found the questions on the screening measures difficult to answer. This was often because they did not know how to interpret the question and applied their own interpretation, which led to uncertainty about whether this was right.

“Does that mean does she go off to her room and be by herself quite a lot, is that right in doing that? I’m not sure...I don’t know how to answer that one really...I took them to mean the same thing” (Laura)

Tick box options

The difficulty of the tick box option answers and applying those to the child was an issue raised by every participant.

“It’s not just as easy as not true, somewhat true or certainly true. There might be a little sort of story with it...Sometimes it’s not just as simple answer...If you get isolated events it’s like it’s happened so it’s certainly true but it isn’t really because it’s isolated” (Ben)

“Sometimes they seem to fall in between...Sometimes they are but not often yeah, not always true but sometimes true but it’s not consistently true” (Mary)

Need for multiple informants

The fact that foster carers do not see their foster child in every situation and the importance of gaining multiple perspectives in order to get a holistic picture, was raised by every participant.

“I found that one hard (SDQ) purely because we don’t get to see all the sides to the child because they’re either at school...” Kate

“When it talks about with their peers, we don’t see them...Social relationships we don’t really get to see...” (Ben)

Relevance

The importance of the relevance of the questions for the child and foster carer was something that was highlighted. This impacted on the ease of answering the questions for some participants.

“The child at the moment that I’m thinking of that (BAC) more suits her...behaviour...so it was easier to fill it” (Mary)

“Goes back to the relevance of the question...the relevant ones you know and you can just answer them like that” (Ben)

Laura and Jane, who had teenage foster children, commented on the SDQ covering a large age range, which made some questions difficult to answer.

“Some of these questions read as for a younger child...I kind of have to erm...change it in my head slightly to relate to a 16 year old...it (SDQ) covers such a age range, some of the questions are obviously relating to a younger child so I kinda have to think a bit harder on how to relate that to a teenage girl” (Laura)

“Child of 7 for arguments sake, their understanding of what a 15 year old understands is totally different isn’t it...The SDQ is obviously not her age related because its general across the board” (Jane)

Theme 2: Usefulness

Feedback and acknowledgement

All of the foster carers discussed not knowing what happens to the questionnaires once they have been completed, and not receiving any feedback from anyone about the results.

“I’ve not had any feedback from them...it would be nice to know what happens to these forms” (Laura)

“I wonder who’s reading this and what they’re actually doing with the answers in the first place...I wouldn’t know if they’ve even been shredded. I wouldn’t know if they’ve even been received wherever they go” (Jane)

It was also noted by foster carers with foster children over the age of eleven, who could complete the self-report version, some comparison should be made between the carer and child results. Foster carers were aware of potential discrepancies between carer and child ratings but these had not been discussed with, or raised by, anyone.

“Comparing the answers of the foster child’s and the carers and seeing how they marry up, I mean if they’ve got completely different views on that child, that can’t be right and is that being highlighted, is somebody investigating?” (Laura)

Paperwork

Most of the participants felt that completing the screening measures had not benefitted them or their foster child. Participants felt it was just more paperwork and they were not sure what happened to this afterwards. They imagined it was useful for professionals rather than for them.

“To me it’s another piece of paper that I have to fill it in the mist of paper...and someone takes it. Often you don’t hear anymore. You fill it in annually now don’t you I think and you never hear anymore.” (Mary)

“With fostering there’s so much paperwork and a lot of it is unnecessary and you don’t know where it’s going or what’s being done...” (Jane)

Additions

Participants generated a number of additions that they thought should be in the screening measures to further improve them. These included having a non-applicable box, more questions around school and family relationships (both with biological families and foster families) and space to write in additional information.

“Normally their emotions are...mostly around family contact...But there’s nothing on either one.” (Sally)

“To write a little paragraph about this child like an end of year report, to me that would be something that would be much more helpful than like I say the tick box side of things, that to me isn’t, what’s that showing if you know what I mean?...very blank, it’s not a personal thing...” (Jane)

Also, as they had teenage foster children, Laura and Jane commented that they would prefer to have two versions of the SDQ for younger and older foster children, as the BAC has to make it more relevant and age appropriate.

“SDQ could be perhaps done into age brackets rather than just across the board” (Jane)

Although participants felt that providing extra information to explain and support ratings would be more useful, they also felt that they were unable to do this, because it would not translate to a number and so would not fit in with the system.

“Sometimes it’s necessary to add something but then you can’t add that up can you if that makes any sense.” (Kate)

“Obviously you can’t do that because whoever’s reading these wants to go yeah yeah yeah and not read through a paragraph” (Laura)

A few participants felt that completing both of the questionnaires together would capture a wide range of functioning for their foster child as they felt each of the measures had valuable questions.

“There’s a huge range of different scenarios and feelings and things that go on in a child’s life...both of them together cover quite a lot don’t they? Everything that I could think of.” (Laura)

“Could they combine the two?...there’s some very good questions on both” (Jane)

Theme 3: Services and support

Long term placements

All participants reported that their foster children were not on long-term placements and they would not receive any support (from CAMHS for example) until the child was in a long term placement. Some participants felt their foster child needed support but this was not available due to the placement type.

“You don’t normally go to CAMHS until they are in a long term placement, and that’s quite hard when they’re in a short term placement for quite a long time...Because he wasn’t in long term foster placement they wouldn’t refer him to CAMHS and it was horrible to see because ya know you could see that he was at the age where he needed, he could have been turned around with that support” (Kate)

This was something participants found hard to understand.

“I just think if you need some help you need it wherever you are, however long you’re there not just when you’re in...” (Ben)

“It’s like 10 months or 6 months wasted...in a child’s life. I don’t see why that work can’t be carried on” (Mary)

Matching response to need

Some participants felt that their foster children would have benefited from additional support but that was not available. Also, when support had been offered it was not accepted or felt it was not the right time.

“It’s not because CAMHS weren’t there or the social worker wasn’t there it’s because the system that couldn’t get in place quick enough...and there wasn’t, we kept getting told oh we need to get some support from CAMHS, we need to get some advice from CAMHS, we need this” (Kate)

“The needs there but nothing’s happening now” (Mary)

Sally discussed her previous experience of receiving support for a foster child for whom they felt the help was not required at the time. At a later date, support was required, but was not available.

“He was offered bereavement counselling. It was offered very well but too early and he wasn’t ready...that’s social services thinking that he really needs this, he didn’t but...perhaps would now but...ya know...at the end there’s nothing for them now” (Sally)

Similarly Laura discussed professionals wanting her foster child to access support with the foster child not engaging.

“Social work team were...wanting her to look at working with CAMHS and things like that. She never wanted to, erm, and she never did.” (Laura)

Jane had requested some support for her foster child five months ago and was still waiting for this.

“This happened before Christmas and I’m still waiting for someone to come and speak to her about her behaviour... no that’s not being dealt with.....” (Jane)

Theme 4: The ability of the measures to capture functioning

Areas of functioning that were captured well

Participants identified that both the SDQ and BAC captured a number of issues well. They felt that the SDQ captured lying, stealing, social aspects and peer relationships well.

“Yeah, the erm, lying, stealing and....the....fighting, bullying...fidgeting...obedience, solitary...temper tantrums.” (Sally)

“There’s things about friends or bullied” (Jane)

Participants reported that the BAC better captured sexualised behaviour, friendliness with strangers, acting like a parent and difficulties with food.

“On the BAC sexualised behaviour not appropriate for age... too friendly with strangers that is a good one on that one” (Kate)

“The rejection, the lack of guilt, the insecurity...the suspicious, the jealousy” (Sally)

Comparison of the measures for capturing functioning

Participants reported that sexualised behaviour, food and behaviour with strangers were not captured on the SDQ but were on the BAC. On the BAC lying, stealing and bullying were not captured whereas participants felt they were on the SDQ.

“There are things on here (BAC) that I don’t think are covered on here (SDQ)...gorges food...the jealousy (BAC)...I don’t think they were covered in there (SDQ)” (Laura)

“Friendly with strangers on the BAC, there’s nothing about that on the other one.” (Jane)

Results (Clinician study)

Descriptives

Nineteen males and fifty seven females participated with a mean age of 44.9 years ($SD=10.85$). Participants’ mean years of experience working with LAC was 12.8 years ($SD = 9.9$). Seventy four participants had used the SDQ before (97.4%) and 2 participants had not (2.6%). The BAC had been used before by 6 participants (7.9%) and not by 70 (92.1%). The range and number of professions of the participants is presented in Table 3.

Table 3. The professions and number of the participants.

| Profession | Number of participants (N=76) |
|---------------------------|-------------------------------|
| Clinical Psychologist | 31 |
| Play therapist | 8 |
| Art therapist | 8 |
| Psychotherapist | 5 |
| Family/systemic therapist | 5 |
| Psychiatrist | 2 |

| | |
|-----------------------------|----|
| Mental health nurse | 2 |
| Assistant psychologist | 1 |
| Mental health social worker | 1 |
| Other* | 13 |

* Included 7 drama therapists, 3 educational psychologists, 1 child and adolescent psychotherapist, 1 counselling psychologist and 1 drama, play therapist and counsellor.

The mean ratings for the ability to capture difficulties with interpersonal difficulties, attachment, relationships difficulties, social skills, trauma, self-esteem, internalisation, unusual behaviour with food, sexualised behaviour, shyness, self-injury, engagement in extra-circular activities, school performance and school attendance were higher for the BAC compared to the SDQ. The difficulties which participants rated the SDQ as capturing better than the BAC included prosocial behaviour, disruptive behaviour, social functioning, externalisation, aggression and withdrawal. The mean ratings for the SDQ and BAC for each question are shown across Figure 1a and 1b.

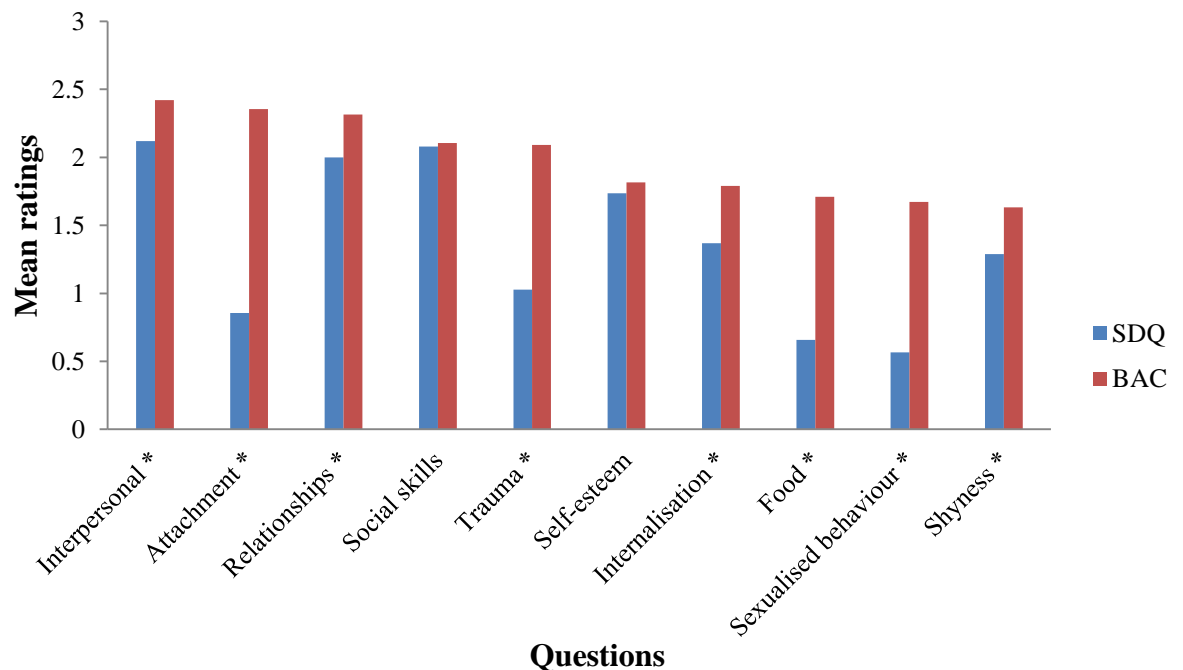


Figure 1a. The mean ratings for the SDQ and BAC. * denotes significant preference for the BAC and ** for the SDQ from the Wilcoxon Signed Ranks Test.

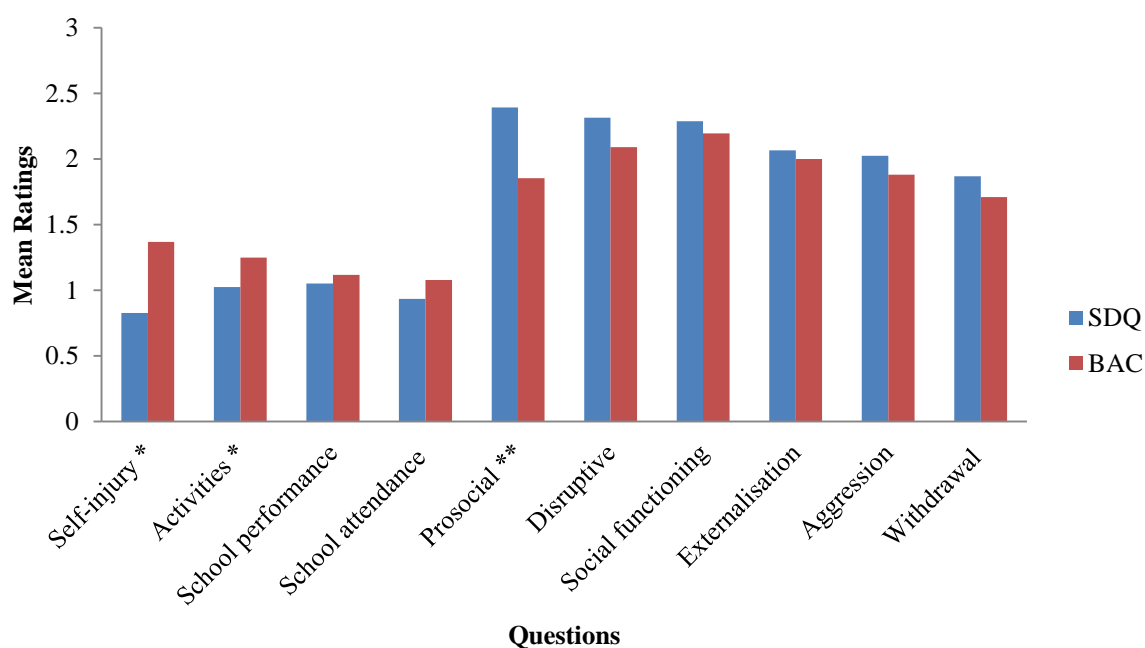


Figure 1b. The mean ratings for the SDQ and BAC. * denotes significant preference for the BAC and ** for the SDQ from the Wilcoxon Signed Ranks Test.

The largest difference between the mean ratings for the SDQ and BAC came from the question on ability to capture attachment which was rated better on the BAC. Ability to capture sexualised behaviour, trauma, and difficulties with food were the next largest differences in mean ratings between the two measures which again favoured the BAC. Self-injury, internalisation, shyness, relationships, interpersonal difficulties and activities had the next largest differences in the mean ratings between the two measures with the BAC rated as better able to capture these aspects. The final, smallest differences in mean ratings in favour of the BAC were for school attendance, self-esteem, school performance and social skills. Prosocial behaviour had the largest mean difference in preference for the SDQ. The ability to capture disruptive behaviour, withdrawal, aggression, social functioning and externalisation had smaller mean

differences in favour of the SDQ. Figure 2 shows the mean difference ratings for the SDQ and BAC.

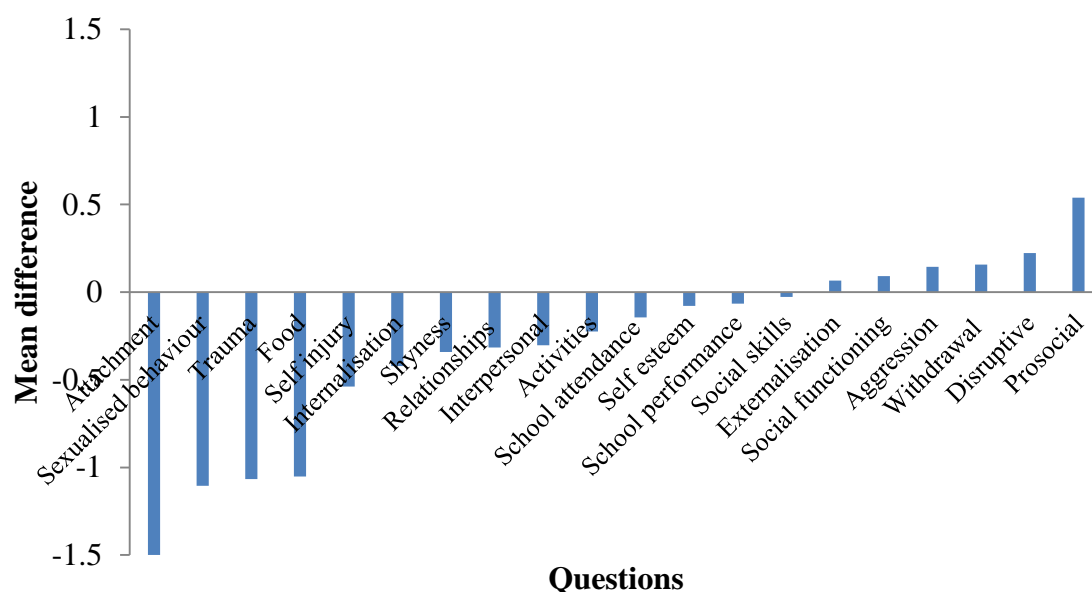


Figure 2. Mean difference ratings for the SDQ and BAC.

Negative values show preference for the BAC as being better able to capture a need and a positive difference indicates a preference for the SDQ.

Wilcoxon Signed Ranks Test

Table 4 shows the results of the Wilcoxon signed ranks test for each of the questions on the clinician survey. Participants assigned a higher rating for the BAC compared to the SDQ for the ability to capture attachment, trauma, self-injury, sexualised behaviours, unusual behaviour with food, interpersonal difficulties, relationship difficulties, engagement in extra-curricular activities, shyness and internalised difficulties. These differences were statistically significant with effect sizes ranging from 0.01 to 0.75. A larger number of participants rated the SDQ more highly than the BAC for the ability to capture prosocial behaviour. This difference was statistically significant with a medium effect size. The remaining differences for preference between the SDQ and BAC were not statistically significant.

Table 4. Results of the Wilcoxon signed ranks test for each question on the survey.

| Question | Preference for SDQ | Preference for BAC | No Preference | Exact p value | Wilcoxon Z value | Effect size |
|------------------------------------|-----------------------|-----------------------|------------------|------------------|---------------------|------------------|
| Attachment | 4 | 56 | 16 | 0.000 | -6.550 | 0.75 (Large) |
| Trauma | 5 | 46 | 25 | 0.000 | -5.414 | 0.62 (Large) |
| Self-injury | 4 | 25 | 47 | 0.000 | -3.847 | 0.44 (Medium) |
| Sexualised behaviours | 1 | 44 | 31 | 0.000 | -5.835 | 0.67 (Large) |
| Unusual behaviour with food | 1 | 41 | 34 | 0.000 | -5.430 | 0.62 (Large) |
| Interpersonal difficulties | 12 | 25 | 39 | 0.018 | -2.371 | 0.27 (Small) |
| Relationship difficulties | 13 | 24 | 39 | 0.038 | -2.073 | 0.24 (Small) |
| Extra- curricular activities | 8 | 16 | 52 | 0.045 | -2.025 | 0.23 (Small) |
| Shyness | 6 | 21 | 49 | 0.001 | -3.238 | 0.37 (Medium) |
| Internalised difficulties | 7 | 24 | 45 | 0.001 | -3.172 | 0.36 (Medium) |
| Prosocial | 42 | 10 | 24 | 0.000 | -3.809 | 0.44 |

| | | | | | | |
|---------------|----|----|----|-------|--------|----------|
| behaviour | | | | | | (Medium) |
| Social | 23 | 17 | 36 | 0.316 | -1.028 | 0.12 |
| functioning | | | | | | (Small) |
| Social skills | 20 | 19 | 37 | 0.983 | -0.037 | 0.01 |
| School | 7 | 12 | 57 | 0.078 | -1.807 | 0.21 |
| attendance | | | | | | (Small) |
| School | 11 | 14 | 51 | 0.451 | -0.795 | 0.09 |
| performance | | | | | | |
| Self-esteem | 12 | 18 | 46 | 0.492 | -0.747 | 0.09 |
| Externalising | 20 | 15 | 41 | 0.621 | -0.510 | 0.06 |
| problems | | | | | | |
| Aggression | 21 | 17 | 38 | 0.242 | -1.187 | 0.14 |
| | | | | | | (Small) |
| Withdrawal | 23 | 15 | 38 | 0.279 | -1.107 | 0.13 |
| | | | | | | (Small) |
| Disruptive | 28 | 12 | 36 | 0.063 | -1.848 | 0.21 |
| behaviour | | | | | | (Small) |

Overall when asked to choose which measure they felt was more successful at capturing the needs of LAC, 51 participants (67.1%) chose the BAC and 25 participants (32.9%) chose the SDQ.

Qualitative Analysis

There were two open ended, optional questions for participants to write any additional comments in relation to the SDQ or BAC. For the SDQ 37/76 participants (49%) made comments and for the BAC 26/76 participants (34%) made comments ranging from one word to five sentences. Thematic analysis was used to identify themes from

participants' responses. Table 5 shows the four main themes that were identified, each with subthemes based on common points that were raised across numerous participants.

Table 5. Themes and subthemes from the online clinician survey.

| Themes | Subthemes |
|---|---------------------------------------|
| Theme 1: What it is that the screening tools are measuring | <i>Internalised difficulties</i> |
| | <i>Externalised difficulties</i> |
| | <i>Behaviours</i> |
| | <i>Attachment</i> |
| | <i>Trauma</i> |
| Theme 2: How the screening tools are used | <i>Starting point and use alone</i> |
| | <i>Part of the assessment process</i> |
| | <i>Widespread use</i> |
| | <i>Mandatory use</i> |
| | <i>Multiple raters/perspectives</i> |
| Theme 3: The usefulness of the screening tools | <i>Measuring change</i> |
| | <i>Sensitivity</i> |
| | <i>Meaningfulness</i> |
| | <i>Not specific for LAC</i> |
| Theme 4: Other assessment | <i>Specific measures</i> |
| | <i>Clinical assessment</i> |

Theme 1: What it is that the screening tools are measuring

Participants discussed specific aspects of what the screening tools measured and captured and what they did not capture so well. The theme was divided into five subthemes detailed below.

Internalised difficulties

Participants felt that internalised difficulties were often common in LAC and that these problems were not captured by the SDQ.

“Doesn't pick up those children who are 'under the radar, i.e. who have learned to internalise their emotions”

Externalised difficulties

Externalised difficulties were something that participants reported the SDQ focused on and emphasised as a measure.

“Has questions that many average everyday children would score on such as temper tantrums/not sharing/not being obedient-so I don't think personally it yields a lot of useful information” (SDQ)

“Emphasises externalised problems” (SDQ)

Behaviours

There was a sense amongst participants that the SDQ focused on behaviours and symptoms and did not go beyond or beneath this to look at underlying causes which appeared to be important for them.

“It (SDQ) seems very much to focus on surface 'troublesome' behaviours (presenting problem) rather than touching on the underlying Trauma and Abuse issues”

Attachment

For responses to the SDQ question participants reported that attachment was something it failed to capture for LAC which was an important difficulty that LAC often have problems with.

“I don't really like the SDQ as it doesn't pick up on self-harm or attachment issues generally, which you often see in LAC.”

For the BAC attachment was something participants appeared to feel the BAC was better able to capture this aspect.

“BAC much more sensitive to assessing attachment issues”

Trauma

Trauma was another difficulty that participants reported was prevalent and important for LAC. Similar to attachment, it was felt the SDQ did not capture trauma very well.

“As a clinician with many years experience of working with trauma ... SDQs have proven to be woefully inadequate as an assessment tool”

“Developmental trauma isn't reflected at all, and this is what I am usually required to assess and work with.” (SDQ)

Less was mentioned in terms of the ability of the BAC to capture trauma difficulties.

However there was a sense that the BAC was better able to capture difficulties commonly found with LAC.

“BAC much more sensitive to assessing attachment issues and difficulties as it includes sexualised behaviours as well as pseudo maturity, self-harm and eating issues which the SDQ doesn't”

Theme 2: How the screening tools are used

Starting point and use alone

Some participants commented on the fact the either screening measure (but in particular the SDQ) should not be used alone as an assessment tool. Participants also reported that they would use such tools as a starting point in their work.

“It (SDQ) is not adequate as a standalone assessment”

“I think that together the measures would be pretty good as a set of screening measures. One by themselves would not be adequate.”

Part of the assessment process

Many participants viewed the measures as being one part of the assessment.

“It is one of a range of tools used at initial assessment”

Widespread use

The SDQ seemed to be used widely and recognised by different professionals. There were some advantages to it being commonly used as well as some criticisms.

“Useful for referrals as it (SDQ) is recognised by outside agencies”

“Main issue with the SDQ in relation to LAC is that it is used too often.”

As the BAC was a recently developed measure in 2013 it was unfamiliar to many participants.

“I have never seen or used the BAC before”

Mandatory use

It is a Government requirement that an SDQ is completed annually for every child who is looked after. Its statutory use was highlighted by participants.

“I feel that it is used as a paper exercise”

“As well as doing it every year, every service wants to evaluate to satisfy commissioners about the effectiveness of their service and SDQ is one of the few measures that is widely accepted for this purpose, therefore even if you prefer other tools you have to do SDQ as well.”

Multiple ratters/perspectives

Something which was valued on the SDQ by participants was the multiple versions (self, parent and teacher) to gather different perspectives to be able to triangulate the findings.

“Discrepancies between how the child is functioning at school and at home is very revealing rather than the isolated score.”

“We ask a young person to fill in one as well as school so results can be triangulated which is useful.”

As yet there is only one version of the BAC to be completed by carers. Having multiple versions was highlighted as useful with the SDQ and was recognised as missing from the BAC.

“No child version though, or school version”

Furthermore, participants raised the issue of carers completing the parent version of the SDQ and the issues that could arise.

“SDQ takes no account of the fact that foster carers and residential staff are not linked emotionally in the same frame as natural or adoptive parents and have other agendas”

“Issues with foster carers filling in the parent form and no specific foster care form is available”

Theme 3: The usefulness of the screening tools

Measuring change

Something that participants highlighted solely for the SDQ was the ability of it to capture change and how this may be missed in the LAC population.

“Does not show internal change particularly well” (SDQ)

“It (SDQ) has to be used repeatedly over a long period of time for it to pick up the changes”

Sensitivity

An additional aspect referred to with the use of the SDQ was its sensitivity to the difficulties and changes for LAC.

“It (SDQ) lacks sensitivity particularly on emotional difficulties”

“The SDQ does not seem a sensitive enough measure for the LAC population”

Meaningfulness

The information gathered from using the SDQ and the meaningfulness and usefulness of it was something several participants highlighted.

“Don’t think personally it (SDQ) yields a lot of useful information”

“SDQ provides generalised assessment, no new information about the young person has been provided”

Not specific for LAC

The fact that the SDQ was not developed or intended for LAC and that the BAC was a specific measure for this population was recognised by participants.

“Not designed for use with LAC”

“I do not feel the SDQ is extensive enough or the questions focused enough on the looked after population”

“Excellent as covers such a range of behaviours more typical of looked after children rather than generic CAMHS issues.” (BAC)

“More appropriate” (BAC)

“Seemed much more relevant to my work with LAC” (BAC)

Theme 4: Other assessment

Specific measures

Participant’s detailed some other measures which they found useful as part of their assessment process in addition to the SDQ or BAC.

“I would use more specific measures, like the RPQ for specific attachment issues, or for mood I would use the BYI, for trauma I would use the Trauma Symptom Checklist. I also use the longer Tarren-Sweeney, the Assessment checklist for children as this gives a greater range of information and has captures some useful information”

Clinical assessment

The importance of a holistic assessment and use of the clinical skill of discussions with people were emphasised.

“The most important tool is the face to face assessment by skilled clinicians”

“The conversation around the tool is the most important info I capture.”

Discussion

Principles from models highlighting social, emotional and psychological factors in wellbeing and health, along with evidence from research highlighting difficulties LAC encounter were used to gather views from foster carers and clinicians regarding screening measures.

The aims of the studies were to gather opinions of foster carers and clinicians as to whether the SDQ captured the needs of LAC and whether a new, specific measure for LAC (the BAC) was equally or better able to capture their needs. The involvement of service users was an attempt to address this gap in the literature in line with Government policies (Department of Health, 2010).

Summary (Foster carer study)

Foster carers did not find the measures helpful to themselves or their foster children and all participants reported that they had not received any feedback from them. Many were unsure what actually happened to them. Similarly, discrepancies between self-report and carer report were not being followed up. Despite this, foster carers were still keen to suggest ways in which the measures could be improved to be most useful. They felt the tick box options meant important information was missed which they wanted to add.

They also felt that it was important to capture information from other informants as they did not see the child in all situations, for example, school. The BAC was praised for the division into age groups and felt it contained questions which were more appropriate to the age of their foster child rather than the general questions on the SDQ. Foster carers identified aspects of functioning that were captured well and not captured by the SDQ and BAC. A few foster carers felt support for their foster child would be helpful but was not available until long term placement.

Meaning and interpretation

Foster carers reported completing measures but never receiving any feedback. This could affect the value they assign to screening measures and risk that they are seen as more “paperwork” to complete, losing all meaning. This could also be de-motivating for foster carers and research has shown communication from services, information sharing and involvement is vital for good relationships which will affect fostering ability and success (Rosenwald & Bronstein, 2008). Furthermore, foster carers are often the gateway to accessing services and provide valuable and accurate information (Mount et al., 2004). Therefore, although research suggests altruistic motivation is key in foster care and they comply with what is asked for them, they need to be given feedback to ensure they feel involved in the process, motivated, engaged and continue to provide such information (Rodger, Cummings, & Leschied, 2006). The need for feedback after completing measures has also been echoed by parents of children accessing CAMHS (Stasiak et al., 2013).

Similarly, foster carers reported being aware of discrepancies between their reports and the young person’s self-report. However, these had not been identified or addressed. There needs to be a process in place to follow-up such concern and it would be recommended that foster carers be supported. The perceived need for support by foster carers has been shown in previous research (Murray, Tarren-Sweeney & France, 2011). Foster carers need support to be able to support the children they care for whom often have complex needs (MacGregor, Rodger, Cummings, & Leschied, 2006). In this study emotional support, trust, respect and communication were reported by foster carers to be important in feeling supported. When these aspects were present in relationships between foster carers and services, foster carers felt valued, motivated and encouraged to continue fostering (Samrai, Beinart, & Harper, 2011).

Some foster carers found it difficult to decide on which box to tick and they felt this meant valuable information was lost. It was suggested that being able to write in additional comments and to explain answers would be useful. This finding was consistent with research from focus groups of parents with children accessing CAMHS (Moran et al., 2012). They found that parents felt the tick box options were unable to capture the variety of difficulties and space for additional comments was required to reflect the complexity of problems. Together these are consistent with Turner's (1998) suggestions that both qualitative and quantitative measures should be used. It is also in line with research emphasising the importance of holistic assessment and not relying on a single measure for the assessment of mental health and is also consistent with the findings from clinicians (Richards et al., 2006).

The need for multiple perspectives was highlighted as foster carers do not see the child in all contexts, particularly at school. This was consistent with research on parent's views of measures for those accessing CAMHS (Moran et al., 2012). The SDQ was seen as a useful measure for the triangulation between the self-report, parent and teacher. This was also echoed by clinicians. Goodman et al. (2004) and Jee et al. (2011) support this and show that the accuracy of capturing difficulties for LAC is maximised with multiple raters. However, currently for the BAC there is only a carer version.

A strength of the BAC compared to the SDQ was the division into two age categories. This meant the questions on the BAC were seen as more relevant and age appropriate while the questions on the SDQ were more general and difficult to apply to different ages. Considering the developmental stage of a child is important in determining the appropriateness of behaviour and any difficulties encountered (Brann, 2010 and Piaget, 1951). Some foster carers interpreted the questions in their own way which may result in inconsistencies and under or over reporting of difficulties. Having separate age

groups and more age appropriate questions may also have contributed to foster carers feeling that the BAC was more relevant and easier to answer than the SDQ. As the BAC was developed for LAC these findings were expected and qualitatively support the findings regarding the validity and level of accuracy of the BAC (Tarren-Sweeney, 2013).

Foster carers identified external behaviours such as lying and stealing as important aspects which they felt were captured by the SDQ but were missing from the BAC. These behaviours will inevitably impact on social functioning and relationships. LAC can have difficulty relating to adults and peers which will affect their relationships and can impact on self-esteem (Gross & Keller, 1992 and Millward et al., 2006). Therefore such areas are important for targeting interventions. Clinicians also highlighted that externalised behaviours were emphasised in the SDQ but unlike foster carers felt this was a less positive aspect to capture and could mask internalised difficulties. This showed differences in perspectives and what different informants report (Brann, 2010). It has been suggested that carers may focus on external behaviours as they may cause disruptions while internalised difficulties may not be recognised (Arcelus, Bellerby & Vostanis, 1999). Whereas clinicians will be looking for signs of internal distress (Brann, 2010).

Sexualised behaviour, unusual behaviour with food and friendlessness with strangers were the main areas foster carers felt were covered by the BAC but not the SDQ.

Research has shown these difficulties are common in LAC (Tarren-Sweeney, 2006, 2008), therefore they are important areas for assessment currently not covered with the SDQ and thus could represent an area of unmet need.

Family contact was highlighted by foster carers as causing problems for the children in their care but was not captured by either measure. Emotions and changes in emotions

were often linked to contact with biological family and so was considered an important area to capture. This contrasts with the literature which suggests positive outcomes for contact and could be the reason for it not being covered on the measures (Neil, Beek & Schofield, 2003). Therefore this is an area which requires assessment that may not currently be covered.

Foster carers found it difficult to think of aspects of functioning that were not captured well by the measures and tended to compare them against each other. This could be because together they covered a wide range of behaviours, emotions and difficulties and so sufficiently captured functioning. On the other hand, foster carers may not be aware of internalised difficulties their foster child experiences and so were unable to comment on these (Arcelus et al., 1999). Alternatively, as none of the foster children were in contact with mental health services they would be considered a non-clinical sample. Therefore, if they were not experiencing significant difficulties then these may not have been at the forefront of their minds and be difficult to imagine. This suggests that although a holistic assessment is important, there perhaps needs to be a standardised assessment measure to ensure aspects of functioning are not missed. Research has shown that discussions with social workers can lead to overly optimistic views of health compared to SDQ ratings by the same workers (Cousins, Taggart & Milner, 2010). Therefore it is possible there are other areas of functioning not captured by the SDQ or BAC that were not thought of by foster carers and relying on interviews alone may result in too optimistic a picture.

A few foster carers felt their foster children would have benefitted from additional support, from CAMHS for example, but were not receiving such support due to being in a short term placement. This highlighted the importance of not only appropriate screening for LAC but also having the support and interventions available when

required. These reports also contrast with Government policy which suggested all LAC regardless of their placement type should be offered support and interventions when necessary (DCSF, 2009). This may also be contributing to the discrepancy between level of need and service access and use (Stanley, Riordan, & Alaszewski, 2005). Clearly this issue needs further investigation and every child should be entitled to support when they need it. Support and interventions not only improve psychological wellbeing but can affect aspects such as placement stability which is also an important area for LAC and their wellbeing (Holland, Faulkner, & Perez-del-Aguila, 2005). It also highlights an issue with the system, which foster carers report working within can be one of the most stressful aspects of fostering (Farmer, Lipscombe, & Moyers, 2005).

Summary (Clinician study)

The clinician survey revealed that the BAC was favoured for difficulties such as attachment and trauma difficulties, sexualised behaviour, problems with food and internalised difficulties. This was also reflected in clinicians' qualitative data and similar to foster carers' reports. It was felt the SDQ tended to emphasise externalised behaviours and neglected internalised behaviours. Neither measure was considered adequate as a standalone measure, especially the SDQ and the value of clinical assessment was emphasised. Similar to foster carers, clinicians also highlighted the importance of multiple informants and the SDQ had this advantage over the BAC.

Meaning and interpretation

As hypothesised, clinicians highlighted aspects of functioning for LAC that were not captured by the SDQ. The SDQ was not designed for this population and so it was expected that there would be areas not covered that were relevant to LAC. The aspects they highlighted which were not covered by the SDQ and covered more by the BAC were consistent with the research on the difficulties LAC encounter (Tarren-Sweeney,

2007 and Turney and Tanner, 2003). However, this contrasts slightly with the research suggesting the SDQ is a suitable measure for mental health problems for LAC (Newlove-Delgado et al., 2012; McCrystal & McAloney, 2010; Richards et al., 2006; Marquis & Flynn, 2009 and Jee et al., 2011). Therefore there appear to be discrepancies between the research and the views of clinicians using the measure regarding its usefulness and ability to capture difficulties for LAC. It seems the SDQ may highlight general mental health difficulties for LAC but perhaps not the specific difficulties LAC encounter.

Clinicians highlighted some positive uses of the SDQ and like foster carers they felt the multiple informant versions of the SDQ were useful for triangulating the information. Prosocial behaviours were also felt to be captured by the SDQ and research has drawn attention to the fact that LAC also have strengths as well as difficulties which should not be overlooked (Jee et al., 2011).

The research on how professionals view measures in general is inconsistent. Some have suggested they have little utility (Liptzin, 2009) whilst others found them helpful in clinical practice (Blais, Frank, Nierenberg & Rauch, 2009). Many clinicians in the current study considered measures as a starting point for further assessment and emphasise the importance of clinical skills in assessment. Some specific assessment measures were detailed by clinicians to focus their assessment of LAC, for example, the Trauma Symptom Checklist for assessing trauma (TSCC; Briere, 1996) and the Relationship Problems Questionnaire (RPQ; Minnis, Rabe-Hesketh, & Wolkind, 2002). Clinicians also referenced the use of the longer version of the BAC, the ACC (Tarren-Sweeney, 2007). This was preferred in many cases as a more in-depth assessment rather than a brief screening tool. The importance of a holistic assessment and caution against using a screening measure as a standalone tool has also been highlighted in previous

research (Richards et al., 2006). Parents of children accessing CAMHS also reported it was important to include a mixture of methods in the assessment of outcome (Moran et al., 2012). Therefore the SDQ in particular is only seen as useful as a starting point and part of a wider assessment.

The third hypothesis that clinicians would find the BAC more clinically useful was not fully supported. However, the open ended questions revealed that the measure was new and unfamiliar to some, so it would be hard for some clinicians to make this judgement. It was also important to note that there were a high number of no preferences which could be explained by the unfamiliarity with the BAC. Further research around this measure in time is therefore required. Alternatively, this could be explained by dissatisfaction with both of the measures for capturing mental health difficulties for LAC. This would be consistent with the overall relatively low ratings of the measures for their ability to capture a range of aspects for LAC and some of the qualitative data. This again highlights the importance of clinical assessment rather than reliance on screening measures.

An interesting point raised by clinicians but not foster carers was the fact that the SDQ is a parent report version which foster carers are completing. A parent and child relationship will be a different dynamic to a carer and child relationship with different skills required for the latter (Ellerman, 2007). One issue raised by a clinician was that care work is employment, which may affect the way carers complete such measures. However, as foster carers did not raise this they may not see a problem with completing a “parent report” screening measure. It is possible that foster carers see this as part of their job which would be consistent with the views of foster carers suggesting they are seen as paperwork and are not useful to them but they still complete them. The research into the role foster carers perceive themselves to have is mixed, with some identifying

themselves as parents and others as professionals (Blythe, Wilkes, & Halcomb, 2013). Some research has suggested this can be influenced by the length of placement. With short term placements foster carers liken the role to employment and in long term placements, with the opportunity to develop attachments, the role is seen as a parental one (Kirton, 2001). Alternatively they may not have been aware of the fact the SDQ is a parent version or did not want to raise the issue.

Clinical implications

It has been highlighted that the SDQ fails to capture difficulties that LAC commonly encounter. The SDQ was not designed for this population and so the Government requirement of mandatory annual use needs to be questioned. There could be unmet and unidentified need through reliance on the SDQ as a screening measure. However, some positive aspects of the SDQ emerged and as suggested by foster carers, both of the SDQ and BAC together would cover a wide range of emotions and behaviours. The inclusion of the BAC into the screening process would also allow for more age appropriate questions to be incorporated as it is divided into two age categories unlike the SDQ.

There is a need for multiple perspectives which is consistent with broader psycho-social models for capturing information from the wider systems around LAC (Bronfenbrenner, 1979 and Coman and Devaney, 2011). In particular, school, as for any child, is an important part of their life and a potential area of difficulty for LAC (Zima et al., 2000). The inclusion of the teacher SDQ as part of the mandatory assessment would strengthen the assessment to enable a more holistic view and this is currently suggested in Government policy (DCSF, 2009).

In addition to screening for LAC support and interventions also need to be on offer or available when need is identified. Foster carers reported frustration that support was required for their foster children but that it was not available. This was apparently due

to the placement type. Government guidelines state that LAC should be offered interventions regardless of their placement status and so this requires further attention (DCSF, 2009). Furthermore, existing research has shown discrepancies between the level of need and the input from services (Stanley et al., 2005). Assessments will be more meaningful if there is a link to service provision on identification of need. Arguably the screening process is meaningless when no further intervention can be offered on the back of this.

Foster carers also need to receive feedback after completing measures in order to maintain their cooperation. All the participants reported never receiving any feedback. Providing feedback may help foster carers understand the value of accurate completion. Foster carers are often the people who initiate help seeking for foster children and so it is important that screening measures are completed with care and attention (Mount et al., 2004).

Limitations

Foster carers were considered to be able to provide a more holistic view of how well the measures captured various aspects for LAC as they care for their foster child in their own home and therefore may see more aspects to their functioning compared to care workers working shifts. This study did not capture the views of residential care workers which may have contributed to our understanding of the usefulness of the screening measures for capturing need for LAC. It would also have been interesting to compare the views of foster carers and care staff to see whether any differences emerged. Furthermore, the sample size was small and the foster carers were only recruited from one geographic area and therefore were not culturally and ethnically diverse. Although this limits the generalisability of the findings a helpful start has been made on understanding foster carers' views of screening measures. It would be interesting to

know whether similar findings would be evident in a larger sample and in more diverse fostering populations.

The views of LAC themselves were not sought in this study. Young people may have been able to highlight important aspects to screen for. However, research consistently shows young people rate their difficulties lower than carers or teachers and so it is possible that they minimise difficulties, possibly to reduce the stigma of mental health (Fleming et al., 2005; Goodman et al., 2004; Newlove-Delgado et al., 2012 and Richards et al., 2006). Nevertheless, young people's views would have yielded further potential triangulation.

The clinician survey gathered views of a range of professionals from across the UK to provide a representative sample. Clinical psychologists were the predominant profession who participated. This might be due to the fact that clinical psychologists use psychometric assessment in their work routinely, and this may not be the case for other professionals. It would have been interesting to see a wider range of views of the clinical utility of the screening measures from different professionals as each individual will contribute a different perspective (Brann, 2010).

The BAC appeared unfamiliar and new to many and a few participants commented that it made it difficult to answer the survey questions. The items of the BAC were provided for clinicians before the study, but if they had not used the BAC in clinical practice, it may have been difficult for them to know how well it captured different aspects. This may have affected clinicians' ratings and accounted for the high rates of no preferences.

Future research

This study has provided promising support for the use of the BAC with LAC as a screening measure. However, it is still a relatively new measure, unfamiliar to many clinicians. It does however have good validity and reliability (Tarren-Sweeney, 2013).

This study has called into question the use of a single measure to assess need in a vulnerable population and further research is required to ascertain what the best type of assessment would be.

Consideration and further research could be given to the fact that carers are being asked to complete a “parent” report measure and the possible implications this could have.

The scores assigned to the measures may be affected by this and thus the level of need may be affected. For example, it is possible that new carers may be conscious of appearing to be doing well with the children they look after and want to minimise any difficulties they may be having.

Conclusions

This study has contributed to the research evidence by addressing the gap in service user involvement with outcome measures for LAC. Views of foster carers and clinicians were collected regarding the use of the SDQ and BAC. As the SDQ was not specifically developed for LAC whereas the BAC was, it was not surprising that the BAC captured difficulties such as attachment, trauma, sexualised behaviour and internalised difficulties. On the other hand the SDQ was found to neglect these aspects and focused on externalised behaviours. As the BAC is divided into two age groups the questions were considered more age appropriate and the SDQ more general. The SDQ was favoured for its multiple informant versions for triangulation which the BAC does not currently have. Therefore, the Government’s mandatory requirement for annual completion of the SDQ for LAC is not appropriate alone and needs revision. However, not many choices for measures currently exist and future research could focus on LAC specific assessment. Until then, the teacher version of the SDQ could also be included in an attempt to capture more holistic information and a more specific and relevant measure for LAC could also be included such as the BAC. Furthermore, after

completion foster carers need to be given feedback as they currently do not know what happens to the measures which potentially affect the quality of completion. There also needs to be support offered to LAC and foster carers when it is needed, regardless of young people's placement status and local gate keeping policies. Finally, a more holistic screening process would help identify areas of need. Identified needs then require follow up intervention to make the process meaningful for children, carers and professionals.

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Appendices

Appendix A. Manuscript Submission Guidelines for the Children and Youth Services

Review

NEW SUBMISSIONS

Submission to this journal proceeds totally online and you will be guided stepwise through the creation and uploading of your files. The system automatically converts your files to a single PDF file, which is used in the peer-review process.

As part of the Your Paper Your Way service, you may choose to submit your manuscript as a single file to be used in the refereeing process. This can be a PDF file or a Word document, in any format or lay-out that can be used by referees to evaluate your manuscript. It should contain high enough quality figures for refereeing. If you prefer to do so, you may still provide all or some of the source files at the initial submission. Please note that individual figure files larger than 10 MB must be uploaded separately.

References

There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/book title, chapter title/article title, year of publication, volume number/book chapter and the pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct.

Formatting requirements

There are no strict formatting requirements but all manuscripts must contain the essential elements needed to convey your manuscript, for example Abstract, Keywords, Introduction, Materials and Methods, Results, Conclusions, Artwork and Tables with Captions.

If your article includes any Videos and/or other Supplementary material, this should be included in your initial submission for peer review purposes.

Divide the article into clearly defined sections.

Figures and tables embedded in text

Please ensure the figures and the tables included in the single file are placed next to the relevant text in the manuscript, rather than at the bottom or the top of the file.

REVISED SUBMISSIONS

Use of word processing software

Regardless of the file format of the original submission, at revision you must provide us with an editable file of the entire article. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier:

<http://www.elsevier.com/guidepublication>). See also the section on Electronic artwork.

To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.

Article structure

Subdivision - numbered sections

Divide your article into clearly defined and numbered sections. Subsections should be numbered 1.1 (then 1.1.1, 1.1.2, ...), 1.2, etc. (the abstract is not included in section numbering). Use this numbering also for internal cross-referencing: do not just refer to 'the text'. Any subsection may be given a brief heading. Each heading should appear on its own separate line.

Introduction

State the objectives of the work and provide an adequate background, avoiding a detailed literature survey or a summary of the results.

Material and methods

Provide sufficient detail to allow the work to be reproduced. Methods already published should be indicated by a reference: only relevant modifications should be described.

Theory/calculation

A Theory section should extend, not repeat, the background to the article already dealt with in the Introduction and lay the foundation for further work. In contrast, a Calculation section represents a practical development from a theoretical basis.

Results

Results should be clear and concise.

Discussion

This should explore the significance of the results of the work, not repeat them. A combined Results and Discussion section is often appropriate. Avoid extensive citations and discussion of published literature.

Conclusions

The main conclusions of the study may be presented in a short Conclusions section, which may stand alone or form a subsection of a Discussion or Results and Discussion section.

Appendices

If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Essential title page information

- **Title.** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.
- **Author names and affiliations.** Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.
- **Corresponding author.** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that phone numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address. Contact details must be kept up to date by the corresponding author.**
- **Present/permanent address.** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract

A concise and factual abstract is required. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separately from the article, so it must be able to stand alone. For this reason, References should be avoided, but if essential, then cite the author(s) and year(s). Also, non-standard or uncommon abbreviations should be avoided, but if essential they must be defined at their first mention in the abstract itself.

Graphical abstract

A Graphical abstract is optional and should summarize the contents of the article in a concise, pictorial form designed to capture the attention of a wide readership online. Authors must provide images that clearly represent the work described in the article. Graphical abstracts should be submitted as a separate

file in the online submission system. Image size: Please provide an image with a minimum of 531 × 1328 pixels (h × w) or proportionally more. The image should be readable at a size of 5 × 13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. See <http://www.elsevier.com/graphicalabstracts> for examples.

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Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate file in the online submission system.

Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point). See <http://www.elsevier.com/highlights> for examples.

Keywords

Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Abbreviations

Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

Acknowledgements

Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

Math formulae

Present simple formulae in the line of normal text where possible and use the solidus (/) instead of a horizontal line for small fractional terms, e.g., X/Y. In principle, variables are to be presented in italics. Powers of e are often more conveniently denoted by exp. Number consecutively any equations that have to be displayed separately from the text (if referred to explicitly in the text).

Footnotes

Footnotes should be used sparingly. Number them consecutively throughout the article. Many

wordprocessors build footnotes into the text, and this feature may be used. Should this not be the case, indicate the position of footnotes in the text and present the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.

Table footnotes

Indicate each footnote in a table with a superscript lowercase letter.

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TIFF (or JPG): Bitmapped line drawings: use a minimum of 1000 dpi.

TIFF (or JPG): Combinations bitmapped line/half-tone (color or grayscale): a minimum of 500 dpi is required.

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Tables

Number tables consecutively in accordance with their appearance in the text. Place footnotes to tables below the table body and indicate them with superscript lowercase letters. Avoid vertical rules. Be sparing in the use of tables and ensure that the data presented in tables do not duplicate results described elsewhere in the article.

References

Citation in text

Please ensure that every reference cited in the text is also present in the reference list (and vice versa).

Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Web references

As a minimum, the full URL should be given and the date when the reference was last accessed. Any

further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

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Reference to a book:

Strunk, W., Jr., & White, E. B. (2000). *The elements of style*. (4th ed.). New York: Longman, (Chapter 4).

Reference to a chapter in an edited book:

Mettam, G. R., & Adams, L. B. (2009). How to prepare an electronic version of your article. In B. S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281–304). New York: E-Publishing Inc.

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Appendix B. List of excluded studies.

- Attar-Schwartz, S. (2008). Emotional, behavioral and social problems among Israeli children in residential care: A multi-level analysis. *Children and Youth Services Review, 30*(2), 229-248.
- Garwood, M. M., & Close, W. (2001). Identifying the psychological needs of foster children. *Child psychiatry and human development, 32*(2), 125-135.
- Hayek, M., Mackie, T. I., Mulé, C. M., Bellonci, C., Hyde, J., Bakan, J. S., & Leslie, L. K. (2013). A Multi-state Study on Mental Health Evaluation for Children Entering Foster Care. *Administration and Policy in Mental Health and Mental Health Services Research, 1*-16.
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- Sullivan, D. J., & van Zyl, M. A. (2008). The well-being of children in foster care: Exploring physical and mental health needs. *Children and Youth Services Review, 30*(7), 774-786.
- Tarren-Sweeney, M. (2007). The Assessment Checklist for Children—ACC: A behavioral rating scale for children in foster, kinship and residential care. *Children and Youth Services Review, 29*(5), 672-691.

Appendix C. Methodological quality tool.

| Section | Criteria | Responses | | | | Comments |
|---------------------------------|--|------------|---------------|----------------------------|-----|----------|
| | | Yes (2) | Partly (1) | No or Can't tell (0) | N/A | |
| Abstract | Provides a clear, informative and balanced account of what was done and the findings | | | | | |
| Introduction | | | | | | |
| Background and rational | Explanation of the theory and rationale for the research | | | | | |
| Objectives | Statement of aims and objectives including any hypotheses | | | | | |
| Qualitative | | | | | | |
| Sources | Are the sources of qualitative data (archives, documents, informants, observations) relevant? | | | | | |
| Analysis | Is the process for analysing qualitative data relevant to address the research question (objective)? | | | | | |
| Context | Is appropriate consideration given to how findings relate to the context, e.g., the setting in which the data were collected? | | | | | |
| Researcher influence | Is appropriate consideration given to how the findings relate to the researchers' influence, e.g., through their interactions with participants? | | | | | |
| Quantitative descriptive | | | | | | |
| Sampling | Is the sampling strategy relevant to address the quantitative research question? | | | | | |
| Representative | Is the sample representative of the population understudy? | | | | | |
| Appropriate | Are measurements appropriate (clear origin, or validity known or standard instrument)? | | | | | |
| Response rate | Is there an acceptable response rate (60% or above)? | | | | | |

| | | | | | | |
|--|---|--|--|--|--|--|
| Quantitative Non-randomised | | | | | | |
| Participants | Are participants recruited in a way that minimises selection bias? | | | | | |
| Measures | Are measurements appropriate (clear origin, or validly known)? | | | | | |
| Reponses | Are there complete outcome data (80% or above) and when applicable an acceptable response rate (60%) or above? | | | | | |
| Mixed methods | | | | | | |
| Design | Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)? | | | | | |
| Integration | Is the integration of qualitative and quantitative data (or results) relevant to address the research question (objectives)? | | | | | |
| Limitations | Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results) in a triangulation design? | | | | | |
| The qualitative and appropriate quantitative criteria must also be applied for the mixed methods designs | | | | | | |
| Discussion | | | | | | |
| Key results | Summary of key results with reference to the aims of the study? | | | | | |
| Limitations | Discussion of the limitations of the study considering sources of potential bias or imprecision and direction and magnitude of this bias? | | | | | |
| Interpretation | Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies and other relevant evidence? | | | | | |
| Generalisability | Discusses the generalisability (external validity) of the study results | | | | | |
| Totals | | | | | | |

Appendix D. Data extraction tool.

| Study characteristics (Title, authors, date, country of origin) | Study aims (Rationale, hypotheses) | Participant characteristics (sample size, age, gender, sociodemographics) | Method of assessment (Measures) | Main Findings | Conclusions (Quality score) |
|---|--|---|---------------------------------------|---------------|--------------------------------|
| | | | | | |
| | | | | | |
| | | | | | |

Appendix E. Methodological quality assessment.

| Item | Criteria | Mount et al (2004) | Jee et al (2011a) | Jee et al (2011b) | Newlove-Delgado et al (2012) | McCrystal & McAloney (2010) | Richards et al (2006) | Goodman & Goodman (2012) | Goodman et al (2004) | Marquis & Flynn (2009) | Cousin et al (2010) | Rees (2013) | Blower et al (2004) | Bernedo et al (2012) | Shore et al (2002) | Altshuler & Poertner (2003) | Fleming et al (2005) | Total | Maximum | Percentage |
|------------------------------------|--------------------------|--------------------|-------------------|-------------------|------------------------------|-----------------------------|-----------------------|--------------------------|----------------------|------------------------|---------------------|-------------|---------------------|----------------------|--------------------|-----------------------------|----------------------|-------|---------|------------|
| Abstract | Clear and balanced | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 28 | 32 | 88 |
| Introduction | Background and rationale | 1 | 1 | 1 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 2 | 18 | 32 | 56 |
| | Objectives | 2 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 20 | 32 | 63 |
| Quantitative Descriptive | Sampling | 2 | | 2 | | | | | 2 | | | | 2 | | | 1 | 2 | 11 | 12 | 92 |
| | Representative | 1 | | 2 | | | | | 2 | | | | 1 | | | 0 | 2 | 8 | 12 | 67 |
| | Measures | 2 | | 2 | | | | | 2 | | | | 2 | | | 2 | | 10 | 10 | 100 |
| | Response | 0 | | 2 | | | | | 2 | | | | 2 | | | 2 | 2 | 10 | 12 | 83 |
| Quantitative Non-randomised | Recruitment | | 2 | | 2 | 1 | 2 | 2 | | 2 | 1 | 2 | | 2 | 2 | | | 18 | 20 | 90 |
| | Measures | | 2 | | 2 | 2 | 2 | 2 | | 2 | 2 | 2 | | 2 | 2 | | | 20 | 20 | 100 |
| | Response | | 2 | | 1 | 0 | 2 | 1 | | 0 | 2 | 2 | | 2 | 2 | | | 14 | 20 | 70 |

| | | Mount et al (2004) | Jee et al (2011a) | Jee et al (2011b) | Newlove-Delgado et al (2012) | McCrystal & McAloney (2010) | Richards et al (2006) | Goodman & Goodman (2012) | Goodman et al (2004) | Marquis & Flynn (2009) | Cousin et al (2010) | Rees (2013) | Blower et al (2004) | Bernedo et al (2012) | Shore et al (2002) | Altshuler & Poertner (2003) | Fleming et al (2005) | Total | Maximum | Percentage |
|----------------------|----------------------|--------------------|-------------------|-------------------|------------------------------|-----------------------------|-----------------------|--------------------------|----------------------|------------------------|---------------------|-------------|---------------------|----------------------|--------------------|-----------------------------|----------------------|-------|---------|------------|
| Qualitative | Sources | | | | | | | | | | | | 2 | | | | 2 | 4 | 4 | 100 |
| | Analysis | | | | | | | | | | | | 2 | | | | 2 | 4 | 4 | 100 |
| | Context | | | | | | | | | | | | 0 | | | | 0 | 0 | 4 | 0 |
| | Researcher influence | | | | | | | | | | | | 0 | | | | 0 | 0 | 4 | 0 |
| Mixed Methods | Design | | | | | | | | | | | | 2 | | | | 2 | 4 | 4 | 100 |
| | Integration | | | | | | | | | | | | 2 | | | | 2 | 4 | 4 | 100 |
| | Limitations | | | | | | | | | | | | 0 | | | | 0 | 0 | 4 | 0 |
| Discussion | Key results | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 1 | 29 | 32 | 91 |
| | Limitations | 1 | 2 | 2 | 1 | 1 | 2 | 0 | 0 | 1 | 2 | 1 | 1 | 1 | 0 | 0 | 0 | 15 | 32 | 47 |
| | Interpretation | 2 | 2 | 2 | 2 | 1 | 2 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 1 | 1 | 1 | 24 | 32 | 75 |
| | Generalisability | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 1 | 0 | 6 | 32 | 19 |
| Total | | 15 | 17 | 19 | 14 | 11 | 16 | 11 | 15 | 13 | 13 | 16 | 24 | 16 | 13 | 13 | 21 | | | |
| Maximum | | 22 | 20 | 22 | 20 | 20 | 20 | 20 | 22 | 20 | 20 | 20 | 36 | 20 | 20 | 22 | 34 | | | |
| Percentage | | 68 | 85 | 86 | 70 | 55 | 80 | 55 | 68 | 65 | 65 | 80 | 67 | 80 | 65 | 59 | 62 | | | |

Appendix F. Epistemological statement.

This statement aims to explore the underlying epistemological assumptions underpinning the research questions and chosen methodology.

Initially a quantitative approach was considered. However, after months of trying to design and plan a study I struggled to find a method which would address the research questions. After taking a step back to think about the methodology I realised that a quantitative approach usually based on a positivist stance that there is a shared reality that can be measured would not achieve what I was setting out to do (Willig, 2001). That was when I decided a qualitative approach with foster carers based on a relativist stance which values individual experiences, values and diversity with the existence of many “realities” would achieve the aims much better (Morrow, 2007 and Ponterotto, 2005). Such approaches are important in clinical psychology to help encompass a holistic view based on individual experiences rather than a reductionist, biomedical approach (Murray & Chamberlain, 1999).

I was keen to still keep a clinical element in the project to ensure it was clinically relevant and meaningful. As I was wanting to hear from the people using the measures it seemed important to me to include clinicians who were working with the measures and would have a range of experiences with screening measures to be able to contribute their insights. However, the practicalities of including clinicians meant this could not be a qualitative approach and so the study developed into a mixed methods design. Therefore a quantitative design which is usually represented by a positivist stance was used. However, as this contrasts with my relativist stance, I also included two open ended questions at the end to allow for any additional comments clinicians wanted to make.

Thematic analysis

As I was new to qualitative research a number of different approaches to analysis were considered before the data collection process began. Thematic analysis was chosen as the method of analysis for the foster carer study as it is not bound by any theoretical framework and so can be used flexibly to identify themes and patterns from participants.

Content analysis was considered for the analysis of clinicians' responses to the two open ended, optional questions at the end of the online survey. However, much more data was collected for this than the researcher expected. Given that clinicians had taken the time to participate and contribute to the optional questions the researcher felt some of the richness, depth and detail of the data may have been lost by focusing on the frequencies of words and phrases (Stemler, 2001). It was felt that a basic thematic analysis on the data set would provide some interesting and clinically useful pieces of information.

Braun and Clarke (2006) recommended a number of questions were considered before the analysis stage of thematic analysis. These included deciding on how a theme was going to be defined. As well as the prevalence of a theme across a data set it was also thought by the researcher that "keyness" was an important consideration when defining a theme. "Keyness" referred to whether a theme captured something important related to the research questions. As no "right" way exists in qualitative research it was important to ensure consistency of their approach throughout. Similarities between participants were evident which were used in the development of themes. However, individual comments were not discarded as the aim was to gather people's views and each person will contribute a different perspective.

Another question that was considered before analysis was whether to provide a detailed description of the data set or to focus on a particular theme. The former method has been suggested as useful when exploring a less prevalent research area or when participants' views about the area have not been researched. As foster carers and clinicians had not been asked their views about the screening measures before it was decided to provide a detailed description of the data set.

The way in which themes are identified through an inductive approach involves being led by the data to identify themes without the influence of pre-existing theoretical perspectives or framework to code (Patton, 1990). The alternative would be a theoretical approach which would be led by theory and often results in a focus on specific areas of the data set (Boyatzis, 1998). As it had been decided to take a detailed description of the whole data set and identify themes from the data itself rather than being guided by questions or theory it was decided to take an inductive approach.

A semantic or latent level of analysis can be used in thematic analysis. The former involves focusing on themes from what participants report. Latent level involves further analysis and looks beneath what has been said. As the current study was interesting in views of participants to help inform the future use and development of screening tools it did not feel necessary to analyse beyond the views expressed by participants and so a semantic level of analysis was used.

A final question considered before analysis concerned the research epistemology.

Thematic analysis can involve a realist/essentialist or constructionist ideas.

Realist/essentialist assumes language reflects meaning and experience whereas constructionist approach views language, meaning and experience as being socially constructed. As the research was interested in the views of participants, what they said

on the surface was taken to identify themes. Therefore a realist/essentialist approach was taken.

IPA

Other methods of analysis were not felt appropriate, for example, Interpretative Phenomenological Analysis (IPA) focuses on people's experiences and the understanding of these (Smith & Osborn, 2003). The aim of the study and the research questions were not focused around foster carer and clinician experiences, instead it was focused on their views and opinions which would not be consistent with the theoretical framework of IPA.

Discourse Analysis (DA)

The focus of DA is to explore the use of language in describing experiences (Willig, 2008). The present study was concerned with participants' views rather than the language they used to describe them therefore this approach was rejected.

Grounded theory

The aim of grounded theory is to generate a new or refine an existing theory (Willig, 2008). The generation of a new theory was not the purpose of the study and there is little evidence on service user views about screening measures and therefore little to build upon. This approach was also rejected.

Assumptions

After spending a lot of time reading the literature around LAC and their experiences and difficulties I was quite surprised and shocked at some of the findings and did not realise the extent of the difficulties and experiences they can encounter. I therefore struggled to see how a set of 25 questions that were designed for children who probably did not have

any similar early experiences to LAC could capture. When I then discovered the specific measures for LAC and the ways they had been developed and the questions they contained I much preferred this measure for capturing things that would be relevant for LAC. Therefore I was probably biased towards the BAC (Tarren-Sweeney, 2013) over the SDQ (Goodman, 1997). This could have influenced the questions I asked and my interpretation of the data. However, I tried to present a balanced view of the results and positives came out for the SDQ which I reported and some things were suggested to improve the BAC which I also included. I was keen to hear other people's views about the topic which helped in trying to maintain some neutrality.

I also find outcome measures and quantitative data difficult as I cannot help feeling that they reduce a person's experiences to a number and how do we decide which number is "ok" and "normal" and which number is "problematic" and requires an intervention. With today's culture of Payment by Results, "clustering" and demonstrating outcomes this serves to emphasise what feels to me to be a reductionist approach (Department of Health, 2011). I therefore much prefer a clinical assessment to the use of measures but recognise their use is inevitable, especially in today's climate and tried to keep an open mind about their use.

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Appendix G. Ethical approval letter.

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Foster Carer Participant Information Sheet

Foster carers' and clinicians' perceptions of screening measures used with looked after children

My name is Sarah Lewis and I am a trainee clinical psychologist on the Doctorate in Clinical Psychology course at the University of Hull. As part of my course I am required to carry out research. I have decided to look at the mental health screening measures that foster carers are asked to complete about their foster children. As you are a foster carer I would like to invite you to take part in the study. Before you decide to take part it is important that you know and understand what the research is for and what it will involve. This information sheet explains these things, so please read it carefully before making a decision. If anything is unclear or you have any questions please contact me using the details below. Please also discuss it with anyone you wish.

- Part 1 is information about the study and what it involves
- Part 2 is further information about the study

Part 1

What is the study about?

It is now a Government requirement that foster carers complete the Strengths and Difficulties Questionnaire (SDQ) for foster children who have been in their care for at least 6 months. The SDQ is a screening questionnaire to detect mental health problems in children aged between 4-16 years old. A new measure called the Brief Assessment Checklist (BAC) was developed in 2012 specifically for looked after children to spot difficulties often experienced by these children, such as attachment issues. We are interested in foster carers' views of the SDQ and BAC and their experience of completing them to see whether they are detecting important things that are relevant to foster children and carers.

Why am I been invited to take part?

You have been identified as a foster carer with a foster child aged between 4-16 years old who has been in your care for at least 6 months. We are therefore keen to hear about your experience of filling in the SDQ and BAC and explore your views about these questionnaires.

Do I have to take part?

No. You do not have to take part, it is voluntary and up to you whether you participate or not. If you do participate you are free to withdraw at any time without giving a reason. If you choose not to participate, OR participated and then withdrew from the study, it would not affect your support or access to services for you or your foster child.

What will happen if I do take part?

If after reading this information sheet you decide you would like to participate, please contact the researcher using the details below and a time and place will be arranged for the interview. The study would involve:

- First, completing a consent form to say you have agreed to take part in the study.
- Second, looking the SDQ and BAC, which consist of 20 and 25 items each to rate 0,1 or 2 about the child you currently foster

- Third, completing a demographics information sheet which collects general information about you and your foster child
- Finally, an interview with the researcher which would take no longer than 1 hour. The interview would be audio taped and involves discussing your foster child, their functioning, any difficulties they may be having, your experience of completing the SDQ and BAC and how useful they are.
 - If you have more than one foster child you will be asked to choose to focus on one foster child who is between 4-16 years old and who has been in your care for at least 6 months. If more than one child qualifies please choose one.

Will it cost anything?

There is no cost involved in taking part in the study.

Will it benefit me or my foster children in anyway?

There may not be any immediate benefit for you or your foster child to participating in the study. However your answers will inform the future development and use of screening measures which are appropriate for looked after children and capture their needs and difficulties. It is hoped that appropriate services and support could be identified more quickly for foster children with specifically developed measures.

Are there any advantages?

Your views about the screening measures would help inform us about the appropriateness and usefulness of their use with looked after children. Some people may be keen to share their views about such matters.

Are there any disadvantages?

It is possible that some of the questions on the screening measures or discussions in the interview may evoke emotions or memories. If this did happen then we can suggest people who may be able to provide further support.

If after reading the information in part 1 you are still interested in taking part please continue to read part 2.

Part 2

What will happen with the results?

The results will be collected, analysed, written up and submitted for the purposes of the Doctorate in Clinical Psychology. It will also be submitted for publication in a relevant journal. If you would like to receive information about the results of the study once it has been completed, please complete the question about this on the demographics sheet. A summary will be sent to you on completion of the study.

What if I change my mind?

You are free to change your mind and withdraw from the study at any time until the write up of the study without giving a reason. This will not affect any support or service that you or your foster child receive.

Will my information be kept confidentially?

Yes, all information you provide will be kept confidentially, it will be anonymous and whilst direct quotes may be used in publication, you will not be personally identified. Information will be stored in a locked cabinet at the University of Hull. Only the researcher and other authorised persons (research supervisor) will have access to the

information. After the study has been completed the information will be kept for around 10 years.

Confidentiality may be broken, in line with current legislation, only if information is shared that raises concerns for your safety, the safety of your foster child or the safety of anyone else. If this happened it would first be discussed with the social worker and an appropriate course of action decided.

What would I do if any problems came up?

If at any point you had any concerns, problems, questions or queries you could contact the researcher using the contact details below. The researcher will try to answer any questions as best they can.

Risk

No risks have been identified for participants to take part in the study.

Has anyone reviewed the study?

The study has been reviewed and approved by the Faculty of Health and Social Care Research Ethics Committee at the University of Hull.

Thank you for taking the time to read this information sheet. If you have any questions please contact me using the details below:

Sarah Lewis
Trainee Clinical Psychologist
Department of Clinical Psychology and Psychological Therapies
Hertford Building
University of Hull
Hull
HU6 7RX
Telephone: 07787973029
Email: research2013@aol.co.uk

Sources of support

More information about fostering can be found at:

www.fostering.org.uk

www.baaf.org.uk

If you feel you need some support for yourself please contact your GP.

If you feel you need support for your foster child please contact your social worker.

Foster Carer Consent Form

Participant ID:

Title of study: Foster carers' and clinicians' perceptions of screening measures used with looked after children

Researcher: Sarah Lewis

Please read the statements below carefully and if you agree to them please complete your details in the spaces below.

Please initial the boxes

- | | |
|---|--------------------------|
| 1. I confirm I have read the information sheet about the above research project and would like to participate in the study. | <input type="checkbox"/> |
| 2. I understand what the project is for and what it involves. | <input type="checkbox"/> |
| 3. I understand that participation in the project is voluntary and that I can withdraw at any time until the write up of the project for no reason without it affecting my foster child's social support or legal rights. | <input type="checkbox"/> |
| 4. I understand that my participation, information about me and contact details will be kept confidentially. | <input type="checkbox"/> |
| 5. I have had the opportunity to ask any questions I had and confirm I have had satisfactory replies to these. | <input type="checkbox"/> |
| 6. I have considered all of the information provided and would like to participate in the above study. | <input type="checkbox"/> |

Name of foster carer

.....

Signature of foster carer

Date

Contact telephone number.....

Name of researcher.....

Signature of researcher

Date.....

If you have any queries please phone me on – 07787973029 or email me on research2013@aol.co.uk

When completed: 1 for participant; 1 for researcher site file.

Appendix J. Foster carer demographic form.

Participant ID:

Title of study: Foster carers' and clinicians' perceptions of screening measures used with looked after children

Foster Carers Demographic Information

Please complete the information below. If you have more than one foster child please base your answers on the foster child who you plan to discuss in the interview with the researcher.

About you

1. Name(s)

.....

2. Age(s)

.....

3. Gender (Please circle)

Male

Female

4. Ethnicity

.....

5. Marital status (Please circle one)

Single

Married

Divorced

Living with a partner

Civil

partnership

Widowed

Other (please specify).....

6. Occupation(s)

.....

7. Length of time you have been a foster carer/foster carers

.....

8. Total number of children you have fostered

.....

9. Number of children you currently foster

.....

10. Have you ever completed the:

| | Yes | No | Approximate number of times |
|--|-----|----|-----------------------------|
| Strengths and Difficulties Questionnaire (SDQ) | | | |
| Brief Assessment Checklist (BAC) | | | |

11. How well do you feel you know and understand your foster child to be able to complete questionnaires like the SDQ and BAC?

Very well
all

Well

Neutral

Not well

Not very well at

Yes No

When was this?

What professionals were involved?.....

What was the problem?.....

What help was received?.....

What was the outcome?.....

13. Age of your foster child

.....

14. Gender of your foster child (*Please circle one*)

Male Female

15. Ethnicity of your foster child

.....

16. Age of your foster child when he/she first came into care

.....

17. Length of time your foster child has/have been in your care

.....

18. **Number of placements your foster child has previously had** (*please leave blank if it is their first placement*)

.....

19. **Would you like to receive information about the results of the study once it has been completed?** *If so please provide contact details to send this information to (address or email)*

Appendix K. Strengths and Difficulties Questionnaire (SDQ).

Removed for hard binding.

Appendix L. Brief Assessment Checklist (BAC).

Removed for hard binding.

Appendix M. Foster carer interview schedule.

Interview Schedule

The interview will begin with an outline of the project, what the interview will involve and confidentiality will be explained and the limits of this. It will be explained to foster carers that the audiotape of the interview will be kept confidentially but if information is shared that puts anyone at risk then appropriate action will be taken.

Foster carers will be asked to complete the consent form before beginning. Foster carers will then be asked to complete the demographic form, after which the SDQ and the BAC will be introduced.

1. What are your experiences of completing the SDQ and BAC? (*Prompts below if needed*)
 - a. Ease
 - b. Relevance
 - c. Usefulness
2. What do you feel the SDQ and BAC captured well about your foster child and their needs/functioning and wellbeing? (*Prompts below if needed*)
3. What do you feel the SDQ and BAC did not capture well about your foster child and their needs/ functioning and wellbeing? (*Prompts below if needed*)
 - a. Relationships/interactions with family members
 - b. Relationships with peers
 - c. Social functioning
 - d. Social skills
 - e. Social activity/extracurricular activities
 - f. School attendance and performance
 - g. Self-esteem
 - h. Prosocial and cooperative behaviour
 - i. Aggression and fighting,
 - j. Withdrawal
 - k. Disruptive behaviour
 - l. Shyness
 - m. Internalizing problems
 - n. Externalizing problems
 - o. Attachment
 - p. Trauma
 - q. Anxiety
 - r. Inter-personal problems

- s. Self-injury
 - t. Sexualised behaviour
4. How well do you feel you know and understand your foster child to be able to complete measures such as the SDQ and BAC?
 5. How useful do you feel the SDQ and BAC are in identifying need for foster children? (*Prompts below if needed*)
 - a. Have you benefitted from support as a result of scores on the SDQ?
 6. How do you feel the two measures (SDQ and BAC) compare in their ability to capture need for looked after children?
 7. Do you have any other comments you wish to make about the SDQ or BAC?

Appendix N. Rationale for Interview Schedule.

| Interview Schedule | Rationale |
|---|--|
| General experiences of the measures | To gain an overview of foster carers general views about the measures in line with involving service users in service development and the use of outcomes measures (Department of Health, 2010 and Moran, Kelesidi, Guglani, Davidson & Ford, 2012). |
| Areas they felt the SDQ and BAC captured well and not well about their foster child and their functioning | <p>Relationships and social functioning- LAC have been found to have difficulties forming and maintain relationships and interactions with people (Millward, Kennedy, Towlson, & Minnis, 2006).</p> <p>School attendance and performance - research suggests this is lower in LAC (Zima et al, 2000).</p> <p>Extra-circular activities – engagement in these have been associated with positive outcomes (Attar-Schwartz, 2008)</p> <p>Self-esteem – can be affected by LAC especially with their early experiences and difficulties within the care system (Kaufman, & Cicchetti, 1989).</p> <p>Externalised behaviours - are often reported (Vanschoonlandt, Vanderfaeillie, Van Holen, De Maeyer, & Robberechts, 2013).</p> |

| | |
|--|--|
| | <p>Internalised difficulties – are often present but may not be recognised or captured (Arcelus, Bellerby, & Vostanis, 1999).</p> <p>Early experiences leave LAC vulnerable to specific difficulties such as trauma, attachment, sexualised behaviour (Tarren-Sweeney, 2008).</p> |
| How well foster carers feel they know their foster child to complete the measures | Without sufficient knowledge or understanding of their foster child, it may be difficult for foster carers to recognise difficulties or changes in behaviour/emotions (Mount, Lister & Bennun, 2004). |
| The usefulness of the measures to foster carers and foster children for identifying need | The Government introduced annual screening with the SDQ for all LAC in 2009 and stated that LAC should receive further assessment and intervention when this was identified (Department for Children, Schools and Families, 2009). However, foster carers views about the usefulness of this have not been sought. |
| How the SDQ and BAC compare in their ability to capture need | The SDQ was not specifically developed for LAC whereas the BAC was (Tarren-Sweeney, 2013) therefore there may have been differences between their ability to capture need. |

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Appendix O. Worked example of data analysis.

Example of annotated transcript (Kate and Ben)

| | | |
|---|---|----------------------------------|
| Exploratory comments | K-I think we found it...I found that one hard (SDQ) | Themes |
| SDQ=hard | purely because we don't get to see all the sides to the child because they're either at school and it's not really... | Completion |
| Don't get to see the child in all contexts | B-Yeah just give you an example when it talks about with their peers, we don't see them... K-No B-Apart from... K-Or we don't see them with other children...erm and they're not allowed out by themselves you know | Multiple perspectives |
| BAC=more specific, easier, better wording | as a generally....yeah I found that more difficult... R-Was that the SDQ? | Relevance of the questions (BAC) |
| SDQ=longer to answer | K-Yes the SDQ rather than the other one the other one seemed to be more specific to, to him rather than | Ease of completion (BAC) |
| Some questions are easier to answer than others | that one erm... I don't know whether it's the way its worded I couldn't... it took me a long time to answer whereas the other one I knew straight away what what they were | |

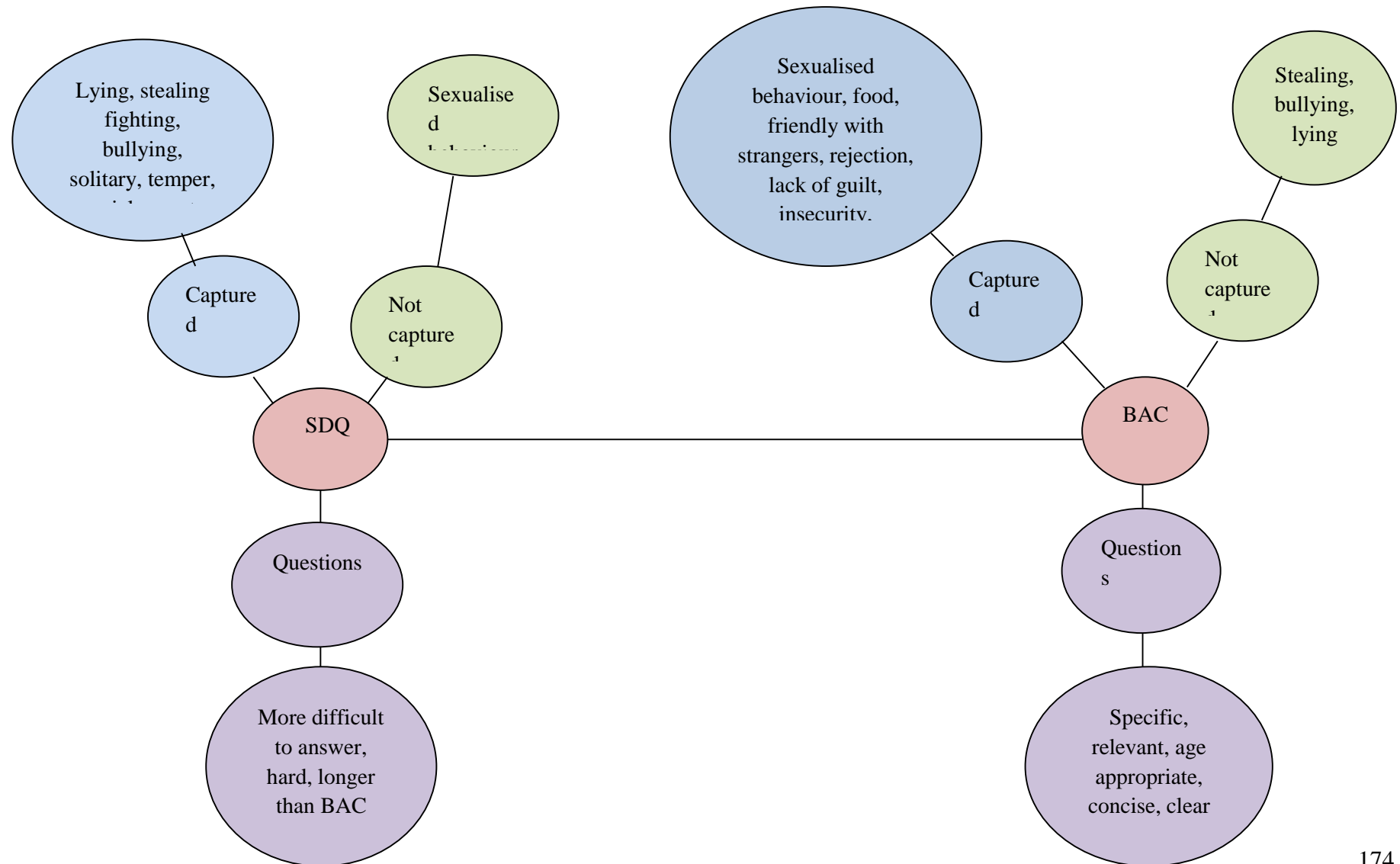
| | | |
|---|---|----------------------------|
| Relevant ones=easier to answer | <p>B-Um the relevant ones you know and you can just answer them like that...</p> <p>K-Yeah</p> <p>B-Can't ya but the ones that ...we couldn't sort of get around could we?</p> | Relevance of the questions |
| Uncertainty about the "right answer" | <p>K-No. No I think that's both times that time it took me a little while as well and I have to.. check with you to make sure (<i>Laughing</i>) I'm doing the right ones</p> <p>R-How do you find them to them to fill in? Easy? Hard?</p> | Tick box options |
| Restrictions of boxes | | |
| Easy to complete if easy to answer | <p>B-They're easy to fill in it's just whether it's easy to answer if ya know what I mean. Yeah they're certainly easy to fill in aren't they?</p> <p>K-Well yeah it just takes me a little...</p> <p>B-That could be split into 2 parts though, it's easy to fill in but easy to answer.</p> <p>K-Yeah</p> | Ease of completion |
| Importance of relevance when considering how easy the questions are to answer | <p>B-Again that goes back to the relevance er of the question I suppose...</p> <p>K-Um</p> <p>R-And how relevant do you find the questions on each of the questionnaires?</p> | Relevance and ease |

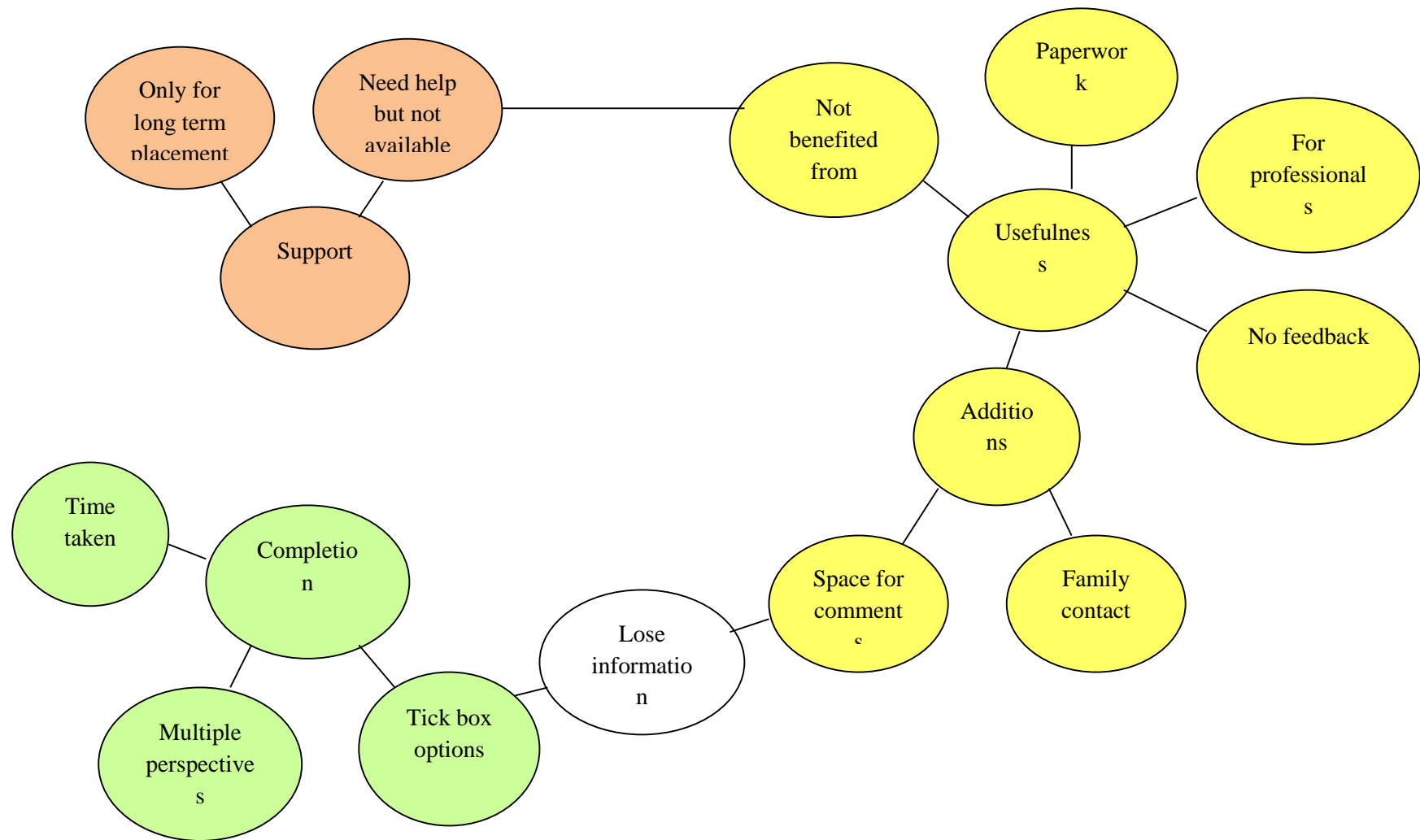
| | | |
|---|--|--|
| | Asks to look at questionnaire again | |
| | B-Thinking back...I would say it goes in favour of... | |
| | K-This one... | |
| BAC=more relevant and easier | B-The easier one yeah. That one. | |
| | K-Yeah. Yeah.... I don't I don't I can't pinpoint it | |
| SDQ=harder BAC=easier difficult to explain why | why I just found it a lot lot harder I don't know why erm whether it's because erm I can't explain that I suppose (<i>laugh</i>) I don't know... | Ease of completion |
| | B-I think it's sometimes like when we write in the | |
| Not easy to fit into the boxes and options ratings Information lost and missed, not easy short answer | book sometimes it's not just as easy as not true somewhat true or certainly true. There might be a little sort of story with it...not story but ya know what I mean like filling out the book. Sometimes it's not just as simple answer. | Tick box options Additional information |
| Want to add extra information but it is not a score Does not fit into the boxes given | K-Cos it says on one of them doesn't it that we did saying don't write anything else it's either that box or anything else and sometimes it's necessary to add something but then you can't add that up can you if that makes any sense. | Usefulness |
| Tick boxes don't give useful, representative picture | B-If you get isolated events it's like it's happened so certainly true but it isn't really because it's isolated. | |

| | | |
|--|---|-----------------|
| | K-It's somewhat true. Erm...yeah. | |
| | R-How useful would you say they are as a whole and thinking about, maybe thinking about individual questions and the usefulness of them? | |
| | K-Useful for us? | |
| | B-To who? To us? | |
| | R-Yes | |
| | K-Or useful for them? For the child? | |
| Useful for professionals to be collecting the information, but not them? | R-Both really in terms of erm... whether it identifies some needs...are there questions sort of useful in doing that? | Usefulness |
| BAC= easier, more sure of answers | B-Well I think it's useful for, for fostering services to get information from what we're saying but erm... K-I could relate to this one a lot better but I could say yes yes yes yes definitely on that one (BAC). With this one (SDQ) I, I, I personally wouldn't don't | Relevance (BAC) |
| Does not know what happens to the forms | think you'd be able to get an um erm...cos what's the one I noticed that looks at...I can't think what one that was...erm... I mean obviously don't know what happens to these after, I know we completed one for CAMHS for | Feedback |

| | | |
|--|--|---------------------------------|
| Do not get any support until in long term placements | for X beforehand erm but I knew that it wasn't going to really, although they told us it was going to go to CAMHS and he was going to get support from | Support and Long term placement |
| Nothing happens after completing forms | CAMHS... they don't get support from CAMHS until they're in long term fostering so I don't know why I don't know why we were completing it | Matching response to need |
| Do not know why they are completing them | because I didn't think it was going to...And I think what is going to happen...I just thought it was going to go to into, into the oblivion (<i>laugh</i>). | Feedback |
| Need support but not available | R-That sort of leads onto my next question, I was going to ask how sort of meaningful it is for you and does it, you know, do you think by completing this you know something is going to come of it or how | |
| | K-We I didn't think to begin with I thought because we were told right from the start that children that are in care don't get CAMHS support until they're in at least long term fostering. Erm the things that X was doing and the er um I went on a course and er me and my social worker completely...recognised our foster child in this course and his behaviour and that we really really could do with some support | Support and Long term placement |
| Being told that children do not get support until long term placements Service and placement constraints | erm.. | Matching response to need |
| Need support but not available | | |

Appendix P. Thematic map of foster carer data.





Appendix Q. Clinician online survey.

Clinician Survey

My name is Sarah Lewis and I am a trainee clinical psychologist on the Doctorate in Clinical Psychology course at the University of Hull. As part of my research I am looking at the screening measures used with looked after children (LAC).

Although it is now a Government requirement that foster carers complete the Strengths and Difficulties Questionnaire (SDQ) annually, there are possible problems regarding the usefulness and appropriateness of a measure that has not been designed for this population. Given that LAC often experience additional difficulties compared to other children there could be the problem that it does not capture these specific difficulties.

Specialist measures are beginning to emerge for LAC, such as the Brief Assessment Checklist (BAC). This research is interested in gaining the views and experience of mental health clinicians working with LAC either currently or within the last 6 months about the SDQ and BAC and their ability to capture need for a range of difficulties.

The study will involve a short survey which should take around 10 minutes to complete. There are 21 questions and two additional questions for you to write further comments if you wish. Your responses will be anonymous.

If you have any questions please contact the researcher on:

research2013@aol.co.uk

If you would like to participate please continue on to the survey: *(by clicking on the survey you are agreeing to participate. As this survey is anonymous, once it is completed your data cannot be withdrawn)*

1. **Age**
.....

2. **Gender**

Male

Female

3. **Profession**

Clinical psychologist
therapist

Family/systemic

Assistant psychologist

Psychiatrist

Mental health Nurse

Art therapist

Mental health social worker
Worker

Primary Mental Health

Play therapist

Psychotherapist

Other (*please specify*)

4. **Length of time in profession** (*number of years or months*)

.....

5. **Have you used the Strengths and Difficulties Questionnaire (SDQ) before?**

Yes

No

6. **Have you used the Brief Assessment Checklist (BAC) before?**

Yes

No

Please have a look at the SDQ and BAC before starting and answer the questions thinking about and drawing from your general experience or thinking about a particular looked after child.

The SDQ can be found on the following link:

[http://www.sdqinfo.org/py/sdqinfo/b3.py?language=Englishqz\(UK\)](http://www.sdqinfo.org/py/sdqinfo/b3.py?language=Englishqz(UK))

The BAC for ages 4-11 can be found on the following link:

[http://www.childpsych.org.uk/BAC-C_English\(UK\).pdf](http://www.childpsych.org.uk/BAC-C_English(UK).pdf)

The BAC for ages 12-17 can be found on the following link:

[http://www.childpsych.org.uk/BAC-A_English\(UK\).pdf](http://www.childpsych.org.uk/BAC-A_English(UK).pdf)

1. How well, in your opinion, do you feel attachment difficulties are captured by the:

SDQ

Very well Well Neutral Not well Not very well

BAC

Very well Well Neutral Not well Not very well

2. How well, in your opinion, do you feel trauma difficulties are captured by the:

SDQ

Very well Well Neutral Not well Not very well

BAC

Very well Well Neutral Not well Not very well

3. How well, in your opinion, do you feel self-injury behaviours are captured by the:

SDQ

Very well Well Neutral Not well Not very well

BAC

Very well Well Neutral Not well Not very well

4. How well, in your opinion, do you feel sexualised behaviours are captured by the:

SDQ

Very well Well Neutral Not well Not very well

BAC

Very well Well Neutral Not well Not very well

5. How well, in your opinion, do you feel unusual behaviour with food is captured by the:
- SDQ**
- | | | | | |
|------------------|-------------|----------------|-----------------|----------------------|
| <i>Very well</i> | <i>Well</i> | <i>Neutral</i> | <i>Not well</i> | <i>Not very well</i> |
|------------------|-------------|----------------|-----------------|----------------------|
- BAC**
- | | | | | |
|------------------|-------------|----------------|-----------------|----------------------|
| <i>Very well</i> | <i>Well</i> | <i>Neutral</i> | <i>Not well</i> | <i>Not very well</i> |
|------------------|-------------|----------------|-----------------|----------------------|
6. How well, in your opinion, do you feel interpersonal difficulties are captured by the:
- SDQ**
- | | | | | |
|------------------|-------------|----------------|-----------------|----------------------|
| <i>Very well</i> | <i>Well</i> | <i>Neutral</i> | <i>Not well</i> | <i>Not very well</i> |
|------------------|-------------|----------------|-----------------|----------------------|
- BAC**
- | | | | | |
|------------------|-------------|----------------|-----------------|----------------------|
| <i>Very well</i> | <i>Well</i> | <i>Neutral</i> | <i>Not well</i> | <i>Not very well</i> |
|------------------|-------------|----------------|-----------------|----------------------|
7. How well, in your opinion, do you feel relationship difficulties with family and friends are captured by the:
- SDQ**
- | | | | | |
|------------------|-------------|----------------|-----------------|----------------------|
| <i>Very well</i> | <i>Well</i> | <i>Neutral</i> | <i>Not well</i> | <i>Not very well</i> |
|------------------|-------------|----------------|-----------------|----------------------|
- BAC**
- | | | | | |
|------------------|-------------|----------------|-----------------|----------------------|
| <i>Very well</i> | <i>Well</i> | <i>Neutral</i> | <i>Not well</i> | <i>Not very well</i> |
|------------------|-------------|----------------|-----------------|----------------------|
8. How well, in your opinion, do you feel social functioning is captured by the:
- SDQ**
- | | | | | |
|------------------|-------------|----------------|-----------------|----------------------|
| <i>Very well</i> | <i>Well</i> | <i>Neutral</i> | <i>Not well</i> | <i>Not very well</i> |
|------------------|-------------|----------------|-----------------|----------------------|
- BAC**
- | | | | | |
|------------------|-------------|----------------|-----------------|----------------------|
| <i>Very well</i> | <i>Well</i> | <i>Neutral</i> | <i>Not well</i> | <i>Not very well</i> |
|------------------|-------------|----------------|-----------------|----------------------|
9. How well, in your opinion, do you feel social skills are captured by the:
- SDQ**
- | | | | | |
|------------------|-------------|----------------|-----------------|----------------------|
| <i>Very well</i> | <i>Well</i> | <i>Neutral</i> | <i>Not well</i> | <i>Not very well</i> |
|------------------|-------------|----------------|-----------------|----------------------|
- BAC**
- | | | | | |
|------------------|-------------|----------------|-----------------|----------------------|
| <i>Very well</i> | <i>Well</i> | <i>Neutral</i> | <i>Not well</i> | <i>Not very well</i> |
|------------------|-------------|----------------|-----------------|----------------------|
10. How well, in your opinion, do you feel engagement in extra-curricular activities is captured by the:
- SDQ**
- | | | | | |
|------------------|-------------|----------------|-----------------|----------------------|
| <i>Very well</i> | <i>Well</i> | <i>Neutral</i> | <i>Not well</i> | <i>Not very well</i> |
|------------------|-------------|----------------|-----------------|----------------------|
- BAC**
- | | | | | |
|------------------|-------------|----------------|-----------------|----------------------|
| <i>Very well</i> | <i>Well</i> | <i>Neutral</i> | <i>Not well</i> | <i>Not very well</i> |
|------------------|-------------|----------------|-----------------|----------------------|
11. How well, in your opinion, do you feel school attendance is captured by the:
- SDQ**
- | | | | | |
|------------------|-------------|----------------|-----------------|----------------------|
| <i>Very well</i> | <i>Well</i> | <i>Neutral</i> | <i>Not well</i> | <i>Not very well</i> |
|------------------|-------------|----------------|-----------------|----------------------|
- BAC**

Very well Well Neutral Not well Not very well

12. How well, in your opinion, do you feel school performance is captured by the:

SDQ

Very well Well Neutral Not well Not very well

BAC

Very well Well Neutral Not well Not very well

13. How well, in your opinion, do you feel self-esteem is captured by the:

SDQ

Very well Well Neutral Not well Not very well

BAC

Very well Well Neutral Not well Not very well

14. How well, in your opinion, do you feel externalising problems are captured by the:

SDQ

Very well Well Neutral Not well Not very well

BAC

Very well Well Neutral Not well Not very well

15. How well, in your opinion, do you feel prosocial/co-operative behaviours are captured by the:

SDQ

Very well Well Neutral Not well Not very well

BAC

Very well Well Neutral Not well Not very well

16. How well, in your opinion, do you feel aggression is captured by the:

SDQ

Very well Well Neutral Not well Not very well

BAC

Very well Well Neutral Not well Not very well

17. How well, in your opinion, do you feel withdrawal is captured by the:

SDQ

Very well Well Neutral Not well Not very well

BAC

Very well Well Neutral Not well Not very well

18. How well, in your opinion, do you feel disruptive behaviour is captured by the:

SDQ

Very well Well Neutral Not well Not very well

BAC

Very well Well Neutral Not well Not very well

19. How well, in your opinion, do you feel shyness is captured by the:

SDQ

Very well Well Neutral Not well Not very well

BAC

Very well Well Neutral Not well Not very well

20. How well, in your opinion, do you feel internalised difficulties are captured by the:

SDQ

Very well Well Neutral Not well Not very well

BAC

Very well Well Neutral Not well Not very well

21. Overall, which screening measure do you feel is more sensitive and better able to capture need in looked after children: the SDQ or the BAC?

SDQ

BAC

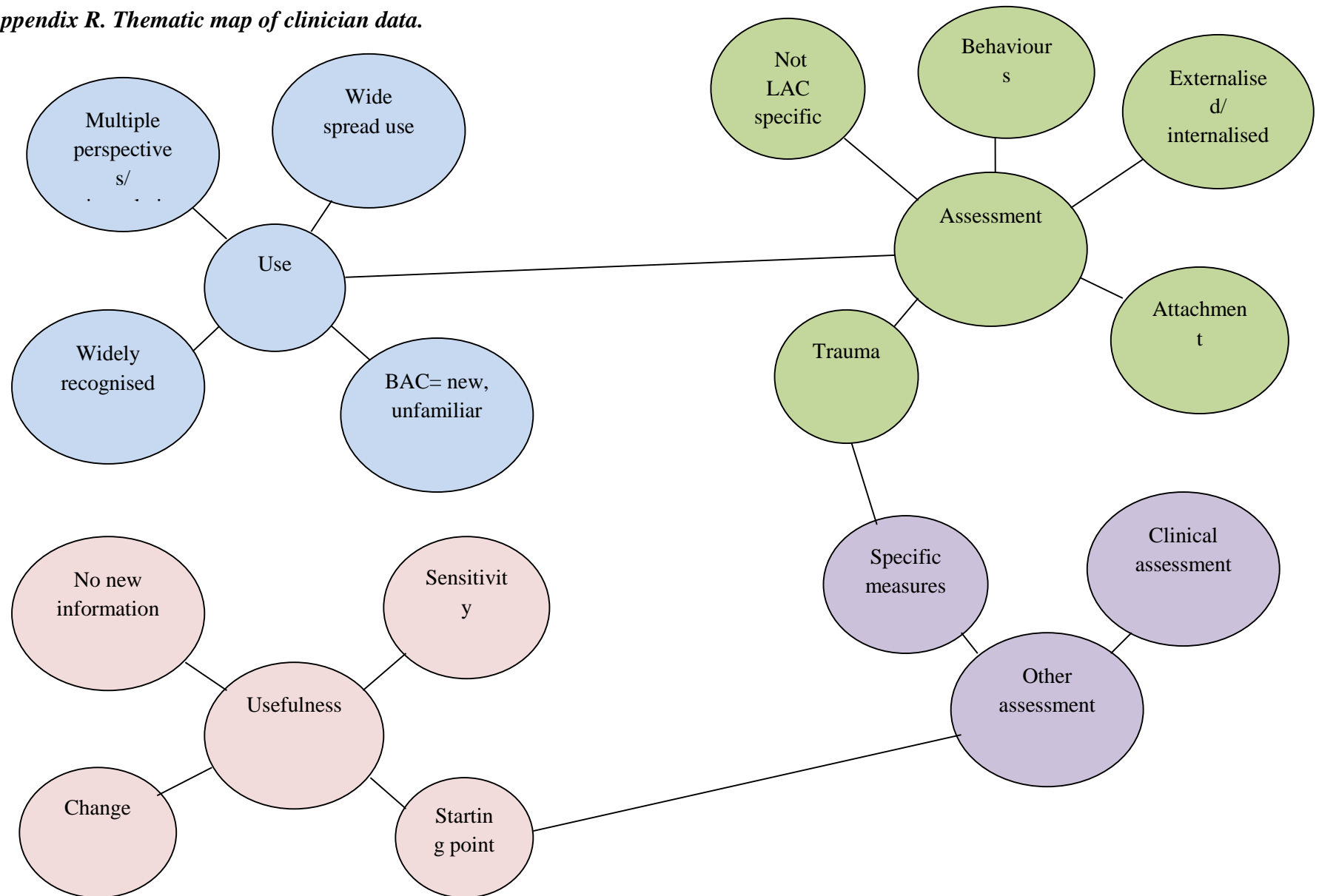
22. Any other comments about the SDQ in relation to use with looked after children as a screening measure:

23. Any other comments about the BAC in relation to use with looked after children as a screening measure:

Many thanks for your cooperation. If you wish to see summary findings of this research, please email me on: research2013@aol.co.uk and I will forward you a summary report on the completion of the work.

Thank you.

Appendix R. Thematic map of clinician data.



Reflective statement

I am writing this statement towards the end of a three year journey which has been full of emotions, thoughts, experiences and challenges. I will attempt to outline all of these in each of the key stages of the research process and finish with some overall reflections and thoughts about the future.

Planning the study

The first stage was to decide on the research topic. I was keen to choose an area that I had an interest in and passion for and also something that would be clinically relevant and contribute to the research base. I was aware that I would be working on the project for three years and so it was important that I took the time to make the right decision. I can remember attending the research fair and being slightly overwhelmed by all of the different possibilities and areas that research had to offer. By that stage I had already started my first clinical placement working with children in a Child and Adolescent Mental Health Service (CAMHS) which I was really enjoying and knew I wanted to do a project related to children in some way.

I heard that locally the council and authorities were keen for research to be undertaken with Looked After Children (LAC) and thought this would be a good opportunity to get involved in some meaningful research. The difficult bit was deciding on a specific area and developing a research question. This involved hours of searching databases and reviewing existing literature to try and find gaps where further research was required. I came up with a few ideas but through discussion in supervision it was decided that they would not really contribute anything new to the research base. My search of the literature continued for several weeks after and then I was discussing research ideas with a local Clinical Psychologist working with LAC. We began discussing possible options and she mentioned the use of measures, specifically the Strengths and

Difficulties Questionnaire (SDQ), with LAC and whether this was a reliable and valid measure for mental health problems in LAC and for measuring change in this population. This idea really appealed to me as it was child related and sounded like a project that would have some benefit clinically. Just as I thought it may be an easier process after I had decided on a specific idea I was quickly brought back down to earth with the realisation that it was only the beginning! There was a basis of an idea but no method or plan for how to achieve the proposed research questions.

Seven months of reading around the literature, supervision sessions and meetings with the field supervisor then followed. The fourth research proposal I submitted was peer reviewed and the feedback was that the method I had suggested would not achieve the research aims and questions of the study. This meant going back to the drawing board, again! It was really frustrating and disappointing that I was finding it so difficult to develop a research project to address the aims. It was also quite confusing as no one really knew how it would be possible to achieve what we wanted to and I felt lost with it all many times. I spent a long time thinking about what was important with the project. Initially it was going to be a quantitative project but the more I thought about it the more I realised that contrasted with what I was trying to achieve. I wanted to research whether the SDQ was appropriate for use with LAC and whether it was capturing need. Rather than being a quantitative design looking at numbers and scores it felt more appropriate to take an holistic view and who better to provide that information than the carers who were being asked to complete the measures and clinicians who were using the measures in their everyday clinical work. I therefore decided that a qualitative approach would be more suitable and fit more comfortably with me. I was slightly nervous about this choice as I had never done qualitative research before. However, any nerves were outweighed by excitement about trying and learning something new.

As much as I would have loved to take the same approach with clinicians I knew that this would not be practical. I was also wanting to gather views from a range of professions from across the UK. Therefore I decided an online survey would be the most suitable and viable method. To make it as easy as possible for participants and thus increase the number of participants I decided to make an online survey using Likert type scales. As I had developed an interest in qualitative approaches and wanted to hear clinicians' views I also included two open ended questions.

Recruitment

Before even planning the research I was nervous and apprehensive about the recruitment of participants. With how busy everyone always seems to be nowadays I was unsure about how many people would be willing to give up their time to take part in the study. This anxiety was alleviated greatly when I met with my field supervisor and the manager of the fostering team who reported that foster carers were always keen to take part in things such as questionnaires that were sent out. I was extremely relieved to hear this and I thought that I would not have many difficulties with recruitment, especially as the inclusion criteria were quite broad. However, this was very naïve view and my original fears were confirmed and recruitment was very difficult. The fostering team were very supportive and sent out my research information sheets a few times. I needed to change the approach and attended a foster carer meeting that they hold. I thought the personal, face to face approach may be more successful. This seemed to work and I recruited all of my participants this way. I was very excited to recruit the first participants. In the future I would try to make the recruitment process as personal as possible and try and recruit people by discussing the research face to face.

As much as I wanted to gather clinician views I was unsure about realistically how many clinicians would participate. However, I was pleasantly surprised with the number

of clinicians who participated. Initially I began by emailing the link to the survey to CAMHS teams and LAC teams that I could find online. This approach was not overly successful and so I began emailing clinicians directly whose email addresses were online through for example the British Psychological Society, The British Association of Play Therapists and other relevant websites and professions. This approach was more successful and it was encouraging to see the number of participants increasing each day.

Interviews

I had mixed emotions before my first interview, part of me was really excited, part of me was relieved to have some participants and part of me was nervous. Having never done qualitative research before I was conscious of getting it “right”. However, it was comforting to know what there was no “right” way of doing it. I was also conscious that it was an interview for research and not a clinical interview in the process of therapy. I found it quite difficult to try and not ask too many questions like I would have done in a clinical assessment. This also then led me to worry about whether participants would think I wasn’t interested in what they were saying if I wasn’t talking much. However, I was aware that I could still be interested and show this through facial expressions and gestures rather than through asking questions or talking. I also explained to participants at the start that I would remain quite quiet to allow them to speak without me influencing them too much.

Online survey

I really liked the idea of an online survey from building the questions and formats to then watching the results come in. I did have a similar feeling to with the interviews and a desire to get it “right” and ask the “right” questions. I ended up looking over the survey numerous times before finally launching it. To begin I wanted to advertise the research and survey in what I thought would be a safe and supportive space on the

Clinical Psychologists working with Looked After and Adopted Children (CPLAAC) website. Shortly after posting my research it was met with a response that I felt was critical of the research and the way I was carrying out the research. This was really upsetting and knocked my confidence about the research. I made use of supervision with my research and field supervisor to process this feedback and think of possible reasons for it. After that I received some feedback that was much more positive and encouraging as the participants felt it was a really important area of research and could be useful clinically. This reminded me of the original reasons I embarked on the project and renewed my enthusiasm for it.

Analysis and write up

Despite what I had heard about transcribing I was actually looking forward to this part. I thought it would be quite enjoyable and not too stressful. It highlighted to me that I was not as fast at typing as I imagined I would be for transcribing! This meant lots of pausing and rewinding and swapping from the audio recording to the word document over and over again. I then got a few tips from colleagues about slowing the speed of the recording down which brought it more in line with my speed of typing! After a while I seemed to get into the “swing” of it and did find it easier and less stressful than at the start.

I then had pages of data that I had to analyse using thematic analysis with no idea how or where to start. All of my colleagues who were doing qualitative research were using IPA which made me feel even more lost. After some reading I found the guide to thematic analysis by Braun and Clarke (2006) which was exactly what I was looking for – an explanation of what thematic analysis was and written in an easy to understand manner. I read through this a few times and read papers which had used thematic analysis before making a start at analysing my data. Once I had an idea of what to do I found it

enjoyable re-reading through the transcripts and making sense of it through the themes. Although it was time consuming I did not find this part stressful and would be keen to do further qualitative research in the future.

It had been three years since I last used SPSS and so I found myself having to go back to basics and get my “Introduction to statistics and SPSS” textbooks back out to refresh myself. Once I had a bit of an understanding what I needed to do and starting practicing I quickly became familiar with it again. It has always amazed me how SPSS works and how it allows vast amounts of data to be entered and within seconds it is processed and produces the statistics you ask of it. I also very thankful for such technology and could not imagine doing anything statistics related by hand!

The write up of the empirical paper was quite difficult given the inclusion of both foster carers and clinicians. Despite attempts to ensure the article was concise, in the end it was a lengthy paper. Developing the skill of being concise with my writing is something I have worked on whilst completing the doctorate and especially during placements. As much as I would like to write long and detailed summaries and letters, the context within the NHS does not allow for this and people seem to prefer short and precise written communication. Everything I have included in the empirical paper I felt was necessary to introduce the study and also give enough space and attention to the results and implications of these. This was important to me especially after foster carers and clinicians had given up their time to share their views with me and the importance of the subject matter in relation to Government policy. I have also had discussions in supervision and with other professionals about dividing the empirical paper into two studies to submit separately. Therefore I did not want to reduce the paper any further for submission for the purposes of the Doctorate and wanted to present a full account of both parts of the study. The Children and Youth Services Review was chosen as an

interdisciplinary journal and so it would target a mix of professionals. I was keen for the research to be disseminated widely and with the emphasis on multi-agency working this was felt an appropriate journal.

Systematic Literature Review

The SLR was one piece of work that I completely underestimated the time and effort it would involve. I had taken the advice of colleagues further on in training and staff in the department and started it early but I don't think I realised just how difficult and time consuming it would be to even find a question before starting the process of the review.

The ideas I generated had either been reviewed recently or there was not enough literature to generate a review. After around six months of searching databases and reading the literature I had an idea I went with. I started the process of searching, going through the results, highlighting papers to include and then I discovered that the area had been reviewed a few times before. It was so disheartening to think I had spent hours, days and weeks searching a topic to then find it was not a viable SLR.

Supervision helped me to reframe this from "wasted time" to time well spent becoming familiar with the literature and ruling out possible topics.

I cannot quite believe I am about to write this but after I had got over the challenges and endless searching and decisions and had my final papers with my final research question, I actually quite enjoyed the process of extracting the data from the studies. No one could see the floor of the spare room for a few weeks with all the articles, A3 sheets of paper with data extracted and posit notes colour co-ordinating different points, but I found it enjoyable and quite relaxing! At many stages of this process those are not words that I would have used to describe the SLR but at that point I had overcome the challenges and made most of the decisions and it was just a case of writing it. However, the SLR then presented me with the next challenge – synthesising the results into a

coherent description. I do not have the best memory so remembering which studies had found which results etc whilst being completely immersed in the process and thinking about nothing else it was difficult to make sure I was making sense with what I was writing.

Overall, there have been many challenges to overcome with the SLR. I hope I have produced a piece of work which is clinically useful, an aim that I have had in mind since the start. After finally coming out of the other end of the SLR process I have gained the upmost amount of respect for the people who complete SLRs. I enjoy reading SLRs for my clinical work and the next one I read will be with an appreciation of the time, dedication, attention, patience and endurance that will no doubt have gone into it.

Supervision

The supervision sessions with my research supervisor were invaluable at keeping me sane throughout the last three years in the research process! There were so many stages along the way that I became stuck, lost, anxious, frustrated and stressed. It was so useful to talk through the difficulties and share the successes and positives. Even when there was no answer or solution to something it was still comforting and helpful to be able to share what was happening at various times. Supervision also taught me to think outside the box and be creative.

The future

All the things that I was worried about before starting research (recruitment etc) were realised and various challenges were encountered along the way. Despite this I feel proud of the research I have produced and hope it will be of use clinically to the future use and development of measures. I feel I have developed a number of skills through the process that I could use in future research projects. There are also things I would do

differently that I could also take forward. I feel more confident now about research and would be keen to do further research in the future with other people who were interested in the same areas.

From the start of the project I had been looking forward to being able hand in the portfolio. However, now I am at that point my feeling around that has changed as it represents a significant moment in time in nearing my training as a Clinical Psychologist on the course. As much as I am looking forward to completing all of the assignments on the course that also means it will be coming to an ended. Although the last three years have been a “rollercoaster” of emotions they have also been an incredible three years full of new people, experiences and learning that have been invaluable and has shaped the clinician I am today. I will be forever grateful for being given the opportunity to join the Doctorate Course in Clinical Psychology at the University of Hull.