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Social Workers Views on the Use of the Strengths and Difficulties Questionnaire (SDQ) with Looked After Children

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Abstract

This thesis investigates the views of English social workers and child and adolescent mental health service (CAMHS) clinicians about how social workers use the Strengths and Difficulties Questionnaire (SDQ) with looked after children. Focus groups and semi structured interviews (conducted 2011 - 2013) examined social workers' (n = 58, from nine local authorities) understandings of the mental health needs of looked after children and their use of the SDQ in assessing this, as well as how CAMHS clinicians (n = 24, from 11 Health Trusts) viewed the role of social workers in appropriately assessing mental health problems. Normalisation Process Theory was used to appraise how the SDQ had been routinely operationalised in everyday social work practice. A case study of one local authority explored the working practices of looked after children's social workers and specialist CAMHS clinicians working in a co-located (high integration) service which had achieved consistently high annual SDQ returns over a number of years.

The study found most social workers were not aware of the SDQ scores of the children or young people they were allocated and did not know how to interpret it in terms of looked after children's mental health. Routinely collected SDQ data on looked after children who had been in care for a year or longer was not utilised by most of the social workers or the local authorities which collected it. Specialist CAMHS used the SDQ alongside social workers in only two local authorities. Level of integration (based on degree of co-location of social workers and CAMHS) did not appear to be associated with social workers' SDQ use. Detailed examination of one local authority showed that although it contained a highly integrated service and was the best in the country at getting completed SDQ forms returned from foster carers, having a robust process for data collection was not enough to ensure the SDQ was integrated within social work practice in the organisation.

Given challenges to local authority budgets and services, any recommendations to improve current practice must be mindful of resource implications. Better utilisation could therefore be made of existing local authority processes and resources to embed the SDQ into routine practice. A multi-agency approach remains critical to establish the routinised usage of the SDQ. This has the potential to benefit all agencies and most importantly, looked after children.

Table of Contents

List of Tables and Diagrams

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Author's Declaration

I declare that this thesis is the result of my own independent work, except where otherwise stated. It has not been written or composed by another person and all sources have been appropriately acknowledged by giving explicit references. This work has not been previously submitted or accepted in substantially the same form for any degree and is not concurrently submitted in candidature for any degree.

Christine Cocker

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Definitions/Abbreviations

ADCS – Association of Directors of Children's Services

ADHD – Attention Deficit Hyperactivity Disorder

CAMHS – Child and Adolescent Mental Health Services

CBCL – Child Behaviour Checklist

CCG – Clinical Commissioning Group

CORC - Child Outcomes Research Consortium

CPLAAC - Clinical Psychologists working with Looked After and Adopted Children

DfE - Department for Education

DH – Department of Health

DSM IV - Diagnostic and Statistical Manual of Mental Disorders – fourth edition

FC – Foster Carer

HT – Health Trust

ICD 10 – International Classification of Diseases (mental health disorders) - Version 10

IRO – Independent Reviewing Officer

JSNA – Joint Strategic Needs Assessment

LA – Local Authority

NICE – National Institute of Health and Care Excellence

NPT – Normalisation Process Theory

SCREC - Social Care Research Ethics Committee

SDQ – Strengths and Difficulties Questionnaire

SW – Social Worker

Chapter 1 Introduction

1.1 Introduction

This thesis investigates the ways in which social workers use the Strengths and Difficulties Questionnaire (SDQ) in their work with children in public care, or 'looked after children' in England[1]. This is an important area of research for two reasons. Firstly, prevalence figures for mental disorders within the looked after children population in the UK are high. We know that over 45% of looked after children in England, Scotland and Wales have a diagnosable mental disorder, which is over four times the rate found in the general population of children (Meltzer et al., 2003, Meltzer et al., 2004a, Meltzer et al., 2004b).

Secondly, since 2009, SDQ data have been collected annually for looked after children aged between 4-16 living in England, who have lived in care for one year or longer. This potentially provides a focus through which to investigate the way in which social workers use the SDQ to understand and identify mental health issues within the looked after children population, including the processes that organisations develop to embed this work into day-to-day practice. This has not yet been investigated by anyone.

1.2 Looked after children – the English context

The term 'looked after child' was introduced in the Children Act 1989 and refers to all children who are legally cared for by a local authority in the UK, whether that be via court order (including Care Order or Placement Order) or accommodated via a voluntary agreement with the parents for more than 24 hours continuously. However various terminologies are used in the international literature, including 'children in care', 'out of home care', 'public care',

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[1] Unless indicated otherwise, statements can be assumed to apply in England only.

'institutional care' and 'state care'. In this thesis I use the term 'looked after children'[2].

The looked after children population is not a homogeneous group. There are many reasons why children enter care, but most children are in care because of abuse and neglect (Department for Education, 2016a). The only two factors all looked after children have in common are their experiences of separation and loss (Fahlberg, 2012). At 31 March 2016, there were 70,440 looked after children in England, which is an increase of one percent compared to 31 March 2015 and six per cent compared with five years previously, and is the highest number of looked after children since 1985. Three quarters of these children are cared for in foster placements. Of all children looked after at 31 March 2016, 68% (48,200) had one placement during the year, 21% had two placements and 10% had three or more placements (Department for Education, 2016a).

The movement of this population in and out of care is considerable. During 2015-16, 31,710 children ceased to be looked after. This included 4,690 children placed for adoption and 7,970 children who ceased to be looked after when they were 18-years-old, (Department for Education, 2016a).

The 2016 outcome data for looked after children in England (Department for Education, 2016b) showed that these children have poorer educational outcomes than children not in care, with 57% having special educational needs at the end of key stage 2 (age 11). Over half have emotional and behavioural needs that are cause for concern and they are twice as likely as their peers to be permanently excluded from school and three times as likely to have a fixed term exclusion. At

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[2] I do not abbreviate 'Looked After Children' to LAC, even though this is common in practice, because it is not appropriate to refer to a group of children as an acronym, especially when 'LAC' sounds like 'lack'. The wholesale labelling of looked after children as underachievers is profoundly unhelpful, and this is in essence what this acronym is in danger of doing. The only time I will use terms other than 'looked after children', most notably 'children in out of home care', is in the literature review, where I describe international studies, which use different terms. Where the term 'LAC' is used in a direct quote in the research findings, it is because the practitioner has used this term.

key stage four level (age 16), 13.6% of looked after children achieved five or more A*-C GCSE's compared with 53.1% of children not looked after (Department for Education, 2016b).

On the surface, this paints a damning picture of state care provision, but Stein (2006) and Forrester et al., (2009) suggest that the current emphasis on the care system as a catastrophic failure is wrong. They point to problems in analysis in a number of areas, including: not taking full account of which children within the care system are there for many years and which children were highly vulnerable already on entering care; the importance of pre-care experiences is underplayed as a key determinant of outcomes; and the current outcome measures for looked after children are too crude. Hare and Bullock (2006) and Berridge (2007) concur with this view. For example, many of these children will have been seen as 'failing' within the education system and will have had unmet health needs (including mental health needs) prior to their entry into care. This could be due to a host of reasons and these should be identified and tracked over time along with the child or young person's progress. Dimigen (1999) and Sempik et al. (2008) showed in their studies a much higher rate of mental health problems and disorders at the point of entry into care than among other children within the general population. But until 2007, regular screening of the mental health of looked after children did not occur.

1.3 Social workers and looked after children

Social work is an internationally recognised profession that seeks to work with people (children, adults and families) to encourage positive change in their lives. The International Federation of Social Work definition states that,

> '*The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work*' (IFSW 2014).

All looked after children have an allocated social worker whilst they are in care, and it is the social worker's role to act as a corporate parent to the looked after child. This means that they are responsible for overseeing the health and wellbeing, including mental health and educational progress of looked after children. The responsibilities of the local authorities who employ these social workers are set out in Sections 22 and 23 of the Children Act 1989.

Whilst there is a substantial literature about work with looked after children, no available study has focussed on the role of the social worker in terms of the assessment they make about a child's mental health and the influence that they may have over decisions made about the child in terms of treatment. Within England, emotional and behavioural issues are usually regularly addressed by social workers and monitored by Independent Reviewing Officers[3] (IROs) in twice yearly statutory looked after children reviews. Social workers are therefore potentially very significant people in the lives of looked after children, however mental health screening or assessment tools have not been routinely used by local authority social workers in England working with looked after children.

1.4   Mental health of looked after children

One of the first papers reviewing the research needs relating to the health of looked after children in the UK (Bamford and Wolkind, 1988) highlighted gaps in existing knowledge about the mental health of this group of children and young people. Since that time the work of various other researchers (McCann, 1996, Dimigen, 1999) has provided seminal evidence about the high rates of mental disorders of children in care in England and Scotland. Concern has been raised about the amount of time it can take for social workers and other professionals to not only identify problems but also to seek appropriate help and treatment where this is necessary. However, this is not a difficulty that can be laid solely at the feet of the social work profession, as timely access to child and adolescent mental health services has been problematic historically. In 1999, the Audit Commission published a report that talked about a 'postcode lottery'

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[3] IROs are social workers who are appointed to oversee the effectiveness of the care planning processes for looked after children. IROs are independent of the local authority social work line management structure for the looked after child. The IRO role is legally prescribed under section 118 of the Adoption and Children Act 2002.

concerning the length of time some children had to wait to see a Child and Adolescent Mental Health Services (CAMHS) specialist. At that time, only 14% of CAMHS referrals were from Social Services and Education, compared with much higher referral rates (66%) from NHS clinicians such as GPs and Paediatricians.

The Audit Commission suggested on the basis of anecdotal evidence that the reasons why social workers did not refer children to CAMHS were their concerns that children would have to wait for a considerable period of time for an appointment and that there was no flexibility concerning where the child was seen. Children were seen in health service clinics, rather than in a familiar setting for the individual child (Audit Commission, 1999). This still remains the case for mainstream CAMHS. At the time of the Audit Commission report, a number of other critical reports were also published about CAMHS, which made it increasingly apparent that looked after children with emotional and behavioural difficulties were not getting the services they needed, and were a group of children with high needs that were not being met (NHS Advisory Services, 1995, Utting, 1997, Mental Health Foundation, 1999).

As CAMHS became more of a political priority in the UK, the Government's 'Mental Illness Specific Grant', provided an opportunity for the development of 24 pilot projects for Local Authorities and Health Services in England to provide joint specialist CAMHS provision for looked after children (Kurtz, 2003, Richardson and Joughin, 2000). These projects paved the way for the development of specific jointly commissioned and funded mental health services for looked after children across England, where this study is based, in the early 2000s (Kurtz, 2003, Cocker and Scott, 2006, Cocker, 2003).

1.5 Existing systematic and non-systematic reviews of the literature about the mental health of looked after children

In searching the research literature relevant to the mental health of looked after children, a number of systematic (n=13) and non-systematic reviews (n=5) were identified. These reviews investigated three broad areas about the mental health of looked after children that are related to this study. These comprise: the characteristics of individual children that may contribute to their entry to

and outcomes from care (n=8); the role of foster placements in supporting children (n=4); and interventions that are effective with this client group, including improved access to services (n=3). In addition, the non-systematic literature reviews highlighted the views of children and young people receiving services (n=3), which the systematic reviews did not, and this is the main reason for including them in this summary. This section presents an overview of the findings from these literature reviews.

1.5.1 The characteristics of children

A number of key characteristics which are known about children and are measured at entry into care can positively or negatively affect psychosocial and/or placement outcomes. These include: low birth-weight; prematurity; disability; injuries; and attendance at Accident and Emergency, but a number of reviews suggest that individually these factors are not predictive of outcome (Simkiss et al., 2013).

Several reviews (Pritchett et al., 2013; Jones et al., 2011) have found that at the point of entry into care, a child's mental health is a key characteristic that can affect outcomes. One review identified an association between emotional problems and placement stability on the one hand, and risk factors and outcomes for children on the other (Jones et al., 2011). The numbers of placements that children have during their time in care can also affect outcomes, with children who come into care at a younger age having better placement outcomes in terms of permanency than do older children (Pritchett et al., 2013). A number of child characteristics are associated with placement problems, including externalising behaviours, older age of children and children's experience of multiple social workers (Rock et al., 2015).

Rock et al., (2015) found other characteristics were not so clear cut by way of influence on outcomes, although children with a disability were more likely to have negative outcomes. There was no evidence that the gender of a child affected their outcome, and the evidence in respect of education/cognition on outcomes was mixed. The evidence suggested that if a child had problems in school or a learning disability at the point of entry into care then it was more likely to negatively affect placement outcomes, although the majority of studies

identified in the Pritchett et al., (2013) review reported no effect of education or cognition on placement outcome. Again, the authors specifically noted that causality was not implied.

A review by Oswald et al. (2010) examined the relationship between a history of maltreatment and mental health problems in foster children and found that children in foster care had experienced high rates of abuse and neglect prior to coming into care. Oswald et al. (2010) noted that many of the children included in these studies presented with developmental delays as well as mental disorders. The authors champion assessments being undertaken on looked after children that include considering the child's development, behavioural and emotional indicators as well as psychosocial functioning so that children can be referred on to specialist services if required.

A review by Forrester et al., (2009) investigated the impact of public care on the outcomes for looked after children and identified 12 studies in the British literature that either compared children in care with children from similar backgrounds that had not entered care (three studies), or tracked children in care over time (nine studies). These studies consistently reported the serious emotional problems that looked after children have when they enter care, likely because of their abusive and neglectful experiences, living with parents who have drug or alcohol problems or mental illness, and showed that these problems improved for children in care over time (Forrester et al., 2009). This finding is consistent with the international literature.

1.5.2 Foster placements

Foster placements are seen as key and critical to the outcomes that children are able to achieve in public care. The warmth of the carer's parenting relationship with the child/young person, including their persistence or 'stickability' and ability to set boundaries is critical, as is the interplay between the two (Pritchett et al., 2013).   Rock et al's (2015) review also acknowledged a number of protective factors, including; more experienced foster carers with strong parenting skills, older foster carers, and placements where foster carers enable children's academic development. Common to both these systematic reviews is the '*concept of 'fit' between the child and the foster family*' (Rock et al., 2015,

p197), linked to the child and carers liking each other and the child being treated equally alongside other children living with the foster carers with no rivalry within these relationships. The framework that Rock et al. (2015) developed to explore this 'fit' between foster child and foster carer divided up background and risk and protective factors related to the child and foster carers, but it did not give any indication of how to weigh up and prioritise these elements and it is precisely this task that professionals struggle with.

Targeted training and support for foster carers may assist with strengthening the factors which are known to produce beneficial outcomes for children. However, the systematic reviews that have evaluated evidence on this have found mixed results and limited impact of foster carer training or support on the behavioural problems of looked after children, placement stability or mental health. In their review, Everson-Hock et al., (2012) found that very few courses for foster carers had been evaluated using Randomised Controlled Trials (RCTs) to ascertain the impact of the training on the child's within-placement behaviour and wellbeing, including problem behaviours and placement stability (Everson-Hock et al., 2012). Of the five studies identified in this review, three reported benefits of the training for the behaviour and wellbeing of the child or young person in placement (all were USA studies), and the other two (both UK studies) reported that the training had no significant impact. Better child outcomes are associated with foster carer training programmes that last for longer periods of time, but have shorter follow ups (Dozier et al., 2006, Chamberlain et al., 2008, Sprang, 2009). In their review, Turner, Macdonald and Dennis (2005) also found that whilst the provision of training to foster carers increased their caring attitudes and skills and reduced behaviour problems in foster children, evidence for the efficacy of CBT-based training intervention for foster carers was inconclusive (Turner et al., 2005).

1.5.3 Interventions and improved access to services

Although there is no dispute about the higher rates of mental health problems within looked after children compared to those in the general population (Meltzer et al., 2003), less is known about the issues looked after children face accessing support services and the types of interventions available. A review by

Jones et al., (2012) found little evidence of interventions aimed at improving access to health and mental health services for looked after children and young people, commenting that such evidence was in its infancy and that methodological problems with the small number of studies included in the review affected the quality and generalisability of findings (Jones et al., 2012). However, a number of points were made about interconnected factors that are worth mentioning as relevant to this thesis. Firstly, effective information sharing between agencies may not on its own be enough to guarantee appropriate and timely assessments and referrals to specialist services. Secondly, there were a number of factors affecting how looked after children experienced services, such as the attitude of staff toward them, the length of the waiting list, opening times and location of the service, and the way they perceived and labelled such services, which may have impacted on whether they chose not to attend. Additionally, the nature and context of a looked after young person's problems did not always match the services available within local areas, as these were services designed for children living in their birth families. By contrast many looked after children will not have lived with their foster carers for a long period of time, and community CAMHS might expect them to have lived in their current placement for at least two years before accepting a referral. This can further compound problems for looked after children:

> '…it is acknowledged that the lack of timely and appropriate interventions from specialist mental health services can compound or create a circle of LACYP[4] with emotional and behavioural problems unable to receive appropriate treatment or help from services due to placement instability but continuing to experience placement disruption because of their unresolved or untreated emotional distress or behavioural difficulties'.
> (Jones et al., 2012, pp82)

A review commissioned by the National Institute of Health and Clinical Excellence, examined empirical studies that investigated the identification, assessment and treatment for attachment difficulties in children who are looked after. It provides clinical guidance for practitioners about evidence-based interventions for looked after children and young people with attachment

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[4] LACYP = looked after children and young people

difficulties (National Collaborating Centre for Mental Health, 2015). The two main factors identified as associated with poor attachment outcomes for looked after children are: the birth mother's sensitivity/responsiveness to the child prior to care (this is causally related to the child's attachment); and placement instability, including numbers of placements and placement breakdowns the child has experienced in care. Other associated areas of concern were the child's poor emotional/behavioural functioning/wellbeing; poor foster carer attitude, knowledge and behaviour; criminal status of the child; and developmental status of the child (National Collaborating Centre for Mental Health 2015). Suggested research based interventions for looked after primary school aged children identified in this review included: intensive support to foster carers and adopters as required (including supervision via daily or weekly telephone contact, weekly support group meetings and a 24 hour crisis intervention service); alongside training using a behavioural management method; help with peer relationships; support with school; and help to defuse conflict. Other age-related service recommendations emerging from the reviewed research were listed for secondary school aged young people, including group-based sessions for adopters and foster carers and individual sessions with young people to assist with developing self-confidence.

In a review of 106 studies, Luke et al., (2014) raised issues with the overall low quality of the intervention research with looked after children. Most studies had small sample sizes and very few were randomised. Taking this into account, the review found that a number of factors were associated with better outcomes for interventions offered to looked after children and foster carers. Structured programmes that used attachment theory and social learning theory were best used in combination to address behavioural issues the foster carer might be experiencing. The most effective approaches concentrated on relationship-building between the child and foster carer and focused on caregiver sensitivity and attunement, including helping the foster carer develop insight into the reasons for the child's behaviour. Development of the child or young person's understanding of their own emotions and identity was helpful for maximising the success of any intervention. A high level of commitment by the child/young person and the foster carer to the programme would also impact on the success

of the intervention. Some flexibility was needed to meet specific needs of children, and follow-up support was advantageous (Luke et al., 2014).

1.5.4 The views of Looked After Children

Two non-systematic reviews have examined the literature on looked after children's views of mental health services (Davies and Wright, 2008, Winter, 2006). Davies and Wright's review of 14 qualitative studies pointed to the ethical and consent complications around involving looked after children in research and the difficulties that professionals have in asking even less vulnerable children and young people their views about the services they receive. The authors were not able to identify any studies that solely addressed the views of looked after children about mental health services received. Rather, looked after children were included as part of a wider group of vulnerable children, which also comprised of adopted children and children with histories of abuse who were either living at home or with extended family. There were some differences between these groups and children in the general population: vulnerable children, including those in the care system, expressed a marked ambivalence about mental health services; the need for practitioners to pay close attention to building relationships with looked after children appeared to be as important in respect of the work done with the child as the techniques and theories used by the therapist; and looked after children expressed an ambivalence towards talking, valuing the use of non-verbal communication as a way to access and connect with the therapy. However, the numbers of looked after children were small and the authors cautioned against generalising these results, instead pointing to the need for further research, examining the views of looked after children where therapy had been effective, as well as when it had not been.

The participation of looked after children in their health care was a key theme explored in Winter's (2006) review. She also highlighted the lack of research with looked after children that addresses their views or participatory experiences in relation to their health. *'Instead most research concerns either the level of need, contributory factors and/or the effectiveness of particular service interventions.'* (Winter, 2006, p78). What was missing was an in-depth investigation about the experiences and participation of young people and younger children in their health and mental health care. Winter highlighted the

consequences of this needs based discourse, which was concerned with identification of need, provision of services and review of effectiveness of such services, to which much research interest had been focussed. She pointed to theoretical approaches and models of development that were used by social workers, where children were the 'object' of study and, *'...are presented as passive, with little focus on their own agency, capacities and capabilities.'* (Winter, 2006, p88).

1.5.5 Key features of reviews

The information found in these systematic and narrative reviews provides evidence about what factors are important in determining how well a child may do in a foster placement and there are a number of similarities in the factors that the existing reviews indicate are significant. These include age at first placement, type and duration of abuse experienced prior to entry into care, behavioural problems of the child in the placement, warmth in the relationship between the foster carer and looked after child, and boundary setting abilities of the foster carer. Each review points to the complex relationships between factors intrinsic to the child and the skills and attributes of the foster carers, including their parenting approach. This is critical when thinking about the factor or factors that are most important for each child and placement and goes some way toward helping think about how to actively support the mental health of looked after children in foster care, given the impact that mental health difficulties have on the functioning of children and their families in all aspects of everyday life. The views of children and young people are largely missing from studies which have looked at mental health provision for looked after children. What work does exist points to the importance of relationship building as a key part of an intervention strategy, alongside the need to understand the different nature and context of the problems that looked after children and young people have, and the problems that affect timely assessments and referrals to specialist services.

Despite the statutory use of the SDQ with looked after children since 2009, none of the reviews addressed how the SDQ is used with this population.

1.6 **Aims of the Study**

It is against this background, following the introduction of the SDQ collection in England in 2009 for all looked after children who have been in care one year or longer, that this thesis explores social workers' understandings of the mental health needs of looked after children and their use of the SDQ to achieve understanding. All looked after children have an allocated social worker whilst they are in care. However, no available study has focused on the role of the social worker in terms of the assessment they make about a child's mental health and the influence that they have over decisions made about the child in terms of access to services. Social workers are significant people in the lives of looked after children. They act as a corporate parent for the council which is responsible for the looked after child's wellbeing whilst in care, and this includes the child's emotional, social, physical and educational wellbeing. I aim to examine how they understand using the SDQ for screening and gaining access to mental health services for looked after children and how other Child and Adolescent Mental Health Service (CAMHS) professionals view the role of the social worker in enabling this process to occur.

1.7 **Research Questions**

The main research questions I have identified for the study are:

- What are the views and experiences of social workers and CAMHS clinicians about the SDQ and its suitability for use with looked after children?

- How do social workers assess the mental health of looked after children, and do they perceive the SDQ as having a role?

- The annual SDQ screen provides information about the mental health of looked after children, but how do social workers use this information and what is it used for?

- How do the working relationships between a looked after child's social worker and CAMHS specialist worker affect the way in which the SDQ is used?

These questions emerged following the systematic literature review (see chapter three).

1.8   Thesis Chapter Plan

The thesis comprises nine chapters. Chapter one is the introduction to the thesis and sets out the rationale for the study.

Chapter two provides an overview of the SDQ as it is the key screening tool which forms the focus of this research. The overview includes a description of its benefits as a research tool and screening instrument in clinical practice. Additionally, the publication of SDQ aggregated data by the Department for Education in England is outlined and discussed.

Chapter three comprises a systematic review based on PRISMA framework/guidelines to review the empirical literature on looked after children, mental health and the SDQ that forms the general background for this study. The chapter addresses how the SDQ has been used to screen and assess the mental health problems of looked after children. The gaps in knowledge as related to the thesis are also identified.

Chapter four outlines the qualitative methods used in the thesis, describing the sampling, recruitment, and methods used to gather data from focus groups and individual interviews conducted with social workers and CAMHS clinicians. The theoretical framework used in the thesis, Normalisation Process Theory (NPT), is also outlined.

An overview of the results are provided in chapter five, with further, more focused results and analyses presented in chapters six and seven. Chapter five presents the results under three themes: looked after children, mental health and other factors; social workers, mental health and the SDQ; and the interface between local authority social work and CAMHS. Chapter six uses NPT as a framework though which to present the results and examine the processes and outcomes of introducing and routinising a change in practice, such as the SDQ screen, to an organisation. Chapter seven explores the way in which agencies work together to deliver mental health services to looked after children.

Chapter eight uses a case study to investigate and analyse the practices on the use of the SDQ as a screening tool for looked after children in one particular local authority. This particular local authority appeared to have incorporated the SDQ into its social work services in a more integrated manner than the other local authorities included in this research. The reasons for this are explored.

Chapter nine summarises the results of the research and discusses how they relate to the research questions. Recommendations are made for future research.

1.9 Chapter Summary

This chapter provides an introduction to the thesis. This chapter outlines the English context for looked after children, introduces the role of social workers for looked after children, outlines the mental health issues for these children and provides an overview of relevant systematic reviews. It provides the aims of the thesis and lists the research questions. The introduction ends with an outline of each chapter of the thesis. The next chapter examines the use and development of the SDQ with looked after children.

Chapter 2 The Strengths and Difficulties Questionnaire

2.1 Introduction

This chapter provides an overview of the Strengths and Difficulties Questionnaire (SDQ) (Goodman et al., 1997) as it is central to my research. The SDQ is an internationally validated questionnaire used in clinical practice with individual children as well as in research as a measure of mental health across populations of children. It has been used in the UK since 2009 as a screening tool and measure of looked after children's mental health in the annual statistical return for looked after children (Department for Education and Department of Health, 2015). A basic outline and description of the SDQ is given in this chapter, including its benefits as a research tool and screening instrument in clinical practice. The publication of SDQ aggregated data by the Department for Education in England is outlined and the use of the SDQ as a population based screening tool is also discussed.

2.2 The SDQ

The SDQ is designed for use with children aged between four and sixteen years, although it has recently been validated for use with children as young as two. It comprises 25 items, each scored 0-1-2, which can be broken down into five scales covering: emotional symptoms; conduct problems; hyperactivity or inattention; friendships and peer relationship problems; and prosocial or positive behaviour. A 'general difficulties' score is identified by adding together the scores from the 20 items comprising the first four categories (www.sdqinfo.org). The potential range of this overall 'general difficulties' score is between 0-40. The scoring of the SDQ enables classification of the general difficulties score into one of three categories: normal (score is between 0-13); borderline (score is between 14-16); or abnormal (score is between 17-40). There are three versions of the SDQ: the parent/carer, teacher and the self-report scale (completed by 11-16 year olds), which provide the potential for triangulation of information about a child across the different versions. An 'impact supplement' is available on an 'extended' version of the SDQ, which asks whether the respondent thinks

that the child or young person has a problem and then asks further questions about 'chronicity', 'distress', 'social impairment' and 'burden to others'. This enables clinicians and researchers to gather additional information about the impact of any difficulties on the child (Goodman, 1999).

I have added a page of information about the other measures used in CAMHS, including CBCL, DAWBA and Tarren Sweeney's measures. The information ends with a comment about why the SDQ is a more appropriate measure. It reads as follows:

In addition to the SDQ, there are a number of other general screening tools and questionnaires commonly used in clinical practice in CAMHS in England with looked after children. These include the Child Behaviour Checklist (CBC – developed in the US), the Development and Well-Being Assessment (DAWBA - UK) and the Assessment Checklist for Children (ACC - Australia). These general screening tools are used in a number of the studies reviewed in Chapter three, alongside the SDQ. I have provided a brief outline of each of these general tools, including the clinical advantages and disadvantages when compared with the SDQ.

Apart from the SDQ, the CBCL (Achenbach, 1991) is the measure used most widely in CAMHS. It is also heavily used in the US, has been evaluated alongside many other tools (Rosanbalm et al., 2016) and used in many research studies examining mental health issues in children aged between 4-18 years. As with the SDQ, it measures internalising and externalising problems, and also has the capacity to seek the views of multiple informants, with a parent/carer, self-report and teacher version. The CBCL has over 113 questions compared with 25 for the SDQ, so is considerably lengthier for clinicians to administer and score and service users to complete.

The Development and Well-Being Assessment (DAWBA) (Goodman et al., 2000) is a diagnostic measure designed to assess ICD 10 and DSM IV psychiatric disorders in children aged 5-17 years of age. Again, as with the SDQ, there are parent/carer, self-report and teacher versions; these can be completed as computer administered interviews as well as interviewer interviews. It is a

lengthy tool – the parent/carer questionnaire is 67 pages long and takes 50 minutes to complete (www.dawba.info). The SDQ is part of its collection of fourteen questionnaires. The DAWBA has been shown to have merit as an epidemiological measure and a clinical tool (Goodman et al., 2000) and has been used in all the British nationwide surveys of child and adolescent mental health completed since 1999.

Tarren-Sweeney has developed a number of screening tools specifically for looked after children. The Assessment Checklist for Children (ACC) (ages 4 to 11 years - 125 items) and the Assessment Checklist for Adolescents (ACA) (ages 12 to 17 years - 105 items), developed by Tarren-Sweeney (2007; 2013), are screening tools that have been used in more than 20 studies with looked after and adopted children in the UK, Europe and Australia. Short versions (the ACC-SF is 44 items, and the ACA-SF is 37 items), and brief versions (BAC-C and BAC-A are both 20 items long) are also available. According to Tarren Sweeney (2013), the ACC and ACA measures have similar screening accuracy (sensitivity and specificity) as the SDQ for identifying mental health problems for children in care. The full and short versions of the ACC and ACA have sub-scales that can be independently analysed, whereas the brief version, which has a similar number of questions as the SDQ, does not. The SDQ has five sub-scales which can be independently examined. There is some evidence that foster carers favour the BAC over the SDQ as it better captures the specific difficulties experienced by looked after children (Lewis, 2014).

The main benefit of the SDQ over these other commonly used child mental health screening tools and questionnaires is that it is quick and relatively straightforward to use. It is also free to use, unlike many of the American equivalents, such as the Child Behaviour Checklist (CBCL) (Achenbach, 1991). Unlike the short form ACC (Tarren-Sweeney, 2013), it has sub-scales. The SDQ is used routinely in CAMHS in the UK (CAMHS Outcome Research Consortium, 2010) and is also used in many other countries, having been translated into more than 80 languages (Goodman, 1997, Goodman et al., 2004a). It has become one of the most widely used and well recognised child and adolescent screening tools internationally (Tarren-Sweeney, 2013). This means that both individual and

population-level findings about looked after children can be easily compared with population norms.

2.3 The usefulness of the SDQ with looked after children

Many CAMHS professionals use standardised assessment tools in their clinical work, as either screening aids or diagnostic tools. These are instruments used to measure data gathered through an interview, or self-completion with a child, young person or adult. Standardised tests have been through a rigorous process of development including publication of data in peer reviewed sources detailing their reliability and validity in respect of whatever they are specifically designed to measure. The test will have been used on different (large) samples of the population in order to create 'normative' data against which individual test scores can be compared. This process has taken place with the SDQ.

There is now therefore considerable research evidence which assesses the psychometric properties of the SDQ (reliability[5], validity[6], sensitivity[7] and specificity[8]) and supports its efficacy as a screening tool in the general population in the UK (Goodman, 1997, Goodman, 1999, Goodman, 2001, Meltzer et al., 2000), internationally (Bele et al., 2013, Tanabe et al., 2013, Van Roy et al., 2009, Amstadter et al., 2011, Elhamid et al., 2009, Anselmi et al., 2010, Abbo et al., 2013, Zakaria and Yaacob, 2008, Gómez-Beneyto et al., 2013, Niclasen et al., 2012, Petermann et al., 2010, De Giacomo et al., 2012, Lai et al., 2014, Woerner et al., 2004) and for looked after children (Goodman et al., 2004b, Goodman and Goodman, 2012b, Ford et al., 2007, Egelund and Lausten, 2009, Marquis and Flynn, 2009).

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[5] Reliability is the ability of a measure to produce consistent results when the same entity is measured under different conditions (Field 2013).

[6] Validity is concerned with whether an instrument measures what it says it measures (Field 2013). There are a number of different ways of establishing validity: face validity; construct validity and predictive validity (Bryman, 2011).

[7] Measures the proportion of positives that are correctly identified by the measure or tool (Bryman 2011)

[8] Measures the proportion of negatives that are correctly identified by the measure or tool (Bryman 2011)

The three versions of the SDQ (parent, teacher and self-report versions) have been validated independently in community samples (Becker et al., 2004a, Becker et al., 2004b, Goodman et al., 2003, Pez, 2012), although some studies report limited agreement between the versions when used together in community samples (Meer et al., 2008, Stokes et al., 2014). When not used together, studies have shown that the parent or carer version has a good degree of reliability when used with looked after children (Goodman and Goodman, 2012b). Additionally, Mason et al. (2012) showed that the SDQ is sensitive to change over time and that there was also a high degree of association between the changes noted over time in SDQ and CBCL measures. The authors suggest on this basis that the SDQ is a cheaper and shorter alternative to longer measures, such as the CBCL.

In a national survey undertaken in England (Meltzer et al., 2003) (n=1,028), a number of instruments were used to assess the mental health functioning of looked after children, including the SDQ and the CBCL. In terms of its use with looked after children, Goodman et al. (2004b) found that comparison of responses by carers on the multi-informant SDQ for parent/carer, teacher, and older children aged 11-16 with other independent psychiatric questionnaires, such as the CBCL, resulted in a specificity for the SDQ of 80% and a sensitivity of 85%. Goodman et al (2004) suggested that the SDQ works best when versions have been completed by both carers and teachers, but both have roughly equal diagnostic predictive value, compared with the self-reports by 11-16 year olds, where the diagnostic predictive value is lower.

2.4 Why was the SDQ introduced into social work?

Historically, mental health screening or assessment tools have not been routinely used by local authority social workers in England working with looked after children. However, emotional and behavioural issues are usually regularly addressed by social workers and monitored by Independent Reviewing Officers, using non-standardised formats, in the twice yearly looked after children reviews. Before 2009, the SDQ was only used with looked after children by mental health colleagues or by specialist jointly funded health and local authority multi-disciplinary mental health projects for looked after children as a

screening tool and outcome measure (Kurtz, 2003). Due to a number of research studies outlining the high prevalence of mental disorders within the looked after children population (McCann, 1996, Dimigen, 1999, Meltzer et al., 2003), and the lack of national data available, the Care Matters White Paper (Department for Education and Skills, 2007) recommended that a new local government indicator (NI58), should focus on the emotional and behavioural difficulties of looked after children. The SDQ was the tool adopted and since 2009 regular annual SDQ carer data collection has occurred as an administrative data exercise undertaken for the annual central government statistical returns that local authorities complete about outcomes for looked after children. Although the NI58 indicator was withdrawn in 2010, the Government continues to collect and publish information on the psychological and emotional health of looked after children who have been in care a year or longer and who are aged between four to sixteen years, using the SDQ carer report version only. Data are collected for each child after around a year and then every subsequent year at some point within the year. These data are presented by the Government in aggregated form.

2.5 Department for Education aggregated SDQ data

At the date of writing (August 2017), seven years of aggregated SDQ data collected by the Department for Education (DfE) are available on the DfE website (Department for Education, 2013, Department for Education, 2014a, Department for Education, 2016b). These aggregated data from the SDQ main carer's questionnaire on looked after children in England show completion percentages for each local authority (n=152). Table 2.1 shows a summary of the aggregated English 2009-2015 SDQ data on looked after children.

Table 2.1: Summary of Department for Education SDQ aggregated data over seven years (2009-2015): (source Department for Education 2013; 2014a; 2016b)

.	2009*	2010*	2011*	2012[#]	2013[#]	2014[#]	2015[#]
Number of valid SDQ returns	22,700	22,810	23,870	23,480	24,080	23,650	26,020
% of those eligible with SDQ returns	68%	68%	69%	71%	71%	68%	72%
Mean SDQ difficulties score˜	13.9	14.2	13.9	13.9	14.0	13.9	13.9
% with 'normal' score˜	50%	49%	51%	51%	50%	50%	50%
% with 'borderline' score˜	12%	13%	13%	13%	12%	13%	13%

% with 'abnormal' score˜	38%	38%	37%	37%	38%	37%	37%

* 2009-11 sample stated as aged 4-16;

2012-15 sample stated as aged 5-16;

˜ SDQ range 0-40, categorised as 0-13 = 'normal, 14-16 = 'borderline', 17-40 = 'abnormal' (Goodman 1997);

The data in Table 2.1 indicate that throughout these years, the return rates were relatively stable, with just over two thirds of eligible children included in the return each year. This means that, conversely, just under one third of eligible children are consistently not included in these returns. This is a considerable amount of missing data that could be a source of systematic bias – for example if the children with the most challenging problems are more likely to be missing.

The DfE aggregated data report also includes a mean of the overall SDQs received. The most recent (2015) the mean SDQ score was 13.9, which is at the top end of the 'normal' category, and again there is relative consistency across the six years of data. Between 2011 to 2015, consistently around half of all looked after children had emotional and behavioural health that was within the 'normal' range on the SDQ, around one-in-ten were 'borderline' and around four-in-ten were within the 'abnormal' range (Department for Education, 2016b).

Whilst SDQ data provide an overview of the emotional and behavioural health of looked after children in England, there are some important points to observe that might affect the validity of the aggregated data and the conclusions, which can be drawn. Firstly, local authorities have many different ways of obtaining these data (CPLAAC, 2009). This includes via administrators based in Social Services or CAMHS, Looked After Children's Health Nurses, Assistant Psychologists, other CAMHS clinicians, Social Services staff and Looked After Children's Designated GP's. A second potential issue in relation to the validity of SDQ data is that foster carers or residential care workers may either over- or under-report mental health issues (Goodman et al., 2004a, Ford et al., 2007). A third issue is the one-third of children from whom data have not been collected; further investigation is needed to understand why this is the case.

Despite these issues, the SDQ data provide an opportunity for scrutiny and analysis on a scale we have not ever had access to before. The government

requirement to collect the SDQ annually has been perceived by some as introducing a population screen for looked after children. The issue of when to use screening instruments in a population has been debated in the health literature for many years, and the next section discusses this in relation to the use of the SDQ as a population based screening tool for looked after children.

2.6 The SDQ as a population based screening tool for looked after children

The literature confirms that the SDQ is an effective screening tool for looked after children at a population level as well as at an individual level (Goodman et al., 2004b, Ford et al., 2007, Goodman and Goodman, 2012a). However, is population screening of looked after children a justified use of resources?

One way to answer this question is to apply the classical criteria previously used to consider whether to screen populations for non-infectious diseases (Wilson and Jungner, 1968, Public Health England, 2013, Public Health England, 2014). The following discussion takes this approach, using criteria suggested by Wilson and Junger (1968):

- **The condition should be an important health problem.**
  As noted earlier, prevalence studies show that mental disorder rates within the looked after population are high (Meltzer et al., 2003, Meltzer et al., 2004a, Meltzer et al., 2004b). The DfE aggregated data show that of the children and young people with completed SDQs, half show levels of 'likely caseness', that is, scores within the 'borderline' or 'abnormal' categories. This has major implications for children and young people and their carers.

- **The natural history of the condition should be understood.**
  This is a little more complicated to define in terms of what is known about looked after children and mental health at an individual child level and population based level. Historically, there is some evidence from studies that highlight the relative stability of the high level of mental health needs within the looked after children population, which suggests that high mental health problems in this population of children have been known about (from studies) for a long time (Wolkind and Rutter, 1973, Rutter et al., 1976, Bamford and Wolkind, 1988). Until 2009 individual level child data were not available.

- **There should be a recognisable latent or early symptomatic stage.**
Meltzer's prevalence study (2003) and the smaller scale studies which have screened children at entry into care (Dimigen et al., 1999; Sempik et al., 2008) would suggest that using a screening tool can be an effective way to identify children who are at 'high risk' of developing mental disorders but whose problems may not yet have become entrenched.

- **There should be a test that is easy to perform and interpret, acceptable, accurate, reliable, sensitive and specific.**
There are a number of questionnaires that are effective at screening children and young people for mental health problems. The SDQ is used internationally and has a number of benefits which have already been identified hitherto. It is also the questionnaire that the Department for Education mandates the use of (Department for Education and Department of Health, 2015).

- **There should be an accepted treatment recognised for the disease.**
This is another more complicated area. Within the general population of children there are a number of more common child mental health problems where accepted effective treatments exist. Treatments are often more complex for looked after children because of the interplay of problems that affect them (Minnis, 2013). Although conduct problems are most common within this population of children (Meltzer et al., 2003), it can be difficult to know which mental health issue to address first when children present with a number of different problems, disorders or adjustment reactions. There is an evidence base that guides interventions for many types of mental health problems faced by children (Luke et al., 2014). However, children within the general population are more usually faced with one problem, not multiple problems, which is the case for looked after children (Minnis, 2013; Cocker and Allain, 2013). Knowledge about what treatments or interventions are effective with looked after children is limited because of the known co-morbidity and overlap of risk factors present for these children. However, some of the interventions for children who live in the community will be applicable to those who are looked after (Luke et al., 2014). Interventions may involve individual sessions with a child to address mental health issues, or consultation or training via parenting programmes to foster carers.

However systematic reviews offer mixed views on the efficacy of such programmes for foster carers (Turner et al., 2005).

- **Treatment should be more effective if started early.**

There is little evidence or research on the effectiveness of early intervention regarding mental health problems of looked after children but early intervention principles for general child psychiatric problems are likely to apply (National CAMHS Support Service, 2011).

- **There should be a policy on who should be treated.**

The statutory health guidance clearly sets out the expectations about which looked after children should expect to receive treatment by CAMHS, including children placed out of borough and children moving from children's services to adult social care services (Department for Education and Department of Health, 2015).

- **Diagnosis and treatment should be cost effective.**

There are a number of studies that provide information on the cost effectiveness of child psychiatric interventions (Knapp, 1997, Beecham and Knapp, 2001, Knapp et al., 2015) and interventions for fostered children (Minnis et al., 2006). Knapp et al., (2015) conclude that '*poor targeting, inequality and inefficiency in the way that mental health, education and social care systems respond to emotional and behavioural problems might explain some of the variation in costs*' (p667). A screening programme may therefore help with better targeting and use of resources. There is evidence to show that costs of support for looked after children who have additional support needs are significantly higher than for those children without such needs and that these additional costs do not lead to better outcomes for children (Ward and Holmes, 2008). These authors suggest this means that a different configuration of services may be required to better meet the needs of children with complex difficulties. However economic analysis has its limitations, as costs for CAMHS only provide part of the picture for how children with complex needs are supported and the full costs of that support (Beecham, 2014), and there is some evidence to suggest that even very expensive interventions could prove cost-effective in the long term (Boyd et al., 2016)

- **Case-finding should be a continuous process.**

> Given the resources available for promoting and monitoring children's health in the UK, identifying need should occur on a regular basis, not as a 'one off' exercise (Wilson et al., 2009). The framework for the looked after children statistical returns provides an opportunity for routine data collection and continuous case-finding, as long as there are clear and effective strategies in place for identifying and referring 'cases'.

Across these criteria, most are fulfilled except that: (a) there is a lack of knowledge about effectiveness of treatment; and (b) local authority teams may not have the systems in place to routinely refer cases for services once the SDQ has highlighted children as having difficulties. There are, therefore, crucial unanswered questions about treatment effectiveness and whether and how these systems work. This latter set of questions is the focus of this thesis.

There are accounts in the literature suggesting that the way in which screening is undertaken may affect its results. For example, a study by Jacobs (1999) examined depression screening as an intervention to prevent suicide, and included a number of additional activities alongside completion of a screening tool; completion of a brief scale or questionnaire; attending an educational session with a qualified professional; leaflets and other written and media based material; and an individual interview with a mental health professional. The latter was seen as key to the success of the screen (Jacobs, 1999). Other studies also point to the need to link effective screening to effective treatment strategies (Chaudron and Wisner, 2014), with some acknowledgement of the complexities of the debates about evidence-based medicine and the implications for clinical work and practice (Miles et al., 2003). For looked after children, social workers and foster carers, there are no data available that evaluate the effectiveness of any of these approaches as an intervention to improve the mental health of looked after children.

One of the effects of some screening tools on individuals can be the Hawthorne effect[9] (McCambridge and Day, 2008), where positive changes are evident whilst

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[9] The Hawthorne Effect is a term that emerged from a study undertaken in a factory in Chicago in the early 20th Century, where researchers observed the effect of changes to the quality of light in the factory on the productivity of workers. Worker productivity increased during the study but as soon as the study ended, productivity went back to the way it was prior to the research being conducted. Researchers thought that the changes occurred as a result to the workers receiving

there is an emphasis on a particular aspect of service provision, but with a quick return to previous levels once the focus is gone.

However, screening programmes are not always useful. For example, in a related field, Sayal et al (2010), working in England, did not find evidence of long-term, generalisable benefits following a school-based universal screening program for ADHD introduced when children were five. Instead they concluded that there may be adverse effects associated with labelling children at a young age with ADHD, with none of the interventions associated with improved outcomes (Sayal et al., 2010). This again raises issues about how screening tools are used within populations of children. If there are no demonstrable benefits – or even harms - observed for the target population of children, the question needs to be asked whether their use should continue.

According to Luke et al., (2014), there are a number of factors that make assessment instruments such as the SDQ useful, including how straightforward the tool is to use and whether it can '*predict mental health service need (when used by non-clinicians) or, for clinicians, whether they can help to select and direct the allocation of resources or further diagnostic assessments*' (p11). From their systematic review, Luke et al., (2014) concluded that the SDQ provided a good approximation of mental health prevalence in looked after children especially during annual health checks, where, '*its use as a screening tool during routine health assessments for looked after children was shown to increase the detection rate of socio-emotional difficulties*' (p12).The study that Luke et al., (2014) referred to which used the SDQ during routine health assessments was American (Jee et al., 2011). Outcome data are not collected about the routine use of the SDQ in annual health assessments in England. Further, Luke et al., (2014) commented that the information gained from the SDQ could be better used: '*although a number of children's services managers currently make use of local data to identify children needing early interventions, there is further potential for this practice to be developed* (p15).

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attention from the research team rather than from the change in light. For the purposes of my research, the change caused by the Hawthorne Effect would include undertaking activities, such as completing screening questionnaires

The next section of this chapter discusses how the English looked after children SDQ data might be viewed and analysed.

2.7 Potential approaches to the use, and analysis of the English looked after children SDQ data

The SDQ data might be used as a performance indicator or to examine geographical variation (local authorities can compare the average mental health of their looked after children population with other local authorities seen as statistically equivalent), or to analyse time-trends (Cocker et al., 2018). Linking the datasets at the individual level would also enable longitudinal analysis to track changes in, and correlates of changes in, the SDQ scores of looked after children.

It might be argued that the year-on-year data generated via this massive undertaking could be viewed, and analysed, from two perspectives. One is that mass screening and availability of results might be expected to impact on the practice of those involved and, in turn, to have the potential to also impact on the mental health of looked after children. Just as a common first step in evaluation of other screening programmes is to examine population trends (e.g. trends in breast cancer mortality over time in order to assess the impact of mammographic screening) (Broeders et al., 2012), so one might also evaluate the impact of SDQ screening of looked after children by examining *aggregate*, population-level trends in SDQ scores. If screening had a positive impact on practice, the result might be expected to be a trend of reducing aggregate SDQ scores since 2009 (or, at least, that scores would be lower a few years after its introduction than they were at or immediately after its introduction), reflecting better mental health of looked after children following this 'intervention'. The second, complementary, way of viewing and analysing these English SDQ data is *individual*: linking the datasets from each year in order to conduct longitudinal analyses on individual children over time to examine changes, and, potentially, correlates or predictors of changes at the individual level. This is complicated or, potentially, precluded, by the considerable number, estimated at 40% (Department for Education, 2015a), of children who move in and out of the care system each year, thereby reducing the numbers with several years' data available for analysis and introducing the possibility that any such analysis might

be conducted on a biased sample, since those who remain in the care system over an extended period are likely to differ from those who move out. Additionally, the SDQ data are not gathered at either entry into care or at regular, fixed times throughout the year so cannot be used to analyse child mental health 'before' and 'after' care. Finally, there are significant amounts of missing data and this also needs to be taken into account. Even with these shortcomings, this vast and annual increasing dataset has great research potential (Cocker et al., 2018).

However, gathering SDQ scores on looked after children with problems is only the first step. The next critically important stage involves understanding what is done with these data to address the difficulties many looked after children experience. The final section describes the expectations of the existing statutory guidance (Department for Education and Department of Health, 2015), which outlines how the SDQ can be used to improve mental health outcomes for looked after children.

2.8 The English Statutory Guidance on 'Promoting the health and wellbeing of looked after children'

The rate of local authority statutory SDQ returns over a period of time is only one factor to consider when judging whether a local authority's use of the SDQ in practice is of a 'good' standard. In addition to considering compliance to the central government's requirements, the second factor is the local authority procedures that detail how to collect and use the SDQ data in practice. To begin this discussion I summarise the process outlined in the *Statutory Guidance on health and wellbeing for looked after children*, considered to be 'good practice' in using SDQ data as a tool to achieve better outcomes.

The Statutory Guidance (Department for Education and Department of Health, 2015) sets out how the SDQ should be used in local authorities. It was issued under section 7 of the Local Authority Social Services Act 1970, which means that local authorities are required to implement the guidance unless the local authority has a compelling reason for not doing this.

The Guidance states that '*mental health is as important as physical health*' (p4), and the use of the word 'health' in the document includes mental and

physical health. The Guidance sets out expectations for local authorities regarding their use of the SDQ, which is, *'Local authorities are required to use the SDQ to assess the emotional well-being of individual looked after children.'* *(p10)*

With regard to the processes that the Statutory Guidance outlines for social workers, it states the following:

> *'As an integral part of care planning, social workers must make arrangements to ensure that every looked after child has:*
>
> - *Their physical, emotional and mental health needs assessed*
> - *A health plan describing how those identified needs will be addressed to improve health outcomes*
> - *Their health plan reviewed in line with care planning requirements.' (p14)*

In terms of the role of social workers in respect of the SDQ, the Statutory Guidance summarises the purpose of the SDQ as providing social workers with information from a reputable tool which, alongside other information and observations that a social worker will make, helps them consider the emotional wellbeing of looked after children and young people. The Guidance states that the main benefit of the SDQ is that social workers do not require any training to administer or analyse the data produced from it.

The Guidance requires that the SDQ is completed by the child's main carer, usually around the time of the child's health assessment. There is some advice in the Guidance about the length of time the carer should have to complete the SDQ (one month) and, that where children have recently moved placement, consideration should be given to which carer would be best placed to complete the SDQ, as the carer has to have some knowledge of the child. The Guidance also suggests that the carer should be told that the questionnaire is about the child and not about the care being provided to the child or young person in the placement.

The Guidance states that the local authority then collects the questionnaire, the child's score is calculated (presumably by the local authority, although this is not explicitly stated, however the Guidance states that the SDQ being, *'a simple questionnaire that does not require any training to interpret' p30*) and made

available for the child's health assessment. The Guidance recommends that where the carer SDQ total score is outside the 'normal' range, the social worker and Virtual School Head[10] should arrange for the teacher's version of the SDQ to be completed and, for children over 11, the young person's version to be completed, in order to triangulate the data. If these additional questionnaires support the carer's view then the guidance suggests that referral for a further/fuller diagnostic assessment of mental health should then be undertaken. *'The SDQ should be used as evidence to support a referral to local targeted or specialist mental health services where appropriate.'* (DfE and DH, 2015, p31). The guidance therefore suggests that the SDQ is used as an assessment tool by social workers with looked after children. These requirements also apply regardless of where a child lives, so social workers and health professionals should work together to assess and arrange for children to have access to the mental health support they need when they live out of borough. This is also the case for children who are moving placements, including from foster care to adoption.

2.9 Chapter Summary

The SDQ is a questionnaire that has been robustly validated by a number of independent international studies as a tool for accurately screening the mental health of children aged from 4 to 16. It has been chosen as the focus for my thesis because it is the tool used by the DfE to collect data about looked after children who have been in care a year or longer. The corresponding data is available publicly in aggregated form.

The next chapter provides a systematic review of the literature, that has used the SDQ to assess the mental health of looked after children.

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[10] Virtual School Head (VSH): an officer employed by a local authority in England whose job is to ensure that the authority's duty to promote the educational achievement of the children it looks after is properly discharged. (Department for Education and Department of Health, 2015, p35)

Chapter 3 Systematic Literature Review

3.1 Introduction

This chapter presents a systematic review of peer reviewed literature about looked after children, mental health and the SDQ. There are no published systematic reviews that collate information from studies that examine how mental health difficulties are screened and assessed in looked after children using the SDQ. This review addresses the questions:

> How has the SDQ been used in research with looked after children in screening and assessing mental health problems?

> Is the use of the SDQ as a screen for looked after children an effective way to gather information about their mental health?

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009) approach was used to conduct this review. Relevant literature was identified that used the SDQ to assess the mental health of looked after children. The PICOS[11] approach (Liberati et al., 2009) enabled me to consider the common factors across the literature that were included in the review. The only commonality between all the studies was that looked after children were the *population* being studied. With regard to the other PICOS factors, even though the SDQ was also common to all studies, only some of the studies reported on the SDQ as an *intervention*. Where study designs used *comparisons*, these were not the same throughout. The studies included in the review also used different *study designs*. Within these studies the SDQ was used differently, including as a predictor or an outcome. For these reasons it was not possible to undertake a meta-analysis of the results of the studies included in the review. Instead the studies were critically appraised to present a synthesis of current knowledge.

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[11] PICOS is an acronym that stands for Population or Participants, Interventions, Comparisons, Outcomes, and Study design (Liberati et al., 2009).

The chapter begins with a description of methods used in the literature search. The inclusion and exclusion criteria can be found in Appendix 1. The PRISMA flow diagram (Diagram 3.1) provides a summary of the numbers of studies identified in the database searches and taken through the process of identification, screening, eligibility and inclusion in the review. Appendix 2 provides the tabulated results for the 40 articles identified from the literature search.

Presentation of the results is divided into a number of sections:
- empirical studies using the SDQ in randomised controlled trials (RCTs) or controlled trials related to the mental health of looked after children;
- empirical studies using the SDQ in cross sectional or other epidemiological approaches related to the mental health of looked after children;
- empirical studies using the SDQ as a screening tool at point of entry into care or whilst in care; these may include cross sectional studies (some of these studies may also be included in the second section).

Each of these three sections ends with a summary of findings. The chapter ends with some conclusions from the review so that links can then be made between the gaps identified in the review and the rationale for this thesis.

It is important to note at the outset that my focus on the SDQ as a measure means that a significant number of very good studies that research and discuss the mental health of looked after children, but do not use the SDQ, are not included in this review. These are discussed in the general introduction to the thesis.

Diagram 3.1: PRISMA Flow Diagram
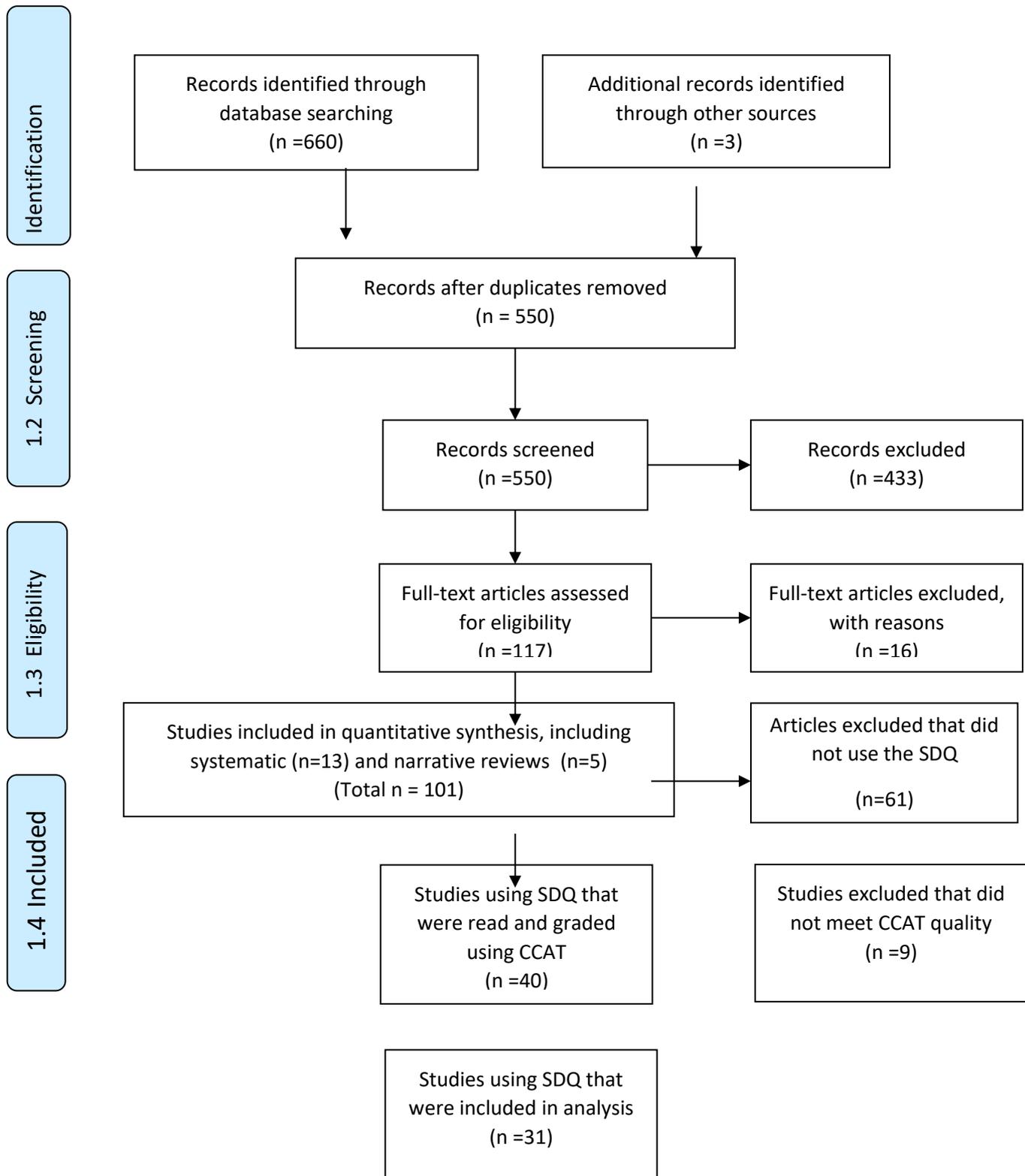
3.2 **Methods**

In undertaking a review of the literature I have used the PRISMA model (Moher et al., 2009) as a systematic process to ensure that as much relevant data as possible were accessed and included. Systematic reviews provide a synthesis of evidence from high quality empirical studies that meet the strict protocols and terms of reference for the review. The methods used in a systematic review are viewed as rigorous and the results are seen as authoritative, representing the best evidence of what is known about a topic at a given point in time. Such reviews mostly draw on quantitative research and because of this, systematic reviews do not exist in all areas of practice, particularly in certain areas of the social sciences, such as social work, although this is changing as some organisations such as the Campbell Collaboration include studies with qualitative design methods in their reviews.

Searches were limited to journal articles published in English between 2000 and 2016. The year 2000 was chosen as the start year because the psychometric properties of the SDQ were first presented in 2001 suggesting that papers pre-2000 might have had methodological weaknesses (Goodman, 2001).

A number of key words or terms were used to search a variety of databases. The key words were:

looked after children; children in care; out of home care (international term); foster care; public care; residential care; mental health; mental disorder; mental health problem; emotional and behavioural difficulty.

Where the database allowed, words were truncated (e.g. child*) to enable a broader search for relevant articles and texts. Boolean terms were also employed in order to join words and phrases together where this was required (e.g. 'looked after child*'). Search terms were used iteratively with some modification in order to locate relevant articles, depending on the database searched. For example, I would change 'looked after child*' to 'child* in out of home care' where the

database did not produce any hits. Where articles closely matched the thesis topic, other search terms were identified from keywords used in the article.

The databases searched were:

> Social Care Online; Web of Knowledge; CINAHL; Psycinfo; EBSCOJournals; MEDLINE Ebsco; MEDLINE Ovid; MEDLINE Pub Med; Science Direct, Ingenta Connect; and SCOPUS.

A similar strategy was followed in terms of how the search in each database was undertaken. The 'advanced search' facility on each database enabled the use of a number of relevant keywords at the same time in order to reduce the volume of 'hits'. References were included on the basis of title and key words including the following:

- 'looked after child*' or 'child* in care' or 'out of home care' or 'public care' or 'state care'; **AND**

- 'mental health', 'mental disorder' or 'emotional and behavioural difficulty'; **AND**

- foster care or residential care; **AND**

- SDQ

In addition, searches were extended by citation searches of key authors highlighted in the initial searches and following links identified in articles, from relevant studies to 'related' articles. Fingertip searches were also carried out looking for all relevant studies published between 2000 and 2016 in the following journals, as a number of relevant articles were identified in these journals: *The British Journal of Social Work*; *Adoption and Fostering*; *Child Abuse and Neglect*; *Child and Family Social Work*; *Child and Adolescent Mental Health*; *Children and Youth Services Review*; *Clinical Child Psychology and Psychiatry*; *Journal of Child Psychology and Psychiatry*. A search was also undertaken of all government-funded research identified in published summary reports between 2000 and 2016. Where these appeared appropriate they were read in full. Finally, experts in the field were contacted and some read the reference list to identify missing studies.

Despite the thorough approach to the literature searches, it is unlikely that every relevant study was included because it is not unusual, in this field, for relevant research to be published in the 'grey' literature. Therefore, while the review appears to be thorough, it cannot claim to be all inclusive. The searches were originally undertaken at the end of 2010, updated in Feb 2014, Dec 2015 and Jan 2017. Diagram 3.1 provides a flow diagram of this process.

After removing duplicates, 550 articles were identified. The abstracts from the references identified in the searches were then reviewed.

From these abstracts, relevant systematic and non-systematic literature reviews (n=18) and empirical research studies (n=99) were summarised in two separate Tables and the key findings from the studies were reviewed.

From these 117 papers, relevant papers were selected for inclusion, using inclusion and exclusion criteria.

The inclusion criteria comprised:

- the topic of the paper had to be the mental health of looked after children;
- written in English;
- be empirical research;
- the research must have taken place in developed nations.

The exclusion criteria comprised:

- if the article was published before 2000;
- children admitted to psychiatric wards;
- the study did not use the SDQ.

A further Table (Appendix 2) lists the empirical studies that use the SDQ as a measure and met the inclusion criteria (n=40).

All studies listed in Appendix 2 were read in full and were graded using the Crowe Critical Appraisal Tool (CCAT) (Crowe et al., 2011). This is one of a large number of available tools to assist in appraising the quality of research papers. I considered the CCAT alongside the Critical Appraisal Skills Programme (Spittlehouse, 2000) and the TAPUPAS[12] framework (Pawson et al., 2003), more commonly used in social care research, which were ones I had previously used. Given that the majority of the papers requiring review used quantitative methods, I decided to use CCAT, because of the rigorous approach used to analyse and grade articles.

In the CCAT, *research designs, sampling techniques, ethics, data collection methods*, and *data analysis techniques* are identified and scored on a five point scale (total 40) according to set criteria listed in the form. To ensure that I had scored the articles correctly, both my supervisors read five papers each. These ten papers (25% of the total) were chosen randomly by someone who had no involvement with the research for this thesis. My supervisors' scores were then compared with mine. There was considerable agreement between us, with most total scores differing by three or fewer marks (out of a maximum possible 40 marks). Where scores differed by more than this, a mark was agreed. The largest difference in scores between the same papers occurred in articles scored by both parties below the agreed cut-off score, which was 22. For these low-scoring papers, my scores were lower than one of my supervisors in particular (seven mark difference). However, there was no disagreement between scores that affected whether papers were included or excluded in the review. All papers just above and below the cut off mark were discussed with my supervisors, and the cut off mark of 22 was jointly agreed as studies below this mark were not deemed to be of sufficient quality (Appendix 3). The papers that were subsequently used for the

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[12] TAPUPAS stands for: Transparency; Accuracy; Purposivity; Utility; Propriety; Accessibility and Specificity.

review (Table 3.1) scored at least one 'four' (out of a maximum five) in one of the eight columns, and the total score for the article was higher than 22.

Following the CCAT grading exercise, nine further papers were rejected, leaving a total of 31 papers included in the review. The summary data from these nine papers are presented in Appendix 3.

3.3   The Results: How has the SDQ been used in research with looked after children in screening and assessing mental health problems?

The next three sections of the literature review chapter contain information from the empirical studies identified in the literature about looked after children and mental health that use the SDQ. Table 3.1 presents the 31 studies that met the eligibility criteria and are included in the next three sections of this review.

Table 3.1

Tabulated summary of articles identified for inclusion in literature review – ordered earliest to most recent

	Author details, year of publication and country of origin	Sample	Method	SDQ versions used			Results	CCAT Quality score (out of 40)
				Carer or SW	Teacher	Child		
1	Minnis, Pelosi, Knapp and Dunn (2001)* UK (Scotland)	N=182	RCT with 3 data collection periods. 182 Looked After Children in foster care (and their foster families) in 17 Scottish local councils were randomly allocated to standard services alone or standard services plus foster carer training (specifically for foster carers on communication and attachment).	x	x	x	60% of Looked After Children had measurable mental health difficulties at baseline. Training was perceived as beneficial by foster carers. Results were non-significant.	36
2	Minnis and Devine (2001)* UK (Scotland)	N=182	RCT with 3 data collection periods. 182 Looked After Children in foster care (and their foster families) in 17 Scottish local councils were randomly allocated to standard services alone or standard services plus foster carer training (specifically for foster carers on communication and attachment).	x	x	x	There was an improvement in the self-esteem of the children during the course of the study. Training was perceived as beneficial by foster carers in terms of their relationship with the children they care for but did not result in changes to the children's emotional and behavioural 3functioning. The training provided rich information about foster carers' communications and interactions with the looked after children in their care.	25

	Author details, year of publication and country of origin	Sample	Method	SDQ versions used			Results	CCAT Quality score (out of 40)
				Carer or SW	Teacher	Child		
3	McCarthy, Janeway and Geddes (2003) UK (England)	N=70	Questionnaire based study. 115 carers of children aged 5-16 years were approached and 70 completed questionnaires were returned	x			59% of the looked after children had a score indicating the presence of a psychiatric disorder. Where significant problems were identified by carers, 65% reported that the problems had existed for over 1 year and almost half the sample stated that the children's difficulties were imposing a significant burden on the families or other carers.	26
4	Meltzer, Corbin Gatward, Goodman and Ford (2003)+ UK (England)	N=1039	This is an epidemiological study using random sampling surveys of looked after children in England to establish the prevalence of mental disorders within the looked after population in England	x	x	x	Among young people, aged 5–17 years, looked after by local authorities, 45% were assessed as having a mental disorder: 37% had clinically significant conduct disorders; 12% were assessed as having emotional disorders - anxiety and depression – and 7% were rated as hyperactive.	38
5	Sinclair and Wilson (2003) UK (England)	N=472	Quantitative and qualitative data collected at t1 and t2 (14 month interval) from a cross section of those involved with looked after children: children's SW family placement SW, FC and some comments from children themselves	x	x	x	'Success' in foster care placements depended on 3 aspects: children's characteristics (children who wanted to be fostered, had attractive characteristics and low levels of disturbance did better); qualities of foster carer (warm, child oriented carers were more successful); and interaction between carer and child. These findings emphasise the importance of the foster carers to outcomes for children, and the need to pay close attention to children's views, and the potential importance of early intervention to prevent negative spirals in interaction between carer and child.	30
6	Meltzer, Lader, Goodman and Ford (2004a)+ UK (Scotland)	N=877	This is an epidemiological study using random sampling surveys of looked after children in Scotland to establish the prevalence of mental disorders within the looked after population in Scotland	x	x	x	45% of those aged between 5 to 17 years of age were assessed as having a mental disorder. Those aged 5 to 10 who were looked after at home or accommodated were six times more likely to have a mental disorder than those children living with families in the community (52% compared with 8%). Those aged 11 to 15 and either looked after at home or looked after and accommodated were four times more likely to have a mental disorder than those children living with families in the community (41% compared with 9%). Some children had more than one type of disorder and these were more likely to be boys	38

	Author details, year of publication and country of origin	Sample	Method	SDQ versions used			Results	CCAT Quality score (out of 40)
				Carer or SW	Teacher	Child		
7	Meltzer, Lader, Goodman and Ford (2004b)+ Uk (Wales)	N=308	This is an epidemiological study using random sampling surveys of looked after children in Wales to establish the prevalence of mental disorders within the looked after population in Wales	x	x	x	For 5 to 10-year-olds, those looked after by local authorities were about eight times more likely to have a mental disorder; 49% compared with 6% of children living in the community. The 11 to 15-year-olds looked after by local authorities were three and a half times more likely to have a mental disorder: 40% compared with 12% of young people living in the community.	38
8	Goodman, Ford, Corbin and Meltzer (2004)+ UK	N=1028	SDQ scores and independent psychiatric diagnoses were compared in a community sample of 1,028 looked-after 5-17 year olds from a nationwide English survey.	x	x	x	Multi-informant SDQs (parents, teachers, older children) identified individuals with a psychiatric diagnosis with a specificity of 80% and a sensitivity of 85%. The SDQ prediction works best when SDQs have been completed by both carers and teachers. When it is only possible to have one adult informant, carers and teachers provide information of roughly equal predictive value. By contrast, self-reports by 11-17 year olds provide little extra information when there is already an adult informant.	39
9	Mount, Lister and Bennun (2004) UK (England)	N=50	Interview and administration of semi-structured interview schedule, then questionnaires and scales were completed.	x		x	Carers were four times more likely to identify mental health needs, both intuitively and on the mental health screen, than the young people themselves. Two thirds of carers were intuitively accurate in identifying mental health need. Fewer than half of children identified as having a need were being seen by specialists. 23% of carers failed to identify needs subsequently identified by the screen.	25
10	Minnis, Everett, Pelosi, Dunn and Knapp (2006)* UK (Scotland)	N=182	Observational study. Information on mental health problems, service use and costs was collected by postal questionnaires and home interviews. The results were then compared with 251 children from local schools	x	x	x	Over 90% of the children had previously been abused or neglected and 60% had evidence of mental health problems including conduct, emotional problems, hyperactivity and poor peer relationships. Those children with highest scores for MH problems were attracting a high level of service support from many agencies except CAMHS. Costs were associated with learning disability, mental health problems and a history of residential care.	30

	Author details, year of publication and country of origin	Sample	Method	SDQ versions used			Results	CCAT Quality score (out of 40)
				Carer or SW	Teacher	Child		
11	Richards, Wood, Ruiz Calzada (2006) UK	N=41	Questionnaire study: Use of SDQ as questionnaire and pre and post care experiences were collected from discussions with SWs and reviewing social work files.	x	x	x	Carer and teacher rates were similar and higher than the self reporters. The high needs for parent (43.9%) and teacher (46.3%) is similar to national prevalence rates. SDQ is recommended as a screening tool	30
12	Beck (2006) UK	N=747	Questionnaire based survey sent to the carers, teachers and young people if over 11 years of age.	x	x	x	A third (30 per cent) of young people had a 'probable' psychiatric diagnosis using the SDQ. Eleven per cent had moved placement three or more times in the last year and they were three times more likely to have a 'probable' psychiatric diagnosis. They were also significantly more likely to report deliberate self-harm in the last six months compared to those who had moved placement less frequently. Although young people who move placement frequently are far more likely to develop psychiatric disturbance than other looked after children, they are much less likely to access mental health services.	30
13	Derluyn and Broekaert (2007)% Belgium	N=166 unaccompanied refugee youths	Self-report questionnaires were completed on emotional and behavioural problems (HSCL-37A, SDQ-self and RATS) and traumatic experiences (SLE), and social workers filled in two questionnaires on emotional and behavioural problems (CBCL/6-18 and SDQ-parent)	x		x	Between 37 and 47% of the unaccompanied refugee youths have severe or very severe symptoms of anxiety, depression and post-traumatic stress. Girls and those having experienced many traumatic events are at even higher risk for the development of these emotional problems. Social workers also report high internalising and externalising problems in this group.	29

	Author details, year of publication and country of origin	Sample	Method	SDQ versions used			Results	CCAT Quality score (out of 40)
				Carer or SW	Teacher	Child		
14	Ford, Vostanis, Meltzer and Goodman (2007)+ UK	N=1453 looked after children; N=10,428 children living in private households	Examined socio-demographic characteristics and mental health problems by type of placement among children looked after in Britain by local authorities and compared these children with deprived and non-deprived children living in private households	x	x	x	Looked after children have higher levels of mental health problems, educational difficulties and neuro-developmental disorders. 'Looked after' status was independently associated with all types of developmental disorders after adjusting for education and physical factors. The prevalence of psychiatric disorder was most associated with those living in residential care and who have had many placement changes.	39
15	Taggart, Cousins and Milner (2007) UK (Northern Ireland)#	N= 165 looked after children of which N=37 had learning disabilities	Mixed Methods Research. Data were collected from social worker reports and the Strengths and Difficulties Questionnaire on these two cohorts who were living in state care for a minimum of one year.	x			The young people with learning disabilities had a higher prevalence of emotional and behavioural problems and were also significantly more likely to score within the abnormal range of the Total Difficulties Score of the SDQ (77.1%) compared with their non-disabled peers (49.6%).	25

	Author details, year of publication and country of origin	Sample	Method	SDQ versions used			Results	CCAT Quality score (out of 40)
				Carer or SW	Teacher	Child		
16	Whyte and Campbell (2008) UK (Northern Ireland)	N=76	Mixed methods: 1. SDQ screening was undertaken with a sample of Looked After Children, carers and teachers. 2. Focus groups with social workers 3. Pre-test and post-test file audits were undertaken to ascertain whether SDQ screening had informed the child's care planning process.	x	x	x	Of the sample of children, 56% of carers, 39% of teachers and 30% of children identified significant difficulties, with 63% of carers, 35% of teachers and 45% of children stating that the difficulties had been present for over a year. While care plans reflected an increase in referrals for further assessment and treatment in 42%, a number assessed with significant difficulties were not referred due to uncertainty about accessing appropriate services or concerns about swamping existing services. Participants reflected on the usefulness of the SDQ in identifying mental health strengths and difficulties to inform decision-making at Looked After Children Reviews. Participants recommended that routine SDQ screening is undertaken with all Looked After Children, with early intervention provided to children identified with some mental health difficulties and prioritisation of children with significant need. The usefulness of SDQ identification of child strengths as a foundation for promoting resilience in Looked After Children was also recognised. Recommendations were also made regarding specific service provision for Looked After Children and training for field social workers, link social workers and carers.	23
17	Osborn, Delfabbro and Barber (2008) Australia	N=364	Detailed interviews were conducted with case-workers, along with extensive case-file readings. Questionnaires were also used	x			Based on the SDQ, over 75% of children were found to have clinical level conduct disorder, two-thirds had peer problems, and around a half were clinically anxious or depressed. The results provided some evidence that children with the poorest overall psychosocial adjustment were most prone to placement breakdowns, but there was no clear relationship between the overall number of family background problems and the level of placement instability. However, individual risk factors, including a history of family violence and abuse were related to more disrupted placement histories for children in care.	34

	Author details, year of publication and country of origin	Sample	Method	SDQ versions used			Results	CCAT Quality score (out of 40)
				Carer or SW	Teacher	Child		
18	Milburn, Lynch and Jackson (2008) Australia	N=171	Multi-disciplinary therapeutic assessment was completed on the child within 7-10 days of a child being accommodated. Standardised measures and interviews with birth parents and foster cares were also completed.	x	x	x	Nearly three quarters of the participants over 5 scored in the borderline or abnormal range of the SDQ. The parents and carers report version was found to be a more accurate assessment of the child's problems than the self-report version. More than 60% of participants met the criteria for psychiatric diagnosis.	30
19	Bonfield, Collins, Guishard-Pine and Langdon (2010) UK	N=113 foster carers, N=108 looked after children	Cross-sectional and between groups design. Data on variables likely to be related to help-seeking were collected from foster carers and looked after young people	x		x	Mental health literacy and help seeing attitudes, in combination with the presence and impact of a mental health problem, and foster care education, are significant predictors of help-seeking.	33
20	Marquis and Flynn (2009) Canada	N=492	This study compared the SDQ scores, based on ratings by foster parents or other caregivers, of 492 young people aged 11–15 years and living in out-of-home care in Ontario, Canada, with normative SDQ scores, based on parental ratings, of a large sample of young people aged 11–15 years from the British general population.	x			The findings suggested that the SDQ is likely to prove useful as a mental health measurement tool in Canadian child welfare services. Early detection, referral and intervention regarding mental health would enhance looked after children's overall psychological, social and academic functioning.	22

	Author details, year of publication and country of origin	Sample	Method	SDQ versions used			Results	CCAT Quality score (out of 40)
				Carer or SW	Teacher	Child		
21	Egelund and Lausten (2009) Denmark	out-of-home care (n= 1072); 'in home care children' (n= 1457); children who are not child protection clients (n=71,321)	Comparison study between 3 types of children: in care; in need and subject to CP interventions but living at home; and non-welfare children.	x			Results show that 20% of children in out-of-home care have at least one psychiatric diagnosis compared to 3% of the non-welfare children. Almost half of the children in care (48%) are, furthermore, scored within the abnormal range of SDQ, compared to 5% of the non-welfare children.	29
22	Cousins, Taggart and Milner (2010) UK (Northern Ireland)#	N=165	Mixed Methods Research. case file data, questionnaires and interviews with social workers	x			70.3% of the young people scored within the abnormal and borderline ranges of the SDQ total difficulties score indicating "high risk'' for meeting the criteria for a psychiatric diagnosis. Over the course of 1 year living in state care, 10 of the 165 adolescents had attempted suicide and 14 had engaged in deliberate self-harm. However, social workers still rated the vast majority (92%) of these young people's overall health as being "as good as'', or "better than'' other young people in their age. It is concluded that as this group of young people have significant contact with health and social services, potential opportunities exist to develop the therapeutic potential of the experience of being "looked after'' in state care.	24

	Author details, year of publication and country of origin	Sample	Method	SDQ versions used			Results	CCAT Quality score (out of 40)
				Carer or SW	Teacher	Child		
23	McCrystal and McAloney (2010) UK (Northern Ireland)	N= 4000 including n=42 looked after children (year 1) and N= 49 (year 4).	The data were obtained during the first year of the study, with looked after young people aged 11 and 12 years, and fourth year, with young people aged 14 and 15 years. The data obtained using the SDQ was compared for young people who indicated they were living in state care with those living with at least one biological parent outside care.			x	The results show a higher proportion of young people living in state care reported scores on the SDQ that indicated a higher propensity to problem behaviour at both stages of the survey. They also show that the SDQ is a tool that may assist professionals to make an informed decision on the health and wellbeing of young people entering the care system and possibly can lead to an empirically assisted decision on intervention planning.	29
24	Jee, Halterman, Szilagyi, Conn, Alpert-Gillis, Szilagyi (2011) USA	N=212	Before and after study design following a practice to screen all youth in foster care for psychosocial problems using the SDQ. This was compared to the rates of psychosocial problems identified in the 2 years prior to the screening tool being introduced (baseline).	x		x	High feasibility of systematic screening. Detection of mental health problems was higher in the screening period than in the baseline period for the entire population (54% vs 27%). More than one quarter of young people had 2 or more significant social /emotional problem domains on the SDQ.	27

	Author details, year of publication and country of origin	Sample	Method	SDQ versions used			Results	CCAT Quality score (out of 40)
				Carer or SW	Teacher	Child		
25	Goodman and Goodman (2012)+ UK	N=1391	Combined data from 3 nationally representative surveys (England, Scotland and Wales) of looked after children aged 5-17 to assess whether differences in mean SDQ scores from parent/carer version reflect genuine differences in child mental health in this group	x			The SDQ is a 'genuinely dimensional measure' of mental health in looked after children and provides accurate estimates of disorder prevalence, despite their having a much higher prevalence of disorder than the general population. Thus, any difference between groups of looked after children in their mean SDQ score will, on average, reflect real differences in their mental health'.	32
26	Biehal, Dixon, Parry, Sinclair, Green, Roberts, Kay, Rothwell, Kapadia, and Roby (2012) UK (Englnd)	N=219	RCT with observational quasi experimental case control study. Measures used were: C-GAS; HoNOSCA; CBCL; SDQ. Data were collected on school attendance, offending and placement disruption. Qualitative data were also collected during interviews with young people and carers.	x			For the sample as a whole, placement in Multi-dimensional Treatment Foster Care showed no statistically significant benefit over the usual care placements. This was true for all the outcomes studied including overall social adjustment, education outcomes and offending. In a subgroup of the sample with serious antisocial behaviour problems, MTFC-A showed improved reduction in these behaviour problems over usual care and also in overall social adjustment. The young people who were not anti-social did significantly better if they received a usual care placement.	37

	Author details, year of publication and country of origin	Sample	Method	SDQ versions used			Results	CCAT Quality score (out of 40)
				Carer or SW	Teacher	Child		
27	Briskman; Castle, Blackeby, Bengo, Slack, Stebbens, Leaver and Scott (2012) UK (England)	N=63 carers and N=89 foster children	RCT: data were gathered about foster children before and after their foster carers attended a specific parenting programme developed for foster carers. Six measures were used, including the SDQ.	x			Improvement across the board in outcomes for intervention group compared with control, including on emotional and behavioural difficulties for foster children, using the total difficulties score of the SDQ; improvement in carer-defined problems and the quality of attachment between looked after children and carers compared to controls. Positive changes were also reported in carer confidence and parenting practices, including greater self-esteem and less stress. 'Eighty-nine percent of these carers said that they would be able to retain the knowledge that they had acquired during the training over the longer-term, and 100% felt confident about using their new skills with other children.'	36
28	Newlove-Delgado, Murphy and Ford (2012) UK (England)	N=23	2 stage screening process: SDQ screen used with children aged 4-16 who had been in care over 4 consecutive months. Where the screening questionnaire suggested a psychiatric disorder was 'possible' or 'probable', the DAWBA was completed and rated by a psychiatrist to generate a diagnosis if applicable.	x	x	x	28% of children eligible for screening were already in contact with some form of CAMHS provision. Seven children from the 18 screened received a formal diagnosis. For 80% of these children, social workers had recognised the children as having potential difficulties.	32

	Author details, year of publication and country of origin	Sample	Method	SDQ versions used			Results	CCAT Quality score (out of 40)
				Carer or SW	Teacher	Child		
29	Rees (2012) UK (England)	N=193	Multi-dimensional multiple-rater population based study of looked after children. Children were assessed in core domains: mental health, emotional literacy, cognitive ability and literacy attainment. Children's data were compared with the general population norms and existing research studies.	x	x	x	Looked after children performed less well in all domains compared with general population norms. 16% of children met the 'positive exception' criteria. Positive performance on individual measures varied from 34% to 76%. A statistically significant association was found between positive exception classification and 2 factors: parental contact and mainstream schooling.	39
30	Lehmann, Heiervang, Havik, Havik (2014) Norway	N=279	Foster parents and teachers completed the SDQ and the DAWBA. Using the diagnoses derived from the DAWBA as the standard, the performance of the SDQ scales as dimensional measures of mental health problems were examined.	x	x		The results support the use of the SDQ Total difficulties and Impact scales when screening foster children for mental health problems. Cut-off values for both scales are suggested. The SDQ multi-informant algorithms are not recommended for mental health screening of foster children in Norway.	35

	Author details, year of publication and country of origin	Sample	Method	SDQ versions used			Results	CCAT Quality score (out of 40)
				Carer or SW	Teacher	Child		
31	Herrman et al. (19 authors) (2016) Australia	N=176 young people, N=104 carers and N=79 case managers.	Australian evaluation study that uses the SDQ as a measure within the study. The research evaluates a complex mental health intervention (The Ripple Project) that aims to strengthen the therapeutic capacities of carers and case managers of young people (12-17 years) in out of home care.	x		x	According to the study, Implementing and researching an affordable service system intervention appears feasible and likely to be applicable in other places and countries. Success of the intervention will potentially contribute to reducing mental ill-health among these young people, including suicide attempts, self-harm and substance abuse, as well as reducing homelessness, social isolation and contact with the criminal justice system.	25

* All Minnis et al reporting on the same study.

Both reporting on the same study

+ the Meltzer et al (2003; 2004a 2004b) studies (4, 5 and 6) used the same method and subsequent studies (7, 16 and 30) used the database from all three Meltzer et al studies.

% This study was included to reflect the range of research undertaken with looked after children that uses the SDQ

3.3.1 A description of characteristics of these studies

The vast majority of the studies identified in Table 3.1 are UK-based (n=23), with the remainder spread between Europe (n=3), Australia (n=3), USA (n=1) and Canada (n=1). The studies can be divided into three groups: those that use the SDQ as an outcome measure (n=19); those that use the SDQ as a screening tool (n=3); and a combination of the two (n=9).

There are many differences in the methodologies used in the studies and it is important to comment on how these differences may then affect the conclusions drawn from the synthesis and analysis of the studies. For example, some studies have very small samples of looked after children and are exploratory in nature, whilst others are population based and contain much larger numbers of looked after children. The range in sample sizes of looked after children varies from n=23 (Newlove-Delgado, Murphy and Ford, 2012) to n=1453 (Ford, Vostanis, Meltzer and Goodman, 2007). The largest studies are epidemiological (e.g. Meltzer et al 2003; 2004a; 2004b).

The studies listed in Table 3.1 use a variety of different methods to gather and analyse the data collected, and these are listed in the Table. A small number (n=6) used both qualitative and quantitative methods (Sinclair and Wilson, 2004; Mount, Lister and Bennun, 2004; Taggart, Cousins and Milner, 2007; Whyte and Campbell, 2008; Osborn, Delfabbro and Barber, 2008; Cousins, Taggart and Milner 2010). The majority of the study designs use quantitative methods, with half (n=14) using control/comparison groups in their design (Minnis, Pelosi, Knapp and Dunn, 2001; Minnis and Devine, 2001; Meltzer, Corbin Gatward, Goodman and Ford, 2003; Meltzer, Lader, Goodman and Ford, 2004a; Meltzer, Lader, Goodman and Ford, 2004b; Goodman, Ford, Corbin and Meltzer, 2004; Minnis, Everett, Pelosi, Dunn and Knapp, 2006; Ford, Vostanis, Meltzer and Goodman, 2007; Marquis and Flynn, 2009; Egelund and Lausten, 2009; McCrystal and McAloney, 2010; Goodman and Goodman, 2012; Biehal, Dixon, Parry, Sinclair, Green, Roberts, Kay, Rothwell, Kapadia, and Roby, 2012; Briskman; Castle, Blackeby, Bengo, Slack, Stebbens, Leaver and Scott,2012). Some of the studies use comparison groups with non-looked after children. To assist with the synthesis of data, the discussion below divides the articles into three groups

based on study type: using randomised controlled trial methods; using cross sectional methods; and using the SDQ as a screening tool. Four themes cut across these study types: high-level mental health problems in looked after young people; child characteristics associated with SDQ scores among looked after young people; the SDQ as a measurement tool; and social workers' use of the SDQ and/or ability to identify mental health problems in looked after children. Each section ends with a synthesis regarding how the different study types explore these themes.

3.3.2 Randomised Controlled Trials of interventions for looked after children

Randomised controlled trials (RCTs) examining specific interventions in out of home care for looked after children are rare. Three have been carried out in the UK over the past 15 years (Minnis et al., 2001, Briskman et al., 2012, Biehal et al., 2012), and all have used the SDQ as an outcome measure. Minnis et al. (2001) investigated the impact of foster carer training on the emotional and behavioural functioning of looked after children (n=182). Sixty percent of the children included in the study had measurable mental health difficulties at baseline (using SDQ cut-off points for "likely diagnosis"). Around half of children had significant problems with hyperactivity, conduct or peer problems. There was one difference in how teachers versus foster carers assessed the emotional problems in this group of children, with foster carers believing that 45% of children had emotional problems whereas teachers thought that only 12% of the same children had problems. Although there was some improvement in children's self-esteem, the intervention had no statistically significant impact on overall emotional and behavioural functioning. The authors comment that the outcome measures, of which the SDQ was one, may not have picked up differences between the groups.

Another RCT was conducted (n=89 looked after children; n=63 foster carers) in respect of the foster care programme 'Fostering Changes' (Briskman et al., 2012). The SDQ scores for children in this study (carer version only was used) were compared with national population norms (Meltzer et al., 2000) and the scores of the sample of looked after children were seven times higher than the national data. The SDQ rates of difficulties identified at baseline were

comparable to the looked after children population norms (Meltzer et al., 2003, Meltzer et al., 2004a, Meltzer et al., 2004b, Ford et al., 2007), with the authors arguing that their sample was representative of looked after children as it shared many of the same characteristics as the above mentioned studies (Briskman et al., 2012, p39). The results of this study showed statistically significant improvements in emotional and behavioural difficulties for foster children, using the SDQ 'total problems score'.

Biehal et al., (2011) conducted an RCT (n=219) using Multi-dimensional Treatment Foster Care for Adolescents (MTFC-A), an intervention for children and young people with challenging behaviour that is included in the National Registry of Evidence-based Programs and Practices in the USA. This RCT was the first to be conducted in England and the first to focus on older looked after children who were already in care. Again, the SDQ (carer version) was used as an outcome measure, but it was not the main measure used to assess the emotional and behavioural difficulties of this group of young people. The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA), Children's Global Assessment Scale (CGAS), Child Behaviour Checklist (CBCL) and Development and Well-being Assessment – Attachment Difficulties (DAWBA – AD) were the main tools used. The SDQ was used at baseline to compare the results to the wider care population (Meltzer et al., 2003) and the population based data for all children (Meltzer et al., 2000). The authors found that 64% of their sample had clinically significant scores, with only 20% having 'normal' scores. They then compared their sample with the sample of 11-15 year olds from Meltzer et al (2003), and found that the young people included in their study had higher levels of need than the general population of adolescents in care. The proportion of the sample with abnormal scores for total difficulties was similar to that for young people in the national study who were looked after in residential placements, whereas only half the MTFC sample and 60% of the control group had been in residential care at baseline (Biehal et al., 2012, p76). The sample also showed rates of hyperactivity seven times the national norm for looked after children and 50 times what would be found in the general population. According to social workers, only one fifth of these young people had received an ADHD diagnosis. Girls showed higher rates of emotional problems than boys and boys showed higher rates of hyperactivity than girls,

which is similar to national trends, but the gender difference was smaller than in the general population figures.

3.3.2.1 Randomised controlled trials: synthesis

The SDQ was used as a tool to gather outcome data after an intervention for these three individual studies. In addition, two of the three studies used the population based SDQ data on looked after children (Meltzer et al., 2003) and the general population (Meltzer et al., 2000) to compare with their own study samples. The study reported on in Minnis et al., (2001) and Minnis and Devine (2001) did not do this because the Meltzer et al., (2003) results had not yet been published, but comparison was made to the seminal McCann (1996) study instead, which did not use the SDQ. The Meltzer et al (2003) research data are over a decade old now: comparison is therefore not made with the more recent aggregated data available from the Department for Education.

The use of the SDQ in the three studies reviewed in this section revealed high levels of difficulties in the individual samples of looked after children that were equal to or greater than the percentages identified in the general looked after population (Meltzer et al., 2003). The sample of looked after children in Biehal et al., (2012) showed much higher rates of mental health difficulties than the national data. This is a specific group of young people where more research is needed to better understand their mental health need and the type of intervention available to meet those needs. In terms of child characteristics, Biehal et al., (2012) were also able to show that there are less obvious gender differences for those children with high levels of mental health need, so the mental health difficulties of looked after children may not follow the same trends as the general population of children in at least two of the subscales within the SDQ ('emotional problems' and 'hyperactivity'). Further investigation regarding the reasons for this would be useful. Finally, the differences in SDQ scores given by foster carers and teachers about the same child potentially highlight differences in how these groups of people understand the problems experienced by children, with teachers reporting problems on less than a third of the children that foster carers had raised concerns about. This triangulation of data using the various report versions of the SDQ means these differences in professional views can be recorded and further analysed. There may be other

explanations for these differences, including whether the school environment acts as a protective factor for looked after children.

The overall quality of the evidence emerging from the RCT studies is high.

3.3.3 Epidemiological (mainly cross sectional) studies

The majority of studies included in this review used cross sectional designs: (McCarthy et al., 2003, Meltzer et al., 2003, Sinclair and Wilson, 2003, Meltzer et al., 2004a, Meltzer et al., 2004b, Goodman et al., 2004a, Mount et al., 2004, Minnis et al., 2006, Richards et al., 2006, Beck, 2006, Derluyn and Broekaert, 2007, Ford et al., 2007, Taggart et al., 2007, Whyte and Campbell, 2008, Osborn et al., 2008, Milburn et al., 2008, Bonfield et al., 2010, Marquis and Flynn, 2009, Egelund and Lausten, 2009, Cousins et al., 2010, McCrystal and McAloney, 2010, Jee et al., 2011, Goodman and Goodman, 2012a, Newlove-Delgado et al., 2012, Rees, 2013, Lehmann et al., 2013, Herrman et al., 2016). This section will discuss the studies that use the SDQ as a measure of mental health.

3.3.3.1 Epidemiological studies: levels of mental disorder

The international research is consistent in finding high levels of mental disorder and mental health problems within the population of children in out-of-home care as compared to children in the general population and the continued effect that these problems can have into adulthood. Many European countries have undertaken research using the SDQ to investigate the prevalence of mental disorders within their looked after children population, for example: England (Meltzer et al., 2003); Scotland (Meltzer et al., 2004a); Wales (Meltzer et al., 2004b); Norway (Kjelsberg and Nygren, 2004, Havnen et al., 2009, Lehmann et al., 2013); Denmark (Egelund and Lausten, 2009). A number of other countries across the world have also undertaken empirical research examining mental health problems with children in public care using the SDQ: Belgium (Derluyn and Broekaert, 2007); Australia (Osborn et al., 2008, Milburn et al., 2008, Herrman et al., 2016); Canada (Marquis and Flynn, 2009); USA (Jee et al., 2011).

There are, however, methodological differences between many of the studies listed in Table 3.1, as well as variation in how services are provided (including

thresholds for entry into care) and placement types for children in out of home care in each country. Whilst all countries report higher rates of mental health problems for children in public care when compared with children living with their parents in the community, even when using the SDQ as a common tool throughout all studies, it is not possible to simply compare rates in one country with another without further investigation and analysis, as other cultural differences might impact on results. Neither is it possible to only use population means to assess levels of mental health difficulties across nations, even though these are widely used in physical health comparisons between countries. Goodman et al., (2012, p1322) state that, '*This is because differences in mean scores may not reflect differences in population health but rather systematic bias in how mental health is reported*.' Their study used data, including the SDQ, from 5 to 16-year olds from seven countries (n=29,225) and concluded that population-specific norms are needed when estimating prevalence as cross-national differences in levels identified via questionnaires do not necessarily reflect comparable differences in disorder prevalence (Goodman et al., 2012). Caution is also required when interpreting cross-cultural comparisons of levels of child mental health problems using only brief questionnaires (Goodman et al., 2012, p1329).

The largest of the UK based studies to have used the SDQ for looked after children are the three epidemiological studies conducted by Meltzer and colleagues in England (n=1039) (Meltzer et al., 2003), Scotland (n=355) (Meltzer et al., 2004a) and Wales (n=149) (Meltzer et al., 2004b). In these studies, the SDQ was used alongside the DAWBA (which is a diagnostic tool) to identify children with mental health problems. With regard to rates of mental health problems within the looked after population, the DAWBA identified 45% of 5-17 year old children in care in England and Scotland and 49% in Wales as having a mental disorder. Subsequent analysis, again based on DAWBA results, compared these children with children living in the general population (n=10,438). This found that looked after children have higher levels of mental health problems, including disorders, difficulties with education and neurodevelopmental disorders than children who are not in care (Ford et al., 2007). Using the data from the Meltzer et al studies (2000; 2003) Ford et al., identified that only 9% of

looked after children scored within the 'normal' range on the SDQ, compared with 53% of the general population of children.

Two international studies (Marquis and Flynn, 2009, Egelund and Lausten, 2009) identified similar patterns as the Meltzer et al., (2003) study. Both studies found that looked after children had much higher scores, with around half the Danish sample (48%) scoring 'abnormal' in total difficulties and another 17% at 'borderline' (Egelund and Lausten, 2009) and over half the Canadian sample (51.4%) scoring 'borderline' or 'abnormal' in total difficulties (Marquis and Flynn, 2009). One other international study (Lehmann et al., 2013) used the SDQ alongside the DAWBA, and concluded that there was 'a good fit' (p11) between high SDQ scores and the prevalence of disorders. They suggest that a total difficulties score above 13 and an impact factor score of above 2 for the parent/carer report would indicate the need for follow up with the child or young person. However, they do not recommend the use of the SDQ predictive algorithm for foster children in Norway, as their results showed '*low discriminative ability for the main diagnostic categories, with an exception being the SDQ conduct subscale, which accurately predicted the absence of behavioural disorders*' (p1).

Osborn et al., (2008) studied children in Australia who had a high level of placement instability (n=364) and found that the number of children with 'borderline' and 'abnormal' total difficulties SDQ scores was over 72%. Seventy-eight percent of the children fell into the 'abnormal' category for the conduct problems subscale (83% when adding 'borderline' scores to this percentage) and 61.5% scored in the 'abnormal' category on the peer relationships subscale (rising to 71% when adding 'borderline' scores to this percentage).

Rees (2013) points out the heterogeneity of children in state care in one English local authority. Whilst this study found similar rates of mental health problems as other English studies (using the SDQ), it also (uniquely) emphasised the positive performance of looked after children (n=193). Whilst the proportion of looked after children that met all the 'positive exception criteria' (p188) was low (16%) (this included an SDQ score of 'Normal' or 'Borderline' from all three completed versions), far higher proportions were rated as positive on individual

measures. For example, between 38-45% of children scored within the 'normal' category for both the SDQ and emotional literacy (assessed using the Emotional Literacy: Assessment and Intervention Inventory), 48% performed within the average range for cognitive abilities (assessed using British Ability Scales II), and 42-44% of children were performing at average or above average literacy levels (also assessed using the British Ability Scales II). All of the looked after children who met the 'positive exception criteria' were in foster care. Finally, only about a third of looked after children were performing at the correct level or above in reading and spelling, but there were positive records for school attendance and numbers of school placements for looked after children. Importantly, both parental contact and mainstream schooling showed significant associations with these aspects of positive performance among looked after children.

McCarthy, Janeway and Geddes (2003) in their English study (n=70) showed the high rate of need among looked after children due to mental health difficulties, with 59% having a score on the SDQ impact supplement that the authors argued indicated the presence of a psychiatric disorder. Via the parent/carer SDQ report, foster carers described high levels of difficulties for looked after children in peer relationships, learning, leisure and home life, with 40% of looked after children reported as experiencing difficulties in three out of four of these areas. Where problems were identified by carers, 65% reported that the problems had existed for over a year, with almost half saying that the children's difficulties imposed a significant burden on them. These problems becoming '*firmly established and possibly entrenched*' (p17), raises issues about how to intervene to create change if many problems are chronic and enduring.

McCrystal and McAloney (2010) used the self-report version of the SDQ only in a large longitudinal study in Northern Ireland (N=4000) examining drug use in adolescence. The sample included 42 looked after children in year 1 (aged 11-12) and 49 in year 4 (aged 14-15). At both time points nearly half the looked after sample obtained a 'total difficulties' scores between 'borderline' and 'abnormal' (45%), which is a similar rate observed in other studies using parent/carer and teacher report versions.

3.3.3.2 Epidemiological studies: predictors of SDQ scores in looked after children

A number of studies using different methods (including comparative studies) have used the SDQ to examine the mental health of children in care, or examined looked after children generally to compare those with and without mental health problems to identify characteristics of those with mental health problems, with a view to ascertaining the importance of particular child characteristics for mental health. Across countries there appears to be broad agreement on the child characteristics associated with increased chances of mental ill health, including: older age at entry to care; being male; having a residential placement; having had a number of previous placement disruptions; having a learning disability; experiencing educational difficulties and also having physical health problems.

In examining predictors of mental health problems in looked after children, Meltzer et al., (2003; 2004a; 2004b) found that experiences of poverty, parental criminality and being male predicted mental health difficulties, regardless of whether children were looked after or living in private households. Various experiences of adversity, such as poverty, domestic abuse, parental substance misuse and physical abuse in very troubled youth scoring highly on SDQ total difficulties scores were common in the Australian study examining relationship breakdowns (Osborn et al., 2008). Ford et al., (2007) suggest that by the time children are in care, they have experienced significant psychosocial adversity which might go some way toward explaining the high rates of mental disorders of this population of children. Ford et al., (2007) also noted that child age, gender and learning disability have a stronger association with rates of mental ill-health in looked after children.

Derluyn and Broekaert (2007) examined the emotional and mental health problems of unaccompanied refugee children and young people children in Belgium (n=166). Using the self-report and carer (social worker completed) version of the SDQ they found that between 28.7 and 30.9% and of unaccompanied children and young people have 'borderline' or 'abnormal' scores for Total Difficulties, with 41% of self-reports scoring at 'borderline' or 'abnormal' for emotional problems, and 50.5% of social workers scoring children

and young people at 'borderline' or 'abnormal' for emotional problems, which was the largest sub-category for difficulties for this group of young people. The authors report a gender imbalance to this result, with girls scoring higher for internalising problems and the number of traumatic events children had experienced also affecting the results on the emotional problems subscale, but there were no statistical differences for age across the sample, up to 17 years, regarding the prevalence of emotional or behavioural problems.

A number of relevant studies only used the parent/carer version of the SDQ, completed by the social worker. Taggart et al. (2007) also found that looked after children with learning disabilities in Northern Ireland (n=165 looked after children aged between 10-15 years, of which n=37 had learning disabilities) had higher rates of emotional and behavioural problems than other looked after children, and children with learning disabilities were more likely to score within the 'abnormal' range on the SDQ total difficulties.

Osborne et al., (2008) found that there were no statistically significant gender differences noted on the conduct problems or peer relationships subscales, but there were gender differences on the hyperactivity and emotionality subscales. Girls fared better than boys in the hyperactivity scale but had worse outcomes than boys in the emotionality subscale. This was an Australian study and so tests were done to establish differences between the indigenous and non-indigenous children. Indigenous children scored lower on the peer problems subscales, and overall total difficulties score, however the mean scores for both groups were 'abnormal' (21.7 for non-indigenous children and 19.3 for indigenous children). The authors' analysis highlighted that one of the main differences between these two groups of children was that indigenous children had been in care for much longer than the non-indigenous children.

Osborn et al's results confirmed the connection between disrupted and troubling family histories, placement instability and poor mental health and identified a very high level of need within a population of children who moved placement frequently. However there are problems identifying the direction of causality. Children who scored highest on the SDQ had the highest numbers of placement moves during the previous two years. The authors comment that, *'the most*

striking finding is that very unstable children do not have highly differentiated family histories … the vast majority come from remarkably similar families characterised by a combination of poverty, domestic abuse, parental substance misuse and physical abuse' (p856), and suggest that better understanding about the relationship between children's mental health difficulties and previous family and placement history would help identify effective therapeutic interventions that address trauma, assist children in developing better attachments and social functioning for these children and young people. However, Egelund and Lausten (2009) suggest that exposure to a number of risk factors is so common for children in care that '*these factors to not have the effect of distinguishing between children with a higher or lower probability of showing psychiatric morbidity'*, thus there are not '*'easy' preventative solutions for forestalling the high prevalence of mental health problems in children placed in care'* (p163-4).

3.3.3.3 Epidemiological studies: placements and foster carers

A number of studies have investigated associations between children's mental health (as measured by SDQ) and placements, including the impact of placements on children's mental health and the impact of children's mental health on placements.

3.3.3.3.1   Impacts of placements on mental health

Sinclair and Wilson (2003) found that where foster carers felt committed to the child they are caring for, a high 'total difficulties' score or low pro-social score was not linked to outcome. However when foster carers achieved a high 'rejection' score, defined as '*the degree to which the carer was fond of the child and perceived her or him as impossible'* (p879), which was rare, placement outcome was strongly associated with a child's 'total difficulties' and pro-social behaviour scores, '*so it is likely that difficult children produce rejection as well as suffer from it'* (p880).

Ford et al., (2007) found that placement type, history of placement disruption and educational attainment are all independently associated with all types of mental health difficulties. '*The care related variables and educational disadvantage may be markers of abuse, trauma and attachment difficulties that*

might explain both the increased prevalence of psychiatric disorder and the poor educational attainment and care history in these children' (Ford et al, 2007, p324). They found that looked after children with serious mental health problems are more likely to be placed in residential care and have a larger number of placement changes compared to looked after children without such problems.

Cousins et al., (2010) found that the SDQ mean scores of young people were higher for those in residential care as opposed to foster care in relation to conduct problems, hyperactivity, peer problems and total difficulties score, but the same in both placement areas for emotional problems.

3.3.3.3.2   *Impacts of children's mental health on placements*

Sinclair and Wilson (2003) used data collected by questionnaires, including the SDQ, sent to foster carers, family placement workers, social workers and children and young people in care (n=472), to investigate reasons for placement success and disruption. A follow up occurred after 14 months, making this study one of a very few longitudinal studies in the review. They identified a model comprising of three elements that were key in determining placement success. The first element concerns the behaviours exhibited by a child in placement along with other factors intrinsic to the child, such as motivation of the child to stay in the placement and the child having personal qualities that the foster carer viewed as attractive. The second element concerns a number of features about the carers that are seen as important, including their 'warmth', persistence and ability to 'set limits', with looked after children. Offering children stability, care and love along with liking and respecting them were seen by foster children as important attributes determining the success of the placement. The third element concerns the interaction between the first and second elements (Sinclair and Wilson, 2003). When considering the characteristics of the child and placement success/disruption, Sinclair and Wilson used three measures, including the pro-social score from the SDQ and the total difficulties score. Unsurprisingly, placements were likely to be more successful when children wanted to stay in the placement, had high pro-social scores and low SDQ 'total difficulties' scores.

Beck (2006) found that young people who moved placement frequently were more likely to have mental health difficulties and less likely to access mental health services. Ford et al., (2007) comment that often it is residential social workers who work with children and young people with serious mental health difficulties and they have little training to assist with the identification and management of this task.

3.3.3.3.3   Foster carers identifying children with mental health problems

In terms of whether foster carers are able to identify children with mental health disorders, Meltzer et al., (2003) found that only 12% of children assessed as having a disorder were *not* reported by their carer via the SDQ to have emotional, behavioural or hyperactivity problems. However, 43% of the children who did *not* have a disorder *were* viewed by their carers as having problems. Based on comparison of foster-carer and youth self-completion SDQs, Mount, Lister and Bennun (2004) found that foster carers (n=50) were four times as likely as looked after young people placed with them (n=50) to identify mental health needs in these young people. When comparing foster carer 'intuitive' responses to the SDQ scores (i.e. what the foster carer thought prior to completing the SDQ), two thirds of carers were intuitively accurate in identifying mental health needs of young people in their care, with just under a quarter of foster carers not identifying needs that were then picked up by the SDQ. Less than half of young people assessed as having a need were then seen by specialists (Mount et al., 2004).

Bonfield et al. (2010) investigated factors that influenced when foster carers sought support for their looked after children (n=113 foster carers; n=108 looked after children).They found that foster carers' education, mental health literacy, and their attitude toward help-seeking, in combination with the presence and impact of a mental health problem identified via carer-report SDQ in the looked after children, were significant predictors of foster carers seeking support.

Another study found foster-carer SDQ-reported conduct problems were the main predictor of whether foster carers felt 'burdened', which suggests a need for foster carers to have access to good levels of support in caring for these children because of the link between conduct problems and placement breakdowns

(McCarthy et al., 2003). They found that 59% of the looked after children (n=70) were scored by their foster carer on the SDQ as having an impact factor of 2+, indicating the likelihood of a psychiatric disorder being present. Additionally, because many looked after children experience multiple emotional and behavioural problems, effective care planning is required for the child as well as support for the foster carer as, '*it seems likely that these children will require multiple strategies of treatment targeted at a range of developmental domains*' (McCarthy et al., 2003, p17).

3.3.3.4 Epidemiological studies: synthesis

The majority of the epidemiological studies which have included the SDQ examined levels of mental health problems in looked after young people or identified child characteristics associated with SDQ scores among looked after young people. The quality of the evidence in this area is robust, with a number of the studies based on large samples with comparison groups enabling population based assessments to be made ((Meltzer et al., 2003, Meltzer et al., 2004a, Meltzer et al., 2004b, Goodman et al., 2004b, Ford et al., 2007, Egelund and Lausten, 2009, Lehmann et al., 2013). These are consistent in identifying significantly higher levels of mental health problems among looked after children compared with the general population. In a number of studies discussed above, the SDQ was used as one of a number of tools, usually diagnostic measures such as the DAWBA, CBCL and/or a clinical interview, and authors were then able to comment on how useful the SDQ was at identifying serious mental health problems for children and young people in care. All the studies discussed above demonstrated that the SDQ was '*a genuinely dimensional measure of mental health need in looked after children*' (Goodman and Goodman, 2012, p427) and able to identify children at high risk of mental health difficulties.

There were some similarities noted in the studies comparing the SDQ scores of children in residential placements versus those in foster care, with children and young people in residential placements having higher scores across all SDQ subscales than those in foster care. Some studies used SDQ scores to examine associations between scores and specific child characteristics, such as sex, age and ethnicity. Many of these reported findings concur with what is already

known about risk factors and children's mental health. For example, the SDQ studies consistently showed boys scoring higher on subscales which record 'acting out' behaviour, and girls show higher results for emotionality sub scales, or 'acting in' behaviours. However, where both boys and girls score very highly on SDQ total difficulties scores and experience multiple placement disruptions, the differences in subscale scores between boys and girls lessens.

Additional research is required to investigate the care planning pathways after children are identified as having mental health difficulties that require professional interventions. A number of studies have identified gaps in the availability of appropriate services and a need for further research, including longitudinal research, to examine the reality of looked after children's experiences accessing and receiving mental health services from CAMHS, especially for children and young people who are known to have acute needs, such as those who move placement frequently. Further research is also required to understand the complexity of children's characteristics, including the direction of causality between children's pre care experiences, their mental health, and placement disruption (Ford et al., 2007).

3.3.4 Empirical studies that use the SDQ as a screening tool at point of entry into care or whilst in care

The argument for screening at the point of entry into care is twofold: firstly, it provides an opportunity to assess children in order to refer them on to services geared toward meeting their specific mental health needs. Given this is a group of children who are known to have high rates of mental health problems, early identification is considered by many to offer benefits. But it is not without problems, as the previous section showed that service recommendations made as a result of screening are not always available. The second reason for screening at point of entry into care is that it provides a baseline measure, where a child or young person's needs can be assessed before the processes of care and care planning begin to have an impact, in order to ascertain whether the care provided to the child or young person has a positive or negative effect on their mental health.

Twelve of the 31 studies included in this review used the SDQ as a screening tool: (Goodman et al., 2004b, Mount et al., 2004, Beck, 2006, Whyte and Campbell, 2008, Milburn et al., 2008, Marquis and Flynn, 2009, Egelund and Lausten, 2009, McCrystal and McAloney, 2010, Jee et al., 2011, Goodman and Goodman, 2012b, Newlove-Delgado et al., 2012, Lehmann et al., 2013) . This section divides discussion into studies that used the SDQ at entry into care, those that used the SDQ as a screening tool once children are in care and, finally, studies focusing on social workers' identification of mental health problems in looked after children.

3.3.4.1 Screening studies: entry into care

The literature search identified two studies that used the SDQ at point of entry into care. These studies report favourable results in terms of its validity. Milburn et al., (2008) used the SDQ as a screening tool at point of entry into care (n=171) and found that the parent/carer report version was an accurate assessment of the child's problems. More than 60% of children and young people in this study met the criteria for psychiatric diagnosis (as defined via a multi-disciplinary therapeutic assessment) and the SDQ scored nearly 75% of children in the study within the 'borderline' or 'abnormal' range (Milburn et al., 2008). When comparing the SDQ total difficulties scores from self-report, teacher and parent/carer with the clinical assessments, the best convergence was with the parent/carer version of the SDQ and the least was the self-report version.

Newlove-Delgado, Murphy and Ford (2012) evaluated a pilot project that used the SDQ to screen 4-16 year olds for mental health problems at entry into care (n=23). The mean total difficulties SDQ scores of the parent/carer, teacher and self-report versions were all higher (16.7; 19.3 and 15.4) than a previous population based study that used the SDQ (Goodman et al., 2004b). From the initial SDQ screen data, 15 of 18 children were categorised as a 'probable' or 'possible' 'case' of psychiatric disorder using the SDQ algorithm. Of this number (n=9) children completed a DAWBA assessment and of that number (n=7) or 38% of the original sample received a formal psychiatric diagnosis. Twenty eight percent of this small sample of eligible children were already in touch with CAMHS provision. Despite positively reviewing the SDQ as '*an acceptable brief screening measure*' (p223), the service where this study took place has since

opted to use the DAWBA because the assessment is more comprehensive, and it can be completed remotely online, which is appealing for children and young people placed out of borough.

3.3.4.2 Screening studies: studies that use the SDQ as a screening tool for services when children are already in care

Goodman et al., (2004) used the results of the DAWBA assessments reported in Meltzer et al. (2003), alongside the SDQ predictions in the same study, to show the accuracy and effectiveness of using the SDQ as a screening tool for looked after children. Using the SDQ data, children were given an 'unlikely', 'possible' or 'probable' prediction of having a psychiatric disorder using the SDQ algorithm, with proportions of children in each of those categories being a quarter, a quarter and a half respectively. The study used multi-informant SDQs from carers, teachers and children and young people over 11 and discovered that the SDQ works best as a predictor of psychiatric diagnosis when the two versions completed by both parents/carers and teachers are used. When analysed separately, each of the adult reports had similar predictive value. However, the young person's self-report version did not add to the assessment where an adult report was available.

Goodman et al., (2004) also discussed the rates of false positives and negatives when using the SDQ full data sets (all 3 questionnaires were completed n=539) as 64 children were predicted by the SDQ algorithm to have a 'probable' disorder, but the DAWBA showed that they did not have any disorder. The sensitivity of the SDQ to predicting specific diagnoses was identified as: 80% for anxiety and depressive disorders; 90% for conduct disorders and ADHD, to near 100% for hyperkinesis and other less common disorders. Goodman et al., comment that there would be more false positives in the general population of children seen by CAMHS than there would be with looked after children, and such differences are to be expected when comparing a high risk group with a low risk group, confirming their belief that the SDQ is fit for purpose as a screening tool for looked after children.

A number of other studies with small samples also comment about the suitability of the SDQ as a screening tool. Mount, Lister and Bennun (2004) suggested that

SDQ screening would improve the discovery, management and treatment of mental health problems in looked after children (n=50). They proposed that routine screening could significantly increase the numbers of children with serious problems who would be seen by CAMHS, estimating that at that time only about 25% of children identified with difficulties within their study had access to CAMHS. Richards, Wood and Ruiz-Calzada (2006) recommended the SDQ as a suitable screening tool after investigating its use for a permanent placement social work team in England (n=41) (Richards et al., 2006). McCrystal and McAloney (2010) used the self-report version of the SDQ in their study involving 4000 young people, which included a sample of (n=42) looked after young people. Higher rates of problem behaviours were noted for young people in care. Again the authors were of the view that the SDQ could be used as an effective screening tool for looked after young people (McCrystal and McAloney, 2010).

In a rare US study to use the SDQ with children in foster care (n=212), Jee et al. (2011) found that its use by foster carers and young people (n=212) at routine health checks improved the rate of detection of mental health problems when comparing the baseline (27%) and screened cohort (54%), with more than 25% of children scoring highly on two or more social/emotional problem domains. The authors suggested that the systematic use of the SDQ in a primary care setting was feasible, as it took 5 minutes to complete before the child/young person was seen by the service provider for their annual health check. This also ensured a very high rate of completion (92%), with the combination of the self-report and parent/carer report version producing accurate results.

3.3.4.3 Screening studies: social workers' identification of mental health problems in looked after children:

Since these studies were undertaken, in England most local authorities now have specialist multi-disciplinary mental health services for looked after children that are jointly commissioned and funded with Health services, which has increased the numbers of children, foster carers, residential carers and social workers who have dedicated input from mental health specialists. This has considerably altered the availability, timescales and delivery method of mental health services for looked after children, with many projects and services evaluating the results of their interventions (Minnis and Del Priore, 2001, Newlove-Delgado

et al., 2012, Herrman et al., 2016). The SDQ is routinely used in the delivery of these services and many of these different projects have provided a growing evidence base about the different ways that services can be specifically directed toward the specific needs of looked after children. Routine mental health screening using the SDQ now occurs in England for looked after children who have been in care longer than one year, although problems have been noted regarding whether these needs are then responded to locally in a timely manner by the professional network and whether specialist services exist that can meet identified needs (Goodman et al., 2004a, Mount et al., 2004, Goodman and Goodman, 2012b).

In a study that uses a similar method to my thesis, Whyte and Campbell (2008) conducted a number of focus groups with social workers and managers (n=76) regarding their use of the SDQ. They found that despite initial reluctance because of social workers' lack of knowledge about the SDQ and of mental health issues generally, participants recommended its routine use as a screening tool and that using the SDQ had increased the number of care plans that recommended further referrals for assessment and treatment. However participants raised issues about a number of children identified using the SDQ not being referred on for further services because of waiting lists, fears of swamping service providers and not being able to access appropriate services (Whyte and Campbell, 2008).

Cousins et al., (2010) found in their study of looked after children in Northern Ireland (n=165), that despite high rates of emotional, social and behavioural problems, with 72% of young people scoring 'borderline' or 'abnormal' on the SDQ, social workers rated 92% of the young people's health as being 'as good as' or 'better than' other young people their age, indicating that social workers are missing signs and symptoms that would indicate otherwise. They show how complex this is by highlighting a number of barriers that they think prevent social workers gaining access to this knowledge. Firstly a social worker's understanding of health is generally limited to physical, rather than also including mental and social health. Secondly, children in care often face discrimination because of their care status and the authors suggest that mental health is one such area where social workers make judgements about children in

care, and some of these will be discriminatory because of their own lack of knowledge about mental health. Finally, existing cultural expectations of high risk behaviour from young people within care, coupled with both social workers' and carers' low expectations of young people in care, impact on how children and young people are supported and helped.

Derluyn and Broekaert (2007) report *'relatively good agreement'* (p156) between social workers and children and young people who were unaccompanied refugees about the emotional and behavioural problems they face, but a few adolescents reported 'severe' emotional and peer problems and social workers are not identifying these needs (p149). Social workers identified more conduct problems and hyperactivity issues than children and young people did on the SDQ self-reports.

However, not all such studies have concluded that social workers have poor skills in identifying mental health difficulties in looked after children. Although a small study (n=23), Newlove-Delgado et al.,(2012) comment that *'One of the messages of this study is that the social workers taking part had a justifiable level of concern for the mental health of the young people in their care'*. (p219). It would appear that it is not as straightforward as suggesting that social workers are unable to identify mental health problems, rather there are a number of other issues that impact on a social worker's decision whether or not to refer. The authors raise the problems of offering screening to identify those children with difficulties if this need is not then met with a relevant service (p222). The danger is that it raises expectations of social workers and service users, and the authors suggest that this might negatively affect referrals to CAMHS by social workers if services are not then available. The study showed that over half social workers referrals were accepted with only one child on a waiting list, but numbers were small. The specialist CAMHS service for looked after children was co-located in the local authority which made referrals straightforward, and the service was not overwhelmed with 'novel referrals' (p 221).

3.3.4.4 Screening studies: synthesis

Studies in this section either used the SDQ as a measurement tool to identify mental health problems in looked after children at entry to/whilst in care, or reported social workers' use of the SDQ and/or their ability to identify problems. Most studies used all three report versions, whilst a few used one or two different versions (see Table 3.1). However, Goodman et al., (2004) showed that the parent/carer and teacher report versions are both valid on their own if only one report version is used. As with the other sections, the studies in this third section use a number of different instruments and tools in addition to the SDQ (e.g. DAWBA) to assess the mental health functioning of looked after children.

In terms of the identification of mental health problems in looked after children, the most robust studies methodologically include Goodman et al., (2004), Richards et al., (2006); Milburn et al (2008); Goodman and Goodman (2012) and Newlove-Delgado et al., (2012). These studies consistently advocate the wider adoption and use of the SDQ as a screening tool at point of entry into care as well as on a routine basis, thus adding some weight to the claim that it is a useful activity to undertake. However, further research is necessary to understand which combinations of report versions would be best to use, the effect that screening might have on service demand given the complexity of funding tensions in the public sector at this time, and the level of co-operation required between key organisations to make this referral process work well for looked after children.

All studies which used the SDQ screen to assess which looked after children had high levels of need agreed that screening was useful, but additional longitudinal research which examined the effects of screening over the course of children's and young people's time in care would add further knowledge about what the impact would be for children and young people's mental health. This is a gap in the current literature.

A good screening tool would identify mental health needs quickly at point of entry into care and result in referral and treatment. One of the problems identified in the literature is that this identification of need is not a guarantee

that services will be provided to children. This would appear to be the case regardless of whether a screen occurs at point of entry into care or whether children have been in care for some time. It is also a point raised in other studies discussed earlier in the chapter. For example, with regard to the numbers of looked after children requiring access to CAMHS, Minnis et al., (2006) found that children who had high SDQ (and other) scores indicating mental health problems had a high level of support from a variety of services, but not CAMHS (Minnis et al., 2006). More studies are needed to explore the relationship between need and CAMHS service provision.

The studies that investigated social workers' use of the SDQ and their ability to identify problems, identified a number of factors that affect the role of social workers. These range from social workers' own prejudices about looked after children including lack of knowledge about mental health impacting their decision-making. In addition, social workers' previous experiences of long waiting lists, fears of swamping service providers and not being able to access appropriate services could also affect their decision-making and referral choices. Further research is needed to provide clarification about the factors that drive social work decision-making in this area.

3.4 Discussion

This chapter presented the results of a systematic literature review that addressed the following questions:

> How has the SDQ been used in research with looked after children in screening and assessing mental health problems?

> Is the use of the SDQ as a screen for looked after children an effective way to gather information about their mental health?

In addressing the first question, empirical research (n=31) used the SDQ either as an outcome measure, a screening tool, or a combination of the two. Although the great majority were UK studies, the SDQ was also used in studies of looked after children in Belgium, Australia, Canada and the USA.

The three RCTs using the SDQ showed it had two main benefits. Firstly it enabled the studies to compare their SDQ results with national population based studies that also used the SDQ. Secondly the SDQ provided a simple continuous measure of change in mental health as a result of intervention. Being able to compare the SDQ scores of vulnerable populations with those of the total population mean has the benefit of highlighting the much higher mental health needs of vulnerable children and young people.

The many cross-sectional studies using SDQ as a measure of mental health in looked after children indicate remarkably consistent findings across studies. In all the included studies, the SDQ 'total difficulties' scores showed raised levels of difficulties in looked after children compared with population levels. Again, some of the larger studies used other measures, such as diagnostic tools and views of children and young people themselves, alongside the SDQ to provide triangulation about children's mental health difficulties. This triangulation, and the consistency of SDQ findings across studies suggests that the SDQ is a brief but effective tool in assessing mental health in epidemiological studies of looked after children. Some of these studies have large sample sizes (e.g. Meltzer et al., (2003). A number of the studies are used as prevalence studies (Meltzer et al 2003; 2004a; 2004b), and others (Ford et al., 2007; Goodman and Goodman, 2012) point to the effectiveness of SDQ at a macro or population based level, whilst many of the other studies use the SDQ at a micro or individual level (e.g. Whyte and Campbell, 2008; Newlove – Delgado et al., 2012).

Most, but not all, of the studies investigating the use of the SDQ as a screening tool tended to have smaller size samples, and a variety of qualitative and quantitative methods were used. There was relative agreement between the studies about the SDQ being an appropriate measure to use as a screening tool. The overall quality of the studies is good. The prevalence studies are robust and many of the smaller studies compare their results to these prevalence studies.

Screening is accepted as a useful activity, and the SDQ has been successfully used by a good number of these studies to assess mental health need with looked after children. There are some gaps in knowledge about young people's

views of their mental health. Although two thirds of studies used the 'youth report' version of the SDQ, young people's perspectives are not routinely included in studies.

The issue of sample size is important since population based studies or studies with large sample sizes are more likely to resist bias provided they have a high proportion of the specific population being studied (Gordis, 2014). It is then possible to understand more about how a specific population of children, such as looked after children, differ from the population of children as a whole.   For many other studies with smaller numbers of participants, the poor representativeness of the sample means that the results cannot be generalised to the population of looked after children, which may then affect the interpretation of the results of the studies. However, studies with large numbers can have biases, as some general population studies may contain small numbers, or biased samples, of people in the group that the researchers may want to study, and not all studies necessarily set out to generalise their findings to the entire population of looked after children. The manner of recruitment may affect the type of people from the specific population coming forward to be included in the study (Gordis, 2014). For example, the Meltzer et al., (2003) research on looked after children had lower response-rates to the general population research (this is discussed in an Appendix to the original study report), because of 'gatekeepers' reluctant to refer looked after children with problems to the study. The 'gatekeeper' issue is also reported in Dixon et al. (2014), related to the Biehal et al., (2012) study.

Another important methodological issue in respect of the reviewed studies is that data derived from several informants give a broader range of views about a particular problem or issue. Table 3.1 notes where the different versions of the SDQ have been used (i.e. parent-report, teacher-report or child self-report) in the design of the studies included in the literature review. Half the studies (n=15) used all three versions of the SDQ, which is useful because triangulating information can reduce bias. A third of the studies (n=10) used only one version of the SDQ, with nine out of ten using the parent or carer version. One study used the child version only. The remainder (n=6) used two versions, with the majority of these using the parent/carer and the child versions. One study only used the parent/carer and the teacher versions.

In addressing the second question, most studies that used the SDQ as a screen for looked after children thought that the SDQ was an effective way to gather information about their mental health. Similar issues were identified across the studies about the usefulness or otherwise of screening looked after children for mental health problems, since not all children who had a high SDQ score received the services that they required. This issue of how the use of the SDQ as a screening tool affects access to the support indicated by the needs identified is an area that is less well researched. There are a variety of reasons that might affect access to the care and support that the SDQ screening indicates, however there is limited research evidence around these critical factors. Whilst the use of the SDQ as a screening tool may be an effective means of gathering information regarding the mental health of looked after children and young people, this information is not necessarily utilised to ensure that children's mental health needs are met appropriately.

In addition, there is limited research investigating the role of social workers, foster carers and teachers in completing the SDQ. This is the gap that this thesis will now move on to address, by looking at how social workers in England utilise the information from the annual SDQs to inform the care pathways and services that individual children are then able to access. Social workers are not the only professionals involved in acting upon screening findings regarding looked after children, but they are very significant people for looked after children, and have an important role in decision-making processes for them.

3.5 Summary and links to the research described in this thesis

This chapter presents a systematic review of peer reviewed literature about looked after children, mental health and the SDQ. It is already known that looked after children are vulnerable to mental health difficulties. There are no published systematic reviews that collate information from studies that examine how mental health difficulties are screened and assessed in looked after children using the SDQ. This review has pulled together these data for the first time. Thirty one studies were included in this review, and this comprised a range of studies with different methodologies, including qualitative, quantitative and

mixed methods studies. Study designs included RCTs, cross-sectional studies, and studies which used the SDQ as a screening tool. Studies in this review either used the SDQ as a measurement tool to identify mental health problems in looked after children at entry to/whilst in care, or reported social workers' use of the SDQ and/or their ability to identify problems. Different versions of the SDQ were used in the studies included in this review; fifteen studies used all three versions of the SDQ, whilst ten studies used one version only. The parent/carer version was the most commonly completed version.

Studies consistently raised points about high levels of mental health need being identified via screening. This is not new information. The next question to be explored is what happens once the SDQ screen has documented a mental health need? Are there sufficient services for looked after children, particularly given the high levels of provision required? How is access to support for these children negotiated between social workers and the specialist CAMHS services who work with them?

The research questions that are outlined in chapter one have emerged from these gaps in knowledge about what the literature tells us about the SDQ, looked after children and social workers. In particular, I wanted to further explore the the views and experiences of social workers and CAMHS clinicians about the SDQ and its suitability for use with looked after children. In addition, I was interested in understanding the extent of social workers' knowledge and ability to assess the mental health of looked after children. In this, I wanted to establish whether social workers used the SDQ information in their work with looked after children. Finally, given the criticality of inter professional relationships in this area of work, I further explored the working relationships between looked after children's social workers and CAMHS specialist workers, particularly regarding their use of the SDQ.

The next chapter outlines the methodological design chosen for this study. A qualitative approach to explore social workers' and practitioners' views of the mental health needs of looked after children, including how CAMHS and social workers work together, was thought necessary to answer the research questions posed.

Chapter 4 Methodology

4.1 Introduction

This chapter describes the methods used to conduct my study.   After providing a general overview of methodologies and methods available, the research process is documented and discussed in detail, including an outline of the decisions relating to choice of methods for the study. This thesis uses a qualitative methodology. A number of issues relating to the qualitative data are discussed, including sampling and the recruitment of subjects and the analytic approach, with the use of FRAMEWORK to code and interpret the data in NVIVO. This chapter also discusses the use of Normalisation Process Theory (NPT) as the theory that has informed and guided the analysis of the study. The chapter concludes by addressing issues around reliability, generalisability and validity, whilst commenting on the qualitative elements concerning credibility, transferability, dependability and confirmability (Guba and Lincoln, 1989, Silverman, 2013). These are critical to the analysis and discussion of findings located in subsequent chapters.

4.2 Methodological Considerations

Any research project must consider the method that will be used to undertake the investigation, as research is not an objective enterprise. Decisions about methods involve the researcher making conscious choices about how the research is undertaken. These choices include explicit ideas about how knowledge is created and validated and it is important to acknowledge these factors in order that these judgments can be defended. The description of methods also allows for the presentation of the theoretical lens that underpins the study. Study design also depends on the question being asked, the area of practice being examined and the kind of information sought from the investigation (Bryman, 2008).

4.2.1 Qualitative and quantitative approaches to research: Epistemology and ontology

Epistemology questions what knowledge is and how it is acquired. Ontology is concerned with whether the social world is independent of, or external to, social actors or is changed by them (Bryman, 2008). There are traditionally two types of research methods used in the creation of knowledge: quantitative and qualitative, and both have different epistemological and ontological positions. The first key decision that must be made in relation to a research study concerns the ontological and epistemological location of the chosen method (in this case a qualitative approach), which necessarily aligns it with a particular theoretical position for viewing the world. A research tool or procedure is therefore linked to a way of seeing and understanding the world (Hughes, 1990).

Broadly speaking, quantitative methods are closely associated with collecting and analysing data as numerical values, using deductive[13] and positivist[14] approaches, and are most commonly used in scientific research to produce 'facts' that are less likely to be disputed because of the manner in which this knowledge has been created. Theory is often used to give meaning to the results obtained, through hypotheses being 'proved' or 'disproved' through the empirical research, although some quantitative methodologies do not require hypotheses to be proved/disproved. There are a variety of different quantitative methods and approaches and these include: experiments; cross-sectional surveys; longitudinal studies; and collation/linkage of routine (official) statistics. Some of these methods will use experimental designs where hypotheses are tested – this includes randomised controlled trials and other experimental methods. These methods produce large amounts of numerical data that are then analysed using statistical methods in order to explore and understand the relationships between variables. The concept of generalisability of data being studied is important in quantitative research, as are reliability, validity and objectivity.

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[13] Where theory guides research. Hypotheses are generated which are then tested to explain laws of nature (Bryman 2011).

[14] An approach that applies the methods of natural science investigation to study social reality (Silverman, 2015).

Qualitative methods collect data in the everyday words of the respondents, or through observations of real life situations and have inductive[15], interpretive[16] and constructionist[17] approaches to data analysis. This is because underpinning this approach is the belief that there are many 'realities' from which consensus will emerge in conclusion rather than 'fact'. It is through the analysis of results that theory is generated. There are many different qualitative data collection methods available, including: case study; semi structured, structured and unstructured interviews; observations; vignettes; and focus groups to gather data. These data are not numerical, rather they primarily comprise of words (although they can be visual, such as photographs, film or video) and are then analysed to find themes and patterns across the data, which are then reported and interpreted. There are also a number of approaches to analysis, including: grounded theory; interpretative phenomenological analysis; discourse analysis; textual analysis; framework analysis; and thematic analysis. The choice of method should be appropriate to what the researcher is seeking to discover and should follow from the question being asked (Punch, 2014). A competent research design is essential, regardless of methodology (Bryman 2008); this should encompass critical and rigorous standards, to evidence a robust process (Silverman 2013). Concepts of credibility, transferability, dependability and confirmability are important for confirming rigour and trustworthiness of qualitative approaches (Shenton, 2004).

Historically, there has been considerable debate concerning the validity of knowledge acquired through qualitative methods. Such methods are often viewed as second-rate in the creation of empirical knowledge, because of the interpretive nature of the conclusions drawn (Robson, 2011; Bryman, 2011). Qualitative approaches are often discussed in terms of how they differ from quantitative methods; often as what they are not, rather than what they are, with both methods being seen as the opposite of each other. This dichotomy limits the manner in which social research in particular is understood, as it

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[15] Where theory is an outcome of research (Bryman 2008, p4).

[16] The opposite of positivism – it requires the researcher to understand the meaning of social action (Bryman 2008).

[17] Constructionist researchers have problems with the notion of 'objective reality'. They believe it is socially constructed. Constructivism is also referred to as 'interpretive' or 'naturalistic' (Robson 2002, p27).

presents a limited way of viewing and approaching research, but research does not need to be bound by such dualisms.

4.2.2 Values, Bias and Practical Considerations

From an epistemological position, the philosophical concepts of 'a priori[18]' and 'a posteriori[19]' are important to consider, as a researcher is 'part and parcel of the construction of knowledge' (Bryman, 2011, p682). 'A posteriori' themes should acknowledge that the information I have about these topics from my professional and personal experience may have affected the manner in which I organised the research and formulated the research questions, as well as observed, examined and analysed the data collected. In order to counteract this, good research supervision is essential, as is ensuring that a robust literature review identifies existing knowledge that the research project itself can then build on. Theory is an essential component of proficient research, as is rigorous analysis. The research presented in this thesis is largely exploratory in nature and not hypothesis driven, which it would be if an 'a priori' position had been adopted. However, this is not entirely clear cut. For example, although I did not begin the research by predicting which model or method of CAMHS service/local authority integration social workers might prefer and test this, I did wonder whether social workers would prefer a CAMHS service integrated into their local authority, making it easier to access. By using a qualitative method, I was able to explore some potential relationships between these associations, including social workers' knowledge of CAMHS and the direction and strength of the relationship between CAMHS clinicians and social workers to understand better the relationships and dynamics. This lends itself more to an 'a posteriori' approach, as it seeks to explore and understand the practice context rather than gain knowledge and reach conclusions without using experience, which is an 'a priori' position.

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[18]' Reasoning or knowledge which proceeds from theoretical deduction rather than from observation or experience OXFORD ENGLISH DICTIONARY 2016. Oxford English Dictionary. Oxford: Oxford University Press.

[19] Reasoning or knowledge which proceeds from observations or experiences to the deduction of probable causes. Ibid.

In addition to epistemological and ontological considerations, Bryman (2008) suggests that there are three other influences on social research: values, theory and practical considerations.

In terms of the position that *values* have in research, whether individual or collective, Punch (2014) suggests that there are two positions. Firstly, a conventional positivist view of research believes that value judgements have no place in scientific research as facts and values are fundamentally different. The second perspective believes that this positioning of facts and values as dualistic concepts is misguided. Lincoln and Guba (1985, p186) stress the value-laden nature of all facts:

> *'…at a minimum, we should be prepared to admit that values do play a significant part in inquiry, to do our best in each case to expose and explicate them…and…to take them into account to whatever extent we can. Such a course is infinitely to be preferred to continuing in the self-delusion that methodology can and does protect one from their welcome incursions.'*

Another factor to take into consideration is *bias*. This has different meanings in qualitative and quantitative research. According to the Association of Qualitative Research, 'bias' is technically associated with quantitative research and refers to the errors that might occur which result in findings deviating from what is termed 'true' findings, if such errors did not exist. In qualitative research, this is more challenging, because the researcher is part of the research process and should be acknowledged as such. There are a number of ways that bias can be minimised in qualitative research, including: undertaking fieldwork in a variety of locations; acknowledging the researcher's views; and by team working (www.aqr.org.uk/glossary/bias).

Bryman believes that there are numerous points at which researcher bias, based on an 'intrusion of values' (2008, p25), can occur during the research process. This includes the very choice of topic being researched, the research questions being asked, the choice of method and approach used to analyse data, and conclusions being reached. Techniques, such as reflexivity, assist in ensuring that such an intrusion of values into the research process does not go

unchecked. Reflexivity refers to how the researcher understands the influence that their own personal background and experiences, cultural identity, and their own role in the study have on the way in which the study is conducted, including analyses made and conclusions drawn. Creswell (2014) believes that this is more than just acknowledging these factors, rather it includes understanding how the researcher's own background may shape the direction of the study '…*such as the themes they advance and the meaning they ascribe to the data.*' (Creswell 2014, p186). This is discussed in further detail in section 4.7.8.

Another important consideration, touched on above, is the role of *theory* in underpinning research. Reference has already been made to the inductive/deductive debate within qualitative/quantitative methodologies and the role of theory in creating and determining knowledge. However, knowledge is not static, and the enterprise behind knowledge creation is multifaceted. The way in which people understand the world changes as do social attitudes, customs and expectations. Empirical or scientific research based on positivist approaches has its place, but understanding the role of social actors in creating change in their own lives and in the lives of others may not be best explained by positivist methodologies. Kuhn (1970) believed that knowledge is a construct that is subject to change and introduced the concept of 'paradigm' to refer to the theoretical and methodological ideas underpinning a number of approaches to research.

There is recognition that the environment in which research is taking place may create obstacles that methodological approaches are required to address. These include the methodological problems that exist with much current research about looked after children as well as the complexity of the practice environment in which this research is located. It was therefore essential that the theoretical approach underpinning the method could also provide a sound structure linking the research paradigms, strategies, and the overall direction of the project (Blaikie, 2010). These methodological problems and a potentially useful analytic tool are discussed in turn below.

Finally, *practical considerations* about how to conduct research are also important. Whilst they may seem mundane, matters such as how the research

will be undertaken and what the potential difficulties or barriers to the research process are, may be as important as philosophical issues (Bryman, 2008). This is discussed in considerable detail in section 4.3.

4.2.3 Methodological problems with research with looked after children

There are a number of complications concerning research undertaken with looked after children, including access difficulties, attrition rates, sample dispersion and limited co-operation by care staff (Rees, 2013). These have affected the design of many studies. Research methods in studies of looked after children often include: documentary analysis approaches (case file audits are common); an examination of specific issues for looked after children (e.g. education); or a focus on specific subgroups, such as those with similar placement types or a common transition, such as leaving care, pathways through care (Dickens et al., 2007, Schofield et al., 2007), or entry into care (Sempik et al., 2008). However, in addition to qualitative methods, various studies also use quantitative or mixed methods or undertake secondary analysis of the administrative data sets that are available in different countries. Appendix 2 contains a list of the 40 empirical studies that use the SDQ, and these demonstrate the diversity of methodologies that are used in research about looked after children.

4.3 Methods of data collection used for my thesis

The next section of the chapter will describe the methods chosen for my thesis. The complexity of the social work practice environment with looked after children and the lack of robust research in social work as outlined above led me to use a qualitative approach, as qualitative methods address 'why?/how?' questions. For this research project, addressing a 'why?/how' question enabled further investigation around the topic, which cannot be undertaken by using quantitative methods. In addition, I was interested in ascertaining social workers' views about how they used the SDQ in their practice and in this regard a qualitative method best suited the research question.

I used methods which allowed me to use an inductive approach to better understand the realities of experiences for the social workers and other professionals who were involved in the research. I provide an overview of the qualitative methods that were considered for the project before discussing the approaches I used.

This qualitative study was largely exploratory in nature, and investigated how social workers in a small number of local authorities reported using the data from the SDQ screening tool to inform their decision-making for the looked after children with whom they worked. As a social work practitioner who had previously managed multi-agency CAMHS and local authority services for looked after children, I was interested in social workers' experiences of using the SDQ, as well as exploring the effects of this tool on looked after children. As outlined in the previous chapter, minimal literature has investigated these issues (Whyte and Campbell, 2008, Stanley et al., 2005, Cousins et al., 2010). Even less literature has explored the relationship between CAMHS clinicians and social workers (Phillips, 1997, Woodcock Ross et al., 2009). Since this is an area where clear gaps in knowledge exist, it became the focus for my study.

The criteria used in the study to select social workers and CAMHS clinicians was that they must work with looked after children.   In considering the methods I would use for the qualitative part of the study, I wanted social workers and CAMHS clinicians to be able to give their views on a number of different topics related to the SDQ, looked after children and mental health.   As the study aims were concerned with asking social workers to describe and explain their practice, I needed a method that would capture their descriptions of their understandings of these topics and reasons for the approaches they took in working with young people with emotional and behavioural problems. Potential methods of data collection and analysis which were considered are outlined below; some were adopted, while, for various reasons, others were not. Subsequent sections in this chapter provide a more detailed discussion of the data gathering and analysis methods which were adopted.

4.3.1 Potential data collection method: Use of Vignettes (not adopted)

Using vignettes with looked after children's social workers was considered for this project because they would provide an opportunity to benchmark and examine the skills and knowledge of mental health that social workers have, which was a gap identified in the literature (Woodcock Ross et al., 2009). Vignettes provide consistency, allowing for participant responses to be compared using a hypothetical example (Arthur et al., 2014). Orme et al (2009) discussed the difficulties in developing a methodology that would appropriately discern levels of analysis and application of knowledge at the beginning and end of undertaking a qualifying programme in social work. The researchers found an absence of published studies testing the accuracy of self-assessed versus observed levels of skill in social work. Evidence from other fields suggests that some degree of caution is necessary when using vignettes, as greater congruence with skills is often achieved in academic assessments than when assessing professional practice (Orme et al., 2009). Vignettes can be used alongside other methods such as focus groups and individual interviews – they are not necessarily a separate method. However, when considering the limited time I would have with participants to gather information and the general time constraints of social workers and CAMHS participants to complete non-essential tasks, like completing a vignette exercise outside of the research interview, this method was rejected.

4.3.2 Potential data collection method: Researcher Observational Assessments (not adopted)

Observational assessments usually involve a researcher being immersed within the environment being studied. It is a method most associated with ethnography and provides an opportunity for the researcher to study the '*cultural norms, beliefs and behaviours that are characteristic ... to observe systematically and record actions and interactions, routines and rituals, and dialogue and exchange...*' (Ritchie et al., 2014, p244). It is rarely the central or only qualitative method used in a study and is not used as widely as focus groups and interviews (Spencer et al., 2003). Assessing competence in a mental health assessment requires more than observing an interview between a social worker

and a child completing a SDQ questionnaire. In addition, resources required to undertake observations, including gaining the consent of children, young people and their parents, as well as the multi-layered and complex nature of the assessment process made this an unsuitable choice.

4.3.3 Potential data collection method: Documentary analysis - Coding Social Work Assessments (not adopted)

Another option was to find a way of coding an assessment that had already been undertaken on a child and analyse this. Analysing documentary data is a major method of social research (Mason, 2002). Many text based documents are regularly completed by social workers in their work with looked after children. It might have been possible to examine and analyse routine data collected by social workers about children (e.g. looked after children review documentation; care plans; permanency plans etc.). From an ontological position, text documents should not be viewed as *'straightforward factual records..., 'hard' or especially legitimate evidence'* (Mason 2002, p107-108) or used solely because of their availability. Even though this approach can be used alongside other methods, scrutinising large numbers of documents can be labour intensive and time consuming. In addition, for my thesis, this would have required the agreement of the local authorities and the adult(s) with parental responsibility for the children and young people whose records I was accessing. It would have been much more labour intensive in terms of time spent gathering data within the organisation and this might have affected the numbers of local authorities agreeing to participate in the study. This method was therefore rejected.

4.3.4 Potential data collection method: Focus Groups (adopted)

Focus groups have their origins in the development of survey instruments in the 1920s, and development of training materials and collection of radio audience feedback in the 1940s. They are now frequently used in market and political research (Finch and Lewis, 2003).   Kamberelis and Dimitriadis (2013) see these origins of focus groups as important as they were originally associated with a positivist epistemology:

> *'Truth was assumed to be out there to be collected through rigorous and highly "focused" interviews – where situations of problems were defined,*

hypotheses formulated, interview protocols generated, and individuals questioned. Moreover, because the individual was the basic unit of analysis in this research, the Truth was thought to be located in individual minds' (Kamberelis and Dimitriadis, 2013, p4).

There is a danger in viewing a focus group as an extension of a one to one interview concentrating on the 'self' (Kamberelis and Dimitriadis, 2013) and missing the opportunities that emerge from group discussions and processes. By locating focus group activities beyond the individual or a group of individuals, it is possible to move away from a 'rational/technical' manifestation of knowledge creation to one where individual and group 'self' is understood in relation to historical and social constructs. Scholars involved in developing critical social theory, such as Antonio Bourdieu and Michel Foucault, have redefined 'self' and 'selfhood' and their relationship with society, moving away from dualistic binaries. There are complex discourses at play; the self is constantly changing:

'…constructing, deconstructing and reconstructing itself in and by multiple discourses and social practices, their effects, and the ways they intersect, transverse and challenge one another …conceived in this way, the 'self' is always already the social' (Kamberelis and Dimitriadis, 2013, p5).

4.3.5 Potential data collection method: Individual Semi Structured Interviews (adopted)

Interviews are commonly used for data collection in qualitative studies, with an emphasis on recording the views and experiences of people in their own words. They are often described as a form of conversation, or a conversation with a purpose (Webb and Webb, 1932). However, unlike most ordinary conversations, the objective and purpose of the conversation for interviewer and participant are not the same. Interviews provide flexibility, are interactive in nature, and are potentially generative of new knowledge (Miller and Glassner, 1997, Blaikie, 2010). In addition:

'Interviews provide access to the meanings people attribute to their experiences and social worlds. While the interview is itself a symbolic interaction, this does not discount the possibility that knowledge of the

> *social world beyond the interaction can be obtained'* (Miller and Glassner, 1997, p100).

4.3.6 Qualitative methods chosen for data gathering

Of the range of methods available to gather data, I used **focus groups**, made up of existing known-to-each-other social work and CAMHS team members, and **individual semi-structured interviews.** I was keen to capture the language, meaning and accounts of participants in the context of every day social work and CAMHS clinical activities (Blaikie, 2010). I also wanted to capture discussions between groups of social workers who worked together and CAMHS clinical teams, in order to identify the discourses present in the team environments and understand why social workers and CAMHS clinicians held the views they did.

Within a focus group, participants present their own ideas, but then also hear from others. This enables participants to listen, think, respond and influence their own and others' views by way of participatory processes; this '...*constructing, deconstructing, reconstructing...*' (Finch et al., 2014) method is synergistic. The group's interactions then generate data. For the purposes of my research the specific teams in which the focus groups were organised were natural groupings and provided a 'social' opportunity for discussion and deliberation on the topics I introduced (Finch and Lewis 2003). Given that the members of each separate focus group knew each other already, I was interested in how ideas and concepts were described and validated within the group's discussion and what technical and other language practices were used by group members. According to Finch and Lewis (2003, p172), these reflect the *'social constructions – normative influences, collective as well as individual self-identity, shared meanings – that are an important part of the way in which we perceive, experience and understand the world around us.'* The importance of these groups is not just what is said, but how it is said and how the group collectively constructs meaning within the session (Bryman, 2011).

There are limitations to the use of this approach (e.g. an over-dominance of some members, difficulty to organise, the effect of being in a group as opposed to an individual interview, and difficulties in analysing data collected) (Finch et al., 2014). A decision was made to use natural groupings rather than introduce

sampling criteria for participants, for both pragmatic and theoretical reasons: natural groups were both easier to organise and allowed me to examine the culture and discourses within the team. The results from these focus groups are not representative of, or generalisable to, the wider population of social workers or CAMHS professionals.

Gaining an in-depth understanding of the context in which an assessment and intervention takes place cannot occur without ascertaining the views of other stakeholders (Milner et al., 2015). This is why it was necessary to not just ask social workers about their views and experiences, but also to ask other professionals, in this case CAMHS clinicians, about their view of social workers' knowledge and practice in this area.

It had not been my intention to use semi-structured interviews as the primary data gathering method in this project. However, it became necessary to use interviews with CAMHS clinicians due to the difficulties I experienced in arranging focus groups with enough clinicians attending. From a methodological perspective, this presented some confounding of method and respondent type as focus groups were used with all social work participants except one team manager who I interviewed individually, and a mix of focus groups and individual interviews were used with CAMHS clinicians. Having a flexible design is advantageous in real world research (Robson, 2011), as research rarely works out as planned. It may be possible to change to another design if resources or time availability make this necessary (Hakim, 1987), however it is important that the objectives of the project are not changed in the process (Sim and Wright, 2000). Thus, 'a*ny research project is subject to various constraints and must therefore be a reasoned compromise between the desirable and the feasible'* (Sim and Wright, 2000, p27).

In summary, the data-gathering methods I used were: focus groups with all but one of the social workers who participated in the study and all but four of the CAMHS clinicians who participated in the study; and semi structured interviews with one social worker and four CAMHS clinicians.

4.3.7 Method for obtaining sample and gaining access:

There are 150 local authorities in England. The Association of Directors of Children's Services (ADCS) has ethics guidelines for researchers to complete in order to gain access to practitioners working in local authorities and I approached the ADCS research group to ensure I satisfied their research criteria before approaching local authorities to take part in the study (see Ethics section in this chapter). Recruiting local authorities to take part in research is difficult because of social workers' high workloads, the corresponding time constraints and well documented financial difficulties affecting the public sector. Gatekeeping by local authorities affects researchers' access to staff.

Because it is more difficult accessing local authority agreement at senior levels without personal contacts, I initially approached local authorities where I personally knew senior managers, in order to get permission to involve their social work staff and those from the attached CAMHS looked after children's services. This proved useful as 'cold calling' a local authority was unproductive. I originally thought I would involve three local authorities and interview a number of social work teams working with looked after children in each of these. I had approached three local authorities prior to gaining approval for my study via the University of Glasgow's medical research ethics committee. I had letters from all three local authorities in question indicating their intention to co-operate with the project. However, I 'lost' one local authority at the point I started advertising for focus group participants. This was because the Director of Children's Services had changed jobs during the time I had received agreement to conduct research in the authority and completed the University and local authority ethics processes. The Director's departure created a chain of people 'acting up' into other management positions to fill posts and agency workers were also employed in some key roles at that time, so I lost continuity of a key contact in the local authority to advertise the focus groups and manage local arrangements, such as booking rooms. In the other two local authorities, I ran a focus group for social workers and one for CAMHS clinicians, but then further arrangements to run additional focus groups for social workers were not successful as no other social workers volunteered to be involved in the research. I therefore needed to approach other local authorities. My professional contacts are predominantly in the London area, which explains the over-reliance on

Greater London local authorities included in my research sample. In total, six local authorities from the Greater London area were involved in the research, with social workers from three other local authorities also taking part in focus groups.

Sample sizes of social worker and CAMHS participants were discussed with my supervisors at the beginning of the research project. We had estimated that including 40 to 50 social workers in six to eight focus groups would ensure that we would collect a variety of views and perspectives of social workers before saturation occurred. In terms of the sample size of CAMHS workers, my supervisors and I discussed trying to include around 25 CAMHS clinicians in the sample, recognising that these staff may be more difficult to recruit.

4.3.8 Social Work Focus Groups

Once I had received permission from a senior manager in each local authority approached, I then completed their individual ethics criteria. This usually involved submitting an ethics form to the local authority's Local Research Ethics Committee (LREC). After successfully completing this, I was put in contact with a team manager or service manager in the local authority who was responsible for working with looked after children in some capacity. I sent them information about the research project and a flyer about the proposed focus group to distribute to their team members and to other social workers working with looked after children in some capacity in that local authority. This maximised the likelihood of participants being based in a variety of teams where work was done with looked after children, for example, looked after children's teams, fostering and adoption teams and disabilities teams. This is the process I followed for each of the six local authorities included in the study. Focus group participants self-selected to attend. Before the focus group started, each was given an information sheet about the project and was asked to sign a participant's agreement. There were between three and nine participants in each of the eight social worker focus groups.

Social workers from nine different local authorities, one private 'not for profit' fostering organisation and 10 health trusts were involved in the study. This

included social workers from: looked after children's services, children with disabilities teams, adoption teams and Independent Reviewing Officers.

Two of the social work focus groups comprised social workers from two cohorts attending a Post Qualifying module about looked after children that I taught on at a university where I previously worked. This is a methodological issue, as my knowing these students may have impacted on what they chose to say. However, I asked for volunteers for these sessions, and participants were given information about the project and asked to sign a participant's agreement form. Students were under no obligation to take part. These focus groups differed from the focus groups run in local authorities as they were comprised of social workers from three or four different local authorities or other agencies. The focus groups were arranged at the end of the module's teaching sessions so participants knew each other fairly well by this point as they had spent five days at University learning together.

In addition to the social work focus groups, I completed one semi structured interview with a social work manager. I had interviewed the team of social workers that this manager was responsible for and we had both agreed that they would be more likely to be open and honest about their views if the team manager was not present so I interviewed the manager immediately afterwards.

4.3.9 CAMHS focus groups

In order to recruit CAMHS clinicians to the study I firstly approached the specialist looked after children's therapeutic services attached to each of the local authorities I had permission to work in. Not all these services agreed to take part in the project, and so after conducting four CAMHS focus groups in the London area, I made the decision to advertise again and interview clinicians individually if need be. I advertised on the Clinical Psychologists working with Looked After and Adopted Children (CPLAAC) website and received five responses from clinicians all over England, which I followed up and individually interviewed a further number of staff outside London. The sample of professionals included in the CAMHS focus groups comprised: psychiatrists, clinical psychologists, clinical social workers, family therapists, clinical nurse specialists, psychotherapists and two clinical psychology students. I also

managed to arrange one further focus group with a CAMHS service in the north of England after meeting a Director of Children's Services from the local authority concerned who was instrumental in enabling me to access the service.

The process for arranging the CAMHS focus groups was similar to that for social workers. I liaised with the managers of the CAMHS, sent them information in advance about the project and relied on them to advertise the project locally. The ethics processes I had gone through with the University of Glasgow and the local authority LREC were satisfactory to the CAMHS I interviewed, as I was not interviewing or requesting confidential information about children, including accessing medical records, which would have required further ethics processes via the local NHS Research Ethics Committee (NHS REC) structure[20]. There were five CAMHS focus groups, with between three and six participants in each.

Table 4.1: Number of focus groups and individual interviews

	Social workers		CAMHS participants	
	Focus Groups	Individual Interview	Focus Groups	Individual Interview
Inner London	4 (2 participants in one of the inner London focus groups worked for a private 'not for profit' fostering organisation)	0	2	1
Outer London	4	1	2	0
Rest of England	0	0	1	4
TOTAL	8	1	5	5

[20] See: www.hra.nhs.uk/about-the-hra/our-committees/research-ethics-committees-recs/ (accessed 20/9/15)

In total, 13 focus groups and six interviews took place between January 2011 and March 2013 and 82 people were involved overall. Five students (two social work students and three psychology students) also attended and contributed to five of the focus groups.

In my research ethics application to Glasgow University I had stated that my sample size would be about 48 social workers of around eight in each of six focus groups, and about 24 CAMHS clinicians of around eight in each of three focus groups. My eventual sample size comprised 56 qualified social workers and 2 students, and 26 CAMHS clinicians and 3 clinical psychology students. The point where I stopped organising more focus groups and interviews was where I reached saturation[21] in the material emerging from the focus groups and interviews (Livingstone and Lunt, 1994).

From a methodological perspective, non-probability sampling methods, specifically purposive sampling (including convenience sampling), and theoretical sampling, were used in this project. Coyne (1997) suggests that the sampling terms 'purposeful' and 'theoretical' are substituted for each other in the literature and clarity about the meaning of these terms should be made explicit. Purposive sampling involves selecting groups or categories to study on the basis of their relevance to a research question, theoretical position, analytical practice and the argument or explanation that is being developed (Mason 2002, p124). A convenience sample is one used by the researcher because of its accessibility and availability (Bryman 2011). Theoretical sampling is '*the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his* (sic) *data and decides what data to collect next and where to find them*.' (Glaser and Strauss, 1967, p45). According to Bryman (2011), theoretical sampling is an ongoing process rather than a single decision made about the process of sampling at a fixed point in time. Strauss and Corbin (1998) believe that it enables the researcher to maximise opportunities to gather data from a number of participants in different locations as the data gathering process unfolds and the gaps in data emerge or

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[21] This is where concepts and ideas have been fully explored and no new insights are being generated (Bryman 2011, p700)

variation in concepts and ideas are uncovered that might not have been identified initially. Theoretical sampling is designed to generate theory which is 'grounded' in the data, rather than established prior to undertaking fieldwork (Glaser and Strauss, 1967, Strauss and Corbin, 1998), and so decisions will be made during the fieldwork about the sample. According to Curtis et al. (2000), this is a different approach to purposive sampling used in qualitative research, *'which is informed a priori by an existing body of social theory on which research questions may be based'* (Curtis et al 2000, p.1002).

The purposive sample comprised of n=42 social workers and n=2 social work students based in a variety of local authority teams working with looked after children. The sample of CAMHS clinicians (n=21) and student clinical psychologists (n=3) was also purposeful and comprised of clinicians from specialist services for looked after children across England. The convenience sample (n=14) comprised of social workers who took part in post qualifying studies about working with looked after children. Adopting a theoretical sampling strategy enabled me to think about specific professional groups that were not represented in the interviews I had done and specifically organise focus groups to target these missing professional groups where these professionals were able to attend. An example of this is, on the advice of my supervisors, I organised a final CAMHS focus group that included two child and adolescent psychiatrists. Child psychiatrists are usually the most senior professionals within child and adolescent mental health teams and they have a different role in child mental health to other CAMHS professionals, principally because of their medical training. Ascertaining their particular views in the focus group provided an opportunity to see whether there was any variation in concepts and ideas that hitherto had not been expressed by other CAMHS professionals.

Adopting a broad and varied sampling strategy and flexibility in terms of method (focus groups or interviews) enabled me to include the views of a wider range of professionals. However, this pragmatic approach to methodology affected the generalisability of the results and the implications of this will be discussed later in this chapter.

4.3.10 The Sample

Table 4.2: Professional backgrounds of participants

Social workers		CAMHS participants	
Looked after children's team	31	Clinical psychologist	8
Adoption team	8	Child psychotherapist	5
Fostering	4	Nurse	3
Child protection/children in need team	3	Family therapist	3
Disability team	2	Child psychiatrist	2
Located within CAMHS	4	Clinical psychology student	3
Independent Reviewing Officers	4		
Social work student	2		
TOTAL	**58 (56 qualified, 2 students)**		**24 (21 qualified, 3 students)**

The sample comprised 82 participants in total: 56 qualified social workers and two social work students, 21 qualified CAMHS clinicians and three clinical psychology students (see Table 4.5). The social work sample of 56 included workers from a variety of different child and family social work specialist teams. The vast majority of social workers (n=52) worked in a local authority setting, with another two of the sample employed in a health setting and a further two employed in the private 'not for profit' sector. The final two participants were social work students. All but a handful of social workers also worked in large urban settings, most within the London area. Social work participants were based in nine different local authorities, one private 'not for profit' fostering organisation and seven health trusts.

Of the 24 CAMHS participants, five different professional occupations were represented, the largest group being clinical psychologists (n=8) and an additional three student clinical psychologists. All CAMHS practitioners worked in a Health Trust in a specialist looked after children service.

4.3.10.1 Socio-demographic characteristics of the participants

Of the total sample, 63 were female (77%), and the percentage of females in both groups was similar (79% in the social worker group and 76% in the CAMHS group).

Fifty six of the total sample were white British or white other (68%), with a further 17 black British or black other (20%). Of the remaining participants, eight were British Asian or other Asian, including two Chinese (14%). The groups differed in respect of ethnicity; 84% of the CAMHS professionals were white compared with 62% in the social work group.

The overall age range of participants was from 20 to 69 years. The median age band for both groups was 39-40.

The time participants had been qualified ranged from zero to 39 years. The median was seven years. For the individual groups, the CAMHS group had marginally more years' experience than the social work group: the range for CAMHS was 0-33 (median = 9), compared with 0-26 (median = 6) for social workers.

4.3.11 Developing the research instruments

In preparation for the focus groups I constructed a topic guide (Appendix 4), which is a document that sets out the key areas to be covered with participants in an interview or focus group (Arthur et al., 2014). These were principally developed from the study objectives. In addition, information from the literature review assisted in focussing and refining the broad areas identified in the study objectives. For example, Whyte and Campbell (2008) referred to the initial reluctance of social workers to use the SDQ because of their lack of

knowledge about it and of mental health issues generally. Topic Three for social workers and CAMHS enabled this area to be explored more widely in the focus groups I conducted. Another example of where the literature review was used to develop topics is Topic Four for both social workers and CAMHS. The Newlove-Delgado (2012) study drew positive conclusions about the appropriateness of many of the social workers' referrals to CAMHS, but many other studies did not (Derluyn and Broekaert, 2007; Cousins et al, 2010). This required further investigation. 'Topic Five for social workers (resilience) was included to further address social workers' reluctance to talk about mental health (Whyte and Campbell, 2008). 'Resilience' is a term that is familiar to social workers and is something that social workers would look to identify and encourage in children they were working with (Cocker and Allain, 2013). Schofield (2001, p9) comments that the life of an adopted or fostered child is constantly evolving and changing:

> The developmental consequences of their early life experiences will not always be known or be predictable, which is why it is so important not to see resilience as a fixed trait in a child. Children who appear to be vulnerable can and should be encouraged to gain certain coping strategies.

Resilience is not a static concept – children's attachments to key caregivers, their skills in adapting to new environments, their self-esteem, their understanding about the influence they have in their life, will all change over time. Rutter (1985, p608, cited in Schofield, 2001, p17) states:

> '.. the quality of resilience resides in how people deal with life changes and what they do about their situations. That quality is influenced by early life experiences, by happenings during later childhood and adolescence and by circumstances in later life. None of these is in itself determinative of later outcomes, but in combination they may serve to create a chain of indirect linkages that foster escape from adversity.

The inclusion of this topic enabled social workers to talk about their work supporting looked after children in a broad way, including making links with mental health and emotional distress in children. This topic was not included for CAMHS workers because it was not necessary to provide a conduit in order to focus the discussion on mental health.'

Ritchie et al., (2014) suggest that an emphasis on topics rather than questions enables a more open, consistent and flexible approach toward data gathering.

> *'Consistency does not mean asking the questions in the same way or asking the same questions of each individual or in each focus group. A topic guide steers the general form of data collection but is not an exact prescription of coverage'.* (Arthur et al., 2014, p149)

Whilst compiling the topic guide I was careful to group and order the topics to avoid repetition and concentrate on the key issues that were to be addressed by the research (Ritchie et al., 2014). The five areas covered by the topic guide for social workers were:

1. Social workers and the SDQ.
2. Social work child mental health assessments and interventions.
3. Social workers' knowledge of child mental health.
4. Working with CAMHS.
5. Resilience.

As an example, additional details of the first area in the social worker topic guide to show how it was covered are detailed below:

1. Map the meaning and the significance of the SDQ for social workers.
    a. what do social workers know about the SDQ ?
    b. what role does it have (if any) in assessing mental health?
    c. knowledge about who administers and analyses the SDQ for the annual DfE return and whether the social workers receive the results of individual children's scores.
    d. how has the SDQ changed individual social workers practice?

Further details about areas two to five in the topic guide, are available in Appendix 4.

The five areas covered by the topic guide for CAMHS clinicians were:

1. The models of local mental health services for looked after children
2. CAMHS and the SDQ.
3. What do social workers know about mental health problems in children looked after?
4. Working with social workers.

5. Monitoring mental health of looked after children.

Again, additional details for the second area in the CAMHS topic guide are given below:

2   Map the meaning and the significance of the SDQ for CAMHS workers

   a. what role does it have (if any) in assessing mental health?

   b. knowledge about who administers and analyses the SDQ for the annual DfE return and whether the social workers receive the results of individual children's scores.

   c. how is the SDQ used in practice and is it effective?

   d. what other screening or diagnostic tools are used with looked after children?

   e. what effect has the introduction of the SDQ had on social workers' work with looked after children?

Further details about the other areas in the CAMHS topic guide can be found in Appendix 4.

The interview schedules (Appendix 5) used with social workers and CAMHS clinicians were developed from the topic guides and comprised of a number of questions (12 social work/14 CAMHS) that were open ended and covered areas that had been raised in the literature. These were also closely aligned to the topic guides I had developed. The questions acted as *an 'aide memoir' of what needs to be explored*' (Arthur et al., 2014, p149), but the same questions were not necessarily asked in the same order in each group or individual interview, although some attention was given to the ordering of the questions to enable sessions to flow. Interview questions should be used intuitively, so that the views and ideas expressed by participants individually and collectively are captured, otherwise there is a danger that the '*researcher's own framing of the subject matter might be imposed*', rather than allowing the views and perspectives of the research participants to take centre stage (Arthur et al., 2014, p149). The reflexivity of the researcher is important and this is explored in further detail on page 124.

Ritchie et al., (2014) suggest that topic guides can be used as tools by the research team and steering group members to discuss the direction and

approach of the research. At an early stage of development, my supervisors were asked to comment on the content, in order that changes could be made to the order and subject matter included in the topics, and to ensure that my own framing of the subject was not impacting on what had been included in the topic guides. Their expert subject knowledge helped identify gaps, difficulties and areas to be prioritised in the focus groups. An example of this is that they drew attention to the relationship between professional background influencing responses to questions, particularly focussing on the potential tensions within multi-disciplinary working. This could affect how the questions might be understood by different professional groups, therefore questions needed to be carefully phrased.

4.3.12 Pilot

All advice about conducting qualitative research interviews points to the necessity of piloting interview topic guides to ensure that the data being collected are relevant to the research questions (Blaikie, 2010; Bryman, 2011; Ritchie et al., 2014). I conducted a pilot focus group with social workers to test the topic guide I had devised, to ensure I was getting the information I needed. The topic guide worked well, and the discussion between group members confirmed my rationale for using focus groups as a vehicle to elicit qualitative data. However, what became clear after this first session was that I needed to stick closely to the time agreed for the interview (one hour). Participants expected to end promptly and leave after that time.

The use of a pilot focus group assisted with my decision about whether or not to use vignettes, and I ended up removing this from my method because of timing issues within the focus group. I had an hour for the focus group and used that time for the session. There was no time to then ask participants to write brief answers to questions asked about a case vignette. In the pilot interview, social work participants were given a copy of the vignette and asked to return it to me, and no-one did. I was therefore faced with a decision – to use some of the allotted focus group time to ask participants to complete the vignette or to abandon the vignette and concentrate on the focus group as my main data collection method. I decided that concentrating on the focus group would yield more valuable material.

In addition to the pilot focus group with social workers I conducted a second pilot interview with a group of clinicians and that also went well. At one point they all started commenting on internal politics at their place of work, and whilst this was partially related to the topic, I had to proactively intervene in order to get the discussion back to addressing the questions that I had within the timescales that I had, which is one of the roles of the facilitator (Finch et al., 2014).

It also became clear after conducting the pilot interview with CAMHS clinicians and then arranging another four CAMHS clinicians' focus groups, with between three and six participants in each, that it was difficult to get CAMHS clinicians together for focus groups. I therefore decided to use individual semi-structured interviews with a number of CAMHS clinicians in other parts of England to increase the sample size. I was keen to get the views of a variety of different CAMHS professionals across the country and this strategy seemed to be the best way of achieving this.

I also examined the data I had collected during the pilot to consider whether or not they provided me with the material I needed to address the research questions identified for the project. The data helped produce ideas relevant to my research questions that influenced themes that I went on to introduce into the main data collection. Examples of this were: exploration of tensions between social and medical models; and the development of ideas about integration levels between CAMHS specialist teams and local authorities.

4.3.13   The main study fieldwork

The focus groups and interviews took place in participants' work offices, except for two social work focus groups that were conducted at a University where I previously worked. These arrangements were made to maximise participant attendance and to make them feel as relaxed as possible in surroundings that were familiar to them. I asked my contact at each local authority to book a room for an hour and a half and I was always there early to welcome participants. I brought along additional information sheets and participant agreement forms for

completion before the interview started. I also answered any questions that participants had about the project before the focus group and interviews began.

Interviews lasted 50-60 minutes and focus groups 60-80 minutes (most around 60 minutes). All were recorded on a digital recorder. I took some notes during the session of points raised by participants that I wanted to return to in order that clarifying questions could be asked if required.

I began with the first topic on the list and in the focus groups, participants explored their answer to this question in conversation with each other, which often led the group onto other subjects that were the focus of other questions on the schedule. Individual interviewees were also able to move the conversation in whatever direction their thinking about the topic took them. There were occasions where additional material was covered by the participant or the focus group in response to questions (Bryman, 2011).

My moderation skills will have exerted an influence over the quality of data collected (Robson, 2011). My role during the focus groups/individual interviews was to: ensure the discussion was as relevant and focussed as possible; make decisions about when to let the group have a full discussion about a topic without my interruption; use silence appropriately (i.e. to aid further thinking time or reflection); and decide when to intervene to ask clarifying questions or move the discussion on by asking another question (Finch et al., 2014). Although the interviews and focus groups covered similar topic areas, participants were able to answer questions in as much or as little breadth or depth as they chose. I used prompts to encourage people to give more information, and asked clarifying questions if I thought that an answer was not clear. I also asked if participants wanted to add anything to the interview at the end that we had not already covered.

From a methodological perspective there are differences between the data obtained via the focus groups compared with the individual interviews. Focus groups explore a different kind of social reality than an individual interview (Sim, 1998), as they explore collective, not individual phenomena. In this regard, focus groups can show the range of views and attitudes held by

participants, but that does not mean that these views will be aired in other focus groups (Sim, 1998, Robson, 2011).

To aid with the focus group transcription, each participant was asked to choose a colour and to name this colour each time they spoke. Each participant in individual focus groups had a different colour. This also ensured confidentiality as people's names were not used during the interview – only their colour. I wrote people's colour on their individual consent form, and these were stored in a locked filing cabinet. I also asked people to complete a brief questionnaire asking them for details about their age, ethnicity, professional qualifications and length of time since qualification.

4.3.14 Transcription

All focus group and interview recordings were transcribed. I transcribed the first four focus groups. This enabled me to get a good 'feel' for the data. However these transcriptions took a considerable amount of time to complete. On the advice of my supervisors, the remaining focus groups and interviews were transcribed by a transcription service. They returned the transcription to me promptly and I read through these with the voice recording and corrected any mistakes.

There is some debate about how detailed transcriptions should be regarding whether every word and phrase, including hesitations, pauses and false starts, should be transcribed. A transcription will not be a complete or objective record of an interview (Mason, 2002) because decisions are made by the transcriber about what to include and not include. This is why I listened again to the recordings and read through the transcriptions completed by the transcription service, so I was satisfied that the transcription accurately recoded the conversations held during the focus groups and individual interviews.

4.4 Data Analysis

4.4.1 Potential method of analysis: Interpretative Phenomenological Analysis (IPA) (not adopted)

IPA is a qualitative research approach which analyses how people make sense of particular events or experiences they have had, and how they reflect on the significance of these. Researchers are interested in the meaning-making that participants give to important events in their lives, and the analyses examine these processes in considerable detail in order to interpret what the experiences mean for the participant. Smith et al. (2009) comment that IPA studies are usually conducted on small sample sizes, and suggests that the sample should be *'relatively homogeneous so that ….convergence and divergence can be explored in some detail'* (p3). There are aspects of IPA that resonate with my study. Data collection usually occurs via semi-structured interviews and the participant has a role in determining what is covered during the interview, but other methods, such as focus groups can also be used. This fitted with the data collection methods I used. IPA's focus on understanding and interpreting how the participants understand and respond to the significance of particular events, in this case the use of the SDQ in practice, illustrates similarities with my study, but there are some differences. Firstly, I did not analyse the participants' interpretation of the meaning of their experiences in such a way as an IPA approach suggests should occur. Instead the focus of my analysis was **what** the participants said. My interpretations and theorising began at this point. The IPA analysis is based on **participants' interpretations** of their narrative stories. Secondly, the preferred use of small sample sizes did not fit, as I wanted to capture a view of a good number of social workers who undertook different roles with looked after children and also CAMHS specialists. Many of the individual social work focus groups, except for two, were homogeneous groups in specialism and role, but collectively there were many differences between groups and there were differences in specialism and role in all the CAMHS focus groups. This method was therefore rejected.

4.4.2 Potential method of analysis: Framework (Ritchie et al., 2014) (adopted)

Thematic analysis is one of the most common approaches used to analyse qualitative data. It is a flexible and useful approach to analysis which identifies, analyses and reports patterns or themes present in data (Braun and Clarke, 2006). It is a process employed within many qualitative methods, such as grounded theory and IPA because of its '*theoretical freedom… which can potentially provide a rich and detailed, yet complex account of data*' (Braun and Clarke, 2006, p5). This versatility was something that I required in the analytical tool I chose, because of the diversity of participants experiences that I then had to analyse.

One of the limitations of thematic analysis is a lack of agreement about how it is done, with insufficient detail given about the process undertaken to draw out themes, including the analysis used.

> '*If we do not know how people went about analysing their data, or what assumptions informed their analysis, it is difficult to evaluate their research…* [thus] *clarity around process and practice of method is vital. (Braun and Clarke, 2006, p7)*

In order to address this concern, I used Framework (Ritchie et al., 2014). This is an approach to thematic analysis developed by the National Centre for Social Research (NatCen) in the UK, and is widely used in health and social science research in the UK now (Jeffery et al., 2013). It uses a robust process to structure and synthesise data (Bryman 2008). Framework is also embedded in NVIVO, so it can be used alongside other qualitative data analysis packages. This analytic method provided me with a clear structure and strong support for organising and undertaking analysis.

Framework requires researchers to develop a matrix '*to order and synthesise data*' (Ritchie and Lewis 2003, p219). Bryman likens this matrix to '*an SPSS spreadsheet with its display of cases and variables*' (2011, p554). Instead these are labelled as rows (cases), columns (codes) and 'cells' of summarised data (Gale et al., 2013, p2). In my research, a 'case' was a focus group or the person who I completed an individual interview with. The strength of this method is

that it produces highly structured outputs of summarised data that can be easily compared across 'cases' as well as within cases (Gale et al., 2013).

There are five different interlinked stages that a researcher works through in order to build a framework (Furber, 2010). These are: familiarisation (getting an overview of the data and identifying topics and areas of interest); constructing an initial thematic framework (the researcher sets out themes and sub themes that include the original theoretical framework, topic guide and emergent themes); indexing and sorting (annotating and labelling the data within the framework for further analysis); reviewing data extracts (the researcher sorts through the data amending and relabelling the data); and data summary and display (this is the extra stage of the Framework approach, which involves the researcher summarising the data and/or writing a precis, which is then entered and displayed in a set of matrices) (Spencer et al., 2014b).

I attended a three day course in Framework run by NatCen to assist me in utilising this method to organise and analyse my data. Helpfully Framework has now been integrated into NVIVO software packages. I used the topic guides and some of the original themes as the basis for development of a framework to structure the data. Separate Frameworks were developed for the CAMHS focus groups and interviews, and for the social work focus groups and interview.

4.4.3 Potential method of analysis: Normalisation Process Theory (adopted)

NPT offers a framework that applies to all stages or various stages throughout a research project: from the very beginning of a project, where it can focus on the areas requiring research; to the design of the research, including sampling and data collection; the coding and analysis of the data; and through to guiding the interpretation, conclusions and recommendations of the project (May et al 2010). For this project NPT was used as a lens through which to analyse parts of the data. The theory enabled examination of the intricacies of organisational change, including the relationship between people, systems and structures, and so was suitable because I was looking at the impact of a process change on individual and organisational practice. NPT enabled a depth of analysis that the other two theories mentioned above could not provide. The use of NPT is

discussed in terms of methodology later in this chapter, with results described in chapters six and eight.

4.4.4 Potential method of analysis: Case Study (adopted)

Case studies are used in both qualitative and quantitative research. A case study is an in-depth exploration and analysis of a specific case, organisation, team or event (Creswell, 1998). This research design enables a detailed and intense analysis of complex phenomena in one case (Baxter and Jack, 2008). Yin (2003) believes a case study approach should be used when 'why' or 'how' questions have been asked and he distinguishes between five different types of case studies: the critical case (the researcher uses a case to show the circumstances in which a hypothesis will and will not hold); the extreme or unique case (often used in clinical studies); the representative or typical case (to capture the everyday or commonplace situation); the revelatory case (where the researcher observes and analyses a previously unobserved situation); and the longitudinal case (where investigations occur at two or more points over time). Bryman suggests that case studies can involve any combination of these types and the significance of a case might not become apparent until a very late stage: '*We may not always appreciate the nature and significance of a 'case' until we have subjected it to detailed scrutiny*' (Bryman, 2008, p57).

The use of a case study in my research was a decision made at a late stage after it became apparent that one particular local authority (a mix of a 'critical' and 'revelatory' case) was successfully using the SDQ in practice to monitor the mental health of looked after children. It was felt that an examination of the particular circumstances of this one local authority could offer some ideas to other local authorities in how to achieve high level functioning in this capacity. One of the big questions and limitations of the case study approach is the generalisability of the results of one case to wider environments or circumstances. However, researchers who use this method say that this is not its purpose (Bryman 2008); Lincoln and Guba (1985) discuss 'lessons learned' from case studies rather than solely focusing on generalisability. This has been considered in the case study that I developed and I triangulated data where this was possible to ensure the robustness of the results. 'Lessons learned' from the case study are also detailed in chapter eight.

4.4.5 Framework: Constructing an initial thematic framework

Following this exercise I continued to summarise the material gathered. I made notes of the main ideas that were emerging from the transcripts (Ritchie et al., 2014). These were collated on a number of large sheets of flipchart paper. I used these recurring themes, along with other documents such as the topic guide and the themes identified with my supervisors, to develop a draft theoretical framework. This framework transformed the data from the participant account in the transcript to a thematic structure to which I could then add summarised data (Gale et al., 2013). Themes and sub themes in the framework were named, numbered and entered into NVIVO as nodes. Each theme contained an 'other' category to place material that did not fit into any of the subthemes identified. One of the themes I identified related to the focus group processes, and this covered data about the focus group itself, such as areas of agreement and disagreement between members of the group.

4.4.6 Framework: Indexing and sorting

I then began indexing or coding the data into the framework. This also included entering in non-identifying characteristics and codes for individual interviewees and focus group participants. This enabled me to link data to people throughout the process. The non-identifying data were also entered into SPSS and some basic descriptive statistical analyses were undertaken (reported in sample description section of this chapter).

This process of indexing aims to classify all of the data to enable comparison of themes across the dataset (Gale, 2013). This involved me reading through each transcript and coding it against the themes and sub themes in the Framework. This involved firstly ensuring that the data in the focus groups was coded to the correct focus group. Each focus group was set out as a case in 'nodes', and the entire transcript was copied to the node. Each individual's contribution in the focus group was copied to their 'case'. Under each case node was a list of participants in that focus group and each participant was cross-referenced to the participants' classification material. Following that I read through the transcript again and then began coding the interview to the analytical framework. At the

end of the coding, the transcript was read through again to check that the coding was thorough and accurate. The final theme node was concerned with focus group processes and this section was completed at the end of the coding process. Spencer et al., (2014b) refers to this coding process as *'applying labels to 'chunks' of data judged by the researcher to be 'about the same thing' so that similarly labelled data extracts can be further analysed'* (p282). The same piece of transcript can fit into more than one thematic area (Spencer et al., 2014a).

After indexing all the transcripts, it was then possible to sort the data so that all the material with similar thematic properties or codes could be viewed at once (Spencer et al., 2014a). Some of the material was categorised under a number of themes. The benefit of using a programme like NVIVO is that reordering the data was a straightforward process. The data were coded so that it was always possible for all data to be seen within its original transcript.

4.4.7 Framework: Reviewing data extracts

After the initial indexing exercise was completed, I reviewed the data that had been added to the themes and subthemes to ensure that they were adequate and that additional changes were not necessary. I also reviewed the material that had not been categorised to check that I had not missed anything.

4.4.8 Framework: Data summary and display

This is the part of the Framework method that makes it distinctive from other thematic analysis processes (Spencer et al., 2014b). This involved rereading the coded material and paraphrasing it so there is a summary for every 'case' in the study.

> *The summaries are then entered and displayed by 'case' and theme in a set of matrices …it is worth spending time at this stage. Well labelled and sorted data provide a firm foundation on which researchers can then build their more interpretive analysis.* (Spencer et al 2014a, p284).

In terms of my own re-reading and summary process, where verbatim text was used in the summary material, this was italicised and highlighted in order to

stand out from the condensed text.   All the text, whether summarised or verbatim, was linked back to the original transcript to enable me to find where it was from very easily (Spencer et al., 2014a, Gale et al., 2013, Bryman, 2008). Framework matrices were then 'charted' (Ritchie and Lewis, 2003). This produces a matrix of manageable text data that can be read easily (Furber, 2010), as it can be visualised as a whole. One matrix was produced for every thematic area that I had created. There were six thematic areas for the social work section of the study and six for the CAMHS clinicians (see Appendix 4 for further information, including sub topic areas). The social worker thematic areas were:

1. The meaning and the significance of the SDQ for social workers.
2. The range of factors that social workers take into account when assessing the mental health of looked after children.
3. The understanding social workers have of mental health issues.
4. The factors that influence referral to specialist CAMHS.
5. The understanding social workers have about resilience.
6. Focus group processes.

The thematic areas for CAMHS clinicians were:

1. The models of local mental health services for looked after children.
2. The meaning and the significance of the SDQ for CAMHS workers.
3. The range of opinions about how well social workers identify mental health problems in children looked after.
4. The relationship between social workers and CAMHS.
5. The way in which the mental health of looked after children is monitored.
6. Focus group processes.

4.4.9 Framework: Abstraction and interpretation

The final stage of the analytical process involved developing categories where themes are mapped across the various matrices to enable the researcher to move from a surface understanding of the themes and associations, to a more in-depth analysis (Spencer et al., 2014b). This may also include the development of

typologies[22], or the mapping of connections between categories to explore relationships (Gale et al., 2013).

Researcher investigations which show the ways in which data are connected across the entire sample are part of this process. For my study, this was a benefit of the Framework method, as my sample included a number of different teams of social workers who had different roles with looked after children and this stage enabled me to '*map the range and diversity of views and experiences, identify constituent elements and underlying dimensions and propose key themes or concepts that underpin them*' (Spencer et al 2014, p285) to see the links between the themes raised in each of the focus groups.

4.5 Normalisation Process Theory

Using the SDQ as a mental health screening tool with all looked after children is tantamount to introducing an intervention into a complex system. A theoretical framework is therefore needed to help understand how/to what degree the SDQ has become embedded in systems. This is where Normalisation Process Theory (NPT), which is the theory I use in this thesis to offer a framework to analyse and explain how the SDQ is used in practice, is valuable. NPT is a sociological theory developed by May et al., (2009) that provides a framework for understanding the processes by which new practices in health care and other complex interventions become routinely operationalised, or 'normalised' in everyday work, and sustained in practice (May and Finch, 2009b). NPT acknowledges the complexities of practice within multifaceted and multiagency work environments, such as local authorities and CAMHS, so is appropriate to this thesis. NPT is not solely focussed on outcomes; processes are also viewed as important and it is this focus on processes around implementation and integration that leads to an understanding of how any new innovation or practice becomes embedded in everyday work (May, 2010).

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[22] Typologies are classifications in which categories are discrete and independent of each other and this can be helpful in understanding divisions or sectors in the social world (Spencer et al 2014b, p285)

In NPT, the concepts of 'implementation', 'embedding' and 'integration' are key and critical to understanding how any new intervention is introduced and consolidated in a practice context. Implementation is concerned with how an intervention is actioned into practice; embedding means ensuring that practices become routine elements of everyday life; and integration refers to sustaining these practices within this work/organisation/social context (May et al., 2009a).

NPT suggests that for a complex intervention to become part of everyday practice, four components need to be considered: '*coherence ('what is the work'); cognitive participation ('who does the work'); collective action ('how does the work get done'); and reflexive monitoring ('how is the work understood')'* (Hooker et al., 2015)(p2). Therefore to understand how an intervention is embedded into practice, it is important to not just look at what the work is, but what people actually do and how they understand the work. This includes managers, professionals, patients/service users and their families. The theory is organized around understanding social phenomena defined by these four mechanisms (Murray et al., 2010). I have used NPT as a framework because it acknowledges the complexities of organisational changes and recognises the investment required by the organisation to ensure change is embedded within it, as well as continued monitoring for compliance and integration. One of the benefits of this theory is:

> '*Within the frame of the theory, human action is not assumed to be reducible to individual factors or to the emergent patterns of corporate direction, and it is further assumed that the contribution of both individuals and groups to the processes that lead to implementation, embedding, and High Integration are interdependent.*' (May and Finch 2009, p540)

Additionally, there is a challenge in researching something like the SDQ within social work as it is already embedded within a complex practice environment, therefore a theory is required to specifically make sense of this environment and other processes.

One of NPT's strengths is that it acknowledges that routine operationalisation is not a 'one off' event:

'It is not enough to adopt and diffuse a complex intervention, people need to keep investing in it or it will atrophy. Continually investing in sense-making, commitment, effort, and appraisal is part of the routinization of a complex intervention. A complex intervention that is routinely embedded in practices ceases to be a 'complex intervention' at all, and instead disappears into the everyday world of normal activities, the things that people just get on and do.' (May et al., 2010)

The development of this theory has taken place predominantly within the health clinical practice arena, over the past ten to fifteen years. Interest was initially concerned with how to develop a model that would successfully 'normalise' an intervention within clinical practice, as linear models were unsuccessful at integrating and sustaining changes in practice (May et al., 2003). Early research recognised a number of necessary elements, including: the need for positive links with and between agencies to *implement* change; successful structural integrations to incorporate the *adoption* of practice; cohesive and co-operative groups being involved to change or *translate* practice within organisations; and *stabilisation* depending on new procedures and protocols integrated into practice by clinicians (May et al., 2003). According to May et al., (2010), this early work was the first of three stages of the theory's development which defined the term 'normalisation' but did little else. The second stage focussed on understanding more about the way in which complex interventions become embedded in practice, and several theoretical papers were published outlining early versions of the model (May, 2006, May et al., 2007a), before a number of other researchers worked together to apply the model to a series of different health based research projects (Gask et al., 2008, May et al., 2007b). The third phase saw the development of NPT as a mid-range theory (May et al., 2009b, May and Finch, 2009b), with growing use in health professions (Ong et al., 2014, Murray et al., 2010, Willis et al., 2012) and more recent publications using NPT coming from outside health disciplines and topic areas, such as telecommunications and Big Data (Shin, 2015), and social workers and family violence (Hooker et al., 2015).

4.6 **Case study**

For this project, I did not initially set out to use a case study approach. However as my analysis progressed, it became clear that a case study would be a useful lens through which I could further analyse my data. It enabled me to focus in detail on a location in which the SDQ appeared to be most 'normalised'. To this end the case study I have used is a mix of a 'critical' and 'revelatory case'. According to Baxter and Jack (2008), there are a number of key elements involved in designing and implementing a case study, including: determining the case study (or deciding on a 'unit of analysis); 'binding' the case; exploring propositions/issues; outlining conceptual frameworks; agreeing data sources; and triangulation. Once I had determined that one of my analytical approaches would be a case study, I had to think about the type of case study I wished to undertake. Baxter and Jack suggest there are seven different types: explanatory; exploratory; descriptive; multiple; (Yin 2003); intrinsic; instrumental and collective, (Stake, 1995). The case study in this thesis uses a descriptive approach, as it describes an intervention and the real life context in which it occurs (Yin 2003).

Following this I had to think about the 'unit of analysis', which assisted with focussing the analysis undertaken with the case study in question. I was interested in analysing the reasons why the use of the SDQ as a screening tool was effective in one particular local authority, where social workers and CAMHS worked well together.

Table 4.5: Research aims identified that applied to the Case Study

Research aims related to the case study	Case study 'unit of analysis'
1. To describe the real life context in which this local authority and CAMHS specialist team is located; 2. To examine the way in which the SDQ data collection process is used by a social work team for looked	The experiences of specialist CAMHS workers and social workers in using the SDQ to make decisions together about the mental health needs of looked after children.

after children and CAMHS specialist team in this local authority; 3. To comment on whether the particular experiences of this local authority could offer ideas to other local authorities about how to achieve improvements on data collection and better use of the SDQ information by social workers.	

As with many elements of research, it is as important to say what is not covered in a case study, as it is to say what is covered. This avoids the case study becoming too broad (Yin 2003; Stake 1995). Baxter and Jack (2008) refer to this as 'binding' a case study, and suggest that this can be done through focussing on time and place (Creswell, 1998), time and activity (Stake 1995) or definition and context (Miles and Huberman, 1994). I was interested in 'binding' the case study by time and activity, (using the SDQ annual screen as the activity, and exploring the timescales that were used in the local authority in question around this process, and using the NPT framework to analyse the processes and relationships) and also by definition and context, (being aware of the context in which the specialist service operated the SDQ screen and its defining criteria and thresholds for service involvement with looked after children and with social workers, and again, using NPT as a lens to further understand the process).

4.7 Ethical issues

In any research project there are a number of ethical issues which must be considered in the study design, approaches to participants, data gathering, and the writing up of the material. There are four major ethical issues for social researchers: whether there is harm to participants; whether there is a lack of informed consent; whether there is an invasion of privacy; and whether deception is involved (Diener and Crandall, 1978). I will consider each of these four areas in turn.

4.7.1 Harm

In considering harm to participants, I provided prospective social worker and CAMHS participants with information about the study in advance of any interview and focus group (see Appendix 6) and I obtained written consent from all participants before involving them in the study (see Appendix 7). The information that I gave participants directly addressed the issue of potential disadvantages and risks from participating in the study. I stated that there were no disadvantages. I also addressed issues of confidentiality in this information sheet, by informing participants that neither their name nor their local authority would be referred to in any publications produced. Participants were also assured that the study had been through the relevant ethics processes.

4.7.2 Informed Consent

The consent form that social worker and CAMHS participants signed gave permission for their involvement in the focus group or interview and this included their agreement that the session could be taped using a digital recorder. Participants were aware that they could withdraw their consent at any time.

I did not directly interview children at any stage during the course of the study. I did, however, collect sensitive non-identifying information about children via the focus groups and interviews for which I received appropriate permission via the ethics processes.

4.7.3 Invasion of Privacy

Issues relevant here, together with issues of consent, anonymity and confidentiality which also apply here have already been addressed in the paragraphs above and below.

4.7.4 Deception

In considering issues of deception, it was important that I did not represent my work as anything other than what it was. However, as Bryman (2008, p125)

points out, *'it is rarely feasible or desirable to provide participants with a totally complete account of what your research is about.'* This is because it may affect the way in which participants respond to and engage with the material and method used by the researcher. However for the purposes of this research, participants were given an accurate account of the aims and objectives of the research via the participant information sheet, and were informed about my own professional background and qualifications prior to beginning the focus group or interview.

4.7.5 Confidentiality

The names and personal details of individual participants contained in the completed participant agreement are stored in a locked cabinet. All other information produced (e.g. transcriptions) do not contain identifiable information.

4.7.6 Security of Data

The data from the individual interviews and focus groups has been stored in accordance with the Middlesex University and University of East Anglia researcher requirements in a separate and secure network drive which is password protected. No-one but the data holder can gain access to them. The laptop is stored in an office which is only available to the data holder. When it is unoccupied, the office is locked. The office is located in a building which has open access. There is CCTV on the outside of the building, but not within the building or in the office where the laptop is located.

4.7.7 Ethics committees

Prior to conducting my research, I obtained ethics approval from the Medical Faculty Ethics Committee at Glasgow University (see Appendix 8). I also made inquiries concerning the appropriate course of action regarding obtaining additional ethics approval for my study. Currently social care research (arguably my research is located here) may be reviewed for ethical issues by NHS committees convened by the National Research Ethics Committees, by committees convened by universities, funding councils, or local authorities.

There is no proportionate and transparent single system for the review of ethics in social care research proposals. This is problematic, as it leads to multiple applications being made to different bodies, depending on the nature of the research being undertaken.

On 17/9/09 I had a telephone conversation with the Social Care Research Ethics Committee (SCREC) Co-ordinator based at the Social Care Institute for Excellence. I was advised that my study did not need to seek ethics approval through the SCREC, as the SCREC only deals with research studies involving adult social care service users.   Her view was that the University of Glasgow's ethical approval would be enough. The Association of Directors of Children's Services (ADCS) research committee only reviews research projects with children where four or more different local authorities are used. The ADCS expects researchers to approach local authorities directly with their requests when the numbers are less than four, which my project originally was (see: http://www.adcs.org.uk/Downloads/Research/ADCS_Guidelines_for_Research_Approvals.pdf). However, due to one local authority not sustaining its interest in my project and difficulties with focus group recruitment in the local authorities I originally identified, I did approach additional local authorities to take part in the study. The number of authorities I ended up working with was more than four, so I retrospectively applied to the ADCS research committee and gained approval for the study (see Appendix 9).

At the time of my application to Glasgow University, I submitted a letter to the University of Glasgow ethics committee from each of the local authorities I originally proposed using, giving their permission and consent to be involved with my research. During the course of my fieldwork, local authorities began adopting the Research Governance Framework (Department of Health, 2005) for research relating to children and/or young people. Two of the local authorities I approached asked me to complete Research Governance Framework ethics forms for their individual councils, which I did. Councils ask for identical information in these forms. As a result of this, any council or CAMHS service that I subsequently approached to take part in the study was provided with evidence of my application to the two Councils concerned.

4.7.8 Reflexivity – Researcher Influence

Reflexivity is the term used in social research to encapsulate the awareness that researchers should have about their own influence on the research that they are involved in and how their knowledge of the social world in which they are researching will also affect their research. This includes acknowledging the impact of their own biases and values on their research as well as understanding how their presence in an interview or a focus group will influence the way in which participants engage with the investigative process. Decisions about methods used in the research, including how literature reviews are undertaken, the data analysis strategies adopted and the way in which research is written up, will also affect the way in which new knowledge is created and how it will ultimately affect the social world being studied (Bryman, 2011). These issues are present in all research involving people (Robson, 2002, p172).

I am a social worker with over 25 years' experience working with looked after children in local authorities and in managing specialist joint CAMHS. I have also adopted a child from care and our family has used CAMHS so I have considerable professional and personal experience of the subject area being researched. Being from the same profession as the social work participants and having had the experience of managing CAMHS specialist services for looked after children meant that I shared a common professional identity, language and experience as the participants I was interviewing. This is a motivating factor for completing this research, but it has been important to ensure that my own views do not affect the way I have approached this project. For example, reflecting on my own role within the focus groups and interviews, particularly decisions in respect of clarifying questions to participants within the focus groups who expressed particular viewpoints, has been important. It has been important to check that my perceptions have not been clouded by my personal experiences, but are based on the experiences of the participants. I have kept a note of when issues like this have arisen and have discussed them with my supervisors.

There are a number of other areas where reflexivity can also identify potential researcher bias. These include: clarifying personal value systems; being aware of personal issues that might affect the research, including potential role conflicts; being aware of gatekeepers' interests; being aware of feelings that indicate a

lack of neutrality at every stage of the research process, including when conducting fieldwork and writing up; and exploring reasons for blocks occurring in the research process (Ahern, 1999). Although it is more likely that issues will be highlighted during the fieldwork rather than the analysis stage (Bryman, 2011), they are also found during analysis. For example, I have been aware of potential biases through my choice of quotes from particular participants. I have been careful to reflect the full range of views expressed by participants, and not just concentrate on those that resonate with my own experience. There are a number of ways to address these issues in research projects (Padgett, 1998), including triangulation, which uses a variety of sources to support the thoroughness of the research. Recognising and addressing these biases has required me to reflect on decisions I have made at every stage of the research process and clarify meaning and interpretation with my supervisors to avoid issues such as confirmation bias (use respondents views to confirm my own beliefs about an issue).

4.8 Generalisability, Reliability and Validity of the Study

These are important issues to consider and address within qualitative research. Being able to illustrate that a systematic approach was used in data collection and analysis at every stage of the project is critical in ensuring reliability, transparency and replicability. Could another researcher follow the same method I have used and draw the same conclusions from the data gathered? How generalizable are the findings from this study to the wider population of social workers working with looked after children?

There has been debate in the social science literature about whether 'reliability' and 'validity' apply to qualitative research, with alternative concepts such as 'dependability', 'credibility', 'plausibility' and 'transferability' suggested as better suited to address the epistemological differences between quantitative and qualitative research (Lincoln and Guba, 1985, Guba and Lincoln, 1994). Robson argues that, '*this attempt to rename and disclaim the traditional terms continues to provide support for the view that qualitative studies are unreliable and invalid*' (Robson 2011, p155). He thinks the terms 'reliability' and 'validity'

have a role in qualitative research, but it is the narrow definition and application to qualitative research that Robson sees as problematic.

Ritchie et al., (2014) discuss the link between these concepts and 'generalisation' and 'replicability', again relating these concepts to qualitative research. The researcher should have confidence in the methods and findings presented within a study and use concepts such as 'validity' and 'reliability' to establish this. My supervisors read and coded nearly half of the transcripts between them and this helped demonstrate the credibility of my approach by triangulating findings. This exercise with my supervisors gave me confidence in the approach I was using to analyse my data. Key areas had been identified by my supervisors and me independently of each other. We also discussed the different themes raised and questioned whether our professional roles might account for any of these differences. Lincoln and Guba (1985) identify researcher bias as one of a number of threats to the validity of qualitative research and one of the strategies suggested by Robson (2011) to counter this is using colleagues/supervisors to independently check and verify analysis methods.

Validity is concerned with the integrity of the findings generated from the research (Bryman 2011). In other words, are the results trustworthy? It is important to show that the analysis of the qualitative material was not based on a few cases, but rather reflected the views of the entire sample of people interviewed. My choice of Framework as my analytical tool with the corresponding use of matrices produced from the interview and focus group data enabled a systematic approach to be used when categorising and reporting data. This process ensures the validity of the findings.

4.9 Critiques and limitations of the research

It is not possible to make any firm generalisations from the data gathered because of the small numbers of social workers and CAMHS practitioners included in the study (n=82), but this was not ever intended. This study is exploratory and the emerging themes provide a necessary first step in developing further projects with different research designs.

My sampling strategy also had limitations. Miles and Huberman (1994) have developed a six point checklist to evaluate qualitative sampling strategies:

1. The sampling strategy should be relevant to the conceptual framework and the research questions addressed by the research.

2. The sample should be likely to generate rich information on the type of phenomena being studied.

3. The sample should enhance the generalisability of the findings.

4. It should produce believable descriptions or explanations that are true to life.

5. Is the sampling strategy ethical?

6. Is the sampling plan feasible?

These six criteria provide a useful frame to reflect on the choices and decisions I have made about sampling in this research study and are reflected in earlier discussions. In the majority of these areas, the sample used meets the requirements. However, there is an issue related to point number three on this list. I have already commented above about the arguments within the literature about the 'generalisability' of qualitative research. However, in my study, the Greater London-based sample of social workers may also affect the generalisability, dependability or transferability of results in this particular study. This is because local authorities and health services based in one geographical area may experience different factors and pressures around urban/rural or county/metropolitan location and scale, service availability, eligibility and demand, funding, vacancy levels for staff and other factors for example, than their equivalents based in other parts of the country. However, there are so many variables affecting local populations and local authority organisational structures, that it is difficult to present an 'average' or 'typical' local authority sample. I have not explored this aspect in my study as this approach to gathering my sample was unavoidable, however the limits to this

approach must be acknowledged. It may or may not affect the generalisability. Generalisations in this kind of research are analytical rather than statistical and are *'applied to wider theories on the basis of how selected cases might 'fit' with general constructs'* (Lucas et al 2000, p1002).

4.10 Chapter Summary

This chapter has discussed the methodology undertaken for this research study, including detailing a rationale for the decisions I have made about methods. Of the various qualitative methods reviewed, focus groups were chosen because they allowed me to generate discussion about practitioner practice issues in their work with looked after children supporting their mental health, including their use of the SDQ. Where it was not possible to conduct focus groups for practical reasons to do with difficulties in organising focus groups with CAMHS practitioners, interviews were used. This method also enabled discussion about practitioner practice issues. Thematic analysis using 'framework' was the method adopted to analyse the data, as this method provided a coherent structure to organise and synthesise the data. I used NPT to further analyse the results because it is a comprehensive change theory that explains how and why changes introduced in practice may or may not become embedded at an individual and organisational level. Finally, a case study was used to provide further information about an organisation where it appeared that the SDQ was well used in social work practice.

The next four chapters present the results of the qualitative data. Chapter five provides a results overview. Chapter six examines the results using the NPT model as a framework for understanding the effectiveness (or not) of change process implementation. Chapter seven focuses particularly on the data regarding the relationship between social workers and CAMHS specialists (research question 4). Chapter eight discusses the results for one particular local authority, which had the most effective SDQ system of the local authorities researched.

Chapter 5 Results overview

5.1 Introduction

This chapter provides a general description and overview of the results of the research. I outline the results from the data collected from the focus groups and individual interviews undertaken with social workers and CAMHS clinicians. I use the Framework matrix headings as a basis for the structure used to give a general overview of the results. This chapter is largely descriptive. Deeper discussion of the themes raised then takes place in chapters six, seven and eight respectively, building on and further investigating the findings presented in this chapter.

The results are presented in four sections and integrate discussions from social worker and CAMHS participants. In addition to highlighting differences and similarities **between** these two groups, differences **within** these groups are also presented. These 'within group' differences for the social worker participants are examined by reviewing the range of discussion points raised by the different work-based/team-based groups (e.g. social workers in adoption, children with disabilities or general looked after children teams). The 'within group' differences for the CAMHS focus groups also relate to the discussion areas covered.

5.2 Results

Chapter four set out the methodology for the qualitative aspect of the thesis. It described in detail the methods used to gather data (focus groups and interview), the justification for these, sampling, recruitment of subjects, the use of Framework to code and interpret the qualitative data in NVIVO, and the approach used to analyse the qualitative data set (thematic analysis). In synthesising the data from these matrices, a number of categories were collapsed across the two matrices:

Table 5.1: Collapsed matrix categories in thematic analysis

	Social work matrix	CAMHS matrix	Collapsed matrix categories
1	The meaning and the significance of the SDQ for social workers	The meaning and the significance of the SDQ for CAMHS workers	Meaning and significance of the SDQ for SW and CAMHS
2	The factors that influence referral to specialist CAMHS	The relationship between social workers and CAMHS	Social work and CAMHS working together
3	The understanding social workers have of mental health issues	The range of opinions about how well social workers identify mental health problems in looked after children	Opinions about social workers understandings of MH and how well social workers identify, assess and monitor mental health problems in looked after children
	The understanding social workers have about resilience	The way in which mental health of looked after children is monitored	
4	The range of factors that social workers take into account when assessing the mental health of looked after children	The models of local mental health services for looked after children	The models of local mental health services for looked after children
5	Focus Group Processes	Focus Group Processes	Focus group processes

Key:

Meaning and significance of the SDQ for SW and CAMHS =
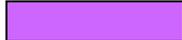
SW and CAMHS working together =

SWs understandings of mental health =

Focus group processes =

Models of local mental health services for looked after children =

Five categories were identified from collapsing the categories in the matrices and reading the summary material in the different matrices. The first was

'*Meaning and significance of the SDQ for social workers and CAMHS'* and is purple in table 5.1 above. This theme supports understanding of views and experiences of these professionals and addresses research questions one and three. The second was '*social workers and CAMHS working together'* and is orange in table 5.1 above. This theme explores research question four. The third was '*opinions about social workers' understandings of mental health (including how well they identify, assess and monitor mental health problems in looked after children)'* and is blue in table 5.1 above. This relates to research question two. The fourth category relates to the three models of local mental health services developed from the descriptions of services given by social work and CAMHS practitioners, and is beige in table 5.1 above. The fifth was '*focus group processes'* and is green in table 5.1 above.

The first theme, '*meaning and significance of the SDQ for social workers and CAMHS'*, examines the role and purpose of the SDQ for social workers and for CAMHS, which includes some of the service issues raised from collecting the SDQ data. The second theme, '*social workers and CAMHS working together'*, examines the relationship between CAMHS and social work, and discussion of this uses the different models of specialist CAMHS for looked after children to identify the practice issues raised by members of the respective teams. The third theme, '*opinions about social workers' understandings of mental health (including how well they identify, assess and monitor mental health problems in children looked after)'*, examines the way in which social workers respond to the mental health needs of looked after children. The labelling and stigma of mental health and looked after children are also examined in this section. The fourth theme explores '*focus group processes'*. This explains how social workers and CAMHS clinicians used the focus group to explore the discussion topic.

Each of the direct quotes used in the chapter is classified according to the role of the professional; the local authority (LA) or health trust (HT) denoted by letter or number respectively; and a three category classification of the model of CAMHS service according to level of integration (for a description of these integration levels and the process for developing them see page 131). These models are the fifth category of the matrix and are detailed in Table 5.2 below:

Table 5.2 Organisation of CAMHS in local authorities included in study

Local Authority	Health Trust	Specialist CAMHS service based in LA?	Other	Model of integration
A		No	Delivered at NHS community building	Non Integration
B	1	No	Delivered at NHS community building	Non Integration
C	2	Yes	Clinicians are based in social work 'units', which are small teams of social work qualified individuals. Clinician is 0.5 a week and is a psychotherapist.	High Integration
D	3	Yes	Fully integrated into the LA and is based in the same floor as the Looked After Children Social Workers	High Integration
E	4	Yes	Based in the LA, in the same area as some Children's Services and has been since team inception in 1999	Moderate Integration
F	5	Yes	Based in the LA in the same office as LAC social workers	High Integration
G	6	No	Delivered at NHS community building	Non Integration
H		Yes	Not in Children's services building – in an Adults Social Care building	Moderate Integration
I		No	Delivered at NHS community building	Non Integration
	7	No	Delivered at NHS community building	Non Integration
	8	No	Delivered at NHS community building	Non Integration
	9	Yes	Based in the LA in the same office as Looked After Children Social Workers	High Integration
	10	Yes	Based in the LA in the same office as Looked After Children Social Workers	High Integration
	11	No	Delivered at NHS community building	Non Integration

The first results section (first theme, '*meaning and significance of the SDQ for social workers and CAMHS*') begins with a case example from each of the three service integration models, using excerpts from focus groups to describe SDQ collection approaches used in three local services.

5.3 Focus Group Processes

In examining the processes of all the social work focus groups, over 40 agreements were observed between participants, with statements like, 'I agree with…', within discussions held over the course of the session. In most of the focus groups, group participants developed and expanded on ideas initially proposed or suggested by other group members. There were virtually no points of disagreements (only on three individual occasions in three separate focus groups). No focus group member was silent in any of the groups and although one or two members did dominate the discussions in some groups, many of the groups saw similar patterns of contributions from all group members. The largest single topic, with 70 contributions across all of the focus groups, was 'facilitators and barriers to CAMHS', whilst across the five Framework matrix headings, the second heading, 'Social Work Assessment of Mental Health' had the most contributions from social workers at 314.

Within the various CAMHS focus groups, there were far fewer agreements (five) within the various focus groups. Most of the focus group members developed ideas from other group members as part of the discussion. There was a similar number (four) of disagreements, but this was within a smaller number of focus group discussions. Two of the student CAMHS clinicians did not make contributions to the discussion groups they were part of but everyone else participated. As with the social work focus groups, although one or two members did dominate the discussions in some groups, many of the groups saw similar patterns of contributions from all group members. The largest single topic, with 49 contributions across all of the CAMHS focus groups, was 'Interactions between the social work role and CAMHS', whilst across the five Framework matrix headings, the second heading, 'Relationship between CAMHS and social work' had the most contributions from CAMHS clinicians at 140.

5.4 Meaning and significance of the SDQ for social workers and CAMHS

5.4.1 The level of social-work/CAMHS integration- a typology

From the thematic analysis of data from all nine local authorities included in the study, it was possible to identify three distinct typologies of social work/CAMHS integration. Table 5.2 includes a column that identifies which typology applied to each of the sample local authorities included in this study. These were determined using the following definitions:

A) Highly integrated services refer to services where CAMHS clinicians were based in the same team or building as the social workers;

B) Moderately integrated services refer to specialist CAMHS services which are based in a LA but not in the same building as local authority social workers;

C) Non Integrated services refer to specialist services that are based in an NHS building separate from local authority social work services.

Each of these three typologies used a variety of ways to gather the SDQ data annually, and this was the case across the sample of local authorities and health trusts included in the study. There were local arrangements between authorities and health trusts that determined which agency/ies were involved in the data gathering processes. Most often a local authority administrator sent out the SDQ forms to foster carers and these were scored by CAMHS upon their return, however a variety of other methods were also used. These arrangements are further explored in chapters six, seven and eight.

The level of service integration of CAMHS in the local authority did not appear to affect the SDQ related data gathering processes used by the local authorities included in this study. This is evidenced by the SDQ return rates which, as Table 5.3 shows, were similar for the highly integrated services compared with non-integrated services over an eight year period.

5.4.2 SDQ returns for the Local Authorities included in this study:

The following Table provides the rate of SDQ returns by all the local authorities included in this study since 2009. Over eight years of data collection, LA D has achieved the highest rates of return when compared with the other local authorities in the study. It has the smallest range (89%-100%) and the highest mean score (96.3%); there is only one year where LA D's percentage of annual return falls below 90%. LA D is the case study discussed in chapter eight.

Table 5.3: Percentage of children for whom SDQ scores were submitted in Local Authorities (LA) and Health Trusts (HT) included in the sample (Source: DfE Outcomes for children looked after by Local Authorities 2011; 2014; 2016) according to integration level

	2009 %	2010 %	2011 %	2012 %	2013 %	2014 %	2015 %	2016 %	MEAN %
LA D - High	115[23]	99	98	98	96	89	92	99	96.3
LA F - High	100	100	100	92	64	67	58	74	81.8
LA C - High	81	83	94	78	66	58	78	80	77.2
HT 9 - High	33	5	72	83	93	85	85	85	67.6
HT 10- High	39	53	41	53	61	78	76	95	62.0
Average return rate for High integration services									76.9
LA H - Moderate	86	71	73	74	90	50	58	90	74.0
LA E - Moderate	0	17	71	70	28	32	67	75	45.0
Average return rate for Moderate integration services									59.5
LA A - Non	74	92	98	99	100	99	97	86	93.1
LA G - Non	77	90	77	91	98	91	83	90	87.1
HT 8 - Non	81	81	81	80	97	96	84	90	86.2
LA B - Non	78	71	79	83	86	88	87	89	82.6
LA I - Non	96	50	59	21	55	64	83	75	62.8
HT 7 - Non	45	58	35	60	54	51	69	68	55.0
HT 11- Non	30	48	45	46	43	40	51	68	46.3
Average return rate for Non Integration services									73.3

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[23] This was the first year the data were gathered by the DfE and this local authority, along with a number of others, submitted more SDQ returns than children who were eligible. This problem did not occur in subsequent years and the DfE published all data received from local authorities. When calculating the mean score I have rounded this down to 100.

When examining the data across the local authorities included within this study (n=14 out of a possible total of 152), after LA D, the next four highest scores for SDQ returns are all located within the Non- integration level (n=7). The mean scores for the local authorities in the Moderate Integration level (n=2) were both in the bottom half of the Table, and the Moderate Integration level had the lowest mean return rate (59.5%) when comparing across the three integration levels. The mean scores across local authorities in the High and Non Integration levels respectively, were very similar (76.9% and 73.3%). A degree of caution should be exercised when analysing these results because of the size of the sample. However, regarding the DfE rate of return for SDQ completion, there appears to be little difference in the average mean scores between authorities located in the highest and lowest integration levels. This raises an issue about the effect of the type of service integration on this data gathering process, as the data suggests that it is not necessary for services to be co-located or integrated in order for proficient data gathering to occur.

5.4.3 The meaning and significance of the SDQ for social workers

The SDQ was routinely used by social workers in their practice with looked after children in only two of the nine local authorities included in this study. In terms of the processes in place to facilitate the Department for Education performance indicator return, this was either done by administrative staff within the local authority who sent the SDQ to the foster carer to complete (a stand-alone system) or it was organised as part of the annual medical examination conducted on each child in care, where a looked after children's nurse sent the form to the foster carer to complete, along with an appointment time for the annual medical. A mixed picture emerged regarding the availability of these results for social workers. Two local authorities (LA D; LA H) provided the social workers with the SDQ results and expected them to use these results in their care planning for the child or young person, including referring on to other agencies. The other seven local authorities did not notify the social worker of the results of the SDQ, although in some they were entered onto the child's electronic records on the local authority computer system independently of the social worker. In two of the local authorities where I conducted focus groups there was

almost 100% compliance with SDQ monitoring (LA A; LA F) but social workers did not look at them; instead the SDQ was seen as information that was collected for management.

5.4.3.1 Independent Reviewing Officers

In all the local authorities, all social workers described how mental health issues were discussed in the Looked After Children Review[24] process. These meetings were chaired by Independent Reviewing Officers (IROs). An IRO is a qualified social worker.

Four IROs attended focus groups and one focus group included three IROs from the same local authority. The IROs reported a preference for discussing physical health issues in the review rather than mental health issues. Three out of the four IROs interviewed (LA B; Non Integration) said that social workers did not independently raise issues about mental health in review meetings but did raise physical health concerns. General emotional and behavioural issues might be covered in the meeting, if foster carers or schools raised these with regard to a child or young person. The fourth IRO, who worked for another local authority, had a different experience:

> *'I would say yes, the child in terms of mental health as a whole is picked up as the standard agenda in terms of the review process and if there's any significant mental health issues or none, that will also get picked up by the LAC medical or via the strengths and difficulties questionnaires. I think that's what I like about them because even as a Chair you could have a view about the presentation of the child in terms of what they might be struggling with in terms of mental health issues. Sometimes it's important when you do get the SDQ and you think 'Ah. see that's where I would've placed it as well in terms of this child.'* (IRO SW; LA D; High Integration)

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[24] A looked after child's review occurs every six months for all children who have been in care longer than four months, and is the arena for gathering all involved agencies together with the child, parent (where appropriate) and social worker to review the child's progress as well as permanence plans for the child.

The IROs commented that there were now more referrals to CAMHS than there had ever been before. One IRO questioned whether social workers should be more discerning with their referrals to CAMHS, and pointed out that caseload pressure might be one of the reasons for this increase in referral rates rather than this having anything to do with SDQ scores.   The IROs also thought that there was a danger that the current focus on speed in adoption, in court proceedings and in other timescales given to social workers to complete assessments, might be counterproductive, as the need to be seen to "do something" like refer a child to CAMHS, dominated the response.

5.4.4 The use of the SDQ by social workers for looked after children

The role that social workers thought the SDQ had on their own practice was minimal:

> *'Social workers don't use the SDQ routinely in their work at all…'* (Looked after children SW; LA F; High Integration)

> *'It's redundant...zilch impact....'* (Looked after children SW; LA C; High Integration)

> *'I think it's a bit sad that its literally being filed and no-one's paying attending to it because you can get quite a lot of really relevant stuff out of it.'* (Looked after children SW1; LA D; High Integration)

> *'I guess it a good safety measure in case something's been missed but so far I haven't noticed that that's triggered anything for us.'* (Looked after children SW; LA H; Moderate Integration)

> *'It's a monitoring tool – a little snapshot of a child's life.'* (Looked after children SW2; LA D; High Integration)

Some social workers, who were not familiar with the SDQ, had limited knowledge about it, did not know its potential capability and had not been offered training on how to use it in practice.

> *'I'd like to be able to use them. I think they'd be useful, but no-one's trained me and I'm not going to faff about with something when I don't*

really know how it works.' (Looked after children SW; LA C; High Integration)

'I'm aware it's done, because we get emails asking for addresses sometimes, saying that they need to do the SDQ, but I've never seen, I don't know where I'd get it. I don't know where the information goes, or I've never seen the outcomes.' (Looked after children SW; LA E; Moderate Integration)

Social workers in two different local authorities said they were not aware that the SDQ was used in their borough (Looked after children SW; LA F; High Integration and Adoption SW; LA G; Non Integration).

Of the social workers who were familiar with the SDQ, most said that the SDQ scores did not tell them anything about their young person that they did not already know through regular visiting.

'It just seems like another top down process, where forms get cascaded down and collected. I mean, the point is, the admin staff send it out because if they left it to social workers, most of them wouldn't go out - but they haven't integrated the forms into …. Nobody's shown us how the form could be used, you know, when you're thinking about mental health…because, you know, when I've got information back about particular children, the scores, it's not been a surprise. We're aware that they have got issues and that's because of the assessments that are done, independent of the form.' (Looked after children SW; LA A; Non Integration)

A number of social work teams spoke positively about their specialist CAMHS service and the way that the SDQ was used by that team.

'I think it's good that there is that net outside of the social worker because I think there's a tendency to try and say "oh well the social worker can do that because it would be good for the social worker to know" and it's like "well actually, sometimes we can't do everything" and we have to be quite realistic about what we can do (Looked after children SW; LA D; High Integration)

A few social workers questioned the science behind the development and use of screening tools and diagnostic tests, and of studies which had published high rates of mental disorder within the looked after children population. The rationale for this given by the social workers concerned was that labels were not helpful for children and indicated a deficit based view of mental health.

> *'I do not think that it is in looked after children's interests to be having a label like that around them, unless that was really the case. You know I'd be trying to defend them from a label like that, if you like, because that kind of feeds into all sorts of ideas that already exist about looked after children being 'damaged goods' if you like.'* (Looked after children SW3; LA C; High Integration)

Social workers in half the local authorities raised concerns in focus groups about how accurately foster carers completed the annual SDQ. Some social workers who saw the SDQ scores for their young person said they did not agree with the scores the foster carer had given. Some thought foster carers overstated the difficulties so that the young person would receive a service, whilst others thought the foster carers understated difficulties for children as they did not want to be judged or seen as incompetent.

> *'I worked on a particular case where when the referral did go across to children's mental health services and they sent the paperwork to the foster carers. And when they filled in the questionnaire, I didn't recognise the child and when the clinicians met the child, they recognised that this is not the child that's been described because the foster carers weren't attuned and they didn't really understand what was going on for the child in their care. It did lead us to move that child because of it… These foster carers felt that if they recorded the information more accurately, it would reflect badly on them, that they weren't doing a good job'* (Adoption SW1; LA G; Non Integration)

5.4.4.1 Adoption social workers

One focus group comprised of adoption social workers who worked in the same local authority. The SDQ was not directly used by looked after children social workers in that authority and the age range of many of the children who were

adopted (under 4) meant that the SDQ was not used with these children. Adoption social workers commented that CAMHS sent SDQs to them to complete when children they were family finding for were older than four years old and in therapy, but this occurred when the looked after child's social worker did not know the child well. The turnover of social work staff was a problem: '*the social workers in the looked after teams change on such a rapid almost weekly basis that they don't actually know the children well enough to pick up any mental health problems or any trauma*' (Adoption SW2; LA G; Non Integration).

5.4.4.2 Children with disabilities social workers

Two focus groups included a social worker who worked with children with disabilities. Both reported not routinely using the SDQ with children and young people in care who had learning disabilities. This was because the reason for some children's and young people's challenging behaviour may be due to the learning disability rather than because of emotional problems. Social workers said that this could cause problems for agencies. However when workers had concerns about the emotional health of their children and young people, they approached services:

> '*If necessary, I would come and seek the advice of the specialist LAC mental health team. However, we have such close ties to the medical community anyway, it makes life a lot easier for us because the community paediatrician will also be holding case management for them. So if I was worried about someone, I would literally be just picking up a phone and the process is much speedier and much easier to get into CAMHS because it's already coming from the medical side of things. It's nowhere near as difficult as I know it is for other teams.*' (Children with disabilities SW; LA D; High Integration)

5.4.5 The role and meaning of the SDQ for CAMHS

CAMHS clinicians had mixed views about the efficacy of the SDQ for work with looked after children. All the clinicians participating in the research know about the use of the SDQ in the annual return for the Department for Education. This was undertaken separately to its use within CAMHS and, except for one CAMHS service (HT3; High Integration), it was not a joined up process for CAMHS either,

as it was not linked to either social work files or CAMHS clinician files and was not used in CAMHS returns to the Child Outcomes Research Consortium (CORC)[25]. One clinician described the process of organisation for the Department for Education return between the local authority and the Health Trust as '*a nightmare*'. (Clin psych; HT 10; High Integration).

> '*And that also then confirms a social worker's worst suspicions that this product is .... a tick box exercise and what was the point in doing that!*' (Psychotherapist; HT 11; Non Integration)

> '*I think the problem is, I think to be honest and I can see their point, Social Workers, they've got so many things to do, doing SDQ's that they do not see any particular value in and nothing hugely happens with it, I could well – I think they think what's the point and I can see where they are coming from.*' (Clin psych; HT 10; High Integration)

One specialist team performed a different role to the other teams, and identified itself as '...*assuming the role of the gatekeeper for mental health for children in care*' (Clin SW; HT 3; High Integration), and the impact of this on the social worker for the looked after child was that mental health was something that was most likely to be addressed in practice. The team was based on the same floor as the looked after children's team and the CAMHS practitioners were known to all the social workers for looked after children, who approached them to ask for advice. All the carer SDQs were sent out by the specialist team and returned to the team. The team provided social workers with a brief overview report on the results of the SDQ including an action list for the social worker, highlighting any areas of concern. The specialist team also routinely collected teacher SDQs for all eligible looked after children, to triangulate the Carer SDQ data. These SDQ data were directly used in clinical practice and were also compiled for the annual Department for Education return. The Independent Reviewing Officers were sent SDQ reports from the team prior to every Looked

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[25] CORC is a membership based learning network of mental health specialists from over 70 Child and Adolescent Mental Health Services (CAMHS) across the UK that are committed to fostering the effective and routine use of outcome measures in work with children and young people (and their families and carers) who experience mental health and emotional wellbeing difficulties. The questionnaire responses from children and families are collected and sent to CORC as anonymised data and a research team process the (anonymised) data centrally and provide feedback and support to members (www.corc.uk.net).

After Child's review. The quote below was from a member of the CAMHS team in this local authority, giving his view on whether social workers could undertake this work with the SDQ that the specialist team did:

> *'I'm not sure social workers can do that with all their cases, you know, I don't think they could do that. They're smart enough, but it's just the workload.'* (CAMHS manager -Clin SW; HT 3; High Integration)

With regard to the SDQ's usefulness in work with looked after children, clinicians noted a number of benefits, including that it was quick and easy to use and did not cost money. It worked best as an initial screening tool and could be scored easily.

> *' So for screening, I think still it's useful though it's probably best for population screening than for high risk screening which is the group we're dealing with. It has probably been taken a bit out of context in terms of what it is best for but the thing is, it's cheap, it doesn't cost any money, it is very easy to score. So I think those are real advantages because I do not think we've got anything any better, that's the problem, there is nothing that is better than it. So for what it does, I think it's good...'* (Psychiatrist; HT 1; Non Integration)

However, most clinicians also expressed concerns about the use of the SDQ with looked after children, because of the variability and context-dependent nature of behaviours:

> *'..the SDQ never points to the real strengths of the child or the foster carer. I mean, looking at, for example, 'often lies and cheats' – we know that these children will lie and cheat, etc. and we know the underlying drivers to it. So that's always going to be a 'yes', or the child might strike it as 'not true' and there'll be a discrepancy and, to me and the rest of our team will say 'actually those are not pointers to mental health or to attachment', because we know that their search is for something much deeper.'* (Clinical Nurse Specialist; HT 7; Non Integration)

Clinicians also raised the possibility of foster carers or social workers consciously or unconsciously 'fixing' the SDQ score, which was a downside of using this scale

as a 'cut-off' for treatment, which was an issue raised by social workers as well. One clinician spoke about the differences between foster carers and birth parents completing the SDQ:

> '...the SDQ was done and validated and generalised as a tool used by the natural parents prior to going to CAMHS or whatever. And natural parents have a view of their child which doesn't change significantly over time or a way of wanting to relate to their child which doesn't change that much. So when they score them 17 plus they will have probably scored them 17 plus a few weeks ago and a few weeks hence or thereabouts. Whereas foster carers, when they take a child, they're full of wanting to see the kid in a very positive light and not wanting to be a downer on the kid. So I suspect that they ignore the sort of behaviours that will niggle them in six months' time but they're able to cope with initially. So they score them, I guess, lower. Then the kid goes through into acting out and whatever, yeah, and then they score, whoosh, right at the top. Then it's too late.' (Family Therapist; HT 8; Non Integration)

Despite these reservations, all but one specialist CAMHS service used the SDQ regularly in their work: at the point of beginning work with a looked after child, every six months whilst work continued and at the end of the work. These scores were not regularly fed back to social workers, however one CAMHS worker who was responsible for scoring the SDQs for the local authority DfE return did feed back high scores to clinicians (not social workers) who were based in social work teams, as her manager strongly believed that to do nothing with these scores was unethical (HT 2; High Integration).

For some referrals to CAMHS, an additional SDQ completed by the social worker or foster carer was required at the point of referral. Some CAMHS used the SDQ score as a threshold for service eligibility. In one of the Health Trusts (HT 8), no child with a score under 17 received a service from the specialist CAMHS service. The CAMHS clinician said this was done to limit service eligibility.

5.4.6 Social workers and CAMHS working together

This section is split into two, focusing first on social workers' responses and second on those of CAMHS clinicians.

5.4.6.1 The relationship between CAMHS and social work – a social work perspective

The design and delivery of services varied enormously within the sample of local authorities and CAMHS included in this study, from more traditional social work teams with 'outpatient' CAMHS support, to specialist looked after CAMHS integrated into the local authority. The three service models of integration (High, Moderate and Non) mentioned earlier in the chapter provide a summary of approaches that local authorities and health trusts had for organising their services. Each borough organised its services differently, depending on resources, staffing and historical services.

Social workers spoke positively about having therapists in the same team:

> *'…a massive difference is having them so that we don't have to do a referral, or we don't have to do paperwork. They can jump NOW!... we don't have to wait all that time, and in a way you've missed your moment more often than not, which used to be very frustrating – the old way of working.'* (Looked after children SW; LA C; High Integration)

However, some of the other, more traditional services were also well regarded:

> *'I must say in terms of my experience of working with our CAMHS pathway, I would regard them as being pretty exceptional. Referral is a very fluid process. As I said, you can have conversations. They're very flexible. One particular difficulty I have is that often my young people won't engage at the beginning so we provide the opportunity for the team to go and gain advice and to see things differently, then often the young person will then join that process. To start on a positive, I think we're pretty blessed.'* (Looked after children SW; LA H; Moderate Integration)

> *'I think once they've been referred to a CAMHS service and the service has been provided, it's usually quite a good service…. To me I think we've got a very good CAMHS service, and in adoption work I think they're absolutely excellent.'* (IRO SW; LA B; Non Integration)

Regardless of the level of integration between social work and CAMHS in an area, mental health issues were primarily viewed by social workers as the responsibility of their CAMHS. Social workers believed that access to specialist support for children, carers and social workers had improved over the past 10 years. Other social workers talked positively of the benefits of having CAMHS workers available for a quick consultation about a child, including for those children placed out of borough. Consultation was a highly valued service and was available in all the local authorities included in this study.

The social work focus group participants outlined a number of issues that affected their relationship with CAMHS. Firstly, there were still issues for some CAMHS about children needing to be in settled placements before long term work would start. There were difficulties in getting a child seen by a clinician when the child was not in a permanent placement, but in transition, or where a child had not already been living in a placement for at least 18 months. Social workers thought that CAMHS were still reluctant to see children, in these circumstances.

> ‘We do have some conflict with CAMHS sometimes when they’re refusing to become involved but all the professionals are feeling it’s right for this child and we’re the professionals that know the child, whereas they might be making a decision … we have rather a bun fight about it and it goes to and fro. In my experience, we have found compromises where CAMHS have agreed to work with the foster carer or birth relatives or even the prospective adopters once the child’s in placement, to gain an understanding of what’s going on for the child but in order not to load all the responsibility on the child to face their problems and maybe get better.’ (Adoption SW3; LA G; Non Integration)

Two other practice issues were highlighted as problematic throughout all local authorities. The first was transitions between CAMHS and Adult mental health services when a young person reaches 18. A small number of CAMHS saw young people up to the age of 21 (LA F; HT 5) or 24 (HT 9) years. This was also a problem for CAMHS clinicians:

> ‘The problem we have is that we don’t want to label children, and unless we label them, post 18 they don’t actually have a service. The labels kind

of carry the service along with them. They don't kind of, you know, we can try as hard as we can with looked after children not to diagnose them. However, when they are 18, if they haven't got a diagnosis then they won't get the service post 18, and then the child's problems become a lot worse, which is why I think a lot of us do refer to CAMHS, especially for the older children to ensure that they do get a service post 18.'
(Looked after children SW; LA F; High Integration)

The second issue was poor CAMHS for children placed out of borough. This was also unanimously acknowledged as difficult for social workers and CAMHS clinicians because of problems with accessing CAMHS out of borough, with reports of long waiting lists in many community CAMHS. Social workers reported being told that many CAMHS did not see children who were the responsibility of another local authority as a priority for their services. There were also problems securing funding from the originating local authority to pay for children to be seen more quickly, including privately, where this was required.

'I think we've got 50% of our kids out of borough and we can't engage CAMHS, it's hit and miss and we can't get our CAMHS on board to assist us with that really, you know...' (Team Manager for looked after children; LA F; High Integration)

Additionally, some social workers raised issues about the inflexibility of CAMHS:

'I think the difficulty is that the service offers a one-hat-fits-all kind of service. It's not flexible. If the child doesn't want to go it doesn't think outside of how we could get the child to engage, it's left to us to do it. I think sometimes they need to maybe leave the offices, see them outside of the offices. Yeah we're going to have a lot of young people who are going to be resistant but as far as they're concerned if they resist they're not interested. There's got to be that trust but we had to build trust. I think they should be having to do the same thing as well.' (Looked after children SW; LA I; Non Integration)

Social workers who were part of focus groups said that they did not like the potential 13 week wait for children to be seen at CAMHS, which was a considerable wait-time, even though this was within national timescales.

> *'You can still access local services via local CAMHS, but there's a long waiting list.'* (SW3 for looked after children; LA F; High Integration)

> *'...it's another difficulty we find as well as the growing waiting list in some areas where adopters are waiting for a long time to see a specialist. That's also another difficulty. Obviously we can put in post adoption support but it's not the same as CAMHS.'* (Adoption SW; LA G; Non Integration)

Social workers commented on some of the specialist Looked After Children services that were run like Tier 3 CAMHS[26]

> *'.. it can be a bit like well we only offer one service, you know, and you have to fit into the service, take it or leave it, or, you know, as IRO1 has said the CAMHS service is good, but for a lot of teenagers they might not feel that that's what they want and that's what works best for them. So then if that's the only service then we're kind of stuck…'* (IRO SW2; LA B; Non Integration).

Some social workers and Independent Reviewing Officers noticed changes to this approach and thought that CAMHS were becoming more accountable for its work through holding regular meetings with social workers to review the progress of children they were seeing. For a small number of social workers, this did not result in CAMHS being any more open about sharing information about what they were doing.

> *'I don't want to be a killjoy but the CAMHS in my particular borough looks good on paper but I don't think serves their purpose. I had a family that I was working with and information doesn't seem to be two-way, do you know what I mean? I feel I get dragged in for a review - how's the child getting on, what's happening? I'm giving them all these things and I've got nothing back. I don't know if there's been any progress being made. They've been in review for long enough. How are you still highlighting the same thing? Clearly your service is not doing the child any good. I've*

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[26] Tier 3 CAMHS are community based services which cover a geographical area usually coterminous with the local authority. These are different services to the specialist LAC services. The specialist service will receive clinical supervision from the Tier 3 service.

got to the stage now where I can't even go for reviews because I think
they're pointless. I've yet to meet a child who has actually said they've
found the service helpful and that's where I am with that at the
moment.' (Looked after children SW2; LA I; Non Integration)

5.4.6.2 The relationship between CAMHS and social work – a CAMHS perspective

Many of the descriptions of mental health services provided by CAMHS clinicians
in the focus groups included comments about the degree of flexibility and
bureaucracy of each service. This included comments about the commissioning
of the service, including the use of the SDQ by CAMHS for CORC returns, for
referral criteria and for the collection of SDQ data for the Department for
Education return.

Commissioning was an issue raised by a number of CAMHS clinicians as affecting
the work they were able to do. One CAMHS clinician stated that the service that
their team had been commissioned to provide included specific numbers of
referrals and they were not able to go above this.

'We have had 20 percent of funding altogether that was lost and at that
point, we were able with the commissioners to renegotiate a reduction in
terms of activity. But like I say, we're still aware that the demand's
there. We're also going out for tender next year and we don't know
whether the financial envelope will be the same size as it is now. It
could be even less.' (Systemic Family Therapist; HT 11; Non Integration)

Another spoke about the SDQs not returning the level of need that the
commissioners were expecting.

'It was quite interesting to then present that back to the Commissioners
to say, well actually it's maybe about the identification of mental health
difficulties ... and it's how that information is used. You'd expect a
higher number of people with higher SDQ scores based on the evidence,
the literature about mental health needs in looked after children. But it
was falling around maybe say 20% rather than 45-50% that you'd maybe
expect in terms of mental health need. So either the SDQ isn't picking up

on that or people aren't identifying it.' (Clin Psych; HT 9; High Integration)

CAMHS clinicians also identified difficulties with services for children and young people placed out of borough and for young people with mental health problems leaving care at 18 and still requiring mental health services. For children and young people placed out of borough:

> *'There's often a lot of argument about who's providing the funding. Some of the different services won't - either they say they've not got the skills or it's not within their provision to be offering looked after work, so sometimes it's access to CAMHS. Sometimes it's the border as to which CAMHS… We do have, even within neighbouring boroughs, lots of tensions actually about CAMHS support to our children so there will be differences across boroughs.'* (Clin Psych; HT 9; High Integration)

For young people with mental health problems leaving care:

> *'transition is very difficult because we don't necessarily know what the provision is in the adult services for young people that have got very high mental health needs because we know we can't put them in our mainstream semi-independent units because there isn't enough support for them.'* (Clin Psych 2; HT 5; High Integration)

In addition, many of the CAMHS and local authority services were in transition themselves, with reorganisations and staffing shortages. New guidelines for referrals were often introduced as part of this process.

> *'Everything started changing-- let's say a foster carer wants a referral to a service. They used to be able to ring up and do it. Now they have to ask their supervising social worker who has to ask the case holding social worker who has to have a meeting – ring the local meeting thing, has to decide what is appropriate to send to us. They have to then get themselves an SDQ, a consent to treatment, fill in the form, email it all over to us, then there'll be a phone call to fit in the slot and it's a massive and bigger process. And the consequence of that is that the number booking them has dropped off.'* (Family Therapist; HT 8; Non Integration)

One focus group comprised of three clinicians in one local authority who were each based in a social work team. The clinicians reported that the integration of clinicians with social workers was highly valued by the social workers as conversations about the mental health of children were part of everyday practice. The borough in question had also invested heavily in systemic training for members of social work staff:

> *'One of the bonuses of working here in a unit is that you have the opportunity to have that therapeutic lens all of the time, as opposed to, occasionally, if you could get a referral. Here, that is our focus, so I think it makes the work therapeutic in itself, as opposed to, 'you do therapy with a therapist'. It just makes all of our work more therapeutic all of the time, as opposed to not'.* (Psychotherapist; HT 2; High Integration)

However, another CAMHS clinician in another area spoke about changes in the local authority structure where social work units had been created based on the 'reclaiming social work' model[27], but the therapeutic role was different from the 0.5 FTE therapist located in the team in the original model:

> *'We've been allocated three hours per unit over the next six months, so that's how much they're probably going to get from me.'* (Family Therapist; HT 8; Non Integration)

Many of the CAMHS clinicians referred to the organisational circumstances in which social workers worked as affecting their ability to undertake direct work with looked after children, including high workloads and high staff turnover.

> *'I think it's not so much about the skill set but the organisational structure around them. Certainly in [area outside London] one of the reasons in terms of the special measures was around caseloads and the supervision and people really not having the reflective space to actually think about the challenge of working through such a vast number. So trying to actually get it to a manageable level so that then you can hold the children in mind and you can be thinking and that you've got*

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[27] This is a model for local authority children's services developed initially in Hackney Council. It is based heavily on systemic and social learning theory approaches to practice.

supervision which then enables and facilitates that, is important...' (Clin Psych; HT 9; High Integration)

5.4.6.3 CAMHS views regarding social workers' knowledge and skills about child mental health

In the focus groups and individual interviews, CAMHS clinicians identified the skills and knowledge that they thought social workers should identify and use in response to a variety of mental health difficulties that looked after children might exhibit. They highlighted a broad range of factors including the need for in-depth knowledge of questionnaires and how they worked. A psychiatrist in one of the CAMHS focus groups had strong views about the ability of social workers to understand questionnaires and how they worked in practice.

'The thing about SDQs is that it's not just about giving a child, parent or teacher a questionnaire. It implies a degree of knowledge about psychiatric properties of any questionnaire, an understanding that this is an assessment tool, it's a screening tool. What does it mean for people to score above and below threshold? So to just put a questionnaire in the hands of a social worker without knowing that they have a degree of familiarity with those concepts means that they're just not going to know what to do with it... It's not indicative of a situation where social workers have the skills to use screening questionnaires which could be extremely helpful if used in the right way.' (Psychiatrist; HT 1; Non Integration)

In addition, a number of other comments identified shortcomings in social work knowledge in the following areas: knowledge of child development; a good understanding of developmental trauma and attachment, looking beyond the symptom, not just at the behaviour; some general knowledge about the early symptoms of mental health difficulties; and to be much more focused on mental health promotion. CAMHS perceived themselves as readily able to distinguish between children who were mentally ill and those children whose adverse experiences affected their behaviour and they would expect a social worker to also be able to understand this. However they recognised a wide variation in social work knowledge about mental health, with some social workers not having suitable knowledge about child development, never mind mental health.

'I'm a little bit disheartened by the lack of social workers' knowledge about things like children's development, for example. Sometimes one could get cross but other times you think about there is an issue really with lack of knowledge. So if you do not really know anything about such an important area or if you know very little, you're really relying on other people and the judgements that other people make and I think that's very hard for social workers...it seems in practice, often part of the thing we've got to do is almost educate the social worker about, "Look, this would be sort of roughly normal development, this really isn't," and things like that... and we have had children with very severe mental health problems including psychotic children, children who are hearing voices and were giving very clear symptoms of mental health disorders that just weren't picked up.' (Psychiatrist; HT 1; Non Integration)

Clinicians also suggested that social workers should develop a number of skills, in particular: skills in talking to children; skills in talking with foster carers to identify issues that might be going on when the foster carer had concerns about the mental health of the child they were fostering; skills to be able to assess and know the difference between behaviours or difficulties that required CAMHS interventions and those that did not; and having enough skills to directly address some issues with the child and foster carer and work in and with the child's current environment. Finally, clinicians identified the need for time to think and reflect about the information that had been gathered and to consider the degree to which it might be a normal reaction to an abnormal situation. In this regard, clinicians thought that social workers needed to be able to formulate and 'hold in mind' the children on their caseloads. They suggested that the social workers that struggled more are those who were overly focussed on practical outcomes for children rather than thinking about emotional concerns that children had.

Clinicians in some CAMHS commented that social workers referred many cases to them that did not meet their criteria or where the social worker could provide some support to the child or young person instead of a CAMHS clinician. Some children displayed a range of behaviours because of their experiences of abuse,

neglect, separation and loss and CAMHS did not necessarily see their role as providing support to these children where their responses were 'normal' given their experiences.

> *'I think there is something about social workers being able to differentiate between abnormal and normal psychological reactions to difficult times.'* (Clin Psych; HT 5; High Integration)

> *'One would hope that understanding would be part of the social worker's skill set because sometimes that's the sort of job that we have to do, to say within the range of experience this child has had, you would expect them to have this particular type of behaviour, in which case maybe the CAMHS intervention isn't the best thing.'* (Psychiatrist; HT 1; Non Integration)

Some clinicians identified particular characteristics for social workers that they thought made a difference to social workers displaying a better understanding of mental ill health and its effect on children and young people in care.

> *'But the other thing I notice is that what I'd see as the 'good social workers who get it' are the ones that perhaps have enough experience that they've got to the point where they can let go of their certainty a little bit.'* (Psychotherapist; HT 11; Non Integration)

> *'I think in terms of the ones that 'get it', quite often they have quite a good understanding of developmental trauma and attachment, and that they look beyond the symptom. They do not just look at the behaviour.'* (Systemic Family Therapist/Nurse; HT 11; Non Integration)

However, three other CAMHS focus groups said almost the opposite; that newer graduates were more knowledgeable around mental health issues than more experienced social workers were.

> *'I think sometimes it's the newly qualified social workers who are a lot more up on what the psychological needs are of the children because they have fairly recently qualified.'* (Looked after children Nurse; HT 5; High Integration)

'I wonder if the newer ones, part of their training must cover some aspect of it, because they seem to know – I'm assuming that, I don't know that.' (Clin Psych; HT 10; High Integration)

In contrast, three CAMHS focus groups referred to the social worker as *'a well attuned parent'*, or knowing *'as much as a lay person'*

'Generally they are the referrer so they are like the parent, so you talk to them like you would a parent and say, 'these are my thoughts about a child, and this is what I am doing, this is who I am going to talk to and this is what my thoughts are.' (Clin Psych; HT 5; High Integration)

Maintaining close links between social workers and CAMHS was valued by both social workers and CAMHS clinicians, and although the integration of the specialist CAMHS teams has helped with this, CAMHS focus group members also spoke about the benefits of establishing relationships with individual social workers through the work, and saw these relationships as essential in creating positive relationships. CAMHS focus group members talked about the educative nature of this relationship, to ensure that they receive the 'right kind of referrals' from social workers. Some also spoke of the training they provided for social workers on mental health.

'We do a lot of training, so there's like the primary intervention team that I mentioned, every year they've got a yearly sort of running programme, things like you know – basic things about what is mental health and then it briefly sort of covers main areas like depression, anxiety, psychosis, those kind of areas. So Social Workers are always invited to those kind of training……. I do get asked to do bits of SDQ training, just a very basic this is what it is, this is what it does, this is what it catches, but it's not mandatory for Social Workers to attend that and it's not something that rolls out every year.' (Clin Psych; HT 10; High Integration)

A small number of CAMHS clinicians spoke about some negative effects of social workers receiving training about mental health:

'..sometimes there are some social workers who have obviously had a little bit of training in mental health and have heard certain words and

then start bandying them around very enthusiastically, which are actually quite severe, like kind of asking whether a child is schizophrenic or has a split personality or something like that and I'm kind of in horrors that they're, don't know, have got some dare I say it false confidence about some of those things.' (Clin Psych; HT 3; High Integration)

'I've got a repeating difficulty with social workers and other professionals telling carers that children have an attachment disorder, to the point where sometimes children have then not found an adoptive placement because there's labels been used. … And the longer term impact of that can be really massive. A little bit of knowledge is quite dangerous in that context and that's happened again and again. Once that label's been used, that carries through, even though it's not based on an assessment.' (Clin Psych; HT 11; Non Integration)

Additionally, some CAMHS clinicians spoke about the social workers they never hear from.

'There's some social workers we don't see. It seems impossible that the caseloads are divided so neatly.'(Psychotherapist; HT 11; Non Integration).

The concern expressed by clinicians was that access to specialist mental health services depended on a social worker's knowledge about mental health rather than the needs of a child. 'Experience', 'confidence' and 'understanding' are the three words that a number of clinicians in different CAMHS used to describe social workers who were more able around mental health issues.

5.4.7 Social Workers' Views of Looked After Children and Mental Health

There were many similarities in terms of how social workers described and understood their role with regard to mental health. It was to monitor, signpost, and liaise with specialist services rather than work directly with the child or young person. Many social workers saw direct work with children as outside their role and others raised as an issue the time pressures that stopped them being able to undertake a lot of direct work with children. Referring the child to

another service was an attractive option, as someone else would then work with the child, allowing the social worker to get on with other urgent cases.

One of the areas of discussion in all the social work focus groups was the role of therapy:

> *'I think that's a tension when we're working with young people when we say "and actually this is going to be really beneficial for you if you will engage with it I think that it will be good in the long term", but actually for a lot of our kids either they want to avoid that pain and they do not want to go there, or that they just won't engage at all and I think that's one of the difficult things.'* (Looked after children SW; LA D; High Integration)

> *'One of the alarming trends I've noticed over the last couple of years is that a lot of people put therapeutic support or therapy as almost like the magic pill that going to fix somebody.'* (Adoption SW2; LA G; Non Integration)

One social worker referred to '*the great river of therapy*', and the need to not expect CAMHS to 'fix' a child via therapy.

> *'…very often the pressure is from people who want something done therapeutically about specific behaviours…. The distress, the sadness, the grief, the depression, all those enormous adult terms that we do and can apply in children, very often get subsumed into, "I wish he'd just stop doing this.'* (Adoption SW1; LA G; Non Integration)

Another similarity emerging from the social work focus groups was that the majority of social work discussions about mental health related to observed behavioural symptoms. A small number of social workers distinguished between behavioural problems that were due to social and environmental circumstances, and mental illness. Some social workers identified the following factors: genetic influences; points of transition for children between placements in and out of care; the importance of understanding the nature/nurture debate; and issues around predicting future behaviours of young children, particularly in adoption. There was a good appreciation of the complexity of understanding about how to

manage this, '*…we haven't got a crystal ball and that's what we struggle with. I don't know about you, I struggle with it all the time…*' (Adoption SW2; LA G; Non Integration). The work that foster carers and other agencies did with children, in particular schools, was noted by social workers.

Social workers in a small number of focus groups showed an understanding of the link between a complex understanding of mental health and the skills required by foster carers and adopters when caring for looked after children.

> *'What we need to look at is adopters who have some understanding of mental health as a positive understanding of supporting it, rather than looking for adopters all the time who want somebody to come in, give people a bit of an MOT, get them over adolescence, define, 'this behaviour's due to adoption, this behaviour's due to temperament, this behaviour's due to nurture', which we do get. We have to accept that people can have highs and lows in their lives, can be affected in terms of their mental health in the same way as their physical health, and they survive it. But I do not feel we often believe that when we say it. We feel that they've got to be got better.'* (Adoption SW3; LA G; Non Integration)

There was also an acknowledgement of the complexity of the caring role and some of the barriers that got in the way of accurate assessments of children's needs (e.g. foster carers blocking children moving on; placement changes for children) and the importance of supporting the foster carers and adopters well in caring for children who were emotionally damaged from many of their pre and in care experiences. In this regard, adoption social workers reported having a different role than their looked after children social work colleagues in having to respond to adopters' questions about the future mental health needs for very young looked after children:

> *'one of our most difficult areas is trying to predict what the future may look like for a particular child depending on their age and obviously we're working with much younger children so we're having to try and guess really what that may look like in the future. In my experience, quite a lot of adopters have quite a high level of anxiety of what that may look like in the future because of their inexperience as parents and*

they want some kind of assurance from the authority or from the placement social workers as to what that behaviour may look like, how they may parent that behaviour and also what kind of support we can offer much further in the future.' (Adoption SW4; LA G; Non Integration)

One social work focus group discussed the kinds of children that were referred to CAMHS, questioning whether the confidence, experience and expertise of the social worker and foster carer had an influence on whether a child was referred to CAMHS, not just the characteristics and behaviours of the child. In other words, a social worker with low confidence led to more referrals to CAMHS. This is discussed further in chapter eight. This also links to comments made by CAMHS clinicians earlier in this chapter and by social workers in another focus group, who did not think they had the correct skills to approach this area of work competently and confidently, expressing a fear of mental illness.

> *'I think there is a real level of panic around mental health, and wanting to try and fix it and make it better immediately, but not actually having as social workers the ability to do that because we are not trained mental health professionals and we're sort of the jack of all trades and micro managers in what we do more than we are a specialist in anything.'* (Looked after children SW2; LA C; High Integration)

Social workers often referred children and young people to other agencies rather than undertake direct work themselves. CAMHS clinicians in focus groups commented on the many external pressures on social work time that affected the level of direct work social workers were able to do with children, including the high caseloads that social workers were expected to manage.

5.4.8 Social Workers and Resilience

Most social workers demonstrated an understanding of resilience and how to encourage resilience in the children they worked with. The relationship the social worker had with the child or young person was seen as crucial. Reliability, stability and dependability were core components of this. *'Being there'*, *'going the extra mile'*, *'let the young person know you are making time for him or her'*

were frequent comments. Social workers saw this relationship as more important than information gathered from a questionnaire like the SDQ.

Social workers talked about their role in encouraging resilience by being able to identify the positive qualities of children and young people, and build on these, even if they were small. Some acknowledged that this could be hard to do for some children:

> '*Sometimes it's quite difficult to try and be positive about a child and to look for the resilience, to look for the positives, their strengths.*' (Adoption SW, LA G, Non Integration).

Participation in school and after school activities, including sports clubs, music and cultural activities could encourage children's and young people's confidence and self-esteem. However some children and young people were not able to take advantage of these opportunities; '*some young people 'kick-off' at every available opportunity*' (SW for looked after children, LA D, High Integration), because of their experiences, their vulnerabilities and low self-esteem. Some children found socialising with peers difficult. Social workers commented that although they saw their role as important in working with and encouraging resilience, their high caseloads affected how much time was available for direct work or life story work.

Another issue emerging from a few focus group discussions was that of temperament and IQ and how this affects resilience.

> '*... you have to know a child's temperament and you have to assess that as much as their emotional wellbeing, and figure out how to build self-esteem.*' (Looked after children SW, LA D, High Integration).

Social workers identified the need to adjust parenting techniques to match the child so that the strengths and weaknesses of children are accounted for and nurtured. They suggested that assessing the resilience of placements was a task for social workers too. Stable placements, good carers, good attachment experiences, health developmental opportunities throughout their life, good health care, education and good social developmental opportunities with peers were the features of good quality placements identified by social workers.

5.4.9 Social work views about labelling and stigma for looked after children – social and medical models

Many of the social work focus groups had views about the labelling and stigmatising of children with mental health problems via diagnosis. This was a big issue for social workers and, they claimed, for children and young people too, to the extent that it stopped young people seeking help and might stop social workers referring children and young people to CAMHS. Some social workers said they would only refer to CAMHS when everything else had been exhausted. There was some awareness of the conflict between the social models and medical models affecting practice:

> *'I also think that mental health diagnoses ... is a very medical way of viewing behaviour and people, and we as social workers try not to prescribe ourselves to look at it in a medical model way. So that's why we're much more into context, much more into relationships and I think that's why we shy away so much from, you know, labels and, because it does go down the 'white coat' avenue and you need a pill or you need a hospital wing, but really we ask ourselves, 'what is that diagnosis going to do? What use is that going to have for this young person in their life right now? What service will it get them that we can't already get them?'* (Looked after children SW; LA C; High Integration)

5.5 Chapter Summary

This chapter has presented a general description and overview of the results of the research. The way in which the SDQ data were collected for the Department for Education return and used in each local authority was different and was dependent on historical agreements between local authority commissioners and CAMHS. For the vast majority of local authorities included in this study, use of the SDQ was largely administrative and was divorced from practice. However, in a small number of local authorities specialist CAMHS used the SDQ alongside social workers in an integrated manner, but this was a minority as most social workers simply did not use the SDQ in their practice. This finding addresses my second and third research questions regarding social workers' use of the SDQ.

All except one CAMHS used the SDQ clinically, but this was not the version completed for the DfE return. However, there was some debate about its efficacy for looked after children as too many children scored highly and it was not sensitive at measuring change. One specialist CAMH service did not use the SDQ as a tool in practice because of this. In one area the SDQ was used as a referral criterion to limit access to CAMHS due to high thresholds (children and young people have to score 17+, which was in the 'abnormal' band). This finding addresses my first research question regarding professionals' views and experiences of the SDQ, including its suitability for practice.

Local looked after children specialist mental health teams were valued enormously by social workers. In the main, they were seen as flexible and approachable and were able to see children reasonably quickly. Long waiting times did apply with some services though, for example general CAMHS had very high thresholds, and out of borough CAMHS were not reliable, with many children who were placed out of borough not receiving a service, despite the existence of national statutory guidance on this issue. Consultation was used effectively in all CAMHS included in this study and was one way in which social workers and foster carers received a timely service about any cases that were of concern to them. This finding relates to my fourth research question, which concerns the working relationship between professionals.

Many CAMHS clinicians did not think that social workers had the correct skills and knowledge about child and adolescent mental health to identify and respond to many of the problems that looked after children might have because of their pre care experiences. This also included being able to use the SDQ in practice. Consequently some of the social work referrals received by CAMHS were not viewed as appropriate by CAMHS. CAMHS practitioners were divided regarding whether it was more experienced social workers who understood the importance of mental health in the lives of looked after children, or whether it was newly qualified social workers, who had received better training on this issue and were thus more responsive to the mental health needs of looked after children. This finding is relevant as background to my second research question; the social workers did not appear to have adequate knowledge and skills in assessment of

the mental health needs of looked after children, which then influenced how CAMHS specialists perceived them.

Social workers understood their role with regard to mental health as monitoring, signposting and liaising with specialist services rather than working directly with children with mental health problems because of time and caseload pressures. Most social workers were able to give a good account of the concept of resilience and how this applied to their work, including the importance of their own role in working directly with children, but they also talked about how work pressures affected their ability to undertake this work. Social workers also acknowledged the complexity of the caring role for foster carers and adopters. Some were critical of how social workers saw therapy as a 'cure all' for looked after children. This finding further explores my second research question regarding how social workers assess mental health needs.

Having provided an overview of the results of my research, the next chapter presents the research findings using the NPT model. This analysis affords the opportunity to review the range of activities comprising the SDQ process across the local authorities researched. The implementation of the SDQ can be considered as a change process; application of the NPT framework revealed the strengths and weaknesses of this process.

Chapter 6 The extent of 'normalisation' of the SDQ in social work practice with looked after children

6.1 Introduction

The purpose of this chapter is to draw together, and examine in more detail, findings presented in chapter five that relate to the first of the three themes outlined in chapter five: *Meaning and significance of the SDQ for social workers and CAMHS* (table 5.1 on p129). The chapter uses Normalisation Process Theory (NPT) (May et al., 2009b), including the four headings and sixteen sub headings developed as part of the model, as a structure with which to consider certain aspects of the qualitative data. It appraises how the SDQ has been routinely operationalised or 'normalised' in everyday work, focussing on how people work together (May and Finch, 2009a).

The NPT framework can be used as a model and framework at various stages in a research project. NPT was not used when formulating my research questions, topic guides or schedules. Instead I have used NPT as a framework to assist with analysis as it is designed to work well with complex interventions. NPT is framed around four questions: What is the task?; Who does the task?; How does the task get done?; and How is the task understood? The focus of this chapter is to investigate social workers' use of the SDQ to help them identify what help and support children need regarding their mental health.

The statutory guidance for the health and mental health of looked after children (Department for Education and Department of Health, 2015) states that:

> *'Information in the completed questionnaires is collected by the local authority and the child's total difficulties score is worked out and available to inform the child's health assessment. This should help the social worker and health professionals to decide whether ... the child needs to be referred for further diagnostic assessment of their mental health. If the child's SDQ scores suggest there are underlying problems,*

> *this should trigger consideration of a fuller diagnostic assessment.'* (p30
> - 31)

The statutory guidance clearly sets out the expected manner in which the SDQ data will be collected (Department for Education and Department of Health, 2015), but there is a degree of flexibility in who is charged with completing the data collection and the manner in which the data collection is undertaken. The Government guidance sets out the process by which it expects this information to be collected and analysed. The child's carer should complete the SDQ, the local authority should collect it and it should be analysed in time for the annual health assessment. If necessary, it says that a triangulation of scores can occur with the teacher version and the self-report version, depending on the age of the child. If the SDQ score is high, then a referral to CAMHS for diagnostic assessment can be considered.

> *'The SDQ should be used as evidence to support a referral to local*
> *targeted or specialist mental health services, where appropriate.'*
> (Department for Education and Department of Health, 2015; p30)

Most local authorities used the annual health review as a focus to collect the SDQ data from the foster carer, but although the 'total difficulties' score was sent to the local authority for the DfE return, in the majority of cases it was not sent to the social worker, or it might appear on the child's electronic record without the social worker being aware of it. This neither meets the DfE expectations, nor ensures that the SDQ informs the planning processes for the looked after child. Only one specialist CAMHS in my sample (HT 3;LA D; Integration level A) routinely triangulated SDQ data from different versions when they collected the SDQ data from carers.

There is a clear statement within the statutory health guidance that says:

> *'While the Department for Education requires local authorities to provide*
> *SDQ data to be completed for looked-after children by their foster carer*
> *or residential care worker, local authorities should not see this as purely*
> *a data collection exercise by central government with which they must*
> *comply.'* (Department for Education and Department of Health, 2010,
> p10)

As a tool, the SDQ has potential to be used in a range of ways, as recognised by the Department for Education. If, as a data collection method, it is undertaken as a 'tick box' exercise, its full functionality is not utilised. As described in chapter five, if social workers are not informed about the results of the SDQ, do not receive the training to understand it and do not have the time to receive and reflect on these data, alongside other information about the looked after child, then the majority of social workers perceive the SDQ as a data collection exercise. This means that they are not likely to utilise the SDQ in their practice with looked after children.

However, in order to understand how an intervention is embedded into practice, it is important to not just look at what the work is, but what people do and how they understand the work. The rest of the chapter uses the NPT framework to examine the qualitative data, beginning with an overview of NPT.

6.2   Normalisation Process Theory

The main tenets of NPT are outlined in chapter four. NPT is part of a growing number of theories concerned with complex interventions and implementation. According to Craig et al. (2008), complex interventions are:

> '*Conventionally defined as interventions with several interacting components, they present a number of special problems for evaluators, in addition to the practical and methodological difficulties that any successful evaluation must overcome. Many of the extra problems relate to the difficulty of standardising the design and delivery of the interventions, their sensitivity to features of the local context, the organisational and logistical difficulty of applying experimental methods to service or policy change, and the length and complexity of the causal chains linking intervention with outcome.*' (Craig 2008, p6)

Given the complexity and diversity of the population of looked after children being screened, although the SDQ is a single tool, it is applied through a complex process (Wilson et al., 2009). NPT provides a framework that acknowledges and encapsulates the complexity of process and content for practice. NPT begins with a position that:

> *'Complex interventions become routinely embedded (implemented and integrated) in their organizational and professional contexts as the result of people working, individually and collectively, to enact them.'* (May et al., 2009B, p2

According to May et al. (2009a), embedding is how practices become part of everyday routines in the workplace; implementation is concerned with the actions by which an intervention is integrated into practice; and integration refers to how these changes to practices are sustained (May et al., 2009a). In other words, what people do and how people work together are important in understanding how practices become embedded and normalised in organisational practices. The three concepts of embedding, implementation and integration are either encouraged or discouraged through what May and Finch (2009b) refer to as the operation of '*generative mechanisms through which human agency is expressed*' (p2). These generative mechanisms are the four core constructs that make up the NPT framework.

In the NPT framework, the four questions listed above directly link to the four NPT core constructs (May et al., 2010): coherence (*what is the task?); cognitive participation (*who does the task?); collective action (*how does the task get done?)*; and reflexive monitoring (*How is the task understood?/Why did it happen like that?)*. Table 6.1 (below) provides a summary of these constructs and their related components. The rest of the chapter discusses how each core construct, along with the four related components, relates to how social workers use the SDQ to identify what help and support children need.

Tble 6.1: The Core Constructs and Components of NPT

Core construct	Components
Coherence (What is the task?)	• Differentiation • Communal specification • Individual specification • Internalisation
Cognitive participation (Who does the task?)	• Initiation • Enrolment • Legitimation • Activation
Collective action (How does the task get done?)	• Interactional workability • Relational integration • Skill set workability • Contextual integration
Reflexive monitoring (How is the task understood?)	• Systematisation • Communal appraisal • Individual appraisal • Reconfiguration

Each section will begin with the relevant section of Table 6.1 to provide an overview of the relevant areas for that construct. At the end of the chapter another similar Table provides a summary of the results presented.

6.3   Coherence - What is the task?

Table 6.2: Coherence - What is the task?

Core construct	Components
Coherence (What is the task?)	• Differentiation • Communal specification • Individual specification • Internalisation

This section of the theory is concerned with understanding the task, i.e. 'sense-making' work. It seeks to understand the way in which practitioners translate a new activity at an individual and collective level into mainstream practice. There are four separate components in this 'sense-making', and each will be addressed in turn in relation to the use of the SDQ by social workers in assessing the mental health needs of looked after children.

6.3.1 Differentiation

Differentiation *'defines a practice and organises its relationships with other practice and contexts'* (May, 2010a). This component is concerned with how social work practitioners differentiate between the usual ways they assess mental health in looked after children and how they are expected to do it since the introduction of the SDQ as a screening tool. When investigating the way in which social workers use the SDQ, the first question to ask is 'why is an annual mental health screen for looked after children necessary as opposed to 'service as usual'?' 'Service as usual' involves mental health being monitored as part of an annual medical examination and via six monthly looked after children reviews. It does not usually involve reference to the SDQ.

> *'I've never known a social worker refer to the SDQ.'* (IRO1; LA B; Non Integration)

A broad range of views were expressed by the social workers who attended focus groups as part of this project about the effectiveness of 'service as usual' compared with using the SDQ as a screening tool and many of these points are outlined in chapter five. These relate to high workloads of social workers which makes introducing another routine task difficult; the absence of training for social workers in using screening tools; social workers not trusting the results of the screening tool and the science behind its development; potentially labelling children unnecessarily with mental health problems; and looked after children annual medicals and six-monthly reviews concentrating on physical health rather than mental health.

According to social workers, mental health issues were not identified via the SDQ but were identified through other means, for example by:

> *'You observe behaviour.'* (looked after children SW; LA D High Integration)

> *'Their presenting behaviour, their social presentation, maybe information received from other professionals.'* (looked after children SW; LA I; Non Integration)

> *'A lot of them it's behaviour isn't it, in terms of how they interact with carers, social workers, and how they respond to, well any professionals*

and their peers, and some young people display very challenging
behaviours or they may start self-harming ..' (Looked after children SW;
LA E, Moderate Integration)

According to social workers, mental health issues were routinely discussed at
looked after children's reviews, and recommendations were then made
according to the individual circumstances of the child:

'Child care reviews usually bring all the professionals and people working
with the young people together, and then that's usually a good
opportunity for any concerns to be raised that they feel might need to be
addressed.' (Looked after children SW; LA F; High Integration)

For a lot of social workers, high caseload numbers limited the work that they
were able to do with looked after children, for example:

'I think nationally caseloads are too high, and I think that will always
affect the level of work you do.' (looked after children SW1; LA C; High
Integration)

In addition, a few social workers commented on the efficacy of the SDQ:

'I saw one spreadsheet, and I was like, 'what?' I think there were, is there
three categories? ....and I was.... I was like, 'that doesn't make any sense
to me at all!' to sort of box the children into one of three categories, and
I was very surprised at some of the categories and some of the
conclusions that had been reached about some of the children.' (looked
after children SW2; LA C; High Integration)

Chapter five mentioned that two of the nine local authorities included in this
research used the SDQ in their practice:

'In (LA H) we have these SDQ forms and questionnaires that we get for
every child and when that comes through during the LAC review times,
we get it and the social worker does the percent numbering and if it's
over a certain number then that's a trigger; that's a definite CAHMS
referral....' (Looked after Children SW; LA H; Moderate Integration)

Within these two local authorities where social workers did routinely use the
SDQ, a number of advantages were identified by social workers, including:

'The SDQ can be used to make sure the child is seen by the right people at the right time and then, as a social worker, supporting that or coordinating that support for the child.' (Looked after Children SW; LA H; Moderate Integration)

'I find the SDQs can be useful as little snapshots sometimes from other people's perspective.' (Looked after children SW; LA D; High Integration)

'When I go to the annual health self-assessment, I look back at the SDQs we've got on file which I understand normally take place at the time of the health assessment. Then I also talk to the teachers to find out how they're doing at school and foster carers.' (Looked after children SW2; LA D; High Integration)

However, social workers in these local authorities also identified a number of the disadvantages associated with routine use of the SDQ:

'… it's all collated, it's put in the system. But I don't see my completion of the SDQ has triggered any kind of action for them.' (Looked after Children SW2; LA H; Moderate Integration)

'… the score was 15 or 16 which triggered basically a referral to CAMHS is what we discussed (in the LAC review) although I'd already done that many, many weeks before.' (Looked after Children SW3; LA H; Moderate Integration)

'…generally, I feel unless it's a brand new case or a case I haven't been able to think about much, usually I've got a better idea from just the normal case work.' (Looked after children SW3; LA D; High Integration)

This shows that there were a range of ways in which social workers used or did not use the SDQ in practice. Taking into account these differentiating responses assists in understanding the ways in which social workers assess mental health of looked after children in their practice, including the reasons why social workers do not use the SDQ.

6.3.2 Communal specification

Communal specification can be defined as forming and organising shared beliefs and knowledge about the purpose of the practice (May, 2010a). The sense-

making work undertaken as part of developing coherence depends on different agencies working together to create an understanding of the aims, objectives, and expected benefits of a set of practices that are shared (May et al., 2010). The responsibility for supporting looked after children is complex, involving the entire professional community working together. Social workers routinely work with a number of different agencies and professionals, including: teachers; nurses; health visitors; GPs; other health professionals; youth workers; police; foster carers; organisations such as ChildLine; drugs projects; and youth justice services. In terms of creating coherence and agreement between agencies involved with looked after children working together, a number of regular meetings routinely involve multi-agency groups. This includes the six-monthly looked after children review meetings, annual Personal Education Plan (PEP) meetings and any 'team around the child'[28] meetings (National Institute for Health and Clinical Excellence and Social Care Institute for Excellence, 2010).

> *'In terms of our monthly visits, our liaison with the school, any other professional that's involved with this young person … we have lots - we have team around the child meetings. Because sometimes different teams know different things about the child … so we have a professionals meeting including the IRO so it's monitored in that way.'* (Looked after children SW; LA H; Moderate Integration)

These meetings acknowledge different agency roles and underpin the importance of sharing relevant information about children in order to ensure that the appropriate agencies are aware of relevant issues affecting children and decisions made about referral to services are jointly agreed and regularly reviewed (Department for Education, 2010). In this regard, these structures provide an opportunity for agencies to address many of the objectives that are required by May (2010a) in multi-agency 'sense-making'. However, this is not straightforward in respect of the SDQ because not all agencies use the SDQ in their practice. The organisation with most significance for social workers, in this regard, is CAMHS and the relationship between CAMHS clinicians and social workers will be explored in depth in chapter seven. For the purposes of this chapter, CAMHS and social workers have different relationships with the SDQ as

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[28] A collaborative team of key professionals and frontline practitioners to support a child or young person. The team may include foster or residential carers (National Institute for Health and Clinical Excellence and Social Care Institute for Excellence, 2010)

a screening tool, as it is used routinely in CAMHS practice with all children at the beginning, middle and end of their work. Chapter five showed that, despite some reservations, colleagues in CAMHS were confident in using the SDQ, and saw it as a tool that was good enough to give sufficient intelligence for them to monitor and assess changes in a child's mental health. Its strengths of being quick, cheap and easy to use, outweigh some of the disadvantages noted regarding its ability to accurately measure small amounts of change for children and young people.

One local authority that routinely used the SDQ in its work collected the teacher version of the SDQ, and social workers were positive about the accuracy of the teacher's reports, as well as how the current system could be improved to maximise the teacher information collected via the SDQ:

> *'Now that we just started doing those in the PEP we're already seeing there's a more detailed sense of information coming from the teachers than there are on the carer SDQs.'*   (Looked after children SW4; LA D; High Integration)

> *'Certainly the school ones that now come through, they're sent directly to my email so therefore I'm going to read them because I print them off and put them on the file. They are a useful tool but their timing could perhaps be slightly changed as well because having just had the PEP, the SDQ pretty much tells us what we've talked about and discussed at the PEP in more detail. So perhaps they could come before the PEP because they can inform the PEP how we shape the PEP and where we're going.'* (Looked after children SW5; LA D; High Integration)

This is a good example of how this local authority has normalised SDQ use, and shows the potential for the SDQ data to be used across agencies and integrated into planning processes for children. Mental health problems also affect children's ability to learn and so schools could be allies for social workers in supporting children to overcome challenges they face in their peer relationships, learning and achievements.

6.3.3 Individual specification

'Individual specification forms and organises personal beliefs and knowledge about the demands of the practice' (May, 2010a). The way in which individual social workers articulated their understanding of their role in using the SDQ was limited and fell into a small number of categories. Most social workers had heard of the SDQ but had not used it in their practice. These shared views created a strong consensus within the focus groups where contributions from individual members about the role of the SDQ as a marginal activity in the boroughs in question were accepted by other focus group members. The main theme that emerged from many of these focus groups was 'it is someone else's responsibility, not ours to do this'. There were a few social workers who had used the SDQ in previous places of work or who said that they were interested in learning more about the SDQ.

> *'I haven't used the strength and difficulties questionnaire with young people in LA F, but I have in another borough, and the young person is not always honest when filling it out, and they'll by-pass bits so I'm not convinced that it's a fantastic tool to be used because the young person doesn't always answer honestly.'* (Looked after children SW; LA F; High Integration)

An Independent Reviewing Officer in one local authority, which used the SDQ in practice, spoke about the benefits of the SDQ as a screening and monitoring tool for individual children.

> *'We've been getting SDQs for quite some time now. For me, why I might be looking at it as a monitoring tool is because I'm seeing I might start off with ... I've reviewed for two years now so some of those kids that I did the initial one with, to see the progression. So in my head, even though I might not do something physically with it, I'm looking at it in terms of development and progression for that particular child.'* (IRO; LA D; High Integration)

The IRO's comments showed the potential of the SDQ screen to monitor children's progress over time. As the independent chair of the looked after child's six- monthly reviews, the IRO was responsible for routinely reviewing the

mental health of looked after children and this included liaison with CAMHS. May et al., (2010) comment on sense-making for individual participants involving completing activities that help them understand their specific tasks and responsibilities around a set of practices. In this sense the IRO's role was crucial, and routine use of the SDQ data was one way of embedding change within social work practice and processes. However, this sense making activity also took place in local authorities where the SDQ was not routinely used by social workers:

> *'Well I mean obviously part of the review process is to look at a child's care plan and it's... you have to look through all parts of their... you know, their development, so emotional, social and behavioural, would be an important part of it ... some IROs will record mental health under health, some will record it under the section on emotional and behavioural development. There's also a section on assessments, so if there was, for instance, CAMHS involved, that might be mentioned under there......so you... so you're sort of signposted to looking at health, and that does include mental health of the child.'* (IRO; LA B; Non Integration)

This suggested that the SDQ may not be having any impact on social-work sense-making.

6.3.4 Internalisation

Internalising sense-making is about understanding the value, benefits and significance of a set of practices (May et al., 2010). My research found that most social workers did not value the SDQ screening tool, nor understand the importance and benefits of using this in a routine practice context.

> *'I think they're yearly that we're sent these forms to complete. It's all collated, it's put in the system. But the young people I see unravelling, I don't see my completion of the SDQ has triggered any kind of action for them.'* (Looked after children SW; LA I; Non Integration)

The results in chapter five showed that the SDQ was not completed by social workers and was most often divorced from the assessment and care planning processes used for looked after children. The majority of social workers did not use the SDQ in their practice.

> *'...my knowledge [of the SDQ] is really limited.'* (Looked after children SW; LA C; High Integration)

> *'There's been a thing about lack of dissemination of information about SDQ's. And I was only made aware by an independent reviewing officer who put it down in her decisions about the SDQ's. I wasn't aware at that point that they were compulsory for every looked after child.'* (Looked after children SW2; LA C; High Integration)

The most recent statutory guidance for the health and wellbeing of looked after children (Department for Education and Department of Health, 2015) stresses the importance of the SDQ screening tool as a mechanism for forecasting the needs of looked after children, but this does not appear to be taking place. This was further discussed in chapter two, focusing on Wilson and Junger's (1968) criteria for screening populations for non-infectious diseases (Wilson and Jungner, 1968, Public Health England, 2013, Public Health England, 2014).

6.3.5 Summary: Coherence

The 'task' as highlighted in this section is whether the SDQ screen identifies those looked after children who need help and support with their mental health, and what social workers do with this information.

Social workers involved in this study relied on concerns about children and young people's behaviour as a trigger to consider whether a referral to specialist mental health services might be appropriate. For most of the social workers, this did not involve using the SDQ screen in any capacity. A number of regular meetings held about all looked after children involved practitioners from a variety of agencies (e.g. PEP meeting and looked after children reviews) discussing the progress of children and young people, including their mental health or emotional and behavioural issues. My data suggested that the SDQ was rarely a focus of these discussions. The experiences of social work staff in local authorities where the SDQ was routinely used was mixed, with positive and negative aspects of SDQ use identified. This makes internalisation difficult, as *'the value, benefits and significance of a set of practices'* (May et al., 2010) are not universally recognised.

6.4   Cognitive participation - Who does the task?

Table 6.3: Cognitive participation - Who does the task?

Core construct	Components
Cognitive participation (who does the task?)	• Initiation • Enrolment • Legitimation • Activation

Cognitive participation relates to the commitment and engagement by participants to build and sustain practice around a new complex intervention (May et al., 2010). This is referred to as **'relational work'.** The 'who' in this instance are the people with the responsibility for gathering and acting on the annual SDQ screening data. There are **four** separate components in this 'relational work': initiation; enrolment; legitimation; and activation. Each will be addressed in turn.

6.4.1 Initiation

According to May et al., (2010), initiation refers to whether or not key participants are working to drive a new or modified set of practices forward. In terms of the SDQ screen, most social workers see this as an administrative exercise that has little relationship with their own practice: they do not drive this new practice and it is not fully integrated into their practice processes in those local authorities.

> *'The SDQ seems to be done very remotely, with the emphasis being on making sure they're done and collecting them … yes, it seems to be a remote tool.'* (Looked after children SW; LA A; Non Integration)

However this did not stop some individual staff using data from the SDQ in their work:

> *'The SDQ is always done as part of the health assessment with the looked-after nurse. And so unless you have sight of the health assessment, the*

recorded health assessment, you won't see the SDQ, and the social worker may or may not, you know, look at it or read it. I've never known the SDQ referred to in the social worker's report, but I've referred to it myself... it should be used, the information should be used and fed through and thought about, otherwise it's... I can't see the purpose of it.' (IRO1; LA B; Non Integration)

In this local authority the three Independent Reviewing Officers (IROs) who were interviewed did recognise both the usefulness of the SDQ as a screening tool and the importance of their role in driving through a change in social work practice in relation to the SDQ. Here, initiation was occurring.

'...you read the health assessment, and if there's an SDQ, then you would see that that's there and then some of the issues that the looked-after nurse has raised. So in terms of our service, given that we (IROs) have the continuity, we could probably argue that this should be a role for actually the SDQs being passed onto us, or highlighted, particularly where the nurses are raising high concerns.' (IRO2; LA B; Non Integration)

One social worker in one of the local authorities that did routinely use the SDQ was able to clearly describe the SDQ process used in that local authority. However this was atypical.

'The SDQs are sent out by the administrators for the independent reviewing officers. They're returned and they're now placed on to an SDQ kind of form that's on our database by our admin. They're then sent to our LAC nurse and then if there's a problem or if they're scoring high they're tasked to an independent reviewing officer who then tasks an action to us and I think it goes to our manager. It's a whole series - I tracked one of them back and that's the process that's been introduced.' (Looked after children SW; LA H; Moderate Integration)

The process recounted above involved up to seven different personnel: the IRO administrator who sent the SDQ out; the foster carer who completed the SDQ; the looked after children team administrator who placed some of the SDQ data onto another form on the council database; the administrator then sent the SDQ to the looked after children nurse to code; if there were problems then the

nurse sent the SDQ score to the IRO; the IRO asked the social worker to action a response; the IRO sent details of this to the social worker's team manager. This local authority was not alone in creating highly administrative methods:

> *'Local authorities had given the SDQ to our head of service and that was given to my social workers to send out to their carers, and once they'd completed that, they had to return it back to the head of service who would then send that off to the local authority social worker. It's a long way of doing things!'* (Supervising social worker for an independent fostering agency)

CAMHS clinicians in all the specialist mental health services for looked after children also became key advocates/initiators supporting social workers developing greater awareness of mental health issues for looked after children and integrating this into their practice. However, alongside this there needed to be an understanding of the social work task. To be effective, services need to be developed to meet the needs of looked after children, with professionals working together understanding each other's contributions with a similar commitment to changing and improving practice.

> *'The LAC psychologists seem to deal with the emotional side of children's issues and the mental health and the clinical nurse specialist tends to deal with the physical stuff, so it feels quite separate really. And they did try to come together at one point, they had … gosh, I think it was called '[name of service]', so we had a LAC psychologist, the clinical nurse specialist, an educational psychologist and I think there was a fourth person and this was available say once every two weeks or something and the social workers could go and take issues to this little forum, but that seemed to die a death really.'* (Looked after children Team Manager; LA F; High Integration)

6.4.2 Enrolment

Enrolment '... *forms and organises the way that participants join in a practice*' (May 2010). The engagement required throughout an organisational structure when a complex intervention is introduced into practice is considerable. This engagement involves individual practitioner and multi-agency group

relationships at the front line, as well as operational and strategic levels of organisations working together.

> *'Part of that, each team now has identified links between the CAMHS team and the children in care teams, as sort of virtual integrated team members with regular fortnightly consultation ... with a view that you help social workers be thinking about mental health of children in their care plan and you identify children earlier into CAMHS.'* (Clin Psych; HT 9; High Integration)

Getting social workers to use the SDQ and 'buy in' to a different way of assessing mental health was vital to its success. However, this was not just about a commitment from individual social workers to use SDQ data in their work with looked after children. It required a deeper understanding of the reasons why looked after children were affected by poor mental health, how tools like the SDQ could be used in practice and knowledge about interventions that were effective;

> *'What they do at the moment I think, from what my understanding is, is that the SDQ total score is put on there [the LA database], it's not broken down and I don't think it's particularly helpful. You just get a total score but you don't know whether it's around attention, conduct, emotional or what it is.'* (Clin Psych; HT 9: High Integration)

It also required a commitment by staff at more senior levels of the organisation to use data that were collected about looked after children across the organisation in a 'joined up' manner when commissioning mental health services for looked after children.

> *'We [clin psych and LA service manager] had meetings a year and a half to two years ago about out of city placements and looking at the data from the SDQ to identify those children who are in need of CAMHS, those that were presenting with really high scores on the SDQ and whether they're receiving it. Now, if you talk to neighbouring authorities, a lot of other services are using 17 as a cut off point in terms of clinical indicator. The LAC nurses will use [the SDQ] like an indicator but there isn't an established formal process of them saying, 'okay there's a high level on an SDQ here, let's prioritise it, let's think about this child'. But that's what we're moving*

towards with this fortnightly consultation programme; to say, 'what is the SDQ score for this child? Tell me a bit about the context - then let's think whether actually that's a need for a referral. Have you thought about a referral? Actually it sounds like it might be needed.' Or 'well, it's understandable that they're within this context, that it's that high at the moment because if you look at that - and actually it sounds like they're being supported so maybe a referral isn't necessary at the moment.' (Clin Psych; HT 9; High Integration)

6.4.3 Legitimation

Legitimation '*forms and organises shared beliefs about the legitimacy of participating in a practice*'. Ensuring that participants think that their involvement is necessary and their contribution is valued is an important component of relational work. May et al., (2010) suggest that new service interventions often fail because of a lack of understanding about the ways in which the intervention might fit with current practice, or might challenge current protocols or ways of working, and this can include multi-disciplinary groups. Working out who takes responsibility for what can expose tensions. An example of this from my own study was one CAMHS clinical psychologist who spoke about long standing arrangements between health and social care senior managers about who would score the SDQs returned to the local authority as part of the annual data return to the Department for Education. As a consequence of this strategic decision, the clinical psychologist had to score all the SDQs alongside other responsibilities and this had not been completed because of other priorities.

> *'...somewhere along the line when the big managers had a meeting, it was agreed there was some funding paid or something, it was agreed that the NHS bodies would analyse the SDQ results for them. So they all get sent over here, they've not yet been analysed and this is a good couple of years on, so then after collecting all these, nothing has been done with them...'* (Clinical psychologist; HT 10; High Integration)

One local authority, which had embedded the SDQ into practice, had two key members of staff championing its use: a looked after children's service manager

and a social work team manager of the specialist CAMHS (High Integration). This helped secure the role of the SDQ within the organisation.

> *'What we will do is not only take their new SDQ, we'll take their old one. We also break the diagnostic predictors down by each year, then we do the brief background and we talk our clinical impressions and initial recommendations. One of the great things about our team is not only do we give therapy, but we signpost. You earlier said what kind of, what do the Social Workers do with it? We've actually kind of reversed that. We have taken ownership of all the mental health, emotional well-being, anything that we can do, we've taken that upon ourselves.'* (Social Work Manager CAMHS; HT 3; High Integration)

This shows how complex legitimation activities are in local authorities. Ensuring that statutory returns are completed is not the same thing as advocating for and supporting the use of the SDQ in practice throughout an organisation at a micro and meso level. Both have their place.

6.4.4 Activation

Activation '*forms and organises the ways that participants continue to support a practice*' (May, 2010b). Once the task or the intervention is introduced into the practice environment, the actions and procedures needed to sustain a particular practice should be shaped and defined by those involved with the intervention. This was a long way from the experiences that many social workers described in the focus groups, which they saw as 'top down', procedurally driven practice, which was divorced from their working reality.

> *'In my experience of the SDQ, I know of it, I know they're used, I think there's a performance indicator attached to it – and in the borough that I work in it's the admin staff who send them out to carers and then they call the carer and remind them to complete them and then they're returned. I haven't seen an SDQ form, I'm aware the data's collected and we pass on information; if the child scores high, you get a message to say 'this child may need some CAHMS input', for example … that's what I know already.'* (Looked after children SW; LA A; Non Integration)

The following quotation gives a more positive account of a social worker's knowledge of process within a particular local authority. The social worker knew what the SDQ was and what the role and responsibility of a social worker was following a looked after child receiving a high SDQ score.

> 'Okay, we have been using this for a while now and yes, they're part of the Performance Indicators and it has to be coming in and you've got to show how many you've done, etc. But in terms of flagging up the scoring, with high scoring, that information would come to us as social workers and it's our job to look at that and then if it says it needs CAMHS or whatever therapeutic intervention or whatever else, then as a social worker it's our role to then take it forward in terms of the referrals or coordinating a service that that child might need.' (Looked after children SW2; LA H; Moderate Integration)

May et al., (2010) suggest that one of the important factors in normalising a new practice is keeping the new practices in sight and being seen to be used, so that this is communicated to the people who need to be 'doing' the new practices. CAMHS clinicians were also involved in this data collection process and experienced in this practice so able to model the practice of using the SDQ. The following lengthy quote shows the layers of complexity involved in negotiating and managing many different elements of services involved in the practice process, including how those involved in the process were shaping and defining how it was integrated into practice:

> I'll tell you what happens and where we're up to with it. I feel like I'm forever chasing people about this. Over in mainstream CAMHS we're part of CORC and they have the standard questionnaires. As part of that we do the SDQ, so everybody – so because I'm governed by the NHS CAMHS, every case I open has an SDQ, every time I close a case they have an SDQ. The admin staff are in charge of sending those out and getting those back in.
>
> So then I came to post in the specialist looked after children service in the local authority and I got involved with the management over in Social Services and they were just saying can you help us with our SDQ's. So

what they are doing at the minute, it literally is a Social Worker's responsibility to try and remember to get the SDQ's done. But I've set the social services admin up with a database as the team are really good at getting them scanned, logged and all on the system, so then we could find how many we have got, who's got them, how long ago. They've got it all logged on to a system individually and collectively for each child that has one. So I then said to them the best way to collect this information would be to have a date, like a month that we choose, where we send them all out and send them in you know stamped addressed envelopes to come back to us. That hasn't yet happened.

They then started talking – because the Social Workers weren't very good at getting the SDQ's filled in, they then contacted the LAC nurses, who are NHS and said to them, for every health assessment you do, can you do an SDQ? So I trained the LAC nurses about the SDQ's and they are very good at doing them. Now the LAC nurses have realised they aren't always doing the health assessments, sometimes they ask the health visitors or the school nurses to do assessments, so now they are asking me to do the training on the SDQ, so that we can get them filling in the SDQ's. So it's a bit of a nightmare really.' (Clinical psychologist; HT 10; High Integration)

6.4.5 Summary: Cognitive participation

The purpose of this section is to comment on who it is that collects the annual SDQ screening data. There are a number of different ways in which this task was undertaken in the local authorities that took part in this study. Sometimes it was embedded into routine practices, such as the looked after child's annual medical examination, where a looked after children's nurse would collect the carer SDQ and the information was then made available at the looked after child's review, or social workers were contacted directly if the child's SDQ score was high. Other local authorities used administrators to send out the SDQs and this was undertaken as an administrative exercise only. Some examples were given of how health services and local authorities worked together, including areas of friction. This 'relational work' section of the NPT framework highlights the degree of 'top down' direction given to the practice processes, with the

statutory guidance (Department for Education and Department of Health, 2015) providing 'legitimation' by setting out expectations for the SDQ returns. Using these NPT concepts, it would appear that the degree of practitioner participation in legitimising the way in which the SDQ was incorporated into practice was minimal, and as a result social workers in a number of focus groups identified heavily bureaucratic processes for collecting and using these data, where staff members' individual and collective ability to shape and define, or legitimate and activate the intervention, was limited.

6.5 Collective action - How does the task get done?

Table 6.4: Collective action - How does the task get done?

Core construct	Components
Collective action (how does the task get done?)	• Interactional workability • Relational integration • Skill set workability • Contextual integration •

May et al., (2010) refer to the characteristics of this, the third NPT core construct, as the **'operational work'** that people do to enact a set of practices or make their intervention function. The consideration in this instance is how the SDQ data were gathered. The four components of collective action are interactional workability; relational integration; skill set workability; and contextual integration. Each will be addressed in turn.

6.5.1 Interactional workability

This refers to the work that people do with each other, when operationalising an intervention such as the SDQ screen into everyday settings (May et al., 2010). There were as many different ways in which local authorities and CAMHS gathered the SDQ data as there were local authorities co-operating with this research. What was clear from the qualitative data was that the majority of social workers interviewed were not routinely involved with the Department for Education collection processes, apart from being asked by administrators to

supply addresses for foster carers. This extended to most social workers not being regularly informed of the SDQ scores for the children they were allocated. As an exception, a small proportion of social workers were informed and were expected to use this information in the care planning processes for the child.

Diagram 6.1 shows the two pathways used by the local authorities and the health trusts to collect the SDQ data.

Diagram 6.1: The two methods used by Local Authority and CAMHS personnel to collect and disseminate the SDQ data
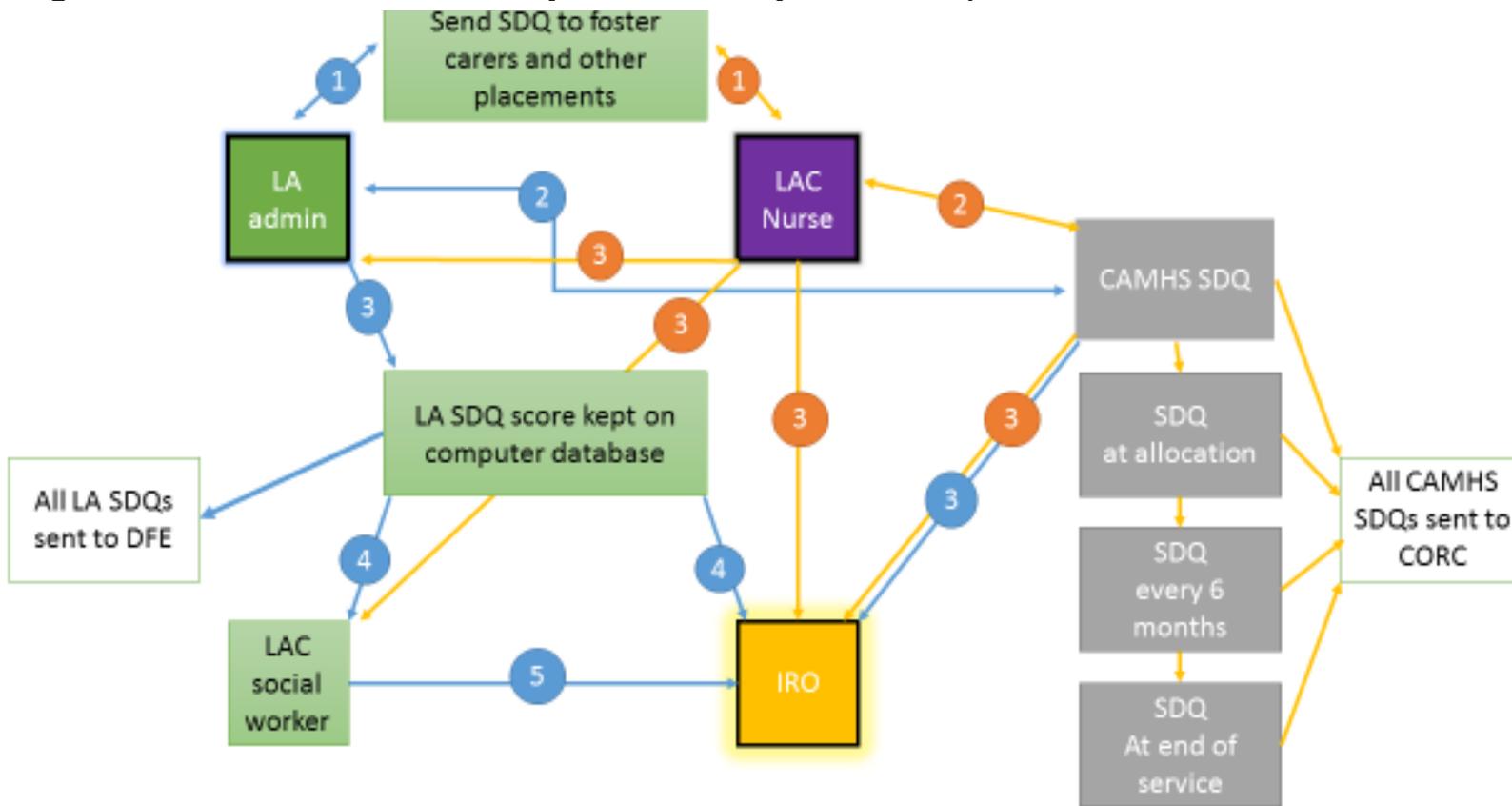
Key:
CAMHS Looked After Child Nurse sends out SDQ (process set out in orange)
LA admin sends out SDQ (process set out in blue)

Independent Reviewing Officer (IRO)
CAMHS
Local Authority

There are two pathways shown in the diagram. The numbers denote the order of events in the diagram and the direction of the arrows indicates who sends the information to who. A double headed arrow indicates that the information is sent out and returned to the originator.

The blue pathway is the pathway that the local authority used to gather SDQ data for the statistical returns. The administrator sent the SDQ to the foster carer or other placement provider (1), who then completed and returned it to the administrator (1). It was then sent to, and scored by a CAMHS clinician (2), who returned it to the administrator (2) who entered the score on the local authority database (3). A CAMHS clinician could also send the SDQ score directly to the Independent Reviewing Officer (IRO) (3), in which case the IRO administrator entered it onto the local authority computer database (4). The social worker could access the score from the computer database (4). The IRO used the SDQ score during the six-monthly looked after child review process to review the mental health of the looked after child, in discussion with the social worker and other professionals present at the review (5). A local authority administrator also prepared the annual statistical return for the local authority, and the SDQ score is included in that return.

The orange pathway involved the looked after children's nurse sending the SDQ paperwork to the carer and then collecting it at the annual medical for the looked after child or young person (1). The foster carer or residential placement provider brought the completed SDQ score to the medical, or the foster carer or residential placement provider completed the SDQ at the annual medical appointment (1). In most cases, the nurse either scored the SDQ themselves or passed the form to a CAMHS clinician to score (2), and the CAMHS clinician then passed the completed SDQ back to the Nurse (2) or to the IRO (3). The Nurse then returned the form to the social worker (3) or the LA administrator (3). As before, the IRO used the SDQ score during one of the six-monthly looked after child review processes to review the mental health of the looked after child. The local authority administrator entered the score on the local authority database and the social worker could access the score from this. A local authority administrator also prepared the annual statistical return for the local authority, and the SDQ score was included in that return.

The CAMHS SDQs (grey boxes to the right of the diagram) which are completed at the beginning, every six months during, and at the end of their work with children, were routinely sent to CORC. This was a separate arrangement from the local authority's SDQ returns.

6.5.2 Relational integration

This relates to professional confidence in the validity of the practices being used (in this case the SDQ) and in the ability of social workers to use the SDQ in their work.

In chapter five, a number of social workers raised their concerns about the validity of the SDQ in terms of whether the carers tasked with completing it did this accurately.

> *'I think some of the foster carers that have completed some of the SDQ's, I'm not so sure sometimes about...about their...about how they perceive the young people, and whether that's a true reflection.'* (Looked after children SW1; LA C; High Integration)

In addition to this, chapter five outlined social work concerns about the validity of the SDQ in identifying mental health problems, and the intended and unintended consequences of labelling children and young people:

> *'You know I'd be trying to defend them from a label like that, if you like, because that kind of feeds into all sorts of ideas that already exist about looked after children being 'damaged goods' if you like. And so it's very much a kind of 'deficit ' based view, and rather than looking at how or what proportion of young people in care have managed to survive really challenging situations, despite the systems that exist supposedly to help, and those would be more hopeful things. This sounds like, 'oh this is all hopeless, we just need to throw more, kind of, mental health workers at people' and I'm not sure that's the message that I think is the right message.'* (Looked after children SW2; LA C; High Integration)

This questioning of the validity of the SDQ showed the lack of confidence that social workers had in the SDQ as a screening tool and in their ability to use the SDQ in their practice.

6.5.3 Skill set workability

Skill set workability refers to the process by which a division of labour is agreed and established around the intervention as it is operationalised in the real world (May et al., 2010). The relationship between the various stakeholders is important, including how each profession understands the skills of the other.

As reported in chapter five, there were a number of factors that impacted both on the way the SDQ was used in practice with looked after children and the division of labour around mental health assessment. In chapter five, a child and adolescent psychiatrist (HT 1) raised concerns about social workers using the SDQ as a screening tool for referrals to CAMHS, because of their lack of knowledge about the psychometric properties of such scales and how they work.

> *'And I suppose the push is that this is a tool that could help us identify and maybe diagnose children's difficulties early. To give it to people that don't know how to use it, it's a little bit of a silly thing to do.'*
> (Psychiatrist; HT 1; Non Integration)

As discussed in chapter five, some CAMHS staff questioned the skill set of social workers, including their ability to use standardised tests as part of a routine assessment. As in the quote above, some CAMHS staff were aware of the potential benefits of the SDQ screen but did not think that social workers could assess this adequately because of a lack of knowledge of mental health and an inability to use standardised tools. For the most part, the division of labour between agencies then pointed toward CAMHS personnel being the responsible party for mental health assessment. However, on occasion, some social workers were able to effectively use the tool in practice:

> *'I've come across one social worker who in my experience had ever used the SDQ, and that's because in her social work training, she did some kind of minor thesis or something about the effectiveness of them, so she had quite a good experience of them and how they can be really a helpful resource and that's really great. She's probably the one social worker*

who is really engaging with clients and feels strongly about building a
relationship with them and she goes that extra mile, so..., you don't see
that as a standard kind of ... she would be unusual for somebody to be
doing SDQ's.' (Psychotherapist; HT 2; High Integration)

6.5.4 Contextual integration

This component of collective action is about resources at micro, meso and
macro[29] levels. Having the power to allocate resources and define the processes
by which complex interventions are executed in practice is a managerial role
and competent management practices are important in the successful outcome
of such practice changes (May et al., 2010).

Resources are required to introduce and use the SDQ as a screening tool within
a local authority, to have the screen completed and then to implement any
changes to practice that might occur as a result. Previous sections have
discussed the bureaucratic processes used by some local authorities to gather
this information and either integrate it into practice in some way or not use it.
With the high 'likely caseness' rates among looked after children, there are
resource implications for what should then happen to those whose scores are
high. Five years prior to its introduction, Goodman et al., (2004, p30) suggested
that

> *'Routine SDQ screening of looked-after children would consume*
> *resources, not only in the administration and scoring of the*
> *questionnaires, but also in the subsequent assessment of screen-positive*
> *children to see if they really have problems that warrant specialist*
> *attention.'*

When the SDQ annual return was set up in 2009, the principal aim was to collect
data that would provide an annual national snapshot of the emotional and
behavioural difficulties of those children and young people who had been
looked after for a year or longer. This was seen as important because of the

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[29] Micro, meso and macro are sociological terms that refer to the different layers of society
GIDDENS, A. & SUTTON, P. W. 2013. *Sociology,* Cambridge, Polity. In this context, micro
refers to the front line/individual practitioner level; meso refers to the organisational level; and
macro refers to the national level.

high rates of mental health problems that looked after children were known to have (Meltzer et al., 2003, Ford et al., 2007, Goodman and Goodman, 2012a). It was also hoped that it would provide an opportunity for local authorities and clinical commissioning groups to use these data for strategic planning purposes within their local areas and for social workers to be able to use individual children's scores to assist with care planning for individual children.

The SDQ was considered by central government to be the appropriate tool to provide mental health data at a national, local and individual level that could then assist with resource allocation to meet local need (Department for Education and Department of Health, 2015). However, resource data are not collected nationally so it is not possible to see how many more social work or CAMHS appointments are offered to looked after children and/or their carers than before the SDQ data collection began. Some CAMHS discussed the increase in demand for services:

> *'The actual volume, the demand for services which I think certainly for looked after children and children on the cusp of care in [the area] are increasing quite dramatically. In [name of service] we have quite a tight contract in terms of number of cases which we provide services to. I'm aware the broader Tier 3 CAMHS service doesn't and within the last year they've seen a 30 percent increase in numbers of referrals broadly. That also includes looked after children so I think that's one of the biggest demands.'* (Systemic Family Therapist; HT 11; Non Integration)

6.5.5 Summary: Collective action

The consideration in this section on collective action relates to how the SDQ data are gathered and the various people involved in this process. The qualitative information showed that there were two methods most commonly used to gather SDQ data and integrate it into the routine practices of the local authority. These are recorded in diagram 6.1, to show the work that people do with each other when operationalising an intervention such as the SDQ screen into everyday settings. The IRO role was important as a lynchpin in having an oversight on the mental health needs of children and young people; s/he acted as a link between health and local authority and could influence how the SDQ was used by social workers in practice, if it was used. Social work professional

confidence in the SDQ appeared poor and this showed in their ability to use the SDQ in their practice. CAMHS clinicians had negative views of most social workers' skills in using any standardised instrument, including the SDQ.

The allocation of resources in determining how the SDQ was operationalised in a real world setting at a micro, meso and macro level was also discussed, including at strategic levels. Resource use data are not collected so we do not know how CAMHS are utilised with looked after children at an individual level.

6.6   Reflexive monitoring - How is the task understood?

Table 6.5: Reflexive monitoring - How is the task understood?

Core construct	Components
Reflexive monitoring (how is the task understood?)	• Systematisation • Communal appraisal • Individual appraisal • Reconfiguration

The final core construct of NPT, reflexive monitoring, refers to the **appraisal work** that people do to assess and understand the ways that a new set of practices affects them and others around them (May et al., 2010): in this instance how the SDQ as a screening tool is understood. The four components of reflexive monitoring are systematisation; communal appraisal; individual appraisal; and reconfiguration. Each will be addressed in turn.

6.6.1 Systematisation

May et al., (2010) suggest that determining the effectiveness of any set of practices will involve collecting different kinds of information in a variety of ways. This 'systematisation' work might be formal (for example, collecting and analysing the SDQ screening data on eligible looked after children), or informal, involving consultations with a wide variety of stakeholders involved in the intervention. Each is valid and is an example of systematisation. These activities might be done through processes at a micro, meso or macro level such as: a looked after child's review (micro); research studies (meso or macro); local authority and health trust publication of strategic documents such as Joint

Strategic Needs Assessments (JSNA)[30] (meso); publication of central government statistical first release data (macro); regional CAMHS network groups (macro); and CORC (macro). The main question posed is how effective and useful the new practice (the SDQ screen) is. The information obtained though my research showed that these data were not collected and analysed together to determine overall effectiveness. No mention was made by social workers of any of these activities informing practice. Some senior CAMHS staff discussed more strategic issues, such as the recommissioning of services and funding pressures:

> '*Funding was last year's crisis. Yes, we have had 20 percent of funding altogether that was lost and at that point, we were able with the commissioners to renegotiate a reduction in terms of activity. But like I say, we're still aware that the demand's there. We're also going out for tender next year and we don't know whether the financial envelope will be the same size as it is now. It could be even less. We've been told it won't be any more.*' (Systemic Family Therapist; HT 11; Non Integration)

It would appear that systematisation was not embedded within the SDQ roll-out or implementation and the data was not used in the range of ways that were intended, in terms of assisting with the strategic planning of CAMHS. It would appear that a number of the CAMHS were vulnerable to financial cuts.

6.6.2 Communal appraisal

This part of NPT involved participants working together, formally and informally, to evaluate practices and processes. There were a range of means to do this. For example the focus groups that were conducted as part of this research project could be seen as communal appraisal groups. May et al (2010) suggest that these events happen continuously and people will ask each other 'is it working?'

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[30] Joint strategic needs assessments (JSNAs) analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The JSNA will underpin the health and well-being strategies, a proposed new statutory requirement and commissioning plans. The main goal of a JSNA is to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities NATIONAL HEALTH SERVICE CONFEDERATION, LOCAL GOVERNMENT IMPROVEMENT AND DEVELOPMENT & ROYAL SOCIETY OF PUBLIC HEALTH 2011. The joint strategic needs assessment: A vital tool to guide commissioning. London: National Health Service Confederation,.

> *'it is how they put the answers to these questions and negotiate the difficulties that stem from conflicts about what sort of information counts, and how it counts for different groups. These are central to the future of any set of practices. Acts of communal appraisal - like data analysis meetings in clinical trials, or quality circles in lean healthcare organizations - are common and may be highly formalized as well as casual and informal.'* (May et al., 2010)

It is not possible to comment on whether the annual monitoring of the Joint Strategic Needs Assessment by more senior managers would have involved some kind of cross agency appraisal of the SDQ. Social workers did not identify any evaluation activity occurring in their organisations (but were not specifically asked about this). The vast majority of social workers discussed the 'top down' approach to the collection of these data, so it is possible that any evaluation would focus on the collection of administrative data. For example, one clinical nurse specialist spoke about being asked by local authority managers why the children and young people in their authority had higher rates of emotional and behavioural problems than the children and young people in the neighbouring borough.

> *'When [clinical nurse specialist] has to explain to [local authority senior managers] why the scores are higher, and [clinical nurse specialist] is saying, 'well that's how they filled them in,' I think the implication is, 'why are our children so unwell? What is it we're not doing?' and there is a pressure of course to think about the fact that we are not doing as well as other boroughs in terms of helping children with their mental health, even though actually we are probably doing a much better job as we are collecting 100% and analysing 100% of the questionnaires, so we are not comparing like with like and it's just that people don't understand statistics.'* (Clinical Psychologist; HT 5; High Integration)

Adopting a 'specialist' approach to scoring and using the SDQs in this manner had the effect of ensuring they were integrated into practice within the organisation. However, the long-term sustainability of this approach was potentially unmanageable because it required additional resources in the form of staff to mainstream the practice. This made it susceptible to cuts at a time of enormous budget pressures within local authorities, and there was a danger of

noncompliance by social workers as it was not seen as their responsibility. Evaluation and appraisals of specialist/generic structures and activities in other areas of social work practice, such as in adult safeguarding, showed similar difficulties (Graham et al., 2014, Norrie et al., 2014)

6.6.3 Individual appraisal

In addition to collective activities, May et al., (2010) suggest that individual practitioners also have a role in appraising the effects of the new practice on their work experience. The value that the individual practitioner places on the new intervention or practice when embedded within everyday routines related to the activity is important. Many examples are given in chapter five and earlier in this chapter of social workers not valuing the SDQ as a tool for assessing the mental health of looked after children. This had implications for how it was then used (or not used) in practice at an individual and communal level within organisations. For example, at an individual level, the SDQ could be completed with a child or young person as a tick box exercise or as part of a broader conversation:

> *'We would do the SDQ, but on random occasions I might ask the social worker to bring it to a young person and to fill it out, and that brings us to how the SDQ is used. Sometimes they are used as very creative...uh... conversations. Sometimes it's just a tick box exercise because you need it and then the result can back up or be used in a clinical assessment to underline some themes that you've seen. In my experience it's more often the clinician who does that.'* (Psychotherapist; HT 2; High Integration)

6.6.4 Reconfiguration

The final component of reflexive monitoring is reconfiguration. This refers to modification of procedures or practices, should this be required in the light of any appraisal work done by individuals or groups. For example, it is important to ensure that screening tools do not do serious harm (Goodman et al., 2004b). If the use of a regular screening measure identifies more looked after children as having psychological problems and there are no effective treatments available, then is there a benefit to the screening process?

Some services talked about how to change the current systems to enable greater use of the SDQ data, but they were at the beginning of the process and could see that this change would require a number of different process changes for staff:

> *'So myself and the head of service, we were saying, 'how can we use the SDQs a bit more practically because at the moment we don't?' It gets completed, but that's it... We're trying to, what we want to do is once we've got all the children in care consultations established is then use those SDQ scores on a regular basis as an indicator of whether they're receiving that help or not. But that's the only standardised measure that I'm aware of that the social workers will use.'* (Clin Psych; HT 9: High Integration)

Further reflections on how agencies work together is the focus of chapter eight.

6.6.5 Summary: Reflexive monitoring

The collection of SDQ data for annual DfE returns had driven the way in which the processes around this SDQ screening activity had been designed, introduced and embedded into routine practice. Appraisal of the effectiveness of this (now very complex) system had not taken place at a micro and meso level in most local authorities. Many of the difficulties and challenges identified at a micro and meso level had not been addressed, including: social workers not using the SDQ data in their work with looked after children; and the organisation seeing little value for the SDQ data apart from it being used for the SSDA903 return. Some local authority and CAMHS organisations were beginning to think together about how they could make more use of the SDQ data.

6.7 Overall summary

The table below summarises the findings detailed above.

Table 6.6: Summary of results using NPT Core Constructs and Components

Core construct	Components	Summary of results
Coherence Task = to understand how social workers use the SDQ to assess the mental health of looked after children.	Differentiation	Very few LAs used the SDQ in practice. SWs used the existing review process to monitor mental health issues. Those that did use the SDQ found it useful, but there were some difficulties.
	Communal specification	Multi agency work with looked after children was important. There were systems in place to routinely assess the emotional and behavioural health of looked after children via reviews and PEPs etc. CAMHS clinicians already used the SDQ in their work, but SWs did not.
	Individual specification	Most SWs had heard of the SDQ, did not use it, and viewed it as a marginal activity. Some SWs had used the SDQ and found it valuable. Some IROs used the SDQ in reviews to monitor the mental health of children over time.
	Internalisation	The SDQ had not been internalised into routine practice activities by SWs. Significant work was required to integrate the SDQ into practice.
Cognitive participation Task = who gathers the annual SDQ screening data	Initiation	Collection of the SDQ data was seen by SWs as a 'top down' and bureaucratic activity which was not integrated into LA practice processes. Where the SDQ was used, processes were lengthy.
	Enrolment	Using the SDQ effectively within a LA required SWs and senior managers to understand the benefits of this tool for front line

	Legitimation	practice, strategic decision-making and commissioning. Legitimation activities were complex. This involved more than just ensuring that SDQ returns were completed. It required the advocacy and support of the change in practice at micro and meso levels.
	Activation	Activation was about supporting practices, which took time as those using the practice made changes to working processes in consultation with those involved in normalising the practice.
Collective action Task = how the SDQ data is gathered.	Interactional workability	This was concerned with the work people did with each other to get the task done. The processes around the LA use of the SDQ were lengthy and involved a significant number of different people, which made it difficult for any one person to establish ownership of the process.
	Relational integration	There were a number of criticisms of the SDQ made by SWs, concerned with carers not completing the SDQ correctly and the scores that children got from the SDQ being used to label children. This lowered the professional confidence that SWs had about using the SDQ as a screening tool.
	Skill set workability	CAMHS clinicians were critical of the skills and knowledge that social workers had about child and adolescent mental health. This affected the way in which CAMHS clinicians and SWs worked together.
	Contextual integration	Resource allocation was important in embedding the use of the SDQ into practice. This involved managers allocating resources at

		micro, meso and macro levels, and included discussions about how 'joined up' processes were within and between agencies.
Reflexive monitoring Task = how the SDQ data screening tool is understood.	Systematisation	Collecting 'formal' and 'informal' data from a wide variety of stakeholders at micro, meso and macro levels to determine the effectiveness of SDQ screening was important. Whilst most LAs collected some SDQ data on eligible children, there appeared to be difficulties in gathering these data about the SDQ across the different levels of organisations.
	Communal appraisal	Enabling participants to evaluate practice and processes across organisations was useful in ensuring that any problems with how SDQ data were obtained and analysed were addressed. Different models were used in LAs (specialist vs generic) and an examination of the strengths and weaknesses of those were useful.
	Individual appraisal	Feedback from individual SW practitioners about the SDQ showed the low value given to the SDQ. However, recognition was given to the potential for the SDQ to not just being a 'tick box' exercise, but a conversation with children and young people about mental health.
	Reconfiguration	This was beginning to occur with discussions between CAMHS and LAs, but was not happening in most areas.

6.8 **Chapter summary**

To understand how an intervention is embedded into practice, it is important to not just look at what the work is but what people do and how they understand the work. This is key to understanding how social workers viewed the SDQ, which addresses the first research question. The NPT framework has been applied to the qualitative results of the research study in order to understand the processes used to embed the SDQ screening tool data into local authority practices. The results of this exercise showed that the SDQ screen was not sufficiently integrated into practice across the local authorities included in the study. For the majority of local authorities, the SDQ data gathering was a 'top down' administrative requirement to provide external performance information, and it was not linked in a meaningful way with social work practice, or in a way that could help social workers identify what help and support children need regarding their mental health. The supports within the system to embed this into practice were not evident as the principal agency driver for practice was completion of the SDQ return data only.

In terms of 'coherence', social workers rarely used the SDQ in their referrals to specialist mental health services, which addresses research question two. Further, in response to research question one, their attitude towards the SDQ was mixed. Regarding research question three, the degree of practitioner 'participation' in legitimising the way the SDQ was incorporated into practice was minimal. Social workers perceived the process as bureaucratic and could not identify a role for themselves in collecting and using these data. The IRO role was the closest to facilitating 'collective action', given the oversight that this role had in co-ordinating the planning the support and care for looked after children. Additionally, 'reflexive monitoring', which supports an understanding the effectiveness of change, was not widely undertaken. Consequently, the lack of engagement of social workers in using the SDQ had not been highlighted or addressed. Significantly, this meant that the Statutory Guidance regarding use of SDQs with looked after children was not being complied with.

The analysis in this chapter provides insight into the complex issues regarding the normalisation of the SDQ in social work practice. In this regard it addresses

several of the research questions posed. The next chapter focuses on the fourth research question, which is concerned with the working relationship between social workers and CAMHS specialists.

Chapter 7 Social Workers and CAMHS Working Together

7.1 Introduction

This chapter relates to the second of the three themes mentioned in chapter five: *social workers and CAMHS working together* (table 5.1 on p129). It applies specific areas within the NPT framework, particularly 'communal specification', which is a component of the NPT core construct 'coherence' and is concerned with how people work together to build a shared understanding of the aims, objectives, and expected benefits of a set of practices (May et al., 2010). This chapter will broaden the focus from solely concentrating on the SDQ to examine social workers' practices of mental health and mental ill health, as CAMHS clinicians in particular are critical of social workers' knowledge and skills in this area.

The majority of staff interviewed for this thesis acknowledged that agencies working together were key to successful delivery of mental health services to looked after children. However, there were a number of concerns about how this is achieved in reality, and these are outlined and explored in more depth in this chapter. A number of small scale studies have pointed to difficulties in CAMHS and local authorities working together, with the remit of CAMHS and referral pathways not being well defined, poor communication reported (Hill and Mather, 2003), and little evidence of multi-agency working (Stanley et al., 2005). These studies pointed to the importance of mental health and social care services operationalising more effectively and putting into practice joint mental health services for looked after children (Rao et al., 2010). This would be equivalent to achieving smooth multi-agency working within all the domains in the NPT framework.

There have been some significant changes in the local service landscape for local authorities over the last 15 years. Since 1999, there has been a rise of specialist mental health services for looked after children, following the Labour

Government's use of the Mental Illness Specific Grant to fund the first pilot looked after children mental health multi agency services (Kurtz and James 2003). These became the 'CAMHS innovation projects' and were well received. Most local authorities and CAMHS jointly commission specialist looked after children's services, but there are now many different models for service delivery. These have been categorised by me into three different intervention models and will be further discussed in the chapter.

Additionally, the knowledge and skills that the social workers interviewed for this study had about mental health will be discussed, as will the views of the CAMHS clinicians about the social workers they worked with. I present a number of typologies relating to social work referrals to CAMHS that have been developed from the data collected from both social workers and CAMHS practitioners.

I begin this chapter with a comment about medical and social models. There are a number of barriers to collaborative work between health and social services, including the different medical and social models used in practice by health and social work practitioners and disagreement about definitions of when a mental health difficulty becomes a problem requiring CAMHS intervention. Further, there are differences in commissioning and funding, eligibility and legal frameworks which affect interrelationships, working practices and culture. These are areas beyond the remit of the current study. This first section of this chapter will draw on the literature to define these concepts before presenting the material from the qualitative study to illustrate how the results apply to this theme.

7.2 The working relationship between CAMHS and social work: Medical and social models

Whilst there is some overlap, broadly speaking, a medical model involves medical and other health professionals acquiring specialist knowledge about the physical and biological causes of illness and disease through their training, involvement in ongoing research and practice experience. Health is viewed as *'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'*(World Health Organisation, 1946), and health

practitioners undertake interventions that use their expert knowledge, in order to relieve symptoms and/or 'cure' the patient (Shah and Mountain, 2007). The social model of health concentrates on environmental and social causes of ill health and focuses on the interplay of these factors (Yuill et al., 2010). Both models are interested in prevention, and take into account factors such as stress and lifestyle. However social work practitioners who favour social models highlight social, economic and political influences on health, such as housing, employment, ethnicity and poverty (amongst a range of factors) as crucially important, and are more likely to consider these in formulating interventions. While acknowledging public health approaches that look at the wider social determinants of health (Marmot, 2010, Marmot and Bell, 2012), the medical model tends to focus on biological/physiological understandings of illness, disease and treatment.

Language and terminologies used by the various professional groups working in health, social care and education to describe mental health, mental health problems and emotional and behavioural difficulties differ (Richardson and Joughin, 2000, Richardson and Lelliott, 2003, Cocker and Allain, 2013). These reflect the different theoretical approaches adopted by each profession (Cocker and Allain, 2013). Many of these terms are used interchangeably and so the intended meaning becomes unclear. Alongside this, although there is some crossover in understanding; the roles of various agencies also affect the way in which the mental health of looked after children is understood in practice. Although there are many benefits in agencies working together, and a broad range of literature suggests that this is essential for looked after children and their mental health, (Broad, 1999, Blower et al., 2004, Rao et al., 2010, Department for Education and Department of Health, 2015), there can also be tensions.

> '… the core business of each agency is (and should be) different, although an effective service interface is essential in meeting the needs of vulnerable groups. Most mental health problems inevitably transcend these boundaries, in relation to the child's behaviour, attachment and other relationships, and emotional functioning, and this is where interagency tensions and service fragmentation are most likely to occur.'
> (Rao et al., 2010, p67)

In exploring these difficulties further, with regard to mental health assessments of children, some medical assessments can involve diagnostic processes. In the social work practice recounted by the social work participants in my research, this was not generally favoured, because social workers did not want to label children with diagnosable mental disorders, given their young age and the ongoing significance of this information for children throughout their lives. For a social worker, more emphasis was given to environmental factors (e.g. chaotic and/or chronic neglectful parenting) affecting the development of a child, and many social workers believed that by changing factors associated with this or physically removing the child from significantly harmful experiences, and introducing parenting that met a child's physical and emotional needs, there was a strong likelihood that observed distress in a child would dissipate over time. For a significant number of children, this was the case, but not for all children. When examining the mental health difficulties of adopted children, after children had been in adoptive placements for a number of years, there were still ongoing mental health problems for a significant number (Dance et al., 2002, Rushton et al., 1993, Selwyn et al., 2015). This kind of social work thinking also made an assumption that CAMHS practitioners are unaware of these wider issues.

Issues of professional hierarchies between social care and health, 'labelling' and ontology for social workers in terms of mental health are not new. Pearce (1999), a child and adolescent psychiatrist, highlighted the contrast in approaches and philosophies between the NHS and social services and provided a useful summary of the medical model:

> '*This is an approach that aims to be objective, analytical and, as far as possible, scientific. The philosophy of the medical model is based on the Hippocratic oath and is focussed on individual patients where there is a duty to do one's best for that patient, considering their needs above all else and maintaining confidentiality in all but the most extreme circumstances. Perhaps most important of all is the overriding imperative to do no harm.*' (Pearce 1999, p151)

Although many social workers found the medical model limiting in its scope, it could be helpful in structuring and understanding information and knowledge

about illnesses and disorders. Pearce suggested that the social models favoured by social workers, such as systems theory, political theory, humanistic and psychoanalytic theories, did not lend themselves to scientific study. Whilst Pearce highlighted many of the polarised positions which could make collaboration between health staff and social services staff difficult, he was careful to avoid proffering simplistic solutions. He cited personality issues, power struggles and misperceptions as frequently affecting effective multi-disciplinary collaboration (Pearce, 1999).

These theoretical differences between health and social services also create differences in generation and use of research knowledge. Although Pearce was careful to acknowledge the importance of both approaches, it was clear that the health approach was generally seen as more robust by virtue of the significant difference in research funding allocated to health and social care (Marsh and Fisher, 2005, Forrester et al., 2009). Pearce suggested that this also had an impact on the way in which social workers practice, in terms of concentrating on 'risk assessment' in their work, whereas health related approaches embraced 'risk management', which was understood within a broader child development approach.

> '*Social work interventions are more often a response to a crisis, rather than a measured reaction to a developing problem. Many of these interactions are time limited …social work interventions have to take into account the needs of society just as much as the individual. At the same time, most social work interventions strategies are driven by bureaucratic processes to a much greater extent than within the NHS*.'
> (Pearce 1999, p151)

Given these criticisms by Pearce, it seems appropriate to draw from the 'skill set workability' component in the NPT, as it is concerned with the critical views of CAMHS practitioners about the skills and knowledge that social workers had about child and adolescent mental health, including theoretical differences. This affected the way in which CAMHS and social workers worked together. Ultimately, this required CAMHS clinicians, social workers and their respective agencies to work closely together at micro, meso and macro levels as part of a 'communal appraisal' activity. Where there were professional differences in

knowledge and skills, this could create tensions regarding how the work was understood, which then affected how new practices such as the use of the SDQ as a screening tool, were 'normalised' into everyday routines.

7.3   **A paradigm for practice**

In analysing the data from the qualitative interviews, I identified three groups of social workers by reference to their approach to mental health. Whilst these groups represented broad typologies, they gave an indication of three general approaches that social workers had toward recognising and dealing with mental health issues in their practice. Alongside providing information about social workers' theoretical approaches to mental health (including social workers' lack of knowledge), these typologies helped categorise potential referral patterns from social workers to CAMHS.

CAMHS clinicians also had views about the mental health knowledge of social workers and the effect that this had on referrals. Again, these views divided social workers into three groups that I have named: Group One – 'Anxious'; Group Two – 'Anti-labelling'; and Group Three – 'Partnership'.

7.3.1 Group one - Anxious (SW perspective):

Mental health makes social workers scared and anxious. These social workers did not think they had the expertise to deal with mental health problems.

> '*As soon as I hear the word 'mental health' and I'm working with anyone with a mental health problem, straight away, I am, should I say, I'm scared, I'm anxious, you know, what am I going to come up against?*' (Looked after Children SW3; LA C; High Integration)

> '*based on my own experience I know that sometimes working with young people with mental health problems, or anyone with mental health can be quite scary for social workers.*' (Looked after children SW4; LA C; High Integration)

For this group of social workers the medical model was dominant; CAMHS clinicians were seen as 'the experts'. Referrals were made to CAMHS primarily

because of behavioural issues, which social workers felt impotent in managing. CAMHS clinicians thought that this group was likely to make many referrals.

7.3.2 Group one - Anxious (CAMHS perspective):

According to CAMHS staff, some of these referrals were made at inappropriate times as the child did not have mental health problems; instead they considered that the child was distressed.

> *'I think they [some social workers] have quite a lot of worries about what mental illness might be. They don't have information about the range of mental illnesses, so I think they're even more worried about having that conversation and the tendency is just do a referral to CAMHS and hope they'll sort it out.'* (Family Therapist; HT 1; Non Integration)

> *'Sometimes we get referrals for children that are upset, but actually they are upset for good reason and they don't need to see a therapist at that stage. i.e. they've had a bereavement or they've only just moved into a placement , they've been separated from their parents; things that you think, 'ok, this is a natural distressing psychological reaction', but it hasn't yet got to the stage where you think, 'oh dear, we need some professional input'. What they need is someone to do what we all need when we are upset, you know. We just need people to be with us and to support us, and something about that differentiating the normal from the abnormal, that there is definitely a kind of theme about, 'oops they're upset, I'll send for the psychologist.' and there is actually a difference. We are not just here to see people that are upset for any reason.'* (Clinical Psychologist; HT 5; High Integration)

In contrast, CAMHS tended to view these children as most appropriately supported by the foster carer and social worker without direct CAMHS intervention. In terms of the working relationship between the parties, CAMHS treated social workers as they would a child's parent.

7.3.3 Group two – Anti-labelling (SW perspective):

Mental health was understood as emotional and behavioural problems in a child or young person. The social model was dominant in this group. These social workers valued the social aspects of these children's lives and were wary of labelling children by involving CAMHS.

> '...*what I'm struggling with in particular with one particular case is when you kind of get a sense that the young person actually would like to have that label, you know, put on them, whereas you, the social worker, your views are that it's ... they can actually kind of come through this difficult, through other means, rather than kind of maybe a label and having to kind of go on medication.'* (Looked after children SW6; LA C; High Integration)

This affected whether referrals were made to CAMHS and the value that was then attached to the CAMHS role. Often the reason for referral was because of behavioural problems frequently judged by the foster carer or social worker to be 'risky'. Some social workers in this group did not make referrals because of the difficulties they perceived with labelling children and young people.

> '*As someone who sees himself as a champion of looked after children, I don't think that I would be thinking that it was in looked after children's interests to be having a label like that around them, unless that was really the case.'*(Looked after children SW1; LA C; High Integration)

7.3.4 Group two – Anti-Labelling (CAMHS perspective):

This is a group of social workers who never referred children to CAMHS. A number of CAMHS focus groups commented on this observation and said it was highly unlikely that the children allocated to these social workers would not have any mental health problems.

> '*I think you get the same social workers who refer in children and you get some social workers who won't, even though we've got two psychologists in the building.'* (CAMHS Specialist Nurse; HT 5; High Integration)

7.3.5 Group three - Partnership (SW perspective):

Social workers integrated mental health into everyday practice with a child or young person. They actively sought to develop their knowledge and understanding of mental health, knowing that it contributed to their overall assessment of a child or young person. Both the medical and social models were used. The working relationship between them and CAMHS clinicians was a partnership, and social workers valued this relationship. These social workers were most likely to make appropriate referrals and not solely because of behavioural concerns.

> *'I think it's quite difficult to separate out behavioural difficulties that come from very traumatic and emotionally deprived backgrounds and a diagnosed mental health problem because I think it's a very blurred line between the two and I think we often try not to label children too quickly, but at the same time you need to recognise sometimes there is an underlying disorder that can be hereditary disorders that can run in the family line so I think you have to be quite sensitive in thinking with other professionals, with your colleagues, about 'is it a mental health diagnosis there that is needed, or is it actually trauma or emotional stuff from many placements being, you know, disordering with regards to attachments, that maybe not need diagnosis and treatment in the mental health field' so I think it's quite a difficult call for us because our children come from such difficult backgrounds so it's actually not mental health per se, it's just having a really difficult, crap life and its quite a reasonable reaction to that life.'* (Looked after children SW2; LA C; High Integration)

> *'I would say that we're about trying to keep an open communication with young people - keep them connected as far as is safely possible - with their networks, and to keep talking with them really and to maintain an open dialogue about what is going on in their lives, and what has happened, rather than seeing it as our job as soon as there is a sort of box that gets ticked that says 'mental health problem - refer them on to another professional!' So wherever possible we try and work with the issues that have been raised for most of these young people by their backgrounds. Within our context we do have therapists who work within*

the units so we have a mental health professional working with us and there's a lot of close co-working around this.' (Looked after children SW3; LA C; High Integration)

7.3.6 Group three – Partnership (CAMHS perspective):

According to a number of different CAMHS, the final group of social workers 'got it'; they used a psychosocial perspective in their work and understood the benefit of the CAMHS role in the life of a looked after child. The working relationship between the two organisations was based on a mutual dialogue.

> *'In terms of our relationship with social workers, I think there's probably a pattern... there's certain workers who, once they become involved with us, they get it and we maintain a relationship with them.'*(Psychotherapist; HT 11; Non Integration)

> *'Some are really skilled, and in tune and sensitive to picking up cues from the children and young people they work with and others are more blind or blunt in their approach. They just see behaviours.'* (Psychotherapist; HT 2; High Integration)

Whilst these typologies were general categories, they provided a way of understanding and reflecting on the patterns of referrals and underlying culture of inter-agency working between social workers and CAMHS. CAMHS clinicians and social workers recognised similar issues relating to the strengths and weaknesses of the knowledge and skills of social workers and how this was evidenced in the referral practices of social workers to CAMHS. This linked to two core constructs in the NPT framework: 'coherence' (what is the task?) and 'collective action' (How does the task get done (collectively)?). In the 'coherence' core construct, 'communal specification' is the term used to understand and address the referral activities of social workers from the perspective of both sets of key stakeholders (social workers and CAMHS clinicians).

The three typologies above help demonstrate the differences in how social workers understood the practice task of knowing when to refer looked after children to CAMHS and provide CAMHS clinicians' views about social workers with

regard to this task. The 'collective action' core construct refers to the operational activities that people perform together and links to the 'skill set workability' NPT component. The next section further expands on the issues raised in presenting these typologies.

7.4 CAMHS and social workers working together: advantages, stresses, tensions

As outlined in chapter five, a number of CAMHS clinicians in my study were of the view that if a child or young person did not have a mental health diagnosis then their problems were social rather than health related. This evidenced their adherence to the medical model. According to these clinicians, some children and young people were inappropriately referred to CAMHS when social workers should work with them directly, alongside foster carers (Group one).   A number of CAMHS staff commented that CAMHS was not a service that should be expected to work with 'upset' children, and children who had recently come into care could reasonably be expected to be distressed by the separation and loss they had experienced.

Given this, and some of the other comments made by social workers and CAMHS clinicians about the knowledge and skills of social workers in relation to mental health, Table 7.1 explores the relationship between social workers' responses to the behaviours and emotional states of looked after children and how this affected their CAMHS referral activities. Reviewing the mental health of a looked after child is a routine part of a social worker's role that is monitored in the looked after child's review. Given that the SDQ was not routinely used by social workers in their practice, social workers said that they based their assessment of a child's mental health on their behaviour. Therefore, social workers' ability to synthesise children's behavioural and emotional problems was important in determining which children were referred to CAMHS. Table 7.1 shows the possible mental health and behavioural problem combinations that need to be considered when making referrals to CAMHS, alongside the expectation from many CAMHS clinicians that the children who are referred by social workers should be mentally ill or show signs of mental illness.

Table 7.1: CAMHS practitioner views of appropriateness of social worker referrals to CAMHS

		Social Worker identification of concerning (clinical) emotional/behavioural problem	
		Yes	No
CAMHS identification of psychiatric diagnosis	Yes	(Y/Y) viewed by CAMHS practitioners as appropriate referral	(Y/N) inappropriately not referred
	No	(N/Y) viewed by CAMHS practitioners as inappropriate referral	(N/N) appropriately not referred

In this Table, only cases where a child is exhibiting concerning behaviour with an emotional or behavioural element that leads to psychiatric diagnosis **(YY)** would be seen as an appropriate referral by CAMHS clinicians (Social work and CAMHS group three – Partnership; Social work and CAMHS group one – 'Anxious'). In this Table it is worth noting that it is CAMHS ability to identify a psychiatric diagnosis that determines whether or not they see the social worker as having made an appropriate referral – therefore for the social worker to get this right all the time, they would need to have as much skill in diagnosis as the CAMHS clinician, which is not possible given the differences in professional education and training.

The other cells can be characterised as:

YN= Cases inappropriately not referred by social workers to CAMHS where psychiatric diagnosis was present but the social worker did not recognise emotional or behavioural problems as concerning. (Social work and CAMHS group two – 'Anti-labelling')

NY= Cases that social workers appropriately referred to CAMHS where a child or young person's emotional problems or behaviour were recognised as

problematic, but there was no psychiatric diagnosis, so it did not meet the criteria for a service or thresholds were so high for services that this referral would be a low priority for allocation. This is problematic. (Social work and CAMHS group one – 'Anxious'; Social work and CAMHS group three – 'Partnership')

NN = Cases appropriately not referred by a social worker, because there was neither a concerning behavioural or emotional element present and the child did not have a psychiatric diagnosis. (Social work and CAMHS group three – 'Partnership'; Social work and CAMHS group two – 'Anti-labelling')

Social workers base a lot of their assessments about children on the behaviours they observe. For most social workers, a child's behaviour was the main criterion used to decide whether or not to refer a child to CAMHS.

> *'Their presenting behaviour, their social presentation, maybe information received from other professionals, concerns, referrals or by an incident that may have happened that brought themselves to the attention of social services, referral by the GP at times...'* (Looked after children SW; LA I; Non Integration).

CAMHS clinicians thought that social workers required advanced knowledge and understanding of child development to know when the behaviour they observed in children was because of trauma or neglect and could be considered an appropriate response to distress and adversity given the circumstances a child had been through, rather than because the child had a mental disorder. Evidence for this was provided in chapter five (p156). Additionally, a number of CAMHS clinicians thought that social workers prioritised 'acting out' behaviour in their referrals, which might explain why more boys were referred to CAMHS than girls (social work and CAMHS group one):

> *'Where there's externalising behaviour, referrals come very fast so boys just starting high school would be one of our picks. I think under represented is then when you ask about other siblings in placement would be the children who've been really good and compliant, the quiet girls. So sometimes we have to seek out with further questioning whether other family members need referrals so that leads me to think*

there's lots of kids out there internalising that we don't see.'
(Psychotherapist; HT 11; Non Integration).

This raised some training and development issues around social workers needing to be able to distinguish a little more between children with mental illnesses and children who were showing distress in response to environmental and social situations, which was experienced as an understandable adjustment reaction rather than mental illness (social work and CAMHS group one – 'Anxious'). However, some social workers did achieve thoughtful and effective practice and understood the implications of making statements about mental health that they were not qualified to make (social work and CAMHS group three – 'Partnership'):

> *'And, more importantly, in terms of how we're recording it – so, for instance, when I suspect a young person may have mental health issues, I will put 'in my opinion, I suspect the young person has mental health problems or concerns' because until I know that that's been diagnosed by a health professional, I've got to bear in mind 'this young person can still read his/her file at any time' and one of the hardest things is, and I've seen it myself, where professionals have said 'this person has mental health' and they're not in a position to make that statement, so I'm very wary about that for a young person.'* (Looked after children SW; LA I; Non Integration).

CAMHS practitioners thought that this effective practice could be because of social workers' experience, including positive working relationships with CAMHS (social work group three – 'Partnership'):

> *'...there are some who work closely with us and seem to be able to pick up, monitor and work with mental health difficulties really well and seek out consultation advice whenever necessary and it works really lovely...'*
> (Clin Psych; HT 11; Non Integration)

> *'I think in terms of the ones that get it, quite often they have quite a good understanding of developmental trauma and attachment, and that they look beyond the symptom. They don't just look at the behaviour, they think what's going on for this young person and to have that holistic view about this behaviour that might need X, Y, Z or they've been too*

quiet, "I wonder what that's about." So they have that broader

understanding…' (Systemic Family Therapist; HT 11; Non Integration)

Conversely there were some social workers who CAMHS never heard from (Social work Group two – 'Anti-labelling'):

'…you do wonder about social workers who just aren't referring to us because they don't have a concept of what we do or what we can do, despite our efforts to do liaison and consultation.' (Psychotherapist; HT 11; Non Integration)

Some social workers were good at holding children in mind and advocating for them (Social work Group three – 'Partnership').

'…and just keep the child in mind and not necessarily the label but also it's just as important to share the information and, increasingly it seems, to fight for the child to get access to CAHMS and mental health services – because sometimes we need to be more creative in how we access the appropriate support.' (Looked after children SW; LA A; Non Integration)

There were many points of agreement between social workers and CAMHS clinicians about whether an increase of referrals to CAMHS was a good thing (because social workers recognised problems earlier), or a response to other problems in child and family social work currently, with high caseloads, and diminishing resources, so social workers almost automatically referred children to CAMHS, as part of a prevention strategy because of the high numbers of looked after children who are reported to have mental health problems (Social work Group one – 'Anxious').

'Our job is the case management of it, to feed it out to where it needs to go and to be communicating that to everybody… I always thought my role was a case manager because I couldn't do all the tasks.' (SW; LA D; High Integration)

There is a danger that this masks some of the perceived difficulties with social workers' knowledge about mental health and mental disorders in children, as reflected in the comments of a number of CAMHS clinicians (Social work Group one - 'Anxious'; and Group two - 'anti-labelling'). These kinds of difficulties are

addressed in the NPT framework, which uses the term 'interactional workability' to describe the processes that occur between people and organisations to get the work done. Where there are difficulties it also affects the 'relational integration' of the process, which lowers the professional confidence of each of the agencies involved in the work.

7.5 CAMHS accepting referrals

Although the availability of CAMHS staff for social workers has improved generally over the past decade or so, another issue that was raised by a number of different CAMHS in my study (referred to briefly in chapter five), was the timing of referrals to CAMHS, with CAMHS not wanting to see children during Court proceedings or immediately after a placement move, as the view was that at that point children need to experience consistent and caring parenting, rather than be seen by CAMHS.

> *'Also at times, there are difficulties coming in to support children when children are involved within the Court process.'* (CAMHS worker; HT 1; Non Integration)

> *'But actually there's bigger complications in the sense that when they first come into care they are often in care proceedings. We often get referrals then because social workers don't know the children, they are often very disturbed at that point, they've been separated from their parents, they might have gone through some recent trauma, some violence, you know, some abuse, and you know they are not in a good place. However, we are in proceedings, we are in Court, often at that point social services will be seeking information and help from outside....and at that point myself and [CAMHS colleague] will be thinking, 'is this the best time to be getting involved?'. You know, we really don't know how this child is going to settle down.'* (Clin psych; HT 5; High Integration)

> *'You do sometimes, unfortunately, have therapists saying, you know, we're not going to do anything with this referral because this child has not been in placement long enough. Although they still should be*

working with the carers, so you know, maybe a specific type of therapy isn't advised, because the child is not settled, but they still should be doing something. But Social Workers are still getting that feedback somewhere along the line, so that is still happening, but I can't quite find out where. It's very difficult to try and track it down.' (Clin Psych; HT 10; High Integration)

This is not a new issue (Hunter, 2001, Cocker and Allain, 2013). The advice provided in the statutory guidance to social workers and others regarding health and mental health assessments (Department for Education and Department of Health, 2015), suggested CAMHS are wrong not to see children at this time:

'Looked after children should never be refused a service, including for mental health, on the grounds of their placement being short term or unplanned.' (Department for Education and Department of Health, 2015, p6)

Another issue consistently raised by all (social worker and CAMHS) participants as being highly problematic was children accessing CAMHS when they were placed out of borough.

'I think there's also an issue with commissioning and who actually pays for it, because although the commissioning guidance is very, very clear about who is to pay for tier 2 services, interpretation can sometimes be different and also depends where the child was on a specific date in 2007, so if the child was actually living in [first LA name] in 2007 and then removed to [second LA name], then [first LA name] would be the ones with responsibility for commissioning the service, even though they may come from our local authority. And that's to do with the commissioning guidance, so it's all well and good if they're in our local authority, but if they've moved around or if they are looked after, where they were on a specific date is the key to who commissions the service. So trying to get someone to pay for it is really difficult.' (Looked after children nurse; HT 5; High Integration)

'It was out of borough in another part of the country which makes it difficult because the health authority didn't see him as belonging to their

area. They saw him as belonging to our borough. Anyway eventually we did get CAMHS involved through a referral to some other team in that area, I can't remember now. There was a lot of assessments and a lot of back and forth before we got the help that he needed.' (Looked after children SW; LA H; Moderate Integration)

This showed problems with 'contextual integration' by way of inadequate resource allocation, and problems with 'reconfiguration', in that after such problems had been identified, services had not been able to change procedures and arrangements with Health Trusts to overcome these practice difficulties. Advice from central government also included arrangements for those children placed out of borough who required access to mental health services and for children leaving care.

> *'Where the child will require specialist health services such as child and adolescent mental health services (CAMHS) the clinical commissioning group (CCG) that commissions secondary healthcare in the area authority should be consulted, so that the responsible authority can establish whether the placement is appropriate and able to meet the child's needs. … CCGs should ensure that any changes in the healthcare provider do not disrupt the objective of providing high quality, timely care. The needs of the child should be the first consideration.'* (DfE/DH 2015, p23)

At a strategic level at least, these clear directions indicated a willingness to unblock structural processes which could restrict looked after children accessing services quickly. However, the experiences of social workers and CAMHS clinicians as reported in this thesis indicated that this remained a problematic area in practice. The wording of the guidance could mean that services for looked after children placed out of borough were linked to mainstream CAMHS and not specialist looked after children services in the borough in question, so children would wait longer, and not necessarily access the specialist services they need.

> *'I wanted to highlight that when the child lives out of borough it does most definitely become more complicated and very frustrating for the social worker to get the right level of support, because in the health service I know they've got a different threshold of what meets their criteria for*

having a mental health presenting issue. Whereas within our specialist looked after CAMHS our threshold is lower because we know they're vulnerable and they need support early on. Unless that child can access our borough's looked after CAMHS, and they can't if they live halfway across the country, it's so hard to get that same level of commitment, passion and what have you from the CAMHS in your local area. Then you get a lot of to-ing and fro-ing about who should be responsible to pay and it is definitely just a question of funding it. Then I think they twist - I think CAMHS in the other places twist their interpretation so that they don't take the referral. I've had them coming back saying, "No that person doesn't want to engage so we're not offering it" when I know very well that person would engage if they only made an effort to engage them.' (Looked after children SW2; LA H; Moderate Integration)

Young people turning 18 were not always eligible for support because the eligibility criteria for adult mental health services were different to CAMHS. One of the ways of countering this was for CAMHS to see young people up to the age of 24, which is the age until which leaving care services still apply, and a number of the CAMHS teams whose members were interviewed for this thesis worked to this arrangement. Those teams who did see children over the age of 18 argued the need for this with health /local authority commissioners.

'...everything always says that LAC should you know extend, the children's services should extend up to 25 at least and in health 18 is the cut off. We managed to get to 19, which doesn't sound like much of a victory, but it really feels like a victory, that one year that we got.' (Clin psych; HT 10; High Integration)

'Our service offers up to age 24.' (Clin Psych; HT 9; High Integration)

'We've worked very hard and I think our counterparts in the adult teams also are beginning to realise that it is much more efficient to work with us rather than let it fester and then pick it up later. But I think there's still problems there. The children who don't meet threshold are left a bit neither here nor there so that's a problem.' (Psychiatrist; HT 1; Non Integration)

The referral criteria used by CAMHS differed markedly between services; some services required an SDQ score of 17 or above before a child or young person would be accepted for referral.

> *'Now they have to hit an SDQ score of 17 or more, or they have to be at risk of placement breakdown for them to be eligible.'* (Family Therapist; HT 8; Non Integration)

> *'...a lot of other services are using 17 as a cut-off point in terms of clinical indicator.'* (Clin Psych; HT 9; High Integration)

In addition, there could be a tension between the threshold criteria for CAMHS at the third and fourth tier where looked after children had particular needs but their needs did not constitute a disorder.

> *'A lot of mental health needs of looked after children are psychosocial and I find that there is a lot of disagreement about whether or not their suffering is social, psychological or mental, and we have a lot of disagreements about which service they are best.., which service is best to provide for them. So for example you can get somebody who may be making suicidal gestures, and from our perspective is very unwell, but may not get a service from core CAMHS even though we think they are high risk, because they don't have a diagnosable mental health disorder. They might have, kind of, issues with their personality functioning, umm, interpersonal issues, but not enough to get them a service.'* (Clin Psych1; HT 5; High Integration)

> *'...so the obvious place where it manifests is when some, I guess more the adolescents, can't seem to cope living in a family, so they live in a residential home that's managed within social care that's funded by social care, but their needs are mental health needs, but PCT's don't generally fund those placements because they come back as saying they don't have a diagnosable mental disorder. Their problems are all to do with their past experiences - they don't have a mental illness. But as soon as they*

> *hit 18 they can be diagnosed with a whole raft of stuff....'* (Clin Psych2;
> HT 5; High Integration)

Rao et al., (2010) suggest that for CAMHS referrals there was a need for a balance between narrow criteria based on mental disorders and wider ranging criteria which were '*over inclusive and ill-defined*' (p68). They argued that such discussions about referral criteria should involve local authority partners so that boundaries between services were not entwined and undeliverable within the current limited budget environment for both agencies. Varying interpretations of eligibility for CAMHS featured as contested areas between local authorities and CAMHS workers. The NPT framework also helped to make sense of this complex practice environment to address these tensions. 'Communal specification' can be difficult where each organisation has a different understanding of its role, including budget pressures, differing agency legal mandates, different thresholds for services and different resources.

7.6 Integration models: Design of services and working relationships

The NPT framework helps to analyse the relationship between levels of knowledge and understanding of mental health issues expressed by social workers and CAMHS clinicians, and the nature of Integration between CAMHS and local authority looked after social work teams. The question being debated in this section is whether level of integration was related to ownership of the process and outcome than teams that were at distance and did not regularly communicate with each other, except through formal meeting structures, such as looked after reviews.

Chapter five outlined how, within the CAMHS directly represented in this research (via focus group or individual interview) or indirectly represented (via social workers from a number of authorities for which no CAMHS staff were interviewed), the specialist looked after children CAMHS could be categorised in terms of three different service models. These were: High Integration service either fully integrated into the local authority or co-located in the same building; Moderate Integration service partially integrated, which are located in the local authority but not with social workers who use the service; and Non

Integration services, which are completely separate and located in health services, for example a CAMHS community team. Examining the effects of these three different models on social workers to then determine the 'best' model for CAMHS provision to looked after children from a social work perspective was difficult and quite possibly overly-simplistic, as the rationale for service design was more complicated in a service environment where everything was commissioned and costed.

However, there were some distinct advantages to each of the various integration service types. In High Integration services, there was a lot more flexibility for CAMHS staff in the way they worked with children. This was the second largest group of specialist CAMHS represented in this thesis. They did not solely offer an office based service and were more likely to visit children in their placements and work outside of a 50 minute 'therapeutic hour' long session.

> '...so we work in a quite flexible way, ...we will do things like go to, we will often go to children's homes, or sometimes meet them in the community if they are really difficult to engage, or they come here to a place that is a Barn. It is basically a building that doesn't have any mental health connotations.'(Child Psychologist; HT 5; High Integration)

> '..you are able to go and speak to social workers without having the barrier of trying to get to the building or trying to get through on the telephone....for any professionals working with looked after children, to be co-located in the same building is a huge, huge benefit.' (Looked after children Nurse; HT 5; High Integration)

There were strong links in-between these specialist services and mainstream CAMHS. The disadvantage was that these specialist teams were more expensive than 'service as usual' for CAMHS, and were therefore susceptible to cuts in times of austerity, unless these were shown to be cost effective.

As a way around this issue, one CAMHS service co-located into a local authority had developed a different approach to screen and review the mental health of looked after children and described their role as one of 'gatekeeper'; not to keep children out of the service, but to navigate a way into mental health

services should they be required, so as to meet a child and carer's needs. Access to mental health services was not dependent on a social worker's perceived knowledge about a child, or how long a social worker had known a child, or how proficient the Independent Reviewing Officer was in reviewing the care plans in place for a child. Rather, there was a separate but integrated layer of support available to the social worker that co-ordinated and monitored mental health issues for all looked after children, using the SDQ as the tool for this task. The team had begun using the teacher version of the SDQ in addition to the carer report version to begin to triangulate data received about children. This CAMHS service and local authority is used as a case study and explored further in the next chapter.

Another integrated approach within a CAMHS service participating in my study involved CAMHS clinicians (psychotherapists) integrated into all social work units in the local authority on a 0.5FTE basis, taking a lead on ensuring that discussions on mental health were incorporated into all thinking, planning and work with children and their families. This particular local authority was one of three local authorities used in a service evaluation by Forrester et al., (2013). They report the following about the integration of CAMHS clinicians into social work teams:

> *'The role of the Clinician was another major difference between the units and the conventional teams. Clinicians did not lead on cases but had specific tasks on specific cases. They also took part in the staff meetings and provided therapeutic psychological or other alternative insight regarding both explanations of a client's behaviour and also methods of working with them. Clinicians typically worked on cases for which some extra work was required with a parent or a child… In general, Clinicians were partly responsible for the fact that psychological theories (for example, attachment, psychodynamic, and social learning) and evidence-based research were a central part of the discussion of cases in some of the units.'* (Forrester et al., 2013, pp97-98)

This local authority had adopted a particular theoretical approach (systemic approach[31]) that underpinned all its social work practice, which was closely aligned to models used by its CAMHS clinicians. Again, children's access to mental health services was not dependent on an individual social worker's knowledge about mental health, as individual cases were allocated to the team with particular tasks assigned to team members. However, the CAMHS clinicians in this local authority commented on difficulties with regular clinical supervision because of staff vacancies and the fact that no-one in the local authority was suitably qualified to offer supervision to these workers. This model had been independently positively evaluated (Cross et al., 2010, Forrester et al., 2013). The UK Government's innovation programme for children's social care (Department for Education, 2014b) had seen many more councils across England adopt this approach. However, since Forrester et al.,'s evaluation, the local authority in question had changed this model and psychotherapists were no longer integrated into every social work team.

In Moderate Integration services, the advantage for the service was that it had some of the flexibility of the High Integration services, in that the specialist service was not based within a Health building and there was some flexibility about how services were offered by the specialist CAMHS practitioners. However, it was not located in the same building as the social work services for looked after children and so networking and liaison between these two services were not as integrated as in the High Integration services. The distinct advantage of this model was that it was based in the local authority as opposed to being in a community health centre and therefore was not as stigmatising for children and young people to access. Only two of the specialist services included in this research were Moderate Integration services. One specialist CAMHS service shared a building with the local authority's fostering and adoption service and was one of the original 24 CAMHS innovation projects established in 1999. The other specialist CAMHS service was based in a community building in the local authority, whereas most of the council services in that local authority were located in a central building in a business district some distance away.

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[31]'In a nutshell, systemic approaches focus on relationships and interactions in the family and wider systems rather than on individual pathologies' (Forrester et al 2013, p94).

Both services were well respected by social workers in their particular local authorities.

In the Non Integration services, the lack of flexibility that traditional outpatient, appointment based CAMHS had was problematic for both social workers and for looked after children, as children had to be seen at CAMHS offices at certain set times. As reported in chapter five, social workers reported a 'take it or leave it' attitude by some CAMHS staff; where young people missed appointments, CAMHS would often have a 'three strikes and you're out' approach where cases would be closed after non-attendance. Social workers were also critical of only one kind of CAMHS service being available for looked after children, with minimal input from social workers about what that would involve. The advantage of this model was that the service was still separate from mainstream CAMHS but closely aligned with it. Professional supervision for staff occurs within the health trust with suitably qualified managers. Looked after children social workers were able to access specialist services more quickly than they would mainstream CAMHS. Half of the CAMHS included in this study were Non Integration services (see table 5.2 in chapter five).

As mentioned in chapter five, all social workers who had CAMHS clinicians integrated into their teams or services spoke positively about the advantages of having CAMHS staff readily available for consultations and quick discussions. In all integration services (High, Moderate and Non Integrated) regular consultations were offered by CAMHS clinicians to social workers and foster carers and these were unanimously highly regarded by those social workers who used them. However, with CAMHS clinicians across the study (in all High, Moderate and Non Integrated services) also commenting about some social workers never referring children to them (Group two – 'Anti-labelling'), questions must be raised about whether access to services depends on a social worker's knowledge about mental health rather than the needs of a child. This would appear not to be dependent on the integration model type, however there are advantages to being part of an integrated model, such as high integration and to a lesser extent moderate integration, because if a social work and CAMHS service is highly integrated so that social workers and clinicians frequently discuss service users, it would be reasonable to expect that social workers might

increase their knowledge of mental health language and thinking. Although I could hypothesise that a social worker from Group three ('Partnership') would be most likely to be based in a service with High Integration, the data I obtained did not allow me to categorise all social workers taking part as either Group one ('Anxious'), two ('Anti-labelling') or three ('Partnership'). Further work would need to examine this as group three (partnership) social workers were also reported by the group of clinicians in Non Integration as referring appropriately, but only where social workers had positive relationships with CAMHS clinicians and demonstrated that they understood the way that CAMHS work.

When considering how the three integration models affected the way in which social workers understood their role in using the SDQ, I did not have sufficient evidence in my data to show that the level of integration directly or indirectly linked to NPT successful processes. The level of integration is not a determinant of change in embedding SDQ practice but it could be one factor in establishing the level of NPT process. For example, the High Integration CAMHS all had different approaches to the way in which they integrated within the local authority teams. Only one of the local authority teams in High Integration used the SDQ in their everyday work (LA D), but that was principally because the specialist CAMHS team did all the administration, all the scoring and wrote a report for the social worker to use in the child's annual review. The CAMHS team used a specialist model to normalise this work within the local authority, where the CAMHS team are the 'specialists' and do the work, and they then discussed the results of the SDQ screen with the social worker. In other models used by local authorities, in LA H, where the specialist service was at Moderate Integration, social workers were responsible for completing the SDQ work themselves as part of their routine duties.

An examination of the strengths and weaknesses of these specialist vs generic models in explaining how the SDQ was normalised into practice was more useful than the level of integration of the specialist CAMHS service. However, these specialist services should not be viewed as static. If the High Integration service above, LA D, were to have its funding cut or the service was to be recommissioned by the local authority and the clinical commissioning group with a smaller budget, this 'specialist' model, where CAMHS specialist services took

responsibility for everything, might not be sustainable. It may be a stepping stone to the 'reconfiguration' of services whereby activities, such as SDQ completion and referral, where appropriate, to CAMHS, then become normalised into routine processes. The fear is that this will occur by default because of funding issues affecting service delivery rather than because processes have become embedded into everyday practice as a targeted and planned piece of work.

7.7   Chapter summary

The fourth research question is *how the working relationships between a looked after child's social worker and CAMHS specialist worker affect the way in which the SDQ is used*. The majority of local authority social workers and CAMHS practitioners were based in separate services and their responsibilities were determined by their professional and institutional requirements. However, social workers and CAMHS practitioners also needed to work together to provide looked after children with services that met their mental health needs.

Chapter five described three different types of integration models identified from the data. These were: High Integration services (between CAMHS and the local authority); Moderate Integration services, where specialist CAMHS services were partially integrated (located in the local authority but not with social workers who use the service); and Non Integrated services, where CAMHS were completely separate and located in health, for example a CAMHS community team. The strengths and limitations of these models have been explored in this chapter.

In addition, this chapter explored three typologies that described individual social worker attitudes toward mental health issues and referrals to CAMHS: those who were most likely to refer and are nervous about mental health (Group one – 'Anxious'); those who were least likely to refer due to viewing children's problems from a social rather than medical perspective (Group two – 'Anti-labelling'); and those who understood how CAMHS works and made appropriate referrals (Group three – 'Partnership'). Linked to this, the chapter also explored how social workers' responses to the behaviours and emotional states of looked after children and psychiatric diagnoses affected their CAMHS referral activities.

Social workers appeared to base their assessment of a child's mental health on the child's behaviour rather than from the use of an assessment tool like the SDQ. This is a key finding in relation to research question two. Therefore, social workers' ability to identify and synthesise children's behavioural and emotional problems was what then determined which children they thought should be referred to CAMHS. From CAMHS perspective this meant social work referrals fell into one of four categories: (Y/Y) viewed by CAMHS practitioners as appropriate referral; (Y/N) inappropriately not referred by social workers; (N/Y) viewed by CAMHS practitioners as an inappropriate referral; and (N/N) appropriately not referred by social workers.

There were no observable patterns of Group one - 'Anxious' or Group two - 'Anti-labelling' social workers tending to work in High, Moderate or Non Integration-level services.   If this were the case, then it might provide insight into what it was that produced these typologies of social workers and, hence, what could potentially be done to produce more Group three - 'Partnership' ones.

There were a great many barriers to achieving an integrated service which was flexible, responsive, cost-effective and well regarded by its users, including children and young people. The NPT concept of 'workability' was helpful in understanding the ways in which staff were able to consistently or inconsistently operate across the interface between CAMHS and social work and a number of these difficulties and challenges have been explored in this chapter.

The next chapter presents a case study of one local authority where the SDQ returns were high, and there was a high level of integration (co-location) between social workers and CAMHS clinicians. This provides an opportunity to explore a critical case and consider any key success factors.

Chapter 8 A Case study of Local Authority D

8.1 Introduction

A case study is an in-depth exploration and analysis of a specific case, organisation, team or event (Creswell, 1998). It enables an opportunity for detailed and intense analysis of complex phenomena in one case or multiple cases (Baxter and Jack, 2008). When examining the data gathered from the nine local authorities who took part in the study, one local authority in particular, local authority D (LA D), appeared to have incorporated the SDQ data collection process into its social work services in a more integrated manner than other local authorities (see Table 5.1 in chapter five). LA D is therefore used as a 'critical case' (Yin, 2003) to identify 'lessons learned' (Lincoln and Guba 1985) about what worked well and identify any areas requiring further development.

The aims of this case study are:

- to describe the real life context in which this local authority and CAMHS specialist team is located;
- to examine the way in which the SDQ data collection process is used by a social work team for looked after children and CAMHS specialist team in this local authority;
- to comment on whether the particular experiences of this local authority could offer ideas to other local authorities about how to achieve improvements on data collection and better use of the SDQ information by social workers.

The qualitative data used in this chapter comprised an interview conducted with the Team Manager of the specialist CAMHS team (this has not been utilised in previous chapters), and the focus groups conducted with the social workers and the specialist CAMHS team working in LA D. These data are presented and discussed to investigate: firstly, whether LA D did include social workers who had higher-level understandings of mental health and better buy-in and use of the SDQ in their practice with looked after children compared to those in the

other local authorities included in this study; and secondly, to elucidate any examples of good practice.

The chapter begins with a brief overview of LA D. Following this, the process used by LA D is evaluated against the statutory guidance, to compare what is expected with what takes place in practice. A number of the models and typologies identified and discussed in the previous chapter are then applied to LA D, with the ensuing discussion bringing together the 'good' practice in LA D with the findings from other local authorities. The results from previous chapters are also highlighted in this discussion. Finally, the NPT framework is used to ascertain the level to which the SDQ has been embedded into local practice in LA D.

8.2   An overview of Local Authority D

Local authority D is an outer London Labour controlled local authority based in the west of the city. The population of the local authority is around 250,000. Just over 50% of the population are White British, with 46% of people identifying themselves as being of Black, Asian and Minority Ethnic origin. The population is more ethnically and linguistically diverse than the London average, and is fluid, with a higher turnover of both international and domestic migrants compared to London and national averages (Office for National Statistics., 2011).

Approximately 63,200 children and young people under the age of 18 years live in LA D, which is 25% of the total population. Just under one third of the local authority's children are living in poverty (30%), which is below the London average of 37% (Trust for London, 2017). Children and young people from minority ethnic groups account for 76% of all children living in the area, compared with 21% in the country as a whole (Office for National Statistics., 2011).

8.2.1 Looked after children in LA D

Over the previous five years (2011-2015), the local authority had an average of 315 looked after children in care on 31st March of each given year (Department for Education, 2015b), which is a rate of 52 every 10,000 children. This is slightly

above the average for the numbers of looked after children per 10,000 children in outer London authorities (49 per 10,000) and below the average for authorities across England (59 per 10,000).

The looked after children's teams for the local authority were all located in the council's head office building. There were three different social work teams for looked after children: the 'through care' team, which worked with children aged between 0-18; 'late entry' team, which worked with children aged between 14-18; and the 'leaving care' team, which worked with young people aged between 18-25. All council services operated from this building.

The specialist health service for looked after children (from here on referred to as the specialist CAMHS team) was based on the same floor as the looked after children social work teams (so highly integrated). This specialist CAMHS team was established in 2009. It worked solely with looked after children and foster carers, offering outreach and consultation to social workers for looked after children and foster carers, and direct work with looked after children. Children had to live within the borough in order to be eligible for referral to this service.

The remit of the specialist CAMHS team included health and mental health issues. It comprised:

- two social workers, both of whom had additional mental health qualifications (e.g. CBT, play therapy, or family therapy), one of whom was a licenced clinical social worker (a qualification gained in another country);
- a clinical psychologist;
- a paediatrician (who undertook the annual health checks); and
- a paediatric nurse for looked after children.

The specialist CAMHS team's social workers were employed by the local authority and the health-based members of the specialist CAMHS team were employed by the Mental Health/Community Health Trusts. The looked after children's teams and the specialist CAMHS team were managed by the same Head of Service (see diagram 8.1 below)

Diagram 8.1: Structure chart for LA D Corporate Parenting Service
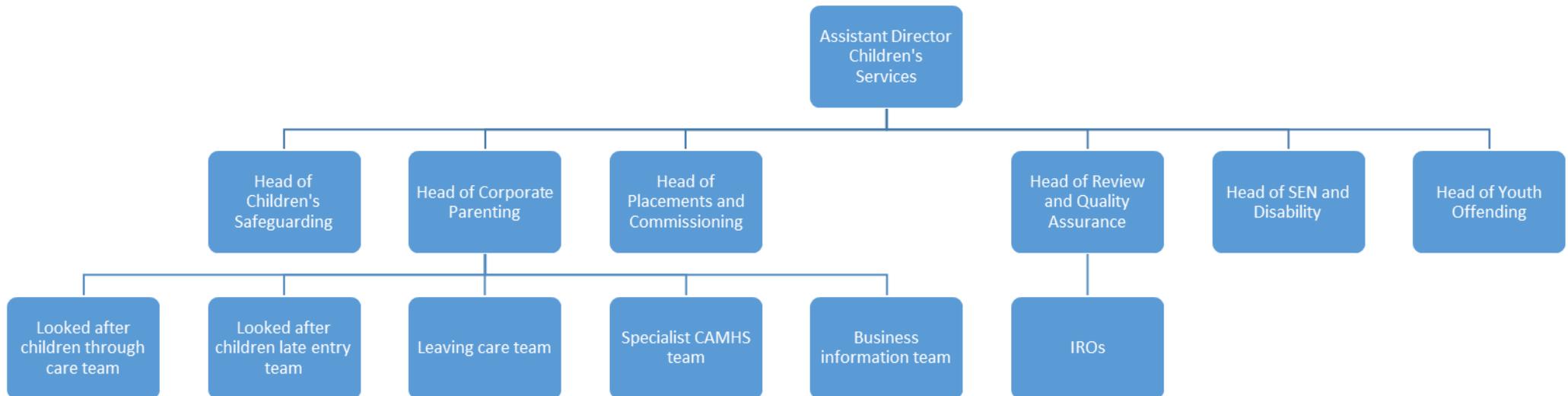
8.3 Processes in LA D

LA D used the SDQ in most of the ways outlined in the Statutory Guidance (Department for Education and Department of Health, 2015). The SDQ carer version was sent to the foster carer prior to the annual health assessment, and these were routinely completed by carers. In LA D, the SDQ was collected and scored by a member of the specialist CAMHS team, rather than a social worker, and this was the main way in which LA D differed from the suggested process in the Statutory Guidance. The SDQ information was made available electronically to both the looked after child's social worker and to the Independent Reviewing Officer for the looked after child's six monthly review. Additionally, the specialist CAMHS team completed a brief report for social workers about every looked after child that gave a summary of background information, as well as the results of sub-scales where any issues that required monitoring or further referral were highlighted.

In the focus group, the specialist CAMHS team in LA D reported using the SDQ to monitor the mental health of the child or young person over time. The SDQ scores were available electronically for social workers. (Please see diagram 8:2 for a flowchart of this process).

Diagram 8.2: The process for SDQ data collection and dissemination via Local Authority and CAMHS personnel in LA D/HT 3
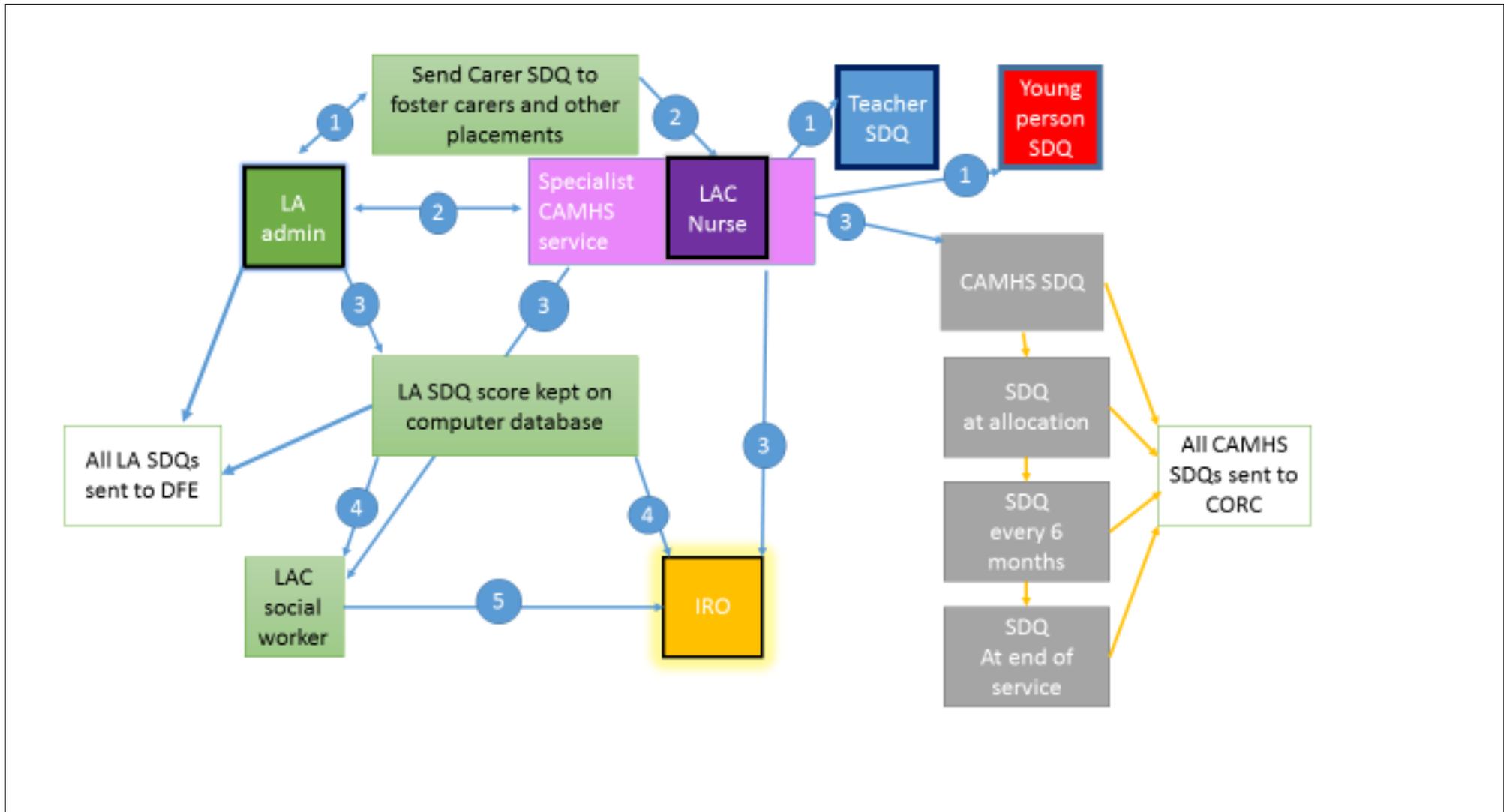
Diagram 8.3: Other local authorities
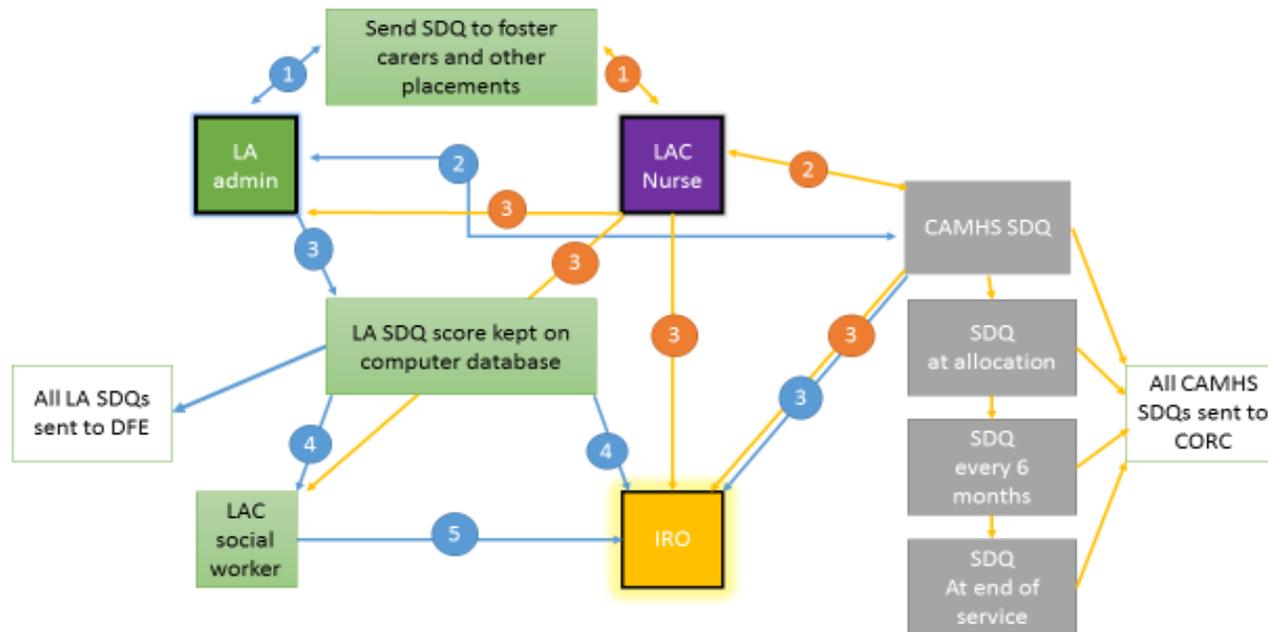
Key:
1. LA admin sends out SDQ
2. CAMHS Looked After Child Nurse sends out SDQ

   IRO
   CAMHS
   LA
   SDQ returns

In LA D an assessment of the mental health of a looked after child involved members of the specialist CAMHS team receiving and scoring versions of the SDQ (carer/teacher and potentially self, depending on the age of the child), compiling a brief background statement about the individual child, and completing a statement summarising the results of the SDQ. This was carried out around the time of a child's annual looked after medical, with a view to this information being available for the child's next looked after review. Looked after children who had been in care a year or longer and not changed placement had two reviews a year. The five SDQ subscales were used in the analysis, which was unusual as most local authorities used only the total difficulties score. This determined whether a child or young person's score was 'normal', or whether mental health difficulties were 'possible' or 'probable' in each of the subscales. From this information, social workers and members of the specialist health team decided together whether additional services might be required, and if so, what services might best meet the needs of the child or young person. According to the Team Manager for the specialist CAMHS team, social workers received this information, as did the specialist nurse for looked after children, the Independent Reviewing Officer (IRO) and the business information officer. If the SDQ was showing something unusual then the team manager for the looked after children team also received copies.

The reason why the specialist CAMHS team undertook this task was because they found that social workers in the looked after children's teams were not routinely looking at the SDQ information and then using the data to inform decision-making:

> *'I think a lot of social workers don't even read these [SDQ]... but they know at the beginning of the month we'll come out there and we'll be talking about certain kids... we'll go talk to the social worker and say 'hey, this is showing up, yeah, we'll go look at it', and so instead of them having to come to us, we will go to them, and they know that we are going to do that. We update this information every month.'* (Team Manager; Specialist CAMHS team; LA D)

The advantage of the specialist CAMHS team having an overview of each looked after child in LA D was that they also knew what services children or young people had already accessed. In an environment where social worker turnover

was significant, this information was useful in ensuring that a 'scattergun' approach to referrals was avoided and children and young people were not unnecessarily re-referred to services.

Because the specialist CAMHS team received the SDQs from foster carers, any training needs for foster carers in how to complete SDQs or about mental health were identified, and this training was organised and delivered by the specialist CAMHS team. The SDQ teacher versions were sent to schools by the specialist CAMHS team for looked after children of school age, and the results collected and reported alongside the carer version. The specialist CAMHS team also encouraged young people aged over 11 to complete self-report versions but tended to use the results of these as discussion starters between the specialist CAMHS team and young people about mental health, rather than analysing them alongside the carer and/or teacher SDQ versions.

The specialist CAMHS team was the gatekeeper for mental health services in the borough, and the team manager viewed this positively:

> *'I think we have assumed the role of the gatekeeper for mental health*
> *for children in care and I think it makes a difference because I'm not sure*
> *social workers can do that with all their cases, you know, I don't think*
> *they could do that. They're smart enough, but it's just the workload.'*
> (Team manager; Specialist CAMHS team; LA D)

The team had access to electronic information about all looked after children, including the SDQ data over a number of years. The team manager had created a management information system which provided the specialist CAMHS team with information about the mental health of every looked after child in the borough, including SDQ data, referrals, assessments, interventions and service refusals.

> *'I went through every one of the charts for every kid we had, it was 352,*
> *and pulled out every bit of information regarding referrals to mental*
> *health, any therapy that we know, everything I could do in that arena,*
> *with psychological behaviour and ...we keep it caught up all the time so*
> *you can come to me about little Susie Q or Johnny, you know, and we can*
> *say, 'well three years ago they were offered a referral but they refused*
> *to come'.'* (Team Manager; Specialist CAMHS team; LA D)

The team manager of the specialist CAMHS team emphasised two factors that he believed made a difference to the success of the team. First was the 'business information officers', who were administrators located in every team responsible for data collection:

> *'So each business information officer sends out the Carer SDQs to the foster carers and they do a tremendous job. If they [foster carers] don't send it back right away they get on the phone, and all of our business information officers, except one really, are very pushy and very proactive.'* (Team Manager; Specialist CAMHS team; LA D)

The second factor identified by the specialist CAMHS team manager as important for the team's success was the support received from the local authority service manager, who was the senior manager responsible for looked after children's services, and for this specialist CAMHS team for looked after children. Every local authority has its own arrangements for managing services run by the council and services run in partnership with health organisations. The model varies – the significance of the model for LA D was that the local authority service manager could create cultural expectations about co-operation and joint working between services she managed, which then supported effective completion of the SDQs. The specialist CAMHS team manager described how the service manager was instrumental in influencing how well the specialist CAMHS team was embedded in the work of the looked after children service in this local authority. Having a clear organisational structure was a facilitator to better working relationships, but the additional leadership of the service manager, was a critical factor in ensuring services worked well across teams.

The local authority service manager was also described by members of the specialist CAMHS team as their 'champion' at LA D's senior children's services management meetings, which ensured that the work of the CAMHS team was understood and valued at a senior level within the organisation. This relationship was viewed as vital in securing the long-term future of the specialist CAMHS team within LA D, and to also influence practice outside the local authority.

> *'…where we could be in five years' time with the right sort of service manager, with the right funding in the future because actually it could be a beacon for outside of our Borough because it [the specialist CAMHS team] is so helpful in a lot of ways… we've had some other people that*

> *worked for other boroughs, and they'd say we're doing so much more
> than everybody else does…'* (Team Manager; Specialist CAMHS team; LA
> D)

These comments were echoed in the focus group that I did with the members of
the specialist CAMHS team.

> *'We're very well managed ourselves with a manager who supports us in
> doing this work and sees the potential of it, and although she's a social
> worker, she has a background in mental health and I'm sure that that's
> had quite an impact on us.'* (Clinical Psychologist; Specialist CAMHS team;
> LA D)

Following changes introduced in the late 1990s within mental health trusts,
people appointed to management roles come from a range of professional
groups, including social work. Within local authority children's services
departments, senior managers are frequently social work professionals, but what
is more unusual, such as in this case, is for these managers to have a mental
health background as well.

The local authority service manager who was responsible for the SDQ returns to
the DfE retired 18 months after I conducted the interview, (which corresponded
with the time that the annual SDQ return dipped to 89%). The team manager for
the specialist CAMHS team had concerns about the impact that this might have
on the service, given the budget pressures and other factors affecting the local
authority. LA D had already experienced the loss of some of their external
services with other national providers, such as the NSPCC, because of funding
restrictions.

In this local authority, one of the unique characteristics of the specialist CAMHS
team was that the team acted as a universal referral point for access to
additional mental health services. This ensured that children and young people
were referred to services that would meet the specific needs they had, and
social workers did not have to complete multiple referral forms to many
different agencies.

> *'When we started centralising all mental health, they [social workers]
> would send out three or four referrals to every agency known that works
> with that kind of child, hopefully just to get someone on board. And so it*

wasn't well thought out. This process makes us think about the right pathway… Every time a new social worker came in, especially the way they used to turn over, they'd say, 'well that kid needs therapy,' so they would do it, especially if it was an IRO or something. And so now we can see what is going on, so, 'No we don't need to do that. They were just there last year.' So it's very centralised with us and I think that's what makes it work. We've taken on the responsibility…and I know social workers appreciate it when I say, 'don't worry about the referral to the [specialist service]. I'll write it out and do the letter.' It makes a big difference to them.' (Team Manager; Specialist CAMHS team; LA D)

In this local authority, the SDQ was part of the health assessment completed on looked after children. Given these processes strongly adhere to what is considered 'good practice', combined with the high rate of SDQ returns that LA D achieved, this local authority should be an environment where social workers had a 'high level' understanding of mental health, including using the SDQ in their work in order to deliver best outcomes for looked after children. So, what did social workers say about the SDQ?

8.4   LA D looked after children's social workers' perspectives on the SDQ

In terms of the value of the SDQ as a tool, the social workers in the focus group expressed a range of attitudes and ideas about its purpose and usefulness, very similar to the breadth of views expressed by social workers in other local authorities included in this study. Some of the data conflicted. A number commented that they did not use the SDQ in their practice, despite it being linked to and available on the child/young person's electronic file.

'I never look at them. For me, it's information that's collected for the management information and it's not really collected for me.' (SW1; Looked after children team; LA D)

'We don't formally get sent them as far as I am aware, I haven't received any since I've been in practice but you do often find then on the file. I think they're quite out of date and you're like, 'this isn't relevant anymore'.' (SW2; Looked after children team; LA D)

As with social workers in other authorities, doubts were also expressed about the validity of the SDQ as an assessment tool, and value was instead placed on the relationship the social worker had with the child/young person and the foster carer, favouring this above relying on the results of the SDQ:

> *'It's just a tick box, little questionnaire and I found them useful as an activity to generate conversation and discussion when doing direct work or getting to know someone and doing your own assessments. But I wouldn't use it as a proper clinical assessment; it's not designed to be that.'* (SW1; looked after children team; LA D)

However, a number of participants challenged this view, recognising the contribution that the SDQs could bring to practice:

> *'I genuinely am really surprised that social workers aren't paying attention [to the SDQ] because you are right, you get very different information that comes in from each different one. The carers will probably be saying something very different to the child but that in itself is quite telling about the relationship, about what the child is thinking about that relationship. I think it's a bit sad it's literally being filed and no-one's paying attention to it because you can get quite a lot of really relevant stuff out of it.'* (SW3; Looked after children team; LA D)

Overall, there did not appear to be any more use of the SDQ by social workers in their day-to-day practice than in other local authorities. Even with the comprehensive processes in place for SDQ data collection in this local authority, including the high numbers of SDQs routinely returned, these views highlighted a potential gap between the process of SDQ data gathering, which happened outside of the social work teams in LA D, and the use of these data in practice across the social work teams. Given that its use by social workers in LA D was patchy at best, social workers described other ways in which they supported the mental health of looked after children, which included using the specialist CAMHS team:

> *'We are really lucky that we've got the specialist CAMHS team with clinical psychologists and social workers that we can go to, even if it's just for a consultation. So when we get that 'I'm out of my depth' feeling, we can go, 'This is what's going on. What do you think?'… I*

certainly would go to the LAC health team and seek their advice and if needs be a referral for them to work with the child.' (SW2; looked after children team; LA D*)*

'Our borough is quite unique in the sort of service we are able to provide for young people, because [the specialist CAMHS team] is round the corner from my office, I walk across and I go, 'I've got this young person, I don't know what to do...' (SW3; looked after children team; LA D)

However, a number of contradictions and disagreements were expressed between members of the focus groups in LA D about processes used for the SDQ and monitoring of looked after children's mental health. Social workers knew that the business information officers sent out the forms to foster carers before the looked after child's bi-annual review, and that the looked after child's review was the appropriate place to discuss emotional and mental health issues. One of the contradictions in the data was that, despite all the social workers clearly reporting that they knew the SDQs were completed at the time of the looked after child's annual health assessment, one (SW2) said at another point in the conversation that the SDQ was not routinely sent to social workers. Others reported not seeing or using the summary reports that the CAMHS team prepared about the mental health of their looked after child. Some social workers were not aware that the teacher version of the SDQ was also routinely collected and that members of the specialist CAMHS team also worked with young people to complete the self-report version of the SDQ.

The focus group held with specialist CAMHS clinicians also raised issues about processes in looked after children's reviews in respect of how SDQs were used, how mental health issues were addressed and how CAMHS clinicians were involved in reviews:

'In the looked after children's review, it's variable in terms of not only whether mental health is covered, but how it's covered. I wouldn't go to a LAC review with a child that doesn't have emotional or mental health needs, so I don't know how that's covered when it's all kind of going well. But thinking about some of the young people that I see, I'm not even invited to LAC reviews or I'm invited the day before sometimes because people are just overwhelmed with work and they're not able to think far ahead. But then it is variable because others I do know invite

me far in advance and it's really an important part of that social worker's relationship with the young person and the system around the young person to think about emotional wellbeing. So, you know, it's variable.' (Clinical psychologist; specialist CAMHS team; LA D)

8.5 Problem areas for SDQ data gathering

One of the problem areas for SDQ data collection raised by social workers in every local authority included in the study, including LA D, was in respect of children in residential accommodation and/or those placed out of borough. Both the focus groups in LA D commented on how difficult it was for children placed outside of the borough to receive timely access to mental health provision.

> *'We're lucky in LA D that we have a health team and we also have an educational psychologist who does one or two days a week, but in the case I've just had, we can't get (a home county on the outskirts of London) to do the psychological assessment we need on the child....I think out of borough placements are harder to keep your eye on but it's about the social worker keeping the child in mind the whole time and that's our role.'* (SW2; looked after children team; LA D)

> *'Young people in prison and strangely enough, young people in very expensive residential placements… it's all around security and control and not around therapy. Somebody said about residential not doing SDQs and there might be an element of that, because they're out of sight. A lot of money has been spent.'* (SW1; looked after children team; LA D)

It was notable that this occurred despite both the Statutory Guidance suggesting clarifying who the responsible Clinical Commissioning Group was for funding services outside the borough and the existence of mechanisms to resolve any funding issues that arose (DfE and DH 2015, p6 and pp23-4).

8.6 **What makes a difference to social workers' understanding concerning the use of the SDQ and the importance of mental health for looked after children?**

The above results illustrated that, regardless of the promising context in which the SDQ data was gathered and made available to social workers and Independent Reviewing Officers who routinely worked with looked after children in LA D, understandings of the SDQ and use of the SDQ data by social workers in this LA appeared very similar to that of social workers in the other local authorities included in this study. As with the other local authorities, some social workers demonstrated more skills and competence in mental health assessment, including knowing the point at which to ask for additional support, whilst other social workers lacked the skills and knowledge to make what members of the CAMHS team described as appropriate referral decisions.

> *'Some experiences make me doubt a little bit their knowledge or interpretation, but it is variable and then there's social workers that'll be emailing you all the time and very much on the ball and wanting support or pathways to something different so it is variable, like in any profession.'* (Looked after children specialist nurse; LA D)

> *'You get some [social workers] who are great at communicating entirely appropriately, and checking in with very complex, worrying cases, then others not so. Sometimes there are some social workers who have obviously had a little bit of training in mental health and have heard certain words and then start bandying them around very enthusiastically, which have a lot of potential implications, you know, like kind of asking whether a child is schizophrenic, you know or has a split personality or something like that and I'm kind of in horrors that they've got some, dare I say it, false confidence about some of those things. So that happens as well.'* (Clinical psychologist specialist health service; LA D)

Many of the points made by the specialist CAMHS team in LA D were also made by other specialist CAMHS teams in other local authorities. There were similar observations around the knowledge and skills deficits of many social workers in

the area of mental health and the same problems were identified, with social workers thinking that therapy was the answer to a child's problems.

> *'I think there is a mind-set within social work that says that therapy can solve it all and therapy is almost like this beacon that's held up and if we can just force these children through the doors and get them to sit down that everything will miraculously be okay.'* (Clinical psychologist specialist service; LA D)

8.6.1 The student social work experience of SDQ use in LA D

One of the participants in the specialist CAMHS focus group was a social worker who had previously been a student in the specialist CAMHS team, and had completed and used the SDQ throughout her placement. Social work students in England undertake two placements for 170 days in total in two contrasting settings. A placement in the specialist CAMHS team had enabled this student to become familiar with the SDQ and with emotional and mental health issues for looked after children more generally. She then worked in another social work team elsewhere in the local authority. Her contribution to the focus group identified a number of challenges for specialist CAMHS practitioners in their work with social work colleagues to support the development of a particular mind-set or way of thinking about mental health:

> *'I was just thinking that from doing the SDQs as a student, coming in and doing the self-report of the SDQs with the young people and then writing up about them and then looking back at their history and analysing it, you start to think in that way. Having done SDQs has made me think about mental health, has made me look into it, read up on it and really think more about it and to be more careful about it - as you were saying, not jumping in and saying "oh I think it's this" and just looking at the basics of what begins, how it begins, where those signs are coming from and how it affects and seeing it through their history of how it's affecting them and how it develops. I feel that if the SDQ was piloted and other social workers were doing the SDQs themselves, generally it would make them think more about it, it would be a beginning point for them to understand it.'* (Social worker (ex-student in specialist health service); LA D)

This social worker was able to provide commentary on why looked after children's social workers responses to mental health were varied, even in a borough where a separate team co-ordinated the SDQ, and identified ways in which all social workers could ensure that mental health issues were routinely addressed.

> *'Discussing mental health issues with social workers it was really varied, some of them don't see it as a health issue. They didn't connect it to the work that we did as within the looked after CAMHS team. Some people see it as a very negative thing and maybe mental health should be discussed not to be like "is there any problems" but you know, "how can we make sure that everything keeps going the way it is going? Are they participating in activities outside? Do they have one close person, a friend to speak to?" All this kind of thing and that's what should be discussed at every LAC review in my personal opinion.'* (Social Worker (ex-student in specialist health service); LA D)

The ex-student social worker's comments acknowledged that the process of social workers addressing mental health issues routinely in their work had to be more than just completing a form in order for the SDQ to have any meaningful impact on practice. She highlighted how the overview reports that CAMHS completed were useful to social workers.

> *'…with the SDQ returns themselves, I don't think they have had any impact on practice whatsoever…[so] I think it's good that there is that net outside of the social worker because I think there's a tendency to try and say, "oh well the social worker can do that because it would be good for the social worker to know," and it's like, "well actually sometimes we can't do everything" and we have to be quite realistic about what we can do. So that kind of thing [report from the specialist team using SDQ data] is really helpful.'* (Social Worker (ex-student in specialist health service); LA D)

The surprise, in the context of a 'good' local authority with high SDQ returns and good links between social workers and the specialist CAMHS team, was that some social workers disregarded the SDQ as meaningful. This particular social worker acknowledged that sometimes this may be about social workers' workload

pressures or staff turnover, which was high, but the clinical psychologist thought that those social workers who understood the importance of mental health demonstrated good 'mind mindedness'. They were able to 'hold the child in mind' and alongside this, and showed good organisational skills. For example, where there were considerable mental health concerns for a child, this type of 'mind-minded' social worker would ensure that members of the specialist team were invited to the child's looked after review in a timely manner. Given that the dates for these reviews were set well in advance, this was a relatively minor communication issue which, when addressed, could encourage closer working between teams where this was necessary.

8.6.2 The Independent Reviewing Officer's experience of SDQ use in LA D

In LA D, the SDQ information was sent to the Independent Reviewing Officer (IRO) as part of the health information for the looked after child/young person prior to their review, to remind them to raise mental health issues routinely in reviews:

> *'one thing I like about the reviewing officers now getting the SDQs is that every 6 months when they lead that review, they follow a template.'*
> (Team Manager; Specialist health service; LA D)

The IRO workforce was acknowledged as being relatively stable in LA D, unlike the social work workforce, where significant turnover of social work staff meant that often the IRO had known the looked after child/young person the longest. In terms of continuity for the looked after child, this was an advantage, and in terms of consistently using the SDQ as a tool, this could support improved understanding of changes in a child's life and behaviours.

> *We don't have a lot of turnover in IROs so that's a consistent in [the looked after child's] life.'* (Team Manager; Specialist CAMHS team; LA D)

One IRO took part in the social workers' focus group. The IRO recognised the importance of mental health being on the agenda of child care reviews:

> *'I would say yes, the child in terms of mental health as a whole is picked up as a standard agenda item in terms of the review process, and if there's any significant mental health issues or none, that will also get picked up by the LAC medical or by the SDQ.'* (IRO; LA D)

However, as another example of process issues, the IRO did not consistently have access to or did not routinely ask for the carer SDQ at looked after children's reviews that she chaired:

> *'I've never really seen a carer's SDQ and I was thinking it would be very helpful to start off by getting the carer's SDQ to pitch it in terms of this is where the child was at when they first were placed in their care and look at progression, particularly of mental health... what I think I could do is start with foster carers – have they completed it? I think I'll add it to the agenda.'* (IRO; LA D)

Given that members of the specialist CAMHS team in LA D reported that the SDQ data were available retrospectively and shared with social workers, it was concerning that the IRO was not aware that these data were already routinely available.

8.6.3 The specialist CAMHS team's observations about social workers and mental health knowledge

Many of the points about the mental health knowledge and skills of social workers made by specialist CAMHS teams in LA D were similar to those of staff working in other CAMHS teams. The clinical social worker in the specialist team thought that social workers still had a fear about mental health and about what the social work role with mental health entailed:

> *'I think there is a real level of panic around mental health, and wanting to try and fix it and make it better immediately, but not actually having as social workers the ability to do that because we are not trained mental health professionals and we're sort of the jack of all trades and micro managers in what we do more than we are a specialist in anything.'* (Clinical Social Worker in specialist CAMHS team; LA D)

Other clinicians also showed some understanding about the pressures that social work colleagues were under in doing their jobs, and had some suggestions for ways in which social workers could work more effectively in assessing and responding to mental health issues.

> *'they're not mental health specialists and we are not asking them to be, but I suppose to have some general knowledge about the kinds of signs and symptoms, the early signs and symptoms of mental health*

difficulties, so rather than going and to try to diagnose things to know what the signs and symptoms are, to listen, to interview not just the young, obviously to interview and listen to the young person, but the people who know them best, because social workers are not going to have time to spend, you know, several hours a week talking to a young person.' (Clinical psychologist specialist CAMHS team; LA D)

8.7 The uniqueness of LA D and the specialist CAMHS team

There were a number of 'good practice' areas identified in LA D that explained the high level of Integration between services and the high SDQ return rates to the DfE over the time period that the DfE has been collecting these data. In order to explore this further, the four core constructs of the NPT framework are applied to the case of LA D to examine how the SDQ has been embedded into the workings of the service and into mainstream practice. Each section below ends with a table that summarises the key components of the NPT framework. These are based on similar tables devised by Gallacher et al., (2013), who used NPT as a conceptual framework to analyse a completely different topic (treatment burden in stroke, heart failure and diabetes). Although the topic is different, the table they devised is a helpful way of locating the change processes within the organisations being studied.

8.7.1 Coherence: What is the task?

In terms of 'sense-making', this local authority had effective administrative systems to ensure that a high rate of SDQ returns were completed for the Department for Education's annual statistical returns. This data gathering system was '*internalised*' effectively into the local authority's processes. There was a high level of compliance and co-operation in completing the SDQs, facilitated by the administrative support. Therefore this aspect of the task of data collection was successful. Procedurally at least, this '*communal specification*' (i.e. achieving this aim co-operatively) had strong benefits, with the specialist CAMHS team sharing relevant information from the SDQ with social workers and IROs, and in so doing, attempts had been made to integrate it into

routine practice for all relevant professionals. This resulted in coherent processes for referrals of children considered to have mental health problems.

However, the level of '*individual specification*' (achieving one's own understanding) articulated by some social workers regarding their use of the SDQ and its use within the organisation was patchy. Some social workers admitted to not using the SDQ information. The reasons given were similar to those from other local authority social workers, namely that they did not find the information helpful and were not able to see the benefits to their work from using the SDQ. They said that this was because it was frequently out of date and they had misgivings about whether a short questionnaire could provide beneficial information compared with their knowledge of individual looked after children. Those that did use it found the information useful and it informed their decision-making.

Going beyond simply collecting SDQ data towards facilitating referral of children with difficulties, one example of '*communal specification*' was the way some social workers benefitted from the geographical closeness of the specialist health service (on the same floor) and would ask for assistance from CAMHS specialists where necessary. This geographical closeness also meant that staff from the specialist CAMHS team could speak to social workers directly if a child or young person's SDQ scores warranted further investigation. This was a unique feature of highly integrated services.

The disparity in social workers' use of the SDQ information showed that there were problems of '*differentiation*' (differences in understanding or knowledge about a particular aspect of practice) within the organisation around expectations of how social workers, as opposed to members of the CAMHS team, applied the knowledge from the data that were gathered. Some social workers seemed unable to integrate the use of the SDQ in their practice, although it was systematically made available. In such a well-integrated local authority as LA D, however, these 'low-SDQ-use-social workers' may have still benefitted from the use of the SDQ by their close neighbours in the CAMHS team.

In any organisation there are a number of strategies or procedures that can influence behaviour, making it easier for people to 'do the right thing' or adopt the desired behaviour (National Institute of Health and Clinical Excellence, 2007). There was a system in place in LA D so that the SDQ information was sent

to the IRO as part of the health information for the looked after child/young person prior to their review, prompting the IRO to raise this in the review. However, once again there were problems with '*differentiation*' at this point in the organisational processes, as not all IROs used the SDQ information in their review meetings. Although they had agreed to routinely use the SDQ data, as good practice in the process of monitoring the mental and emotional health of children over time, this did not always happen.

In summary, the specialist CAMHS team in LA D did a lot of work to ensure that the SDQs were completed, data routinely collected, and the SDQ was integrated into routine practice. This then potentially increased the profile of looked after children's mental health issues with social workers to ensure that these needs might be appropriately addressed. However, this effort at '*communal specification*' was met with limited success. It was not a routine part of social work practice for some social workers, who admitted they never accessed the SDQ data, but others did use it routinely, had '*internalised*' it and saw the benefit for their practice with looked after children and young people.

Table 8.1 NPT based framework for Social Worker's use of the SDQ with looked after children, based on Gallacher et al., (2013) with summary from LA D: Coherence

COHERENCE (sense-making work)	NPT based framework based on (Gallacher et al., 2013)	Summary of results from LA D
Overall task	*SWs understanding about how the SDQ screen can contribute to how mental health problems are assessed and managed in looked after children.*	
Components		
Differentiation	How SWs differentiate between the usual ways they assess mental health in looked after children and how they are expected to do it since the introduction of the SDQ as a screening tool.	LA D had developed effective administrative systems, so a high rate of SDQ returns were completed. However this did not mean that the SDQs were used routinely by social workers and IROs. Those that did use the SDQ found it useful.
Communal specification	Improving SWs use of the SDQ in practice co-operatively, alongside foster carers, teachers and other colleagues from health and CAMHS.	There were systems in place for the specialist CAMHS team to share relevant information from the SDQ with social workers and IROs. Attempts were made to integrate it into routine practice for all relevant professionals. There were coherent processes for referrals of children considered to have mental health problems. The geographical closeness of the specialist CAMHS

		team to the social work teams improved communication.
Individual specification	SWs achieving their own understanding of their role in using the SDQ within their practice to assess mental health issues for looked after children	Most SWs had heard of the SDQ. Some SWs had used the SDQ and found it valuable. Others did not use it, as they did not think it was valuable for similar reasons as SWs in other LAs. Some IROs used the SDQ in reviews to monitor the mental health of children over time.
Internalization	Understanding the value, benefits and significance of the SDQ for practice with looked after children. This includes knowing what the SW role is in addressing and managing mental health and knowing one's limitations, including when to seek help.	The SDQ data gathering process had been internalised into routine practice processes. Work was still required to ensure all social workers used the SDQ data routinely in their practice.

8.7.2 Cognitive participation: Who does the task?

There was an efficient system in place that enabled the collection of these SDQ data. The specialist CAMHS team were the '*initiators*' who were taking forward this process. The statutory guidance said that social workers should use the SDQ to identify children's emotional needs (DfE 2015, p30). However in LA D this task had been delegated to the specialist CAMHS teams and as a result, members of the specialist CAMHS team saw themselves as gatekeepers of mental health support to looked after children in the local authority. In addition, the role of the specialist CAMHS team in LA D was different from that of similar services in other local authorities; their role was to sustain the practice in this local authority regarding the use of the SDQ, which was the '*relational work*'. What was surprising was that even with this resource in place, some social workers still did not look at the SDQ information routinely or systematically.

In addition to taking responsibility for the annual SDQ carer completion exercise, and scoring the returning SDQs, a 'running sheet' had been devised by the specialist team to list all the mental health referrals made and all the services that a child and young person had received since they had been in care. This was a simple yet useful tool and was part of the '*legitimation*' activities for the CAMHS team with social workers. This was also unique to LA D. This information was kept as a resource that the CAMHS team used as background information in assessing specific needs at a particular time for each child. The use of this

resource by social workers was uneven: those reluctant to use the SDQ information also reported not using this background information.

The few social workers in LA D who did not use the SDQ in practice and did not see the benefit of it for their own practice for the children they were responsible for also did not see it as strategically useful for the organisation. For these workers, there was no '*enrolment*' and no '*activation*'. This lack of '*legitimation*' for the SDQ affected how successfully it was embedded into front-line practice.

In an attempt to '*normalise*' the SDQ being routinely used in practice, the LA D specialist CAMHS team supported a variety of initiatives aimed at changing or '*activating*' working practices (such as: reminding the IROs to use SDQ data in all reviews; expanding SDQ data collection to include teacher SDQs). Further, the specialist CAMHS team produceed a brief report for social workers summarising the SDQ scores of individual children. This showed how the specialist CAMHS team had attempted to obtain '*enrolment*' from individual social work practitioners and strengthen the emphasis given to mental health issues.

'*Enrolment*' was also important at other senior levels within LA D. The service manager responsible for the service acted as a 'champion' in order to promote the benefits of the SDQ tool for front line practice, strategic decision-making and commissioning. In this regard, by promoting the use of the tool, the service manager showed leadership in setting the culture and ethos of the service.

Having the ability to track the SDQ scores of looked after children over time was useful for the organisation in identifying service need and arguing for limited resources. This evidenced the '*legitimacy*' of the SDQ at a strategic level and the work of the specialist CAMHS team. The specialist CAMHS team had a good overview of mental health need in their area, understood potential pressures and tensions and held information about other specialist service availability, including general CAMHS. They perceived the SDQ data as being a critical contribution to their understanding of mental health need.

Table 8.2: NPT based framework for Social Worker's use of the SDQ with looked after children, based on Gallacher et al., (2013) with summary from LA D: Cognitive Participation

COGNITIVE PARTICIPATION (relationship work)	NPT based framework based on (Gallacher et al., 2013)	Summary of results from LA D
Overall task	*Understanding who is responsible for gathering and acting on the SDQ screening data, in order that changes to practice and process can be sustained.*	
Components		
Initiation	How SWs are working to change their practice (including changes to knowledge and skills around mental health) following the introduction of the SDQ screening data.	There was an efficient and effective system in place to collect SDQ data, which was integrated into LA practice processes. The specialist CAMHS team were the initiators. They gathered, scored and circulated SDQ data to social workers, but some social workers still did not use these data.
Enrolment	The processes for encouraging SWs to use the SDQ in their practice. This involves individual practitioner and multi-agency group relationships at the front line, as well as operational and strategic levels of organisations working together	The senior manager responsible for the specialist CAMHS team and social workers for looked after children acted as a champion for the SDQ tool, and understood the benefits of the tool for front line practice, strategic decision-making and commissioning.
Legitimation	Ensuring that SWs think that their use of the SDQ is necessary and their contribution is valued and is an important component of success. This includes understanding how the SDQ fits with current SW practice or might challenge current protocols, including work with other agencies.	Legitimation activities included the specialist CAMHS service acting as a 'gatekeeper' for mental health issues for looked after children. This required the advocacy and support of mental health issues in practice at micro and meso levels. A number of the legitimation activities (e.g. compilation of a 'running sheet' by the specialist CAMHS service) had not been adopted by social workers across the service, which indicated that there was a lack of legitimation for SDQ use by social workers despite the 'buy-in' from social work managers. However some of the services were well received (e.g. ease of access for consultation; specialist CAMHS service took responsibility to refer children to external services).
Activation	Once the SW uses SDQ data in practice, the actions and procedures needed to sustain this change to practice should be shaped and defined by SWs. This may involve other agencies, such as CAMHS, showing the SWs how to make use of the SDQ data.	Activation activities by the specialist CAMHS team aimed to support social work practices, such as producing a report on the SDQ for social workers.

8.7.3 Collective action: How does the task get done?

The activity within LA D to '*get the task done*,' in terms of collecting the data for the SDQ was undertaken by the specialist CAMHS team, and good progress had been made in following the statutory guidance for SDQs in assessing the mental health of looked after children. However, there were advantages and disadvantages to this model. The advantage was that by giving this role to a specialist service, the task did get done. In using this model, there was an actual or implied acknowledgement by the organisation of the high workloads of the social workers, which potentially impacted on their ability to collect the information the organisation requires from the SDQs. An additional resource could directly address this by doing the necessary work, either separately from or alongside the social worker. However, as the social workers were not involved in collecting the data and bringing them together from the different sources, they had less ownership of the SDQ information. This had the impact of a variable usage of the data and intelligence that the SDQ provided to inform how children's needs were identified and addressed by social workers.

Another disadvantage of LA D's specialist model was that some children's social workers continued to lack professional confidence in addressing mental health problems and emotional and behavioural difficulties. The model separates the two aspects of the SDQ task (collecting SDQ data and applying the knowledge from the data), despite the fact that the services saw themselves as well integrated. Consequently, social workers did not feel comfortable in their knowledge about mental health and referred children and young people to other professionals who had this specialist knowledge. They saw their role as co-ordinating services for that particular child. This '*skill set workability*' posed problems for CAMHS workers, who were critical about social workers' professional knowledge, as this potentially led to inappropriate referrals and a lack of understanding about what CAMHS teams could actually achieve. Additionally there was an issue about '*relational integration*' affecting professional confidence, with social workers not believing that the SDQ was fit for purpose, and these social workers favoured the knowledge they had gained in their direct work with the child over that gained through a standardised questionnaire. By giving the responsibility for the SDQ to a specialist CAMHS team, which then prepared SDQ reports for social workers, the underlying issues

about gaps in social workers' skills and knowledge about the SDQ and mental health more generally were not addressed. There was a danger that the processes around SDQ integration were shown to be unsustainable.

Some LA D social workers worked well with the specialist health team and utilised the information provided by the team in their work. Their '*relational confidence'* in using the SDQ meant a different depth of discussion and analysis could occur with the specialist service, which ultimately benefitted the child or young person.

In LA D the specialist CAMHS team was the cornerstone of the mental health needs of children and young people being routinely assessed via the SDQ. Management practices had supported allocating specialist team resources to social workers in the form of scoring the SDQs and writing brief reports about children and young people where these were warranted. This indicated efforts by the local authority at '*contextual integration',* as this allocation of resources enhanced relationships with social workers (who benefitted from this work being undertaken on their behalf) whilst also integrated the SDQ into routine practice. It also acknowledged the role of managers (including senior managers) allocating resources at micro, meso and macro levels, including how 'joined up' processes were within the local authority. Whilst the percentage of returned SDQs indicated that the administrative collection process was working well, the evidence was that the impact of the knowledge from the SDQ data was less significant due to the inconsistency of social work practice. There was potential for this to be further developed and this aspect of utilisation of SDQ data improved.

Table 8.3: NPT based framework for Social Worker's use of the SDQ with looked after children, based on Gallacher et al., (2013) with summary from LA D: Collective Action

COLLECTIVE ACTION (enacting work)	NPT based framework based on (Gallacher et al., 2013)	Summary of results from LA D
Overall task	*Investing effort and resources in supporting the changes to practice*	
Components		
Interactional workability	The work that people and agencies do with each other, (particularly local authorities and CAMHS) when operationalising an intervention such as the SDQ screen into everyday settings,	The processes around LA D's use of the SDQ rested with the specialist CAMHS team. There was clear ownership of the process by the specialist CAMHS team, but this might have had a negative effect for social workers, as their role in collecting or applying the knowledge from the SDQ data was not clear;

		consequently they lacked confidence in addressing mental health issues.
Relational Integration	The professional confidence in the validity of the SDQ and in the ability of social workers to use the SDQ in their work	There were a number of criticisms of the SDQ made by social workers, concerned with them not believing the SDQ was fit for purpose, and favouring knowledge gained from direct work over a standardised questionnaire. Because the specialist CAMHS service did everything for the social worker, there was a danger that gaps in social workers knowledge and skills would not be addressed. There was a danger that the processes around SDQ High Integration were shown to be unsustainable.
Skill set workability	The process by which a division of labour is agreed and established around the SDQ as it is used in the real world. The relationship between the various stakeholders is important, including how each profession understands the skills of the other.	Gaps in social workers knowledge about mental health meant they saw their role as co-ordinating services for that particular child, so referrals were made to other services. This posed problems for CAMHS workers, who were critical about social workers professional knowledge, as this led to inappropriate referrals and a lack of understanding about what CAMHS teams could actually achieve.
Contextual Integration	Resources are required to introduce and use the SDQ as a screening tool within a local authority, to have the screen completed and then to implement any changes to practice that might occur as a result. Competent management practices are also important in the successful outcome of practice changes	Resource allocation was important in embedding the use of the SDQ into practice. Senior managers had allocated resources at micro, meso and macro levels, to integrate the SDQ into routine practice. Administrative collection processes were working well but the impact of the knowledge from the SDQ data was less effective due to the inconsistency of social work practice.

8.7.4 Reflexive monitoring: How is the task understood?

Appreciation of the value of the SDQ was mixed amongst the social workers in LA D. The systems set up by this organisation to collect the data were effective. The specialist CAMHS team understood the value of using the SDQ data in casework, and additionally used the SDQ as a training opportunity with foster carers, to improve their knowledge about the tool and about mental health. The specialist service also regularly shared information about the SDQ with social workers and IROs to ensure that the SDQ data were included in the care planning review processes. This did not explain why the use of the SDQ by social workers remained patchy, and why some social workers were so resistant to using the SDQ. Social workers from another Highly Integrated local authority raised

concerns about the 'medical model' dominating practice discourses (see p176 in chapter five), and this might be one reason for social workers reluctance (Rao et al., 2010).

> *'if you look at what the diagnosis could mean and all the negative effects on it, just try and weigh it up with how much risk there is, and do you think you'd be better off not being diagnosed and getting the help and the bad elements of that, or are they better being left as they are. Sometimes it's clear, I think, that they do need that help and other times it's clear that they don't. And other times it could be a really difficult decision to make.'* (Looked after children SW; LA C; High Integration)

In respect of '*systematisation*' work, the geographical closeness of the looked after children social work team and the specialist services had advantages for social workers, in terms of the ease with which they were able to have discussions with mental health experts about concerning cases. Some of the discussions that took place in the social work focus group showed efforts towards '*communal appraisal'* or '*reconfiguration*' with stakeholders, but this was not routine (e.g. the IRO and social work staff discussing the introduction of the teacher SDQ data in looked after children reviews, with some social workers not aware that this should routinely occur).

The large turnover of social work staff in many London boroughs including LA D had an impact on efforts within these organisations to change the culture and approach to addressing mental health across the service. This might be one of the reasons why the specialist CAMHS team took responsibility for collecting the SDQs in LA D. '*Reconfiguration*' became a constant process and embedding change within this environment was challenging. The most recent OFSTED inspection rated LA D's services as 'Requires Improvement' (OFSTED, 2014). One of the strengths noted by the inspection team about the social work services for looked after children was:

> *'Young people looked after who are in need of emotional support are helped to deal with any issues they may have through good therapeutic support delivered by specialist workers, and through the direct*

> *therapeutic work done by their social workers and carers.'* (OFSTED 2014, p5).

This provided external validation about the support for mental health problems available to looked after children in LA D. One of the areas noted for improvement for LA D in the OFSTED report was:

> *'Managers receive a lot of useful information about children's services, but this is not always fully interpreted or understood. This makes it difficult for them to know if the plans that they have in place to improve services are really working. It is also difficult to ensure that services provided can be matched to the changing needs of children and young people.'* (OFSTED 2014, p4)

This statement confirmed the views of some social workers regarding the managerial nature of the SDQ data collection, indicating a problem at the micro level for some social workers, but not for the specialist CAMHS team, who understood the relationship between micro-level data and strategic planning and the utility of both. The OFSTED feedback also indicated potential difficulties higher up the management structure in terms of how management data were used. Whilst this did not specifically apply to the SDQ data, some effort of appraisal of the effectiveness of the SDQ in social work practice may assist the organisation in understanding where best to concentrate on improving services. This is summed up by the following quote:

> *'What I would like to see is a bit more sharing of responsibility between the social worker and the other professionals involved because sometimes it does feel like we get these very complex cases about young people who everyone's very worried about and very anxious about, and they're kind of dumped on us to make it all better whereas it's not that kind of black and white, it's much more about sharing responsibility within the system and everyone taking a part in the work.'* (Clinical psychologist specialist health service; LA D)

Table 8.4: NPT based framework for Social Worker's use of the SDQ with looked after children, based on Gallacher et al., (2013) with summary from LA D: Reflexive Monitoring

REFLEXIVE MONITORING (appraisal work)	NPT based framework based on (Gallacher et al., 2013)	Summary of results from LA D
	Assessing and understanding how the SDQ as a screening tool is understood by social workers	
	Systematization	
Systematization	Routinely determining the effectiveness of the SDQ as a screening tool via formal or informal means, through micro, meso or macro levels within the local authority, including for individual SWs.	The systems set up by this organisation to collect the SDQ data were effective. The geographical closeness of the looked after children social work team and the specialist services had advantages for social work staff, as they were able to have discussions with mental health experts about concerning cases.
Communal Appraisal	Working together co-operatively to discuss and evaluate SDQ practices and processes within a multi-agency context.	LA D used a specialist model for SDQ data gathering and it was effective. However, there were gaps in how the SDQ data were used in practice by social workers and an examination of the strengths and weaknesses of the current system used in LA D would be useful to identify and respond to the challenges identified. The recent OFSTED inspection praised the specialist CAMHS team for looked after children but noted problems in data being used by social workers.
Individual appraisal	Individual SWs assessing the effects of the SDQ data on their practice and the outcomes for looked after children. The individual SW values the SDQ data within their everyday practice and sees this as important.	Feedback from social workers about the SDQ showed a mixed picture regarding the value given to the SDQ. However, recognition was usually given to the SDQ not just being a 'tick box' exercise, but a conversation with children and young people about mental health.
Reconfiguration	The modification of the use of the SDQ data, including procedures used, should this be required in the light of any appraisal work done by individuals or groups.	This was an ongoing process. All parties acknowledged the current political pressures on budgets and services. There were systems in place to try and get SWs to pay attention to SDQs, and this included buy-in from their managers.

8.8 Discussion

This case study has been used to show how social workers for looked after children in LA D regarded SDQ data and used it in their work. In this chapter I have described how LA D has integrated the SDQ into its processes. The NPT framework was used to comment on whether this case demonstrated successful normalisation of the SDQ into practice. In considering the extent to which this case fulfils the criteria for NPT integration, there was partial success. LA D had the highest SDQ returns of all included LAs, but the SDQ was not utilised systematically throughout the services. This service was co-located and managed by the same senior manager in the local authority. The specialist CAMHS team enjoyed better communication with looked after children's social workers than other services that I spoke with because of its geographical location, but it was not a fully integrated service in terms of its shared ownership of assessment of mental health needs of looked after children, and its use of the SDQ as a tool to help those children. Many other studies that have used NPT to evaluate organisational changes have also uncovered barriers and facilitators to embedding such changes to practice (Kennedy et al., 2014, Owens and Charles, 2016). These included identifying multiple factors that shape the effectiveness of the organisational change. For example, when assessing whether brief alcohol interventions were adequately embedded into primary care in the UK, GP *coherence* with the initiative did not translate into *cognitive participation*, or GPs becoming personally involved in using this screening tool in their consultation sessions, even though the evidence suggested that proactive use could significantly benefit quality of life for high risk patients who then go on to receive an intervention. The introduction of this tool had minimal effect on the day to day practice of GPs, as the responsibility was given to others to administer the brief alcohol intervention - the nurse in the GP practice, who was seen by the GP as having more time and the right skills to undertake this work. (O'Donnell and Kaner, 2017). The study highlighted how competing demands on restricted time affects the provision of preventive care, and may account for why recommended clinical guidelines were not followed and why changes were difficult to embed in practice. There were similarities to what was observed in LA D.

There were benefits to examining a specific case and identifying and potentially extrapolating the factors that might be replicable in other authorities. Scrutinising a 'real life' case example also enabled the unforeseen and unintended consequences of specific actions and decisions to be better understood (Yin 2003). One of the limitations of the case study approach is the lack of generalisability of the results of one case to wider environments or circumstances. However, some researchers who use this method say that this is not its purpose (Bryman, 2011). Lincoln and Guba (1985) discuss 'lessons learned' from case studies rather than focusing on generalisability. The 'lessons learned' from this case study were:

- Good administrative support for sending out and collecting SDQ data was essential to maximise compliance and high levels of data returns.

- Support from senior managers was essential in embedding the SDQ data into routine practice as this took time and resources. Senior management support could mean that the issue continued to be championed, alongside the constant pressure and distraction from other crises, initiatives, policy and practice developments within the service.

- A clear 'direction of travel' for the specialist CAMHS team contributed to effective SDQ data collection and interpretation for use with planning for both individual looked after children and strategic services. This specialist team had good ideas for further service development and a good understanding of the obstacles that might affect this progress.

- Good communication between the specialist CAMHS team and the looked after children's social workers was important to ensure that social workers approached members of the CAMHS team if they had concerns about any children they were allocated. Co-location was important here.

- The work of the specialist team enhanced the social worker's role. The brief overview report that was prepared for the social worker raised the profile of mental health. However, there were downsides to this too. Taking responsibility for the SDQs and being the gatekeeper of mental health services, could mean that social workers would then not respond to anything to do with mental health as they saw it as someone else's responsibility

8.9 **Chapter summary**

This case study showed that co-located or integrated services did not necessarily mean that the SDQ was fully embedded into the practice of individual social workers and/or the strategic work of the local authority. Many of the views expressed by the LA D social workers and CAMHS clinicians were similar to those of social workers and CAMHS practitioners who I interviewed in other local authorities with different integration levels regarding research question two. The majority of social workers did not perceive that the SDQ had a role in their work.

LA D was the best in my sample at getting completed SDQ forms returned from foster carers compared to all other local authorities in the country, so clearly it was doing something right in terms of process. However, having a good data collection process was not enough to ensure that the SDQ was integrated within social work practice in the organisation, nor that this automatically led to benefits for children in terms of social workers making appropriate referrals on to services that they needed. The CAMHS specialists did have a good overview of the mental health history of all looked after children in LA D, so there was a high likelihood that the CAMHS service would make appropriate referrals on to external mental health services, where this was needed. In terms of research question three, LA D could provide good SDQ information via the specialist CAMHS but the majority of social workers didn't use this themselves. The CAMHS staff collected and analysed the data and then made it available for social workers, most of whom did not make use of it.

LA D's specialist CAMHS team had a number of strengths, including its geographical location and the clear focus of its work championing the mental health of looked after children and maintaining the profile of mental health in the minds of social workers and IROs. In terms of research question four, inter-professional working relationships were excellent and had some impact insofar as the CAMHS staff were driving the use of the SDQ with social work colleagues. Change in a complex system takes time, effort, energy and resources, as this case study illustrates, and LA D had made good progress in its endeavours to

advocate the use of the SDQ for looked after children with social workers via rigorous focus and process, however further work was required to normalise the SDQ process amongst social workers.

The final chapter draws together the conclusions from the research and presents recommendations for future work.

Chapter 9 Conclusion and Recommendations

9.1 Introduction

This final chapter presents the conclusions and recommendations derived from this research. To recap: this thesis used focus groups and semi structured interviews to examine social workers' (n = 58) understandings of the mental health needs of looked after children and their use of the SDQ in assessing this, as well as how CAMHS clinicians (n = 24) viewed the role of the social worker in assessing mental health problems. Social workers from nine local authorities and CAMHS practitioners from 11 Health Trusts in England took part in the research. Normalisation Process Theory (May and Finch 2009a) was used as a framework to evaluate how the SDQ had been utilised in everyday social work practice. A case study of one local authority (LA D) explored the working practices between looked after children's social workers and specialist CAMHS working in a co-located (highly integrated) service, including how the SDQ was used in this service. This was because LA D had achieved consistently high annual SDQ returns since 2009 when SDQ data were first collected for the DfE annual statistical returns.

In this chapter, the original research questions are reviewed and the results are discussed in relationship to the literature, the strengths and limitations of the research are identified, policy implications are discussed and recommendations for future research are outlined.

9.2 Review of research questions

To recap, the research questions that I identified for the study were:

- What are the views and experiences of social workers and CAMHS clinicians about the SDQ and its suitability for use with looked after children?

- How do social workers assess the mental health of looked after children, and do they perceive the SDQ as having a role?

- The annual SDQ screen provides information about the mental health of looked after children, but how do social workers use this information and what is it used for?

- How do the working relationships between a looked after child's social worker and CAMHS specialist worker affect the way in which the SDQ is used?

9.3 Summary of results

The results of this research showed that the SDQ process was not sufficiently integrated into practice across the local authorities included in the study in order to achieve improved mental health outcomes for looked after children. For the majority of local authorities, the SDQ data gathering process was a 'top down' administrative requirement to provide external performance information to the Department for Education. The SDQ information collection process in most authorities studied did not assist their social workers in identifying what help and support children need regarding their mental health. Opportunities for prompts like the annual medical and six monthly looked after children reviews were not utilised to embed the use of SDQ data into practice. The principal agency driver was the completion of the SDQ return data for performance management purposes rather than practice.

The NPT framework was applied to the results of the research study in order to understand the processes used to embed the SDQ screening data into local authority practices and evaluate effectiveness. It was also used to analyse the strengths and weaknesses of the SDQ process in the local authorities studied. This analysis showed that there were weaknesses in all aspects of implementing the process of adopting routine SDQ screening in terms of the range of NPT domains. For the majority of local authorities included in this study, the SDQ data was not utilised to inform individual child casework. Use of SDQ had not been 'internalised' by social workers into their routine practice.

However, in a minority of local authorities, specialist CAMHS, rather than social workers utilised the SDQ data in routine practice. CAMHS practitioners provided social workers with reports summarising the SDQ results, highlighting any areas of concern regarding individual children. Detailed examination of one of these local authorities (LA D), showed that, although LA D was better than all other

Local Authorities in the country at getting completed SDQ forms returned from foster carers, having a robust process for data collection was not enough to ensure the SDQ was integrated within social work practice in the organisation.

Change in a complex system takes time, effort, energy and resources. The specialist CAMHS service in LA D had made good progress in its endeavours to advocate the use of the SDQ for looked after children with social workers through its rigorous focus and process. The benefits of this for looked after children in terms of quicker and more appropriate referrals to specialist CAMHS were more likely to be realised because the specialist service took ownership of the CAMHS referral process. This was one of the advantages of the highly integrated specialist services. However, even the system in LA D, where specialist CAMHS were strong advocates for the use of the SDQ and prepared regular reports for social workers based on the SDQ data, was not enough to achieve their intended outcomes of the social workers owning the SDQ process.

Each of the research questions is addressed below:

9.3.1 What are the views and experiences of social workers and CAMHS clinicians about the SDQ and its suitability for use with looked after children?

The data presented in chapter five showed that most social workers did not use the SDQ in their practice. Chapter six analysed the reasons for this, using the NPT framework. Social workers saw their role as identifying and assessing mental health problems through evaluating the child's behaviour and then referring children to CAMHS as they judged appropriate (individual appraisal). Some social workers did not demonstrate sophistication in their understanding of the science behind screening tools and diagnostic tests (skill set workability), whilst a few did have knowledge about how screening tools could support their practice. Most social workers had a robust understanding of concepts such as 'resilience', and there was some awareness of the tension between social and medical models that affected the relationship between social workers and CAMHS practitioners (communal specification). Some social workers were resistant to using the SDQ tool because it represented a medical model and could result in children being 'labelled' (relational integration). This was discussed in chapter seven. To this extent, they considered it unsuitable for their practice (individual appraisal,

individual specification). Most had not been trained in its usage so did not understand the benefits of the SDQ for their practice (skill set workability).

The way the SDQ was used by CAMHS clinicians in practice was different from the way it was used by social workers in local authorities, and this was discussed in chapter five and chapter six. CAMHS clinicians are used to using diagnostic and screening tools and generally understood the utility of the SDQ tool for their practice (communal specification). The SDQ tool was used throughout CAMHS because it was seen as quick to use, easy to administer and score, and cheap (internalisation). Most understood its utility as a national data collection mechanism, and supported the usage and data collection as part of routine practice. Clinicians were generally familiar with its usage and CAMHS data collection systems worked well (cognitive participation). Some services used an SDQ score of 17+ (lowest score possible in the 'abnormal' category) as a criterion for acceptance of CAMHS referral. All except one CAMHS used the SDQ clinically. Where it was used by CAMHS (both specialist and mainstream), the SDQ was routinely completed at the beginning, during and at end of service to assess any clinical change for the individual child, but this was not the version completed for the Department for Education return. The local authority SDQ data collection was the one used for this return, for all looked after children.

Many CAMHS clinicians in this sample oversaw the annual collection of SDQ data for the local authority, and reported good triangulation between children who had high SDQ scores and those known to specialist CAMHS/looked after children services. They therefore saw the SDQ as a suitable mechanism for identifying which looked after children they should also provide services for.

However, there was ongoing debate within CAMHS about the efficacy of the SDQ for looked after children, as CAMHS were of the view that too many children score highly and the SDQ was not sensitive at measuring clinical change. This was the reason why one specialist CAMHS did not use the SDQ as a tool in practice and chose other mechanisms to define criteria for assessment.

9.3.2 How do social workers assess the mental health of looked after children, and does the SDQ have a role?

Given that the SDQ was not routinely used by, and appeared not to have made a difference to social workers in their practice, social workers said that they based their assessment of a child's mental health on their understanding of the child's behaviour. This was discussed in chapter seven. Therefore, social workers' ability to synthesise children's behavioural and emotional problems was important in determining which children should be referred to CAMHS. The research showed that social workers' ability to understand the mental health needs of looked after children was affected by their confidence and competence in this area.

Chapter seven also provided further analysis of the social work role in assessing mental health, and three social work typologies were identified: Group One (Anxious) - those who were most likely to refer; Group Two (Anti-labelling) - those who were least likely to refer; and Group Three (Partnership) - those who understood how CAMHS worked and made appropriate referrals. These typologies were then linked to a model comprising of two factors that needed to be considered when making referrals to CAMHS: the appropriateness of the referral based on the behaviours and emotional states of looked after children; and the likelihood of psychiatric diagnosis. This offered further explanation of the relationship between social workers' responses to the behaviours of looked after children and the response of CAMHS to the 'legitimacy' of these referrals. Briefly, Group One over–referred and CAMHS clinicians distrusted their ability to understand the emotional and mental health states of the looked after children; Group Two under-referred and CAMHS clinicians criticised their judgement of the needs of the looked after children; Group Three referred looked after children who CAMHS clinicians agreed had relevant mental health needs. This suggests that there is variation in the ability of social workers to assess the mental health needs of looked after children. Importantly, however, there were some children who were referred appropriately but who did not receive a service due to limited resources.

Given that for most social workers, the SDQ does not have a role in their assessment or decision-making about the mental health of the looked after children they work with, one of the issues to consider is why social workers do

not complete or use the SDQ in their work. What is it about the SDQ that social workers do not like? My study suggests that there are a number of reasons for this. Firstly, some social workers do not believe it is reliable or useful. There appears to be some reluctance amongst some social workers to use standardised assessment tools in their work principally because of their association with medical models of assessing and understanding human behaviour. These social workers would rather rely on their own assessment, observations and intuition than believe that the 25 questions within the SDQ can be scored and coded to give them a reliable indication of a child or young person's mental health. Secondly, in the main, local authority processes do not support the routine collection and analysis of the SDQ scores that are gathered, so these data are not used to inform decision-making. Consequently, social workers rely on their own professional skills and this means there is potential inconsistency in social workers' approaches to assessing children's mental health, which is evidenced in the results from my research.

There is one further consideration; the challenges arising from the impact of the last eight years of austerity are considerable in local government. Changes to central government funding of local government has meant that in many cases front line social workers are under considerable pressure. The numbers of children coming into care has continued to increase year on year over this period and caseloads have risen accordingly. Substantial 'savings' targets have been introduced across local government and health services, which have impacted on CAMH services as well. High caseloads have meant that there are very real pressures on social workers time, and this might be a third reason why social workers do not use the SDQ. They may perceive it as not adding sufficient value to their work in terms of the time taken to undertake the assessment and analysis of results. In addition, the needs identified may not then be able to be met, which defeats the purpose of identification, and might be the fourth reason why social workers choose not to use the SDQ.

9.3.3 The annual SDQ screen provides information about the mental health of looked after children, but how do social workers use it and what is it used for?

Chapter five presented the way in which the SDQ data were collected for the Department for Education return and used in each local authority. This process

was different in every local authority and was dependent on historical agreements between local authority commissioners and CAMHS (indicating variable enrolment, legitimation, activation, contextual integration). The strengths and weaknesses of these processes were discussed in chapter six. Most often the SDQ data were collected and used to compile the annual statistical return for the local authority to the Department for Education only, rather than the data then being routinely used in practice (poor coherence, cognitive participation). A number of local authorities collected the SDQ data at the looked after child's annual medical examination and after it had been scored by CAMHS it was sent to the Independent Reviewing Officer and entered onto the local authority computer database. The SDQ data might have been referred to in the looked after child's annual medical review, but the SDQ was not routinely discussed in most local authority child care reviews (lack of individual specification, internalisation).

Three different types of local authority integration models were identified from the data and presented in chapter five: High Integration services (between CAMHS and the local authority); Moderate Integration services, where specialist CAMHS services were partially integrated (located in the local authority but not with social workers who used the service); and Non Integrated services, where CAMHS were completely separate and located in health, for example a CAMHS community team.

There were no observable patterns in respect of social worker group type ('Anxious', 'Anti-labelling' and 'Partnership') according to service integration level; all types of social workers worked in high, moderate and Non Integration-level services. If there had been a pattern of a social work typology in a particular integration level of service, then this might have provided insight into what it was that produced social workers with this skill set around mental health. If highly integrated services produced 'Partnership' social workers, then this would provide an argument for further integration of services resulting in better mental health outcomes for looked after children, as the social workers would be referring appropriately to CAMHS services for mental health support. The evidence from my research suggested that the level of integration of the local authority made little difference to social workers' thinking about mental health and (likely) use of the SDQ.

9.3.4 How do the working relationships between a looked after child's social worker and CAMHS specialist worker affect the way in which the SDQ is used?

Effective multi-agency working is seen to be key to delivering better services for looked after children (Richards et al., 2006, Marquis and Flynn, 2009). However a number of long-standing relationship issues have been described between CAMHS and local authority social workers (Pearce, 1999, Hunter, 2001), which surfaced during my research and these are discussed in chapters five, six and seven. For example, some CAMHS did not work with children who were in unstable placements (reported in chapter five). Social workers found these decisions from CAMHS to not work with children in unstable placements frustrating and detrimental to the children in these circumstances who needed CAMHS support.

All social workers were complimentary about many other aspects of CAMHS. Social workers from the local authorities with each integration model of CAMHS were *all* positive about aspects of their local services, and in particular mentioned consultation sessions with individual clinical members of staff as beneficial (discussed in chapters five, six, seven and eight). All specialist CAMHS included in this research project routinely provided consultation. This high regard did not appear to be related to how social workers used the SDQ locally or to the specific integration type of the CAMHS service.

In 'highly integrated' services where relationships between social workers and CAMHS specialist workers were more established, due to the close contact between them, the SDQ data were more likely to be provided by the CAMHS workers to the social workers. There was evidence in all services regardless of levels of integration, that CAMHS clinicians could clearly identify social workers according to whether or not they tended to make appropriate referrals.

In the main, specialist mental health services for looked after children were seen by social workers as more flexible, approachable and quick to respond than general CAMHS. However, social workers did comment that long waiting times applied with some services. CAMHS generally had very high thresholds, and many children who were placed out of borough did not receive a service quickly, despite the existence of national statutory guidance on this issue. These looked

after children were seen through general tier three CAMHS rather than the specialist looked after CAMHS in the borough concerned. Consultation was used effectively in all CAMHS included in this study and was one way in which social workers and foster carers received a timely service about any cases that were of concern to them.

There was potential for the SDQ to highlight those children who had mental health problems. However difficulties with being able to refer children to CAMHS services in a timely manner, for example long waiting lists, affected social worker's behaviours. In addition, social workers reported that CAMHS did not involve them in decisions around intervention and treatment options for looked after children, which further undermined the relationships.

CAMHS practitioners are knowledgeable about the mental health of children. In a number of the local authorities used in this study, including LA D, specialist CAMHS practitioners often took the bulk of responsibility for assessment, service provision, recording and dissemination of evidence of emotional and behavioural difficulties for looked after children. This raises questions about what it is that social workers need to know concerning children's mental health if other specialist staff are heavily involved in assessment and service provision. Social workers need to be able to understand enough to identify when specialist assessment and support is needed for a child or young person they are working with. They should know the difference between children's distress and despair, and the beginning signs and symptoms of mental illness. This includes social workers having knowledge about what behaviours they can be reasonably expected to observe in children as a result of traumatic experiences of abuse, separation and loss, that can be resolved over time through the provision of good substitute care, and what may need more specialist intervention and support. This is the knowledge that a Group Three 'Partnership' social worker would be able to demonstrate in practice.

9.4   Situating the findings within the literature

Research that specifically examines social work identification and assessment of mental health problems of looked after children is limited. There are a few UK studies that examine the social work role as referrers in this regard, and these

include; Phillips (1997), Ross, Hooper, Stenhouse and Sheaff (2009), Sempik et al (2008), Whyte and Campbell (2008) and Newlove Delgado et al (2012). The last two studies were the only studies that used the SDQ.

The first two studies were concerned with the skills social workers use to identify those children who need additional mental health support. Both studies highlight shortcomings in the skill set of social workers, with Phillips (1997) documenting a large number of what I have termed as 'anxious' referrals by social workers, as only 27% of the children referred by social workers were accepted by CAMHS. Reasons given by CAMHS in these studies for the other children not receiving treatment were placement instability, inadequate CAMHS resources and insufficient local authority funding. All of these three issues were raised by social work practitioners in my study, and showed little change from the Phillips (1997) conducted 15 years earlier. Ross et al (2009) found that social workers had 'professional guilt' about labelling young children as having mental health problems, something that was also raised by social workers in the focus groups. Further, Ross (2009) queried whether social workers experienced a lack of confidence and expertise in mental health knowledge, skills, ideological beliefs and professional acculturation that affected how they worked within a multi professional mental health environment. The findings from my study also showed that a number of social workers have a lack of confidence and competence in their skills in assessing and supporting children and young people with mental health problems.

Sempik et al., (2008) analysed social work case files to identify emotional and behavioural difficulties of children and young people at their point of entry into care and these files showed high levels of need. This is similar to the findings of Dimigen et al (1999), who used diagnostic screening tools to assess the mental health needs of children in Scotland at point of entry into care, not social work case records. Sempik et al (2008) used *'information on emotional and behavioural problems, as recorded by social workers and subsequently assessed by psychologists'* (p224), in the Action and Assessment Records of the Looking After Children documentation which were used widely in England, but they did not comment on the competence of the social workers in their sample to assess emotional and behavioural difficulties of looked after children, only whether the information was on the case files. They did provide a commentary about the

Looking After Children programme that was introduced by the Department of Health in the 1990s. At that time the Department of Health did not think that social workers had the necessary skills to use validated and standardised psychometric tools as part of their assessment work (Ward 1995). Social workers started using a series of predominantly 'tick box' forms based on the Rutter behaviour scales (Rutter et al, 1970) and similar instruments, including an early version of the SDQ, to evaluate the emotional and mental health of looked after children (Garrett 2003). However, by 2000 the SDQ was part of 'A Family Pack of Questionnaires and Scales' associated with the Assessment Framework (DH, Cox and Bentovim 2000). The most recent statutory Guidance (DFE and DH 2015) stated that the main benefit of the SDQ is that social workers did not require any training to administer or analyse the data produced from it, which is a reversal of their initial position in 2000. I have found in my research that social workers do need training in how to use the SDQ so that they understand its potential for their assessments and work with children and young people.

Prior to my research project, little was known about how social workers use the SDQ in their work with looked after children, however there was one highly relevant mixed methods study. Whyte and Campbell (2008) conducted focus groups with 76 social workers and managers in Northern Ireland to ask their view of the SDQ, which was similar to the method used in my study. However, in addition to this, their study used the SDQ to screen a sample of Looked After Children, carers and teachers, and then used pre-test and post-test file audits to ascertain whether SDQ screening had informed the child's care planning process, which I did not do. Where my study differed from Whyte and Campbell (2008) was in the exploration of specialist CAMHS views about the mental health knowledge that social workers had. It was therefore possible to interrogate data about patterns of social work referrals to CAMHS from the perspective of social workers and specialist CAMHS workers.

In the Whyte and Campbell study, participants recommended that the SDQ was used as a screening tool. In contrast, the majority of the social workers who were involved in my study did not use the SDQ or think it relevant for their practice. One reason for this could be that health and social work organisational structures in Northern Ireland differ from those in England. However, as with my

study, Whyte and Campbell also reported instances of social workers not referring children with high scores to CAMHS for fear of swamping CAMHS with referrals. Social workers in my study reported that not all children who had high scores on the SDQ were referred to CAMHS or other services. Whyte and Campbell suggest that awareness of CAMHS lack of capacity might be one of the reasons why social workers limited the numbers of referrals made. The literature suggests that most CAMHS practitioners are able to assess and then accept referrals involving looked after children who are suspected of having psychiatric problems, but will not accept others, because of service capacity issues (Rao et al., 2010).

In terms of social workers demonstrating skills in being able to identify those looked after children who have mental health problems, my research demonstrates that specialist CAMHS clinicians identified potential problems in the skill set and knowledge of social workers that then affected accuracy of referrals being made to CAMHS. In addition, it was also possible for me to assess whether the level of integration of services (based on degree of co-location of social workers and CAMHS) was associated with local authority SDQ return rates and social workers' SDQ use; there did not appear to be a connection.

There may be another reason for the low rate of 'take up' by specialist services described both in the literature (Phillips, 1997, Mount et al., 2004) and in my sample of social workers. For CAMHS, the presence of behavioural issues and/or attachment difficulties are not enough to warrant specialist CAMHS intervention (Rao et al., 2010). However, such thinking overlooks the difficulties of assessing serious neurodevelopmental and psychiatric problems. In young children, many serious problems may initially present as "behaviour" (Minnis, 2013). Therefore, screening these "upset" or "behaviourally disturbed" children and young people using a tool such as the SDQ is important in order that over time the difference between those who are upset for good (and transient) reasons and those for whom it is actually a symptom of something much more serious and longer term can be established.

Some other studies have also shown that social workers may miss some of the signs and symptoms of mental disorder (Cousins et al., 2010), that they require more training to identify and respond to mental health needs (Stanley et al.,

2005), or have professional guilt about young children being given a psychiatric diagnosis (Woodcock Ross et al., 2009). My study highlighted similar issues about social workers missing signs and symptoms and having professional guilt about children receiving psychiatric diagnoses. One study was positive about social workers skills' in referring appropriately to CAMHS however this was based on a small sample (Newlove-Delgado et al., 2012).

The results of my study, along with those of others, therefore point to some difficulties in social workers' use of standardised and validated tools in child mental health. The first issue is social workers' reluctance about using any standardised tools, which may then explain the poor uptake of the SDQ. Social workers should be able to confidently identify and use appropriate standardised assessment tools and also apply their critical judgement, knowledge and skills to an assessment, to identify the needs of a child and monitor improvements or change that occurs. This is further explored in section 9.6.2.

Secondly, the responsibility for supporting looked after children is complex, involving all relevant professionals working together, and social work is core to the effectiveness of this. Understanding, assessing and improving the mental health of looked after children is a key and critical social work activity. Colleagues in CAMHS are confident in using the SDQ, and see it as a tool that is good enough to give sufficient intelligence for them to monitor and assess changes in a child's mental health. Confident social work use of the SDQ could create a shared language. Despite the centrality of the social work role in the lives of looked after children, social work knowledge about emotional and mental health remains patchy. Use of robust assessment tools by social workers is also erratic, and in terms of how social work is viewed across other agencies, '…it is sometimes difficult for medical staff to understand how a particular decision by Social Services has been arrived at because the decision-making process is more subjective' (Pearce 1999:151). In this area, multi-disciplinary working is essential and the development of specialist mental health services for looked after children over the past decade is to be welcomed. There is a danger of health colleagues seeing social workers as 'anti' evidence based practice, even though it is expected that social work assessments and interventions are based on evidence. This tension between medical and social models of

assessment and intervention could potentially create problems, even though multi-disciplinary working is essential to working effectively with children.

The literature review as detailed in chapter three highlighted a number of studies that suggested that the use of screening tools, including the SDQ, at the point of entry into care is beneficial (Dimigen, 1999, Sempik et al., 2008, Bazalgette et al., 2015, Newlove-Delgado et al., 2012, Milburn et al., 2008, Hayek et al., 2013). This is not currently done but is generally accepted as a valid suggestion because it identifies those children with mental health needs at an early stage in their care experience, and would provide information about the mental health needs that children have at entry into care. Consequently consideration should be given to the benefits of screening children at point of entry into care with their first medical in order that a baseline measure can be taken of their mental health at this point. However, the argument has moved on from initial screening to focus on two other factors: the relationship between referral to CAMHS and the provision of services by CAMHS (Blower et al., 2004; Goodman et al., 2004; Marquis and Flynn 2009; Newlove-Delgado et al., 2012); and improving our knowledge about 'what works' with these children (Goodman et al., 2004; Luke et al., 2014)

9.5 Strengths and limitations of the research

9.5.1 Strengths of the study

A major strength of this research is that it has explored a previously unknown area of knowledge in terms of social work practice with looked after children in England. As a social work researcher, I gained agreement from many of the nine local authorities who agreed to take part in the study, because I was a social worker and not a health worker. These local authorities were interested in improving the knowledge base of social work in this area.

The sample used for the study was significant, with 58 social workers from 9 different local authorities and 24 CAMHS specialists from 11 Health Trusts across England, and is larger than other similar qualitative studies. I had the opportunity to compare the views of social workers and CAMHS clinicians in this research. The focus of the research was on the practice experience of

professionals who work directly with children. I gathered data from social workers who work with looked after children, who work with looked after children who have disabilities, who specialise in working with teenagers who are looked after, adoption social workers, Independent Reviewing Officers, fostering social workers (including family/kinship placement team members) and student social workers. I also gathered data from CAMHS specialists who are clinical psychologists, child and adolescent psychiatrists, clinical nurse specialists, child psychotherapists, specialist social workers, and student clinical psychologists. This is a broader mix of participants than most other qualitative studies.

A variety of different analysis methods were used in the research (e.g. thematic analysis and case study analysis), which enabled me to interrogate the data from a number of different angles. The NPT framework has not been used before to analyse change management within local authority social work with looked after children, or change management within this process. I used NPT to further analyse the results because it is a comprehensive change theory that explains how and why changes introduced in practice may or may not become embedded at an individual and organisational level. This was helpful as it identified gaps which explained the weakness in application and implementation.

Finally, the systematic review completed as part of this PhD has covered new ground. There are no published systematic reviews that collate information from studies that examine how mental health difficulties are screened and assessed in looked after children using the SDQ. This review has pulled together these data for the first time.

9.5.2 Limitations of the study

This study gathered data from two groups of practitioners only, social workers and CAMHS specialist workers, and did not include the views of looked after children or their birth relatives. Senior managers were also not interviewed as part of this project. However, ascertaining the views of children wouldn't have answered the particular research questions I identified for this research. If I had included a sample of looked after children in this research, I would have had a different focus to the research, which incorporated a looked after child/young

person's view. Ideally any research involving children and young people should establish a coproduction model. This is important and it remains an outstanding area, which is acknowledged in my research recommendations.

In respect of the methods used in my study, there are limitations in using both focus groups and semi-structured interviews. Although I kept interviewing people and conducting focus groups until I had reached saturation, there was a danger that in focus group settings, participants would not participate equally, and some participants dominated discussions. In addition, highlighting diverse views and perspectives within focus groups was important and relied on my skills as a moderator, to allow flexibility of discussion but to steer discussion away from unconnected contributions. I was able to address this within the focus group sessions to ameliorate this limitation. Piloting the focus group also helped me identify potential issues and my moderation skills improved over the time I conducted the focus groups

There are other limitations in using (public) focus groups and (private) semi structured interviews that relate to the conversation that occurs within the research process (Miller and Glassner, 1997; Kamberelis and Dimitriadis, 2013). In both the focus groups and semi-structured interviews, participants knew they were being watched (by other participants and the moderator in the focus groups, and the moderator in the interviews) and might have felt under pressure to say what they thought the moderator wanted them to say or would be seen as acceptable to the group or moderator, rather than what they thought.

The sample size (n=82) was a small proportion of the population of all social workers or CAMHS workers in England who worked with looked after children, and so is unlikely to be representative. In addition, the geographical location of local authorities included in the study was limited to the South East of England. I did not have an opportunity to explore whether location had any impact on social work practice behaviour with looked after children and mental health. However, the study is an exploratory examination of the issues raised by the participants in this research. To gain credibility, I used more than one data source within my chosen methods to check the consistency of findings and achieve saturation. This ensured that I had a rich and diverse volume of data.

All focus groups and interviews occurred between January 2011 and March 2013. There are methodological issues concerning the time-bound nature of a particular snapshot of qualitative data, and this applies to the research included in this thesis. However, all qualitative research is time and context-bound to some degree. The question is whether the results can be used as a 'working hypothesis' (Lincoln and Guba, 1985, p.297) and applied to other contexts and time periods outside the original fieldwork, rather than be seen as being either 'time and context free' or 'time and context specific' (Yin, 2016), p19.

In November 2015 the NPT authors published a 23 item survey instrument, called NoMAD, which assessed implementation processes from the perspective of professionals involved in implementing a complex intervention (see: www.normalizationprocess.org). I might have used a different method and asked different questions if this tool had been available at the point in my research where I was gathering data. I could have used this survey instrument to gain the views of a number of participants throughout the organisations I used, including senior managers, which would have enabled me to ask questions about planning and commissioning processes within and between local authorities and Health Trusts.

9.6 Key Messages for Policy and Practice

This research suggests that there are a number of policy and practice implications that need to be addressed and are summarised below. These include: policy implementation deficits; social work practice improvements; SDQ benefits realisations; and embedding culture changes. However, any 'messages' for policy and practice must be viewed against the current political landscape. Since 2010, austerity has featured heavily in local authority resource availability, and along with the uncertainty of Brexit negotiations and arrangements, levels of public sector funding in the short and medium future is uncertain.

9.6.1 Deficits in Policy Implementation

The legislative and policy guidance (Department for Education, 2015) in this area appears sound, however it did not seem to be fully implemented. The SDQ data was not used in many of the local authorities studied to support addressing the mental health needs of individual looked after children. This raises questions about whether the SDQ was used in planning or commissioning mental health services for looked after children by the local authorities or Clinical Commissioning Groups but this was not investigated as part of this research project. Further, there were two other areas where specific guidance was not effective: children being placed out of borough; and children's transitions into adult services. In both areas looked after children were unsupported in terms of addressing their mental health needs.

Social workers in the local authorities in this study did not routinely incorporate the SDQ process or use the SDQ data in their work with this specific group of children who are known to be vulnerable to high rates of mental ill health. The Department for Education requires the SDQ information to be collected, provides guidance on how it should be used for individual children, and at a strategic level, but has no mechanism to assess if this happens. The absence of such a mechanism could be considered a policy implementation deficit.

The research identified problems for looked after children placed out of borough requiring CAMHS intervention. They were not seen by CAMHS in a timely manner, despite the statutory guidance. The main barriers were: identifying who paid for the service; who delivered the service; and the length of the waiting lists. There is guidance on out of borough placements but this is not adhered to, which disadvantages those young people. Consideration of additional protocols and escalation processes to address these barriers could enable access to CAMHS for those children placed out of area so that they are not disadvantaged by the failure to comply with the statutory guidance.

Young people leaving care and becoming adults, who have mental health problems, often experience a disconnect in terms of accessing adult mental health services. The interface with adult mental health services continues to be

difficult because the criteria are different from children's mental health services. Many young people who are vulnerable are no longer eligible for social care or specialist mental health support once they become adults. Practice is changing and some CAMHS services will see young people leaving care up to age 24/25, reflecting the statutory responsibilities of local authorities for this group of young people to age 25. These decisions are local, based on the approaches taken by local Mental Health Trusts and their Clinical Commissioning Groups.

A further potential policy deficit concerns the use of the SDQ score. There was no consistent response to a looked after child obtaining a high score. There was no compulsory action by the social worker and no guarantee of services for those children who obtained a high score. There could be arrangements between local authorities and Clinical Commissioning Groups, supported by Public Health, to review the SDQ data and consider how high scores are responded to, and what local interventions could be identified to meet the mental health needs of these looked after children.

At a population level, there are therefore ethical issues associated with continuing the DfE annual SDQ data collection exercise in its current form should nothing then be done with these data to assess and support looked after children and young people. Routine SDQ data collection is seen by the DfE as both a way of identifying 'the scale of the problem' and, at an individual level, of highlighting 'the likelihood that the child either has, or could develop significant mental health problems' (Department for Education., 2015)(p. 125). The 'compulsory' SDQ monitoring has enabled the scale of mental health problems to be identified amongst looked-after children and young people and as a public health intervention there are benefits to regularly overseeing the mental health of a group that we know is highly vulnerable. The DfE has suggested that 'In the longer term, data from SDQ returns will give an indication on how effective the service provision provided is in meeting the needs of looked after children' (Department for Education 2015, p. 125). However, since the introduction of compulsory data collection, the mean SDQ score has remained consistently close to 14, with around half all children screened falling within the abnormal or borderline score categories. Given the relative stability in this population based data, perhaps there is little benefit in continuing with the expense of data

collection, without firstly addressing the ethical and moral imperatives of the missing data and referral pathways to additional services for individual looked after children and young people where these are identified (Cocker et al., 2018).

9.6.2 Social Work Practice Improvements

Policy is implemented through practitioners and there are opportunities, such as the establishment of the Principal Social Worker role, which could support improving practice of front line staff. It might be more effective to target these roles to have responsibility for addressing practice issues with social workers rather than introduce yet another role into this environment. The Independent Reviewing Officer's role, via the six-monthly review process, is critical in monitoring a child's mental health through their period of time in care. This could be further strengthened so that there is an expectation that mental health is routinely discussed in reviews, rather than being an adjunct. Use of both the Principal Social Worker role and Independent Reviewing Officer's role within each local authority as the sector practice 'champions' in children's social work and working with looked after children would also be helpful in furthering the use of the SDQ in practice and raising the profile of mental health of looked after children with social workers. It could potentially help shift the culture of local authority social work practice in this area to one where there is some consistency of approach toward social workers assessing the mental health needs of looked after children using tools such as the SDQ, which have a proven evidence base for identifying need at individual and collective levels (Ford et al., 2007; Rutter and Rutter, 2012).

Changing social work practice appears difficult for local authorities to embed into organisational systems and processes because many social workers appear not to value the SDQ as a tool that will assist them with their assessment of the mental health of looked after children. Some of this reluctance may be because of ideological positioning (e.g. valuing social models as opposed to medical models), but other reasons may be because routine training about how to use the SDQ effectively is not provided to social workers. Evidence from my study showed that social workers knowledge about the SDQ tended to rely on personal experiences they may have had using the SDQ in other jobs or whilst students themselves.

However, the provision of training or the championing of the SDQ by Principal Social Workers/Independent Reviewing Officers would not necessarily address the challenge of cross-agency communication between the local authority and CAMHS, which would continue to be key to effective partnership working. The champions would need to build effective partnerships with both specialist and generic CAMHS to ensure communication about looked after children with mental health needs is heard and the appropriate language is used to bridge the professional fields.

An Expert Working Group created by the Department for Education to examine how the emotional and mental health needs of children and young people in care could be better met has recently reviewed a range of relevant policy and practice (Milich et al., 2017). It echoed my research findings regarding the need for a champion or stronger leadership for this area of health and social care work with looked after children. The group proposed that:

> *'Building on the success of the virtual school head (VSH), a similar oversight role of a virtual mental health lead (VMHL) is established. This is to ensure that every child and young person in the system is getting the support they need for their mental health and emotional wellbeing'.* (Milich et al., 2017, p34):

This could be one way of building advocacy with senior leadership attributes, however this requires considerable additional funding, which is unlikely in the current economic climate. Using roles already in the system would be more cost effective.

My research indicated that social workers did not use standardised assessment tools routinely in their work. Some CAMHS professionals were scathing about the lack of knowledge that social workers had about the utility of standardised approaches to assessment. Barlow et al. (2012), identify increasing agreement within health and social care settings, including children's services, about the need to use standardised tools to support professional decision-making. This is partly to do with the efficiency of such tests in a context where access to services has become increasingly difficult because of resources, but also because of a number of research studies that report poor accuracy of decision-making in

areas such as child protection, 'with assessments being 'only slightly better than guessing' (Dorsey et al., 2008, cited in Barlow et al., 2012, p4).

Barlow et al's systematic review of models of analysing significant harm in children suggests that there are eight criteria that should be met when using standardised tools within an assessment in children's services (2012, p11). Firstly their use should provide practitioners with a balance of structure to their professional judgement using the data gathered via the standardised tool, so that it does not replace professional judgement and undermine professional capability, and neither should it minimise complexity. It should result in a more accurate assessment of a child's need for services. Secondly, their use should enable assessment and analysis of information that is associated with children's optimal development. Barlow et al., argue that this would mean that the assessment would be consistent with the 'Framework for the Assessment of Children in Need and their Families' (Department of Health, 2000); known as the 'Assessment Framework', and their review aimed 'to build on the conceptual model established by the Assessment Framework' (p4). [32] The third criteria is aimed at ensuring the tool's sensitivity and specificity to the different stages within an assessment and applicability to a variety of different circumstances. Fourthly, the criteria should 'incorporate clear guidance with regard to assessing parental 'capacity to change' using both standardised assessment/diagnostic tools; and goalsetting within agreed timeframes.' The fifth criteria is concerned with ensuring that the whole system is considered within decision-making and assessment, including within organisational management, discussions within supervision, training and CPD, and implementation across organisations and geographical areas. They suggest a model for this – the Structured Professional Judgement (p22-23). The final three criteria are concerned with promoting the tools use within the context of partnership working between children and families and social workers, including the need for productive relationships between staff and service users, and use of best available evidence to enhance good judgements and decision-making.

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[32] *The Assessment Framework was developed in England to provide 'a systematic way of analysing, understanding and recording what is happening to children and young people within their families and the wider context of the community in which they live' GRAY, J. 2001. The Framework for the Assessment of Children in Need and Their Families. Child Psychology and Psychiatry Review, 6, 4-10.(p4). Because it was issued under section 7 guidance under the Local Authority Social Services Act 1970 in England, all local authorities are expected to use it.*

These criteria are met by the SDQ except for criteria two and four. This is because Barlow et al's review was concerned with using standardised tools in child protection assessments that linked closely to the three domains of the Assessment Framework. Because of this, the criteria in relation to assessment tools focused specifically around broader child development issues (criteria two) and parental capacity to change (criteria four) don't apply to the SDQ.

Despite the weight of the case for use of standardised tools, the literature suggests that social workers have been reluctant to engage with their use. In respect of child protection practice, Munro highlights the inadequacies of what she terms the 'one size fits all' approach to child protection service provision, most often driven by adherence to mandated and procedurally driven assessments that do not use standardised tools but have overly prescriptive timescales (Munro, 2010b, Munro, 2010a, Munro, 2011). Munro's review of child protection, commissioned by the Coalition Government of the day, sought to introduce flexibility to this mandated approach, and in-so-doing, value analytical and intuitive forms of reasoning within assessments. It is possible to use a validated assessment tool but be flexible in approach, to assist with an assessment, as these tools can be complementary.

An additional criticism has also emerged from other work undertaken by a number of social work academics examining social workers' use of standardised tools as an aid to risk assessment in child protection (Broadhurst et al., 2010b, Broadhurst et al., 2010a, Gillingham and Humphreys, 2010, Gillingham, 2011). The criticism is that standardised tools often hinder rather than help social workers in their work, because they draw from, 'positivist approaches to science and the generation of knowledge, represented in practice by the development and implementation of practice frameworks and decision-making tools' (Gillingham 2011, p413). Gillingham believes that inexperienced practitioners are most likely to use this form of reasoning, and consequently an over-reliance on decision-making tools and practice frameworks may occur. However, this critique may not necessarily refer to the tools themselves, rather the way in which they are used in practice. Further, social workers may distrust standardised tools as indicative of a medical model rather than a social model of practice. Broadhurst et al (2010b) suggest that practitioners should not solely

rely on structured risk assessment tools if they are to make good decisions and practice effectively. They suggest that

> 'practitioners are ill equipped to select the most reliable instruments, because in general they lack the necessary statistical knowledge (regarding instrument sensitivity, specificity and base rate). In this context, the use of actuarial instruments may create more problems than it solves, with practitioners apt to place too much faith in results generated by so called scientific instruments' (p1049)

Although this comment refers to inappropriate selection of standardised tools, my research indicates that the issue is about how tools are perceived and then not used. The findings from the Barlow et al., (2011) review suggest that the use of well validated tools will include improved assessment practice, analysis and subsequent decision-making. They consider that this will have 'major benefits for children and families' (p12) and for this reason they should be utilised in practice.

My research also illustrated inconsistent knowledge and competence in mental health by local authority social workers. It is essential that all social workers working with looked after children have sufficient knowledge and skills about their mental health. Social workers working with looked after children should have a basic knowledge of mental health issues and how to work with the inevitable distress and loss associated with becoming looked after, and then be able to identify when specialist support is required, to refer appropriately. This knowledge should be covered in social work education qualifying programmes, for example as illustrated in LA D where the specialist CAMHS offered placements to student social workers. Pre-qualifying courses could include more general training on potential value of such tools, along with some of their disadvantages, as well as specific training on the use and interpretation of the SDQ and other standardised tools and measures as one way to recognise problems and refer children appropriately. Any further knowledge and skills deficits could be addressed via continuing professional development post-qualifying level training or opportunities. This would enable social workers to engage with issues raised by Barlow et al. (2012), who talk of social workers needing to develop, 'a new 'mindset' about the use of standardised instruments' (p13) and use these alongside professional judgement. Such CPD programmes

should include opportunities to discuss the reservations that some social workers have in using such measures, with the view to skilling up social workers to incorporate these assessment and analytical approaches into their everyday practice.

Young people's own perspectives are often missing from the information that professionals gather about their mental health (see chapter four). The SDQ can provide an effective way of incorporating the views of children and young people about their mental health into assessment, treatment and reviewing processes. Although this research did not examine this area, a potential benefit of extending the use of SDQ by the young person (over the age of 11), is that it would engage social workers, who have to take into account their views.

9.6.3 Improvements in SDQ Use by Social Workers

My findings support the earlier work of Meltzer et al., (2003), Ford et al., (2007) and Goodman et al., (2012) who argue that there is potential value in monitoring the mental health of this group of children because it is so poor. The SDQ can be used to help identify individual children's mental health needs in order to discuss what referrals might be appropriate, and triangulate the evidence from social workers' observations of children's behaviours so that help can be accessed for those that might need it.

The argument for the SDQ to be used as a screen at the point of entry into care has already been made by many other researchers. We do not currently have a 'baseline' or 'benchmark' of mental health at point of reception into care for individual children and we should have this in order to identify and then address their mental health needs alongside their other needs during their care journey. Using the SDQ as part of the initial assessment would help social workers become more familiar with the tool.

The absence of baseline data about mental health at entry into care could be construed as an oversight in the current system's design, and this could be remedied by incorporating it into the looked after child or young person's first medical at entry into care. Investment in 10 pilot sites that aim to improve mental health assessments for children entering the care system was announced in June 2018, when the Department of Health and Department for Education

(2016) accepted that 'looked after children should undertake the SDQ as a starting point when they come into care, and then each year as part of compiling an accurate picture of their health needs.' (p6). However, this type of screening or assessment should not occur in isolation; investment in better systems would ensure SDQ scores for individual children are scrutinised, used in decision-making and, where they indicate likely psychiatric diagnosis, trigger clear referral pathways. My research suggests that there are benefits using the LA D approach where specialist CAMHS practitioners support social workers around interpretation of SDQs and have oversight of the mental health of all looked after children in the local authority. These actions could result in improved placement and health outcomes for looked-after children, and this would be a worthwhile investment (Cocker et al., 2018).

My study found that where the relationships between social workers and CAMHS specialists were more effective, monitoring CAMHS referrals and take up of therapeutic and counselling services for looked after children had benefits for care planning for individual looked after children. It also enabled better use of scarce mental health resources targeting those children who needed them the most. This practice could be adopted more widely.

9.6.4 Embedding Culture Change in Local Authorities

This research has highlighted that the SDQ had not been 'normalised' into planning and monitoring processes regularly undertaken by social workers with looked after children. 'Normalising' the SDQ into practice should not involve a 'one size fits all' approach to service implementation, as each local authority has different stresses and tensions on budgets and the local populations will have differing needs. However, I found the social workers in most authorities saw the SDQ data gathering as a 'top down' administrative requirement to provide external performance information, and not linked in a meaningful way with social work practice, or in a way that could help them identify what help and support children need regarding their mental health. This is the major barrier for social work staff being able to see any benefit from using the tool in their practice. If the SDQ is to continue to be used, efforts are needed to reiterate its importance for identifying and enabling treatment for looked after children's mental health problems. This might involve looking again at whether SDQ screening could be better placed within new care pathways between social

workers and CAMHS, perhaps involving local authority 'champions', who are best placed to ensure that this practice is integrated into local authority processes. Examining the way in which the role of Independent Reviewing Officers and Principal Social Workers can be used to 'bed in' the SDQ into mainstream practice should be considered.

The evidence from a local authority with robust processes in place for the annual SDQ statistical return suggests that changes to practice in this area took time to embed and depended on a range of success factors. These included: senior management leadership; good inter-professional relationships and communication; a shared focus on aiming to achieve the best outcomes for individual children; and an appreciation of the positive benefits of using the SDQ for individual children and performance information by the specialist CAMHS team. Even so, not all social workers were engaged with the SDQ, and effectiveness depended on the specialist CAMHS services.

9.7 Implications for future practice

There are a number of policy implications arising from my research:

9.7.1 Compliance with statutory guidance and addressing the missing data in SDQ returns

1. The reasons for local authorities not fully complying with Statutory Guidance should be investigated to understand:
   a. Why the SDQ is not used routinely in work with individual children
   b. How children who are placed out of borough can access timely CAMHS assessment and treatment services. This may require the development of additional protocols and escalation processes to address barriers that affect access to CAMHS.
   c. How all looked after children are able to access timely CAMHS assessment and treatment services, if required.
   d. How the transition to adulthood for looked after children who turn 18 with ongoing mental health needs that do not meet the threshold for adult mental health services can be supported by

CAMHS continuing to take responsibility for meeting their mental health needs until they turn 25.

2. There is a need to develop a mechanism to assess how local authorities are collecting and utilising the SDQ data within their localities. This may also provide an opportunity to investigate the large amount of missing data that local authorities are not providing year on year in their annual returns.

3. Local authorities and Clinical Commissioning Groups should make arrangements to review the SDQ data and consider how high scores are responded to, and ensure that these children have access to an assessment service, if they have not already had one.

9.7.2 Mental health competence in social workers

4. The Principal Social Worker role in each authority could act as a 'champion' and have responsibility for ensuring that social workers address the mental health of looked after children in their work. This includes the Principal Social Worker taking responsibility for building effective partnerships with CAMHS specialist and generic services at a local level.

5. The Independent Reviewing Officer's role in each authority could ensure that the emotional and mental health of looked after children is routinely addressed in all looked after children's reviews, and the SDQ is utilised in this process.

9.7.3 Implications for social work education and training

6. The curriculum of social work education qualifying programmes could cover the mental health of looked after children in sufficient detail to improve the knowledge, skills and confidence of student social workers about child and adolescent mental health. These qualifying courses could also include training on the use of tools such as the SDQ in recognising problems and referring children appropriately to CAMHS. Social work qualifying education should also introduce students to standardised tools and measures as part of an overview of different assessment approaches available to social workers.

7. Continuing Professional Development opportunities at post-qualifying level should also cover the mental health of children and adolescents, the use of standardised measures and instruments and should provide social workers with training on how to use tools such as the SDQ.

9.7.4 SDQ use by social workers

8. The SDQ could be routinely used by a social worker as part of the initial assessment process for a child or young person who becomes looked after in order that a baseline measure can be taken of their mental health at this point[33].

9.7.5 Culture change across organisations

9. Social work referrals to CAMHS, and CAMHS acceptance of referrals could be monitored to assess the appropriateness of referrals by social workers and the timeliness of response by CAMHS, with feedback to social workers to help them learn and adapt their referral activities. This would enable better understanding of the effective use of scarce resources.

9.8 Recommendations for future research

A number of recommendations for further research have become apparent whilst undertaking this study:

1. Although this thesis has been concerned with how social workers use the SDQ to assess the mental health of looked after children, one of the key areas highlighted in the study has been what action is taken if a child's SDQ score indicates that the looked after child may have a disorder. Further research could investigate the referral patterns of social workers to therapeutic services, particularly at what stage they refer children and

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[33] Since completing this thesis in Dec 2017, the DfE has announced investment in 10 pilot sites that aim to improve mental health assessments for children entering the care system. (see: https://www.annafreud.org/insights/news/2018/06/improved-mental-health-support-for-children-in-care/)

the reasons for the referral, the type of services they refer children to (e.g. specialist CAMHS; voluntary sector services; private services; or school based counselling services), the period of time over which children are seen, and the effect of these services for the child.

2. The evidence base about 'what works' for looked after children with mental health issues or 'caseness' is thin (Wright et al., 2015). There is a gap in knowledge about the specific mental health interventions that are effective with looked after children, given the co-morbidity of problems that many looked after children have. More resources for research specifically targeted to mental health interventions with looked after children are needed. Further research to map and understand the types of interventions offered to looked after children across the specialist CAMHS services in England may assist in increasing knowledge about 'what works' in this area and could lead to randomised controlled trials to evaluate efficacy.

3. One of the recommendations I have made is to provide social workers with additional knowledge and skills about child and adolescent mental health on qualifying social work programmes or via post qualifying CPD courses. Further research could investigate the effect of this additional knowledge and skills on social workers becoming what I described as 'partnership' social workers; able to make appropriate referrals to CAMHS and support looked after children and their carers.

4. There is a further gap in knowledge concerning the views of looked after children and young people about their own mental health and how this can best be supported by the system designed to address their needs. Future research should include young people's voice as a key 'stakeholder' in the research process, including as potential co-researchers.

9.9 **Conclusion**

Routinely collected SDQ data on looked after children who have been in care for a year or longer is not utilised by most of the social workers or the local authorities who collect these data. Most social workers in this study were not aware of the SDQ score for the children or young people they were allocated and did not know how to interpret it in terms of a looked after child's mental health. Given that this was the situation six years after first introducing the SDQ as a national mental health tool for looked after children, it is clear that changing social work practice takes more than conducting what is seen by social workers as an annual administrative exercise. Further planning is required to 'normalise' and embed this screening activity, with an understanding of the complexity of processes involved across a multiagency environment. At the point of my study, this had not yet happened.

Part of this 'normalising' activity involves a 'culture change' for social workers in understanding how critical looked after children's mental health is across the child's experience of the entire social care, health and education service settings. There were differing views by social workers about how mental health problems are manifest for looked after children. Learning to champion mental health at every point in the looked after child's journey through care is critical, and this will involve some social workers improving their knowledge and skills about mental health so they can better meet the needs of the children they are responsible for.

Among the potential benefits to SDQ data being collected for this vulnerable group of children is social workers developing confidence and competence in using the measure, including the ability to analyse its subscales. Development of clearer referral pathways between social work and CAMHS might help these benefits be fully realised and embed processes into practice so they become routine. Change within organisations regarding use of these data will not happen overnight.

Social workers are one member of a team of people working with a looked after child and as such need to have some knowledge of the mental health of looked after children so that they can advocate effectively for each child with whom they work, and do not find themselves inadvertently silenced by the jargon and

technical language used by CAMHS professionals. Social workers have a corporate parenting role for looked after children. As well as acting as de-facto parent, they have a professional relationship with the child and a responsibility to be able to recognise mental health difficulties at an early stage, and work with children and young people and their carers about the best way of managing these difficulties effectively. This may, in turn, result in referrals to specialist mental health services, because of the high level of emotional and behavioural problems that looked after children display. Knowledge of how to use the SDQ in practice does not replace the use of intuition and critical thinking, but it does go some way toward ensuring that rigorous assessments and referrals to specialist agencies occur in a timely manner. Given the challenges to local authority budgets and services, any recommendations to improve current practice must be mindful of resource implications. A multi-agency approach remains critical to establish the routinised usage of the SDQ. This has the potential to benefit all agencies and most importantly, looked after children.

Appendices

Appendix 1: Exclusion/ Inclusion criteria

Appendix 2: Summary of empirical studies that use the SDQ

Appendix 3: Empirical studies that use the SDQ excluded in the study

Appendix 4: The interview schedule mapped against the research aims for focus groups and semi-structured interviews. Topic Guide for Focus Groups

Appendix 5: Focus Group Questions

Appendix 6: Participant Information Sheet

Appendix 7: Consent Form

Appendix 8: Glasgow University Ethics Committee Letter

Appendix 9: ADCS Letter

Appendix 10: The SDQ Parent Version

Appendix 1: Exclusion/ Inclusion criteria:

I examined the c800 references that were identified in the initial literature search. After removing duplicates (the number decreased to 550), items were excluded if:

- they were not about the mental health or behaviour of looked after children or care leavers, aged up to 25. This is the age at which Local Authorities are no longer responsible for young people who have left care;
- they were published before 2000 as most references are dated after 2000;
- they were not published in either a peer-reviewed journal, report, or a key text;
- they were not empirical research;
- they were not in English;
- they did not relate to a study in the UK, Europe, Ireland, USA, Canada, Australia or NZ.

	Inclusion/exclusion criteria	Guidance
1.	**Exclude: Date of publication:** before 2000	Published before 2000
2	**Exclude: Publication type:** not in peer reviewed journal or report published by reputable organisation/agency	Exclude most books except for key texts, trade publications (e.g. community care); policy and guidance (as an overview will be provided elsewhere)
3	**Exclude: Location:** Studies had to be from western countries. Studies were excluded from countries outside of these areas.	Not in UK, Ireland, Canada, USA, Australia, NZ, Turkey, Israel, Belgium. (D'Oosterlinck et al., 2006, Janssens and Deboutte, 2010)
4	**Exclude: Population:** only include looked after children, or leaving care up to the age of 25	Exclude adoption, but not when studies also included looked after children.
5	**Exclude: Population:** children in prison	
6	**Exclude: Population:** children admitted to psychiatric wards.	
7	**Exclude: Research type**: not empirical	Exclude case study, vignette, opinion piece, commentary, briefing
8	**Exclude: Research Topic:** study did not use the SDQ	Exclude studies that used other screening tools or did not use screening tools
9	**Exclude: Scope:**	has to be relevant to research questions
10	**Include**	Not excluded by above

Appendix 2: Summary of empirical studies that use the SDQ

No	Date	Author	Title	Journal/Book / other	Aim	Method	SDQ used?	Sample Number	Characteristics of sample	Professional undertaking the study	Outcome findings
1	2001	Minnis, Pelosi, Knapp and Dunn	Mental Health and Foster Carer Training	Archive of Diseases of Childhood, 84, pp 302-306	Intervention study to evaluate the impact of training foster carers on Looked After Children's emotional and behavioural functioning.	A randomised controlled trial with immediate and nine month follow up.	Yes	N=182	182 Looked After Children in foster care (and their foster families) in 17 Scottish local councils were randomly allocated to standard services alone or standard services plus training (specifically for foster carers on communication and attachment).	Psychiatrist	60% of Looked After Children had measurable mental health difficulties at baseline. Training was perceived as beneficial by foster carers. Results were non-significant.
2	2001	Minnis and Devine	The effect of foster carer training on the emotional and behavioural functioning of looked after children	Adoption and Fostering, 25(1), pp44-54	Intervention study to evaluate the impact of training foster carers on Looked After Children's emotional and behavioural functioning.	A randomised controlled trial with immediate and nine month follow up.	Yes	N=182	182 Looked After Children in foster care (and their foster families) in 17 Scottish local councils were randomly allocated to standard services alone or standard services plus training (specifically for foster carers on communication and attachment).	Psychiatrist and social worker	There was an improvement in the self esteem of the children during the course of the study. Training was perceived as beneficial by foster carers in terms of their relationship with the children they care for but did not result in changes to the children's emotional and behavioural functioning. The training provided rich information about foster carers' communications and interactions with the looked after children in their care.
3	2003	McCarthy, Janeway and Geddes	The Impact of emotional and behavioural problems on the lives of children	Adoption and Fostering 27(3), pp14-18	To address the way in which the emotional and behavioural problems of looked after children are impacting on their functioning in a	Questionnaire based study.	Yes	N=70	115 carers of children aged 5-16 years were approached and 70 completed questionnaires were returned	Clinical psychologist and social workers	59% of the looked after children had a score indicating the presence of a psychiatric disorder. Where significant problems were identified by carers, 65% reported that the problems had existed for over 1 year and almost half the sample stated that the children's difficulties were

			growing up in the care system		number of key areas: behaviour at home, learning, leisure activities and peer relationships. Secondly to investigate the impact of the emotional and behavioural problems of looked after children and their carers					imposing a significant burden on the families or other carers.
4	2003	Meltzer, Corbin Gatward, Goodman and Ford	The mental health of young people looked after by local authorities in England	The Stationery Office (TSO)	Epidemiological study to establish the prevalence of mental disorders within the looked after population in England	Random sampling surveys of looked after children in England carried out between October 2001 and June 2002.	Yes	N=2500	1039 DAWBA and SDQ completed by parents/carers, teacher and children if over 11; Teachers provided data on attainment, mental age and whether the child had SEN statement and social workers provided data o the child's care history	Researchers, psychologists and psychiatrists	The first part of the report focuses on the prevalence rates of mental disorders among young people looked after by local authorities. The second part shows the way in which children and adolescents with particular disorders vary from those without mental disorders on a range of factors including their background, personal and familial characteristics, physical health, use of services and social functioning. Among young people, aged 5–17 years, looked after by local authorities, 45% were assessed as having a mental disorder: 37% had clinically significant conduct disorders; 12% were assessed as having emotional disorders - anxiety and depression – and 7% were rated as hyperactive.
5	2004	Sinclair and Wilson	Matches and mismatches: The contribution of carers and children to the success of foster placements	British Journal of Social Work, 33, p871-884	To determine characteristics of success in foster placements	Data collected at t1 and t2 (14 month interval) from a cross section of those involved with looked after children: children's SW family placement SW, FC and some comments from children themselves	Yes – in part	N=472	Children already in care in 7 local authorities, seen as highly representative of national profiles. Questionnaires were used to obtain data	Social workers	Success in foster care depended on 3 aspects: children's characteristics (children who wanted to be fostered, had attractive characteristics and low levels of disturbance did better); qualities of foster carer (warm, child oriented carers were more successful); interaction between carer and child. Additionally the findings emphasise the importance of the foster carers to outcomes, and the need to pay close attention to children's views, and the potential importance of early intervention

											to prevent negative spirals in interaction between carer and child.
6	2004a	Meltzer, Lader, Corbin, Goodman and Ford	The mental health of young people looked after by local authorities in Scotland	The Stationery Office (TSO)	Epidemiological study to establish the prevalence of mental disorders within the looked after population in Scotland	Random sampling surveys of looked after children in Scotland.	Yes	N=877	355 DAWBA and SDQ completed by parents/carers, teacher and children if over 11; Teachers provided data on attainment, mental age and whether the child had SEN statement and social workers provided data o the child's care history	Researchers, psychologists and psychiatrists	The Report provides up-to-date baseline information about the prevalence of mental disorders among 5-15 years olds in Scotland. 45% of those aged between 5 to 17 years of age were assessed as having a mental disorder. Those aged 5 to 10 who were looked after at home or accommodated were six times more likely to have a mental disorder than those children living with families in the community (52% compared with 8%). Those aged 11 to 15 and either looked after at home or looked after and accommodated were four times more likely to have a mental disorder that those children living with families in the community (41% compared with 9%). Some children had more than one type of disorder and these were more likely to be boys
7	2004b	Meltzer, Lader, Corbin, Goodman and Ford	The mental health of young people looked after by local authorities in Wales	The Stationery Office (TSO)	Epidemiological study to establish the prevalence of mental disorders within the looked after population in Wales	Random sampling surveys of looked after children in Wales .	Yes	N=308	149 DAWBA and SDQ completed by parents/carers, teacher and children if over 11; Teachers provided data on attainment, mental age and whether the child had SEN statement and social workers provided data o the child's care history	Researchers, psychologists and psychiatrists	This report presents the findings of a survey of the mental health of young people, aged 5-17, looked after by local authorities in Wales. For 5- to 10-year-olds, those looked after by local authorities were about eight times more likely to have a mental disorder; 49% compared with 6% of children living in the community; The 11- to 15-year-olds looked after by local authorities were three and a half times more likely to have a mental disorder: 40% compared with 12% of young people living int he community.
8	2004	Goodman, Ford, Corbin and Meltzer	Using the Strengths and Difficulties Questionnaire (SDQ) multi-informant	European Child & Adolescent Psychiatry, 13, pp25-31	To assess the Strengths and Difficulties Questionnaire (SDQ) as a potential means for improving the	SDQ predictions and independent psychiatric diagnoses were compared in a community sample	Yes	N=1,028		Psychiatrist, Psychologists and researchers	Multi-informant SDQs (parents, teachers, older children) identified individuals with a psychiatric diagnosis with a specificity of 80% and a sensitivity of 85%. The SDQ prediction works best when SDQs have been completed by both carers and

					detection of child psychiatric disorders in the community	of 1,028 looked-after 5-17 year olds from a nationwide English survey.					teachers. When it is only possible to have one adult informant, carers and teachers provide information of roughly equal predictive value. By contrast, self-reports by 11-17 year olds provide little extra information when there is already an adult informant.
9	2004	Buchanan and Ritchie	Using standardised measures to prioritise services for children and families in need	Journal of Social Work 4(2), pp167-178	To investigate the consumer views and levels of satisfaction with social services	Families were contacted by post and telephone, standardised measures of child and adult wellbeing were taken	Yes	N=72	72 families completed a questionnaire and 3 questionnaires - SDQ, GHQ and Wiltshire self assessment schedule. Once this was received by the researchers, parents were interviewed by telephone,	Social work	High levels of parental and child distress. parents reported 69% of children as having borderline or abnormal levels of emotional and behavioural difficulties. Parents with high levels of distress found it more difficult to access Local Authority support. Using standardised measures of wellbeing for both parents and children may help in prioritising service provision.
10	2004	Mount, Lister and Bennun	Identifying the Mental Health Needs of Looked After Young People	Clinical Child Psychology and Psychiatry, 9(3), pp363-382	To investigate whether looked after young people and their carers were able to 'intuitively judge' whether the young person had a mental health problem and when they would seek help and to compare this to a mental health screen	Interview and administration of semi-structured interview schedule, then questionnaires and scales were completed.	Yes	N=50 looked after young people N=50 carers	All young people were aged between 10-18.	Clinical psychologists	Carers were 4 times more likely to identify mental health needs, both intuitively and on the mental health screen, than the young people themselves. two thirds of carers were intuitively accurate in identifying mental health need. . Fewer than half of those identified as having a need were being seen by specialists. of concern, 23% of carers failed to identify needs subsequently identified by the screen.
11	2004	Becker, Hagenberg, Roessner, Woerner, and Rothenberger	Evaluation of the self-reported SDQ in a clinical setting: Do self-reports tell us more than ratings by adult informants?	European Child & Adolescent Psychiatry, 13, pp ii17-ii24	To evaluate the German self-reported Strengths and Difficulties Questionnaire (SDQ) in a clinical setting. To investigate whether this additional information gathered directly from older children and adolescents improves	SDQ self-reports were collected from in- and outpatients. Results obtained with the self-rated questionnaire were compared with the parent and teacher SDQs, corresponding CBCL/YSR scores, and the clinical	Yes	N=214	(81 girls and 133 boys) aged 11 to 17 years	(?)	The scales of the SDQ self-report proved to be sufficiently homogeneous, and acceptable correlations were found with the equivalent parent and teacher ratings. The self-rated version of the SDQ demonstrated good validity with respect to the differentiation between clinically defined cases and non-cases and in detecting various subcategories of psychiatric disorders within the clinic sample. SDQ self-reports significantly contributed to the prediction of diagnostic

					the prediction of clinical status when external ratings from their parents and/or teachers are already available.	diagnostic classification. Finally, the additional diagnostic benefits of the self-reports were examined					status, specifically if only parent or teacher ratings were available.
12	2005	Teggart and Menary	An investigation of the Mental Health Needs of Children Looked After by Craigavon and Banbridge Health and Social Services Trust.	Child Care in Practice 11(1), pp39-49	To investigate the prevalence of mental health difficulties among the group of young people cared for by the named Trust; to investigate the complexity of presentation of mental health difficulties with regard to the likelihood of dual/multiple diagnoses.	This is a questionnaire study and began as an individual needs exercise but was changed after the data had been collected in order that the results could be disseminated more widely.	Yes	N=64		Clinical Psychologists in Northern Ireland	More than 60% of 4-10 year olds assessed may have a diagnostic psychiatric disorder. Amongst the 11-16 year olds, 66% of the sample group were likely to have a disorder. Many of the children appeared in more than one diagnostic category.
13	2006	Minnis, Everett, Pelosi, Dunn and Knapp	Children in foster care: Mental health, service use and costs	European child and adolescent Psychiatry 15, pp 63-70	To assess the prevalence of mental health problems in children in foster care, their families' use of services and the associated costs.	Information on mental health problems, service use and costs was collected by postal questionnaires and home interviews. The results were then compared with 251 children from local schools	Yes	N=182	Sample was taken from 17 local authorities in Central Scotland, and included information gained from young people, their foster carers and teachers.	Psychiatrists, economist and researcher	Over 90% of the children had previously been abused or neglected and 60% had evidence of mental health problems including conduct, emotional problems, hyperactivity and poor peer relationships. Those children with highest scores for MH problems were attracting a high level of service support from many agencies except CAMHS. Costs were associated with learning disability, mental health problems and a history of residential care.
14	2006	Richards, Wood, Ruiz Calzada	The mental health needs of looked after children in a local authority permanent placement team and the value of the Goodman SDQ	Adoption and Fostering 30(2), pp43-52	To identify and highlight the mental health needs of looked after children in a permanent placement social work team and to identify a suitable screening tool for the early identification of mental health need.	Questionnaire study: Use of SDQ as questionnaire and pre and post care experiences were collected from discussions with SWs and reviewing social work files.	Yes	N=41	Children aged between 4-16.	Social worker and assistant psychologist	Carer and teacher rates were similar and higher than the self reporters. The high needs for parent (43.9%) and teacher (46.3%) is similar to national prevalence rates. SDQ is recommended as a screening tool

15	2006	Beck	Addressing the mental health needs of looked after children who move placement frequently	Adoption and Fostering 30 (3), pp 60-65	to compare the mental health needs of looked after children who move placement frequently with the mental health needs of those who do not and to consider how these differences may be addressed in terms of mental health service planning.	Questionnaire based survey. Two questionnaires (including the Strengths and Difficulties Questionnaire – SDQ) were sent to the carers of 747 young people (aged over three years) looked after by one inner-London local authority, to the young people themselves if they were aged over 11 years and to a selected sample of teachers.	Yes	N=747	Children aged 3-17	Psychologist	A third (30 per cent) of young people had a 'probable' psychiatric diagnosis using the SDQ. Eleven per cent had moved placement three or more times in the last year and they were three times more likely to have a 'probable' psychiatric diagnosis. They were also significantly more likely to report deliberate self-harm in the last six months compared to those who had moved placement less frequently. Although young people who move placement frequently are far more likely to develop psychiatric disturbance than other looked after children, they are much less likely to access mental health services.
16	2007	Derluyn and Broekaert	Different perspectives on emotional and behavioural problems in unaccompanied and refugee children and adolescents	Ethnicity and Health 12 (2), pp141-162	To investigate the prevalence of emotional and behavioural problems in unaccompanied refugee children and adolescents living in Belgium. To compare the perspectives of the adolescents with those of social workers on the adolescents' emotional well-being.	Self-report questionnaires we completed on emotional and behavioural problems (HSCL-37A, SDQ-self and RATS) and traumatic experiences (SLE), and social workers filled in two questionnaires on emotional and behavioural problems (CBCL/6-18 and SDQ-parent)	Yes	N=166	A total of 166 unaccompanied refugee children and adolescents, living in different large- and small-scale centres, in foster care or alone, participated in the study.	(?)	Between 37 and 47% of the unaccompanied refugee youths have severe or very severe symptoms of anxiety, depression and post-traumatic stress. Girls and those having experienced many traumatic events are at even higher risk for the development of these emotional problems. Social workers also report a high prevalence of internalising problems in this population and they also report important externalising problems in unaccompanied refugee youths
17	2007	Ford, Vostanis, Meltzer and Goodman	Psychiatric disorder among British children looked after by local authorities: comparison with children	British Journal of Psychiatry, 190, pp319-325	To find explanations for the increased prevalence of psychiatric disorder in children looked after by local authorities	Examined socio-demographic characteristics and mental health difficulties by type of placement among children looked after in Britain by	Yes	N=1453 looked after children; n=10,428 children living in private households	Uses data collected in Meltzer et al 2000 and Meltzer et al 2003.	Psychologists and researchers.	Looked after children have higher levels of mental health problems, educational difficulties and neuro-developmental disorders. 'Looked after' status was independently associated with all types of developmental disorders after adjusting for education and physical factors. The prevalence of psychiatric disorder was

			living in private households.			local authorities and compared these children with deprived and non-deprived children living in private households					most associated with those living in residential care and who have had many placement changes.
18	2007	Taggart, Cousins and Milner	Young people with learning disabilities living in state care: their emotional, behavioural and mental health status	Child Care in Practice. 13, pp401-406	To examine the emotional, behavioural and mental health status of a group of young people with and without learning disabilities residing in state care.	Mixed Methods Research. Data were collected from social worker reports and the Strengths and Difficulties Questionnaire on these two cohorts who were living in state care for a minimum of one year.	Yes	N= 165 looked after children of which n=37 had learning disabilities	Case file data collected about young people and questionnaires and interviews with social workers	Institute of Nursing and Health Research, University of Ulster.	The young people with learning disabilities had a higher prevalence of emotional and behavioural problems and were also significantly more likely to score within the abnormal range of the Total Difficulties Score of the SDQ (77.1%) compared with their non-disabled peers (49.6%).
19	2008	Whyte S and Campbell A	The SDQ: A useful screening tool to identify mental health strengths and needs in Looked After Children and Inform Care Plans at Looked After Children Reviews?: A Focus Group Study of the views of Social Workers and their Managers	Child Care in Practice 14(2) pp193-206		Mixed methods: 1. Strengths and Difficulties Questionnaire (SDQ) screening was undertaken with a sample of Looked After Children (n=76), 37 males and 39 females. SDQ screening was undertaken with 76 (78%) carers, 64 (76%) teachers and 32 (87%) children aged 11+, and the findings provided to the child's social worker for consideration at the child's statutory review. 2. Focus groups with social workers	Yes	N=76	This paper outlines the findings of three focus groups with social workers and managers following SDQ screening of a sample of Looked After Children within four generic childcare teams and a team for children with special needs in Homefirst Community Trust.	Social workers	Of the sample of children, fifty-six per cent of carers, 39% of teachers and 30% of children identified significant difficulties, with 63% of carers, 35% of teachers and 45% of children stating that the difficulties had been present for over a year. Pre-test and post-test file audits were undertaken to ascertain whether SDQ screening had informed the child's care planning process. While care plans reflected an increase in referrals for further assessment and treatment in 42%, a number assessed with significant difficulties were not referred due to uncertainty about accessing appropriate services or concerns about swamping existing services. Participants reflected on the usefulness of the SDQ in identifying mental health strengths and difficulties to inform decision-making at Looked After Children Reviews. Participants recommended that routine SDQ screening is undertaken with all Looked After Children, with early intervention provided to children identified with some mental health

											difficulties and prioritisation of children with significant need. The usefulness of SDQ identification of child strengths as a foundation for promoting resilience in Looked After Children was also recognised. Recommendations were also made regarding specific service provision for Looked After Children and training for field social workers, link social workers and carers.
					3. Pre-test and post-test file audits were undertaken to ascertain whether SDQ screening had informed the child's care planning process.						
20	2008	Osborn, Delfabbro and Barber	The psychosocial functioning and family background of children experiencing significant placement instability in Australian out-of-home care	Children and Youth Services Review, 30, pp847-860	.To obtain a more comprehensive profile of children with high levels of placement instability across multiple Australian States to develop an indicative national profile of these children.	Detailed interviews were conducted with case-workers, along with extensive case-file readings. questionnaires were also used	Yes	N=364	This paper profiles the family and social background, and psychosocial wellbeing of 364 children (Mean age = 12.9 years) with a high level of placement instability in Australian out-of-home care The children were found to originate from families that share many risk factors. In most cases, a family history of domestic violence, physical abuse, and parental substance abuse dominated over a history of sexual abuse and neglect.	Psychologists	Based on the Strengths and Difficulties Questionnaire (SDQ), over 75% of children were found to have clinical level conduct disorder, two-thirds have peer problems, and around a half are clinically anxious or depressed. The results provided some evidence that children with the poorest overall psychosocial adjustment were most prone to placement breakdowns, but there was no clear relationship between the overall number of family background problems and the level of placement instability. However, individual risk factors, including a history of family violence and abuse were related to more disrupted placement histories for children in care.
21	2008	Milburn, Lynch and Jackson	Early identification of mental health needs for children in care: a therapeutic assessment programme for statutory clients	Clinical Child Psychology and Psychiatry 13(1), pp31-47.	Description of a pilot programme to provide an early assessment , input into planning and referral Where appropriate for children who entered care in one city in Australia.	Multi-disciplinary therapeutic assessment was completed on the child within 7-10 days of a child being accommodated. Standardised measures and	Yes	N=171	Aged between 0-17 years	Australian study: Clin psych and social worker	Nearly three quarters of the participants over 5 scored in the borderline or abnormal range of the SDQ. The parents and carers report version was found to be a more accurate assessment of the child's problems than the self-report version. More than 60% of participants met the criteria for psychiatric diagnosis.

			of child protection				interviews with birth parents and foster cares were also completed.					
22	2009	Makinson	Mindful care: the pilot of a new mental health service for young people who are looked after away from home in Moray	Scottish Journal of Residential Child Care, 8(2), pp18-25	To review the project 'Mindful Care', which is a joint initiative between the Action for Children residential care service in Moray and the associated Child and Adolescent Mental Health Services (CAMHS) team.	The project consisted of 3 parts. Phase 1 was a 2 day training package provided to Action for Children residential staff, with training outcomes measured by questionnaire immediately before, immediately after, and 3 months following the training. Phase 2 was the introduction of the Strengths and Difficulties Questionnaire (SDQ) into a new protocol used by AFC staff. The questionnaire was completed by a number of people (the referring social worker, key worker, the young person, and jointly at the in-house residential meeting) at set times and as required to address specific concerns. Phase 3 was a new consultation service specifically for AFC staff. The initial evaluation of the project concludes	Yes				

						that the training increased levels of perceived knowledge and confidence in supporting the mental health and wellbeing of the children and young people in their care.					
23	2010	Bonfield, Collins, Guishard-Pine and Langdon	Help-seeking by foster carers for their 'looked after children': The role of Mental Health Literacy and Treatment Attitudes	British Journal of Social Work, 40, pp 1335-1352	To investigate the factors that influence the help-seeking steps for looked after children with mental health problems within the context of a help seeking model.	Cross-sectional and between groups design. Data on variables likely to be related to help-seeking were collected from foster carers and looked after young people	Yes	N=113 foster carers, N=108 looked after children	Located in the East of England	Psychologists and researchers	Mental health literacy and help seeing attitudes, in combination with the presence and impact of a mental health problem, and foster care education, are significant predictors of help-seeking.
24	2009	Marquis and Flynn	The SDQ as a mental health measurement tool in a Canadian sample of looked after young people	Vulnerable children and Youth Studies 4(2), pp114-121	To compare the SDQ scores completed by foster carers about looked after children living in Canada, with normative SDQ scores completed by parents and caregivers in the UK general population study.	492 young people living in Ontario, Canada were participants in the Looking After Children: Good Parenting Good Outcomes study and the SDQ was completed with the young people as a part of that study.	Yes	N=492	492 young people in care . 57% male, 43% female and young people in care were aged between 11-15 yrs.	Psychologists	Considerably higher proportion of the Ontario looked after sample of young people had SDQ scores in the 'at risk' range (31.6%), compared with the British normative sample (9.9%) – there is no Canadian normative sample.
25	2009	Egelund and Lausten	Prevalence of mental health problems among children placed in out-of-home care in Denmark	Child and Family Social Work, 4(2), pp156-165	To investigate the prevalence of mental health problems among children in family foster and residential care within a Danish context	Comparison study between 3 types of children: in care; in need and subject to CP interventions but living at home; and non-welfare children.	Yes	out-of-home care (n= 1072); 'in home care children' (n= 1457); children who are not child protection	All children, born in Denmark in 1995, who are or formerly have been placed in out-of-home care (n= 1072), are compared with a group of vulnerable children of the same age, subjected to child protection	Researchers	Results show that 20% of children in out-of-home care have at least one psychiatric diagnosis compared to 3% of the non-welfare children. Almost half of the children in care (48%) are, furthermore, scored within the abnormal range of SDQ, compared to 5% of the non-welfare children.

							clients (n=71,321)	interventions but living at home (n= 1457, referred to as the 'in home care children'), and to all contemporaries who are not child protection clients (n= 71 321, referred to as the 'non-welfare children')		
26	2010	Cousins W, Taggart L and Milner S	Looked after or overlooked? An exploratory investigation of the mental health issues of adolescents living in state care in Northern Ireland	Psychology, health and medicine 15(5), pp 497-506	This study aimed to examine the mental health needs of young people aged between 10 and 15 years living in state care in Northern Ireland.	Mixed Methods Research. case file data, questionnaires and interviews with social workers	Yes	N=165	Case file data collected about young people and questionnaires and interviews with social workers	Institute of Nursing and Health Research, University of Ulster.	It was found that the 70.3% of the young people scored within the abnormal and borderline ranges of the Strengths and Difficulties Questionnaire (SDQ) total difficulties score indicating "high risk" for meeting the criteria for a psychiatric diagnosis. Over the course of 1 year living in state care, 10 of the 165 adolescents had attempted suicide and 14 had engaged in deliberate self-harm. However, social workers still rated the vast majority (92%) of these young people's overall health as being "as good as'', or "better than'' other young people in their age. It is concluded that as this group of young people have significant contact with health and social services, potential opportunities exist to develop the therapeutic potential of the experience of being "looked after'' in state care.
27	2010	McCrystal and McAloney	Assessing the mental health needs of young people living in state care using the Strengths and Difficulties Questionnaire	Child Care in Practice, 16, pp215-226	The aim of this study was to use data from the Youth Development Study, a longitudinal study being undertaken at Queens University Belfast, to show the value of the Strengths and Difficulties Questionnaire (SDQ) as a screening tool for mental health issues	The data were obtained during the first year of the study, with young people aged 11 and 12 years, and fourth year, with young people aged 14 and 15 years. The data obtained using the SDQ was compared for young people who indicated they	Yes	N= 42 (year 1); n=49 (year 4)	4000 participated at each stage of the study, which included a sample of 42 looked after children year 1 and 49 LAC in year 4.	Researchers	The results show a higher proportion of young people living in state care reported scores on the SDQ that indicated a higher propensity to problem behaviour at both stages of the survey. They also show that the SDQ is a tool that may assist professionals to make an informed decision on the health and wellbeing of young people entering the care system and possibly can lead to an empirically assisted decision on intervention planning.

					with young people entering state care.	were living in state care with those living with at least one biological parent outside care.				
28	2011	Jee, Halterman, Szilagyi, Conn, Alpert-Gillis, Szilagyi	Use of a brief standardised screening instrument in a primary care setting to enhance detection of social-emotional problems among youth in foster care	Academic Pediatrics, 11(5), pp409-413	To determine whether systematic use of a validated social-emotional screening instrument in a primary care setting is feasible and improves detection of social-emotional problems among youth in foster care.	Before and after study design following a practice to screen all youth in foster care for psychosocial problems using the SDQ. this was compared to the rates of psychosocial problems identified in the 2 years prior to the screening tool being introduced (baseline).	Yes	N=212	Youth aged 11-17 years and their foster carers completed the SDQs.	Doctors, researchers	High feasibility of systematic screening. detection of mental health problems was higher in the screening period than in the baseline period for the entire population (54% vs 27%). more than one quarter of young people had 2 or more significant social /emotional problem domans ont eh SDQ.
29	2011	Aguilar-Vafaie, M, Roshani M, Hassanbadi H, Masoudian Z, Afruz G	Risk and protective factors for residential foster care adolescents	Children and Youth Services Review, 33(1)							
30	2012	Wigley, Preston-Shoot, McMurray, Connolly	Researching young people's outcomes in children's services: Findings from a longitudinal study	Journal of Social Work, 12(6), pp 573-594	Investigation of outcomes for looked after children There were 2 stages to the research	A mixed methods approach was used alongside a multiple case study design undertaken in 2 stages. Scales and measures were administered by social workers at the beginning of the research study (t1) and a year later (t2).	Yes: SDQ and othe rs	N=73 children, N= 32 social workers, N=31 parents and carers	Stage 1 involved 21 young people in residential care; stage 2 involved interviews with 32 social workers and 31 parents and carers regarding 52 children at risk of or who had recently become looked after. 11 children also volunteered to be interviewed.	Social workers	There were challenges in providing low level emotional therapeutic work, building on young people's pro social relationships with peers and finding effective ways of improving children's self esteem and self efficacy. Children were not routinely involved in decision-making. Placement stability, meeting the short and longer term needs of all placed children and addressing the needs of foster carers and residential children's home staff also presented challenges.

31	2012	Goodman and Goodman	SDQ scores and mental health in looked after children	British Journal of Psychiatry 200, pp426-427	To investigate whether the parent SDQ is a genuinely dimensional measure of child mental health and the parent SDQ prevalence estimator equation is accurate.	Combined data from 3 nationally represented surveys (England, Scotland and Wales) of looked after children aged 5-17.	Yes, and DAWBA	N=1391	Looked after children aged 5-16 living in England, Scotland and Wales.	Psychiatrist and researcher	The SDQ is a 'genuinely dimensional measure' of mental health in looked after children and provides accurate estimates of disorder prevalence.
32	2012	Mason, Chmelka and Thompson	Responsiveness of the Strengths and Difficulties Questionnaire (SDQ) in a sample of high-risk youth in residential treatment	Child and Youth Care Forum, 41, 479-492	The aim of this study was to examine the responsiveness of the SDQ among high-risk youth in residential treatment.	External responsiveness was examined with respect to the well-established and lengthier measure, the Child Behavior Checklist (CBCL). Longitudinal SDQ and CBCL data collected as part of routine service delivery were analysed for Assessments were obtained both at intake and approximately 3 months into the programme. Paired samples t tests revealed statistically significant decreases in 3 of the 5 scales of the SDQ from time 1 to time 2.	Yes	N=65	youth entering a large residential treatment programme.		The results indicate that the SDQ is sensitive to changes over time. There was also a relatively high degree of correspondence between changes in the SDQ and changes in the CBCL. The findings suggest that the SDQ may represent a shorter, low cost alternative to longer measures, such as the CBCL.
33	2012	Biehal, Dixon, Parry, Sinclair, Green, Roberts, Kay, Rothwell, Kapadia, and Roby	The Care Placements Evaluation (CaPE) Evaluation of Multidimensional Treatment Foster Care for	Research Brief, DfE-RB194, Department for Education	To examine the efficacy of MTFC-A compared with usual care for young people at risk in foster care in England	RCT with observational quasi experimental case control study. The primary outcome measure was Children's Global Assessment Scale, (C-GAS) and the	Yes	N=219	Looked after children from 18 english local authorities included in the study.	Social work academics and psychiatrists.	For the sample as a whole, placement in MTFC-A showed no statistically significant benefit over the usual care placements. This was true for all the outcomes studied including overall social adjustment, education outcomes and offending. In a subgroup of the sample with serious antisocial behaviour problems, MTFC-A

			Adolescents (MTFC-A)				Health of the Nation Outcome Scales for Children and Adolescents, (HoNOSCA). Standard mental health measures of behavior and social functioning ('Child Behaviour Checklist, CBCL; Strengths and Difficulties Questionnaire, SDQ) were also used and data were collected on school attendance, offending and bias. Qualitative data were also collected during interviews with young people and carers.					showed improved reduction in these behaviour problems over usual care and also in overall social adjustment. The young people who were not anti-social did significantly better if they received a usual care placement.
34	2012	Briskman, J. ; Castle, J. ;Blackeby, K. ;Bengo, C. ;Slack, K. ;Stebbens, C. ;Leaver, W. ;Scott, S.	Randomised Controlled Trial of the Fostering Changes Programme	Department for Education Research Report DfE RR237	To investigate the effectiveness of the 'Fostering Changes' programme developed for foster carers	RCT: data were gathered using 6 measures, including the SDQ.	Yes	N=63 carers and n=89 foster children completed the trial.	N=34 carers n=51 foster children in intervention group; n=29 carers, n=38 foster children in control group	CAMHS service	Improvement across the board in outcomes for intervention group compared with control, including on emotional and behavioural difficulties for foster children, using the total difficulties score of the SDQ; improvement in carer-defined problems and the quality of attachment between looked after children and carers compared to controls. Positive changes were also reported in carer confidence and parenting practices, including greater self-esteem and less stress. 'Eighty-nine percent of these carers said that they would be able to retain the knowledge that they had acquired during the training over the longer-term, and 100% felt confident about using their new skills with other children.'
35	2012	Newlove-Delgado,	Evaluation of a pilot project for mental health	Journal of Children's	To evaluate the feasibility of a screening tool for	2 stage screening process: Questionnaire	Yes	N=23 eligible;	Children were aged between 4-16. 65% were boys, 74%	Psychotherapist and psychiatrists	285 of children eligible for screening were already in contact with some form of CAMHS provision. Seven children from the

		Murphy and Ford	screening for children looked after in an inner London borough	Services 7(3), pp213-225	looked after children in order to identify undetected psychiatric disorders.	screen used with children aged 4-16 who had been in care over 4 consecutive months. Where the screening questionnaire suggested a psychiatric disorder was 'possible' or 'probable', the DAWBA was completed and rated by a psychiatrist to generate a diagnosis if applicable.		n=18 SDQ completed	were black or Asian, 70% were placed out of borough and 65% were voluntarily accommodated.		18 screened received a formal diagnosis. For 80% of these children, social workers had recognised the children as having potential difficulties.
36	2013	Rees	The mental health, emotional literacy, cognitive ability, literacy attainment and 'resilience' of 'looked after children': a multidimensional, multiple rater population based study	British Journal of Clinical Psychology, 52, pp183-198	To provide a 'more representative picture' of the heterogeneity of looked after children, including those who are performing well in care. To offer data on resilience of looked after children	Multi dimensional multiple-rater population based study of looked after children. children were assessed in core domains: mental health, emotional literacy, cognitive ability and literacy attainment. children's data were compared with the general population norms and existing research studies.	Yes	N=193	Population of looked after children in one local authority aged 7-15 were included in the study.	Social worker (?)	Looked after children performed less well in all domains compared with general population norms. 16% of children met the 'positive exception' criteria. positive performance on individual measures varied from 34% to 76%. a statistically significant association was found between positive exception classification and 2 factors: parental contact and mainstream schooling.
37	2014	Brown	Clinical Update: A small service evaluation of a Solihull approach foster carer training group pilot study	Practice: Social Work in Action, 26(1), pp 37-52	To evaluate the foster carer training group	An evaluation of a service using 3 scales at pre and post training: the SDQ; Parental Stress Index - Short Form; Carer Questionnaire	Yes	N=16	16 foster carers Programme being evaluated was delivered over 12 sessions	(?)	'Significant' decrease in the carers ratings of their foster child's hyperactivity and attention disorders and a decrease in behavioural problems.

38	2014	Stine Lehmann , Einar R. Heiervang, Toril Havik, Odd E. Havik	Screening Foster Children for Mental Disorders: Properties of the Strengths and Difficulties Questionnaire	Open access journal – PLOS Published: July 9, 2014DOI: 10.1371/jour nal.pone.010 2134	To examine the mental health of looked after children using the SDQ to see whether the SDQ could effectively e used to identify disorders in looked after children in another country (not UK)	Foster parents and teachers of 279 foster children completed the SDQ and the diagnostic interview Developmental and Well-Being Assessment (DAWBA). Using the diagnoses derived from the DAWBA as the standard, we examined the performance of the SDQ scales as dimensional measures of mental health problems using receiver operating characteristic (ROC) analyses.	yes	N=279	Foster parents and teachers of 279 foster children completed the SDQ and the diagnostic interview Developmental and Well-Being Assessment (DAWBA).	Psychologists and psychiatrists	The results support the use of the SDQ Total difficulties and Impact scales when screening foster children for mental health problems. Cut-off values for both scales are suggested. The SDQ multi-informant algorithms are not recommended for mental health screening of foster children in Norway.
39	2014	Ratnayake, Bowlay-Williams and Vostanis	When are attachment difficulties an indication for specialist mental health input?	Adoption & Fostering 2014, Vol. 38(2) 159–170	The aim of this study was to explore the relationship between attachment and mental health problems among looked after and adopted children and young people attending a designated mental health service.	SDQ, relationship problems questionnaire and a non-standardised questionnaire were completed	Yes	N=83 looked after; N=67 adopted children; N=49 young offenders (compariso n group)		Psychologists and psychiatrist	Attachment and mental health problems were significantly associated across most subscales of the Relationships Problems (RPQ) and the Strengths and Difficulties Questionnaires (SDQ). Adopted children were younger and were rated higher on both measures. One-third of the children were rated below the clinical cut-off SDQ score. The service appeared to adopt broad referral criteria to include attachment difficulties rather than just mental health disorders. The findings are discussed in relation to the varied interpretation of the constructs of attachment difficulties and disorders, and the future development of care pathways for looked after and adopted children.
40	2016	Herrman et al. (19 authors) (2016)	A controlled trial of implementing a complex mental	BMC Psychiatry 2016, 16:436	Australian evaluation study that uses the SDQ as a measure within the study. The	A whole range of measures are used	Yes	N=176 young people, N=104			According to the study, Implementing and researching an affordable service system intervention appears feasible and likely to be applicable in other places and

| | | Australia | health intervention for carers of vulnerable young people living in out-of-home care: the ripple project | | research evaluates a complex mental health intervention (The Ripple Project) that aims to strengthen the therapeutic capacities of carers and case managers of young people (12-17 years) in out of home care. | | | carers and N=79 case managers. | | | countries. Success of the intervention will potentially contribute to reducing mental ill-health among these young people, including suicide attempts, self-harm and substance abuse, as well as reducing homelessness, social isolation and contact with the criminal justice system. |

Appendix 3: Tabulated summary of articles excluded from literature review: my scores (supervisor scores)

Paper no	Date	Author	Prelims	Intro	Design	Sampling	Data collection	Ethics	Results	Discussion	CCAT Total out of 40
1E	2004	Buchanan and Ritchie	2	2	3	3	3	2	2	2	19
2E*	2004	Becker, Hagenberg, Roessner, Woerner and Rothenberger									
3E	2005	Teggart and Menary	3	3	2	3	3	1	3	3	21
4E~	2009	Makinson, Wiles, Jones, Erskine	0 (2)	1 (4)	1 (2)	1 (1)	1 (1)	0 (0)	1 (1)	1 (2)	6 (13)
5E~	2011	Aguilar-Vafaie, Roshani, Hassanbadi, Masoudian and Afruz	3 (2)	3 (2)	2 (2)	2 (3)	3 (3)	2 (4)	3 (1)	3 (2)	21 (19)
6E~	2012	Preston-Shoot, McMurray and Connolly	1 (3)	1 (1)	1 (1)	0 (1)	1 (4)	0 (1)	1 (1)	2 (2)	7 (14)
7E#	2012	Mason, Chmelka and Thompson	4	5	4	3	4	3	4	4	31
8E	2014	Brown	3	2	3	2	3	0	3	2	18
9E	2014	Ratnayake, Bowlay-Williams and Vostanis	4	4	3	2	3	0	3	3	22

* Paper 2E not graded as it was discounted as deemed not relevant to the review after having been fully read.

Paper 7E read and graded but subsequently discounted as the subject matter lay outside the remit of the review

~ Papers 4E, 5E and 6E were also graded by one of my supervisors.

For all papers except 10 and 31 (which, in retrospect, should have been discounted at an earlier stage), a score of 0 (indicating extremely low quality) in any column excluded a paper.

Appendix 4: The interview schedule mapped against the research aims for focus groups and semi-structured interviews.

Detailed objectives: (social workers)

1. Map the meaning and the significance of the SDQ for social workers
    a. what do social workers know about the SDQ
    b. what role does it have (if any) in assessing mental health
    c. knowledge about who administers and analyses the SDQ for the annual DfE return and whether the social workers receive the results of individual children's scores
    d. how has the SDQ changed individual social workers practice.

2. What are the range of factors that social workers take into account when assessing the mental health of looked after children
    a. What role do social workers have in assessments of mental health
    b. How do social workers know when children have mental health problems
    c. what information is used to make an assessment?
    d. how is children's mental health monitored?
    e. how do social workers support children and carers where children exhibit troubled or troubling behaviours?
    f. what are the facilitators/barriers for social workers

3. Describe the understanding social workers have of mental health issues
    a. how is mental health defined/understood by the social worker (generally)
    b. how is mental health defined/understood by the social worker regarding looked after children
    c. what symptoms comprise mental health difficulties for a looked after child

4. What are the factors that influence referral to specialist services
    a. in what circumstances would a social worker refer to CAMHS; who is involved in the decision
    b. how do social workers engage with professionals from CAMHS to assist them in their work
    c. what different kinds of therapeutic interventions do social workers know about for looked after children?
    d. what are the facilitators/barriers to CAMHS involvement?

5. Describe the understanding social workers have about resilience
    a. how is resilience defined/understood by the social worker (generally)
    b. how is resilience defined/understood by the social worker regarding looked after children
    c. how do social workers encourage resilience in the children they work with

6. Map the focus group processes
    a. agreements (I agree with Blue...)
    b. disagreements and challenges (I disagree with Blue...)
    c. idea development from a previous participant (Following on from what blue said...etc)
    d. what were the topics for discussions that involved most people and took up most time within the focus group?
    e. did everyone speak in the group?
    f. any dominant members? did people disagree with dominant members?

Detailed objectives: (CAMHS specialist Looked After Children workers)

1. Map models of local mental health services for looked after children
    a. what services are provided to looked after children, adopted children; foster carers; adopters; residential homes; social workers; social work teams.
    b. what works well?
    c. what are some of the pressures and tensions for services
    d. what are the referral criteria for services

2. Map the meaning and the significance of the SDQ for CAMHS workers
    a. what role does it have (if any) in assessing mental health
    b. knowledge about who administers and analyses the SDQ for the annual DfE return and whether the social workers receive the results of individual children's scores
    c. how is the SDQ used in practice and is it effective.
    d. what other screening or diagnostic tools are used with looked after children
    e. what effect has the introduction of the SDQ had on social workers work with looked after children?

3. Map the range of opinions about how well social workers identify mental health problems in children looked after
    a. how do social workers know when children they work with have mental health problems?
    b. what is the social work role?
    c. what is the social work role in understanding and supporting the emotional and mental health of looked after children?
    d. when do social workers seek to involve CAMHS

4. Describe the relationship between social workers and CAMHS
    a. what are the tensions
    b. what works well
    c. how does the social work role interact with the work of CAMHS?
    d. how involved are social workers in negotiating the kind of service the child will receive?
    e. waiting time?
    f. what do social workers understand the roles of different CAMHS professionals to be
    g. what do social workers understand the different therapies available for working with looked after children to be

5. Describe the ways in which mental health of looked after children is monitored
   a. what are the monitoring processes used?
   b. what are the roles of different professionals?
   c. what are the facilitators and barriers in this process?
   d. timescales for assessment and interventions

6. Map the focus group processes
   a. agreements (I agree with Blue...)
   b. disagreements and challenges (I disagree with Blue...)
   c. idea development from a previous participant (Following on from what blue said...etc)
   d. what were the topics for discussions that involved most people and took up most time within the focus group?
   e. did everyone speak in the group?
   f. any dominant members? did people disagree with dominant members?

Appendix 5: Focus Group Questions

Social Workers:

1. How do social workers know when children they work with have mental health problems?

2. What do you think is the role of social work in terms of understanding and supporting the emotional and mental health of looked after children?

3. What information do you use to make this assessment?

4. How do you monitor a looked after child's mental health?

5. Describe the ways in which a child's social worker can effectively support looked after children with a range of troubled behaviours. When would you seek to refer to specialist services?

6. What is the interagency role in your borough in relation to this area of practice?

7. How do you engage with other agencies to support your work in this area?

8. Has the introduction of a common mental health assessment tool (SDQ) influenced the way social workers work with looked after children? If so, how? (main question for this part of the study)

9. Who administers the SDQ in your borough, and how frequently? Who analyses the data?

10. How does this data inform your practice on a day to day basis?

11. What is resilience? How do we as social workers encourage resilience in the children we work with?

12. What different kinds of therapies exist for children looked after?

Clinicians:

1. Describe the mental health services available for looked after children in the borough where you work. What are the current pressures and tensions from your perspective in meeting the mental health needs of looked after children and young people?

2. In general terms, how well are social workers able to identify mental health problems in the looked after children they work with?

3. What is the role of social work in understanding and supporting the emotional and mental health of looked after children? How do they know when children they work with have mental health problems? What tools (standardised or

non-standardised) do they use to assess this? When do they seek to involve other mental health professionals?

4.   In terms of the Hackney clinician role, what works well and what are the pressures and tensions? (Ask whether being a part of the 'Unit' means that on occasions they lose the perspective that someone working outside of that system can bring, because they become too enmeshed in team dynamics). Who employs the clinicians? Where do they get clinical supervision from? What is their professional base?

5.   How does the social work role interact with the work you do with looked after children?

6.   Describe the relationship between social workers and CAMHS. What are the tensions? What works well?

7.   If a social worker refers a child to CAMHS, how long would the child wait to be seen (on average?)

8.   What different kinds of therapies exist for children looked after in the borough where you work?

9.   If CAMHS accepts a referral and agrees to see a child, how involved are social workers in negotiating the kind of service offered to the child (the type of intervention offered, the worker who would see the child and over what kind of timeframe?) are social workers cognisant of the different roles/theoretical perspectives used by the various mental health practitioners?

10.   How is the mental health of a looked after child monitored? What are the roles of different professionals in this, including social work? What works well in this arrangement and what could be improved?

11.   From your experience, describe the ways in which a child's social worker can effectively support looked after children with a range of troubled behaviours. When do they seek to refer to specialist services? When should they?

12.   What effect has the introduction of a common mental health assessment tool (SDQ) had on social workers work with looked after children?

13.   Who administers the SDQ for all looked after children in your borough, and how frequently? Who analyses the data? Is this fed back to the social worker, anyone else in SSD or kept within CAMHS?

14.   In terms of your own work with children, what do you use to make an assessment of a looked after child's mental health? How does your assessment inform the team's practice on a day to day basis?

Appendix 6: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

1. Study title

The Impact of the Introduction of the Strengths and Difficulties Questionnaire (SDQ) on Looked After Children and their Social Workers

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

3. What is the purpose of the study?

This research project is concerned with understanding more about the mental health needs of children in public care, or 'looked after children' from a social work perspective. We know that over 45% of looked after children in England have a diagnosable mental disorder, which is over four times the rate found in the general population of children.

All looked after children have an allocated social worker whilst they are in care. Social workers are significant people in the lives of looked after children, but studies to date have not focused on their role in terms of the assessment they make about a child's mental health, or their influence over decisions made about the child in terms of treatment.

This research project aims to explore these issues. The context is the recent introduction of a mental health assessment tool (the Strengths and Difficulties Questionnaire or SDQ) for looked after children.

4. Why have I been chosen?

You have been chosen because you are either a qualified social worker located in one of the looked after children teams, or you are another professional who works with looked after children and social workers in one of three local authorities which has agreed to take part in this study.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

6. What will happen to me if I take part and what do I have to do?

Volunteering to assist with this research will involve you giving up two hours of your time if you are a social worker, and one hour of your time if you are another professional.

Social Workers: I will be running two focus groups in each local authority for social workers with around eight social workers in each. In addition, each social worker will be asked to read a vignette case study about a looked after child and provide written answers to a number of questions relating to it.

Other professionals: I will be running one focus group in each of local authority for other professionals, with around eight participants from a number of different professionals. I will be asking about your views of the

way in which social workers assess any mental health problems and difficulties that looked after children may be experiencing.

Your role is to attend one focus group and participate in the discussion. Social workers will also be asked to answer questions relating to the vignette case study.

7. What are the possible disadvantages and risks of taking part?

There are no disadvantages to taking part in the study.

8. What are the possible benefits of taking part?

You will receive no direct benefit from taking part in this study. The information that is collected will improve knowledge of whether the Strengths and Difficulties Questionnaire assists social workers in understanding and assessing the mental health needs of looked after children, and how the information it provides might affect social work practice with looked after children.

9. Will my taking part in this study be kept confidential?

All information, which is collected during the course of the research will be kept strictly confidential and anonymous. You and your local authority will be given an ID number in all publications and any information about you will have your name and work address removed so that you cannot be recognised from it.

10. What will happen to the results of the research study?

I will be disseminating the findings from this research study in a variety of ways:
- a PhD thesis;
- academic articles in social work and psychological journals;
- small (1000 word) articles in 'trade press' magazines such as 'Community Care' and 'Children and Young People Now';
- conference presentations;
- presentations to the local authorities from which my participants were drawn;
- a summary of the findings of this research to these Local Authorities and to individual participants, should they wish to receive this;
- Authorship of a book.

The results will be published after I have completed my PhD in 2013. I will send you a copy of any articles that are published if you provide me with your name and contact address.

11. Who is organising and funding the research?

This research is being undertaken as part of my PhD studies at the University of Glasgow.

12. Who has reviewed the study?

This project has been reviewed by the Faculty of Medicine Ethics Committee at the University of Glasgow.

13. Contact for Further Information

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Principal Lecturer in Social Work
Middlesex University
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My supervisors are:

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Tel: 0141 201 022	Tel: 0141 357 3949 (switchboard)

If you choose to take part, you will be given a copy of the information sheet and a signed consent form to keep.

Appendix 7: Consent Form

CONSENT FORM

The Impact of the Introduction of the Strength and Difficulties Questionnaire (SDQ) on Looked After Children and their Social Workers

Please initial box

	I have read the information sheet that describes this study and agree to be interviewed
	I understand that I do not need to answer any questions if I do not want to and can withdraw from the study at any time without consequence
	I agree for the interview to be tape recorded
	I give permission for brief extracts from my interview to be used for research purposes (including publications and reports), with strict preservation of anonymity. I understand that the taped interviews will become the property of the University of Glasgow

Name of participant   **Date**   **Signature**

_____   _____   _____

Researcher   **Date**   **Signature**

_____   _____   _____

1 for participant; 1 for researcher

Appendix 8: Ethics approval letter from Glasgow University

![University of Glasgow | Faculty of Medicine logo]

Dear Ms Cocker

Medical Faculty Ethics Committee

Project Title: The Impact of the Introduction of the Strengths and Difficulties Questionnaire (SDQ) on Looked After Children and their Social Workers.

Project No.: FM06009

The Faculty Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. They are happy therefore to approve the project, subject to the following conditions:

- The research should be carried out only on the sites, and/or with the groups defined in the application.

- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.

- If the study does not start within three years of the date of this letter, the project should be resubmitted.

- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely

Dr David Shaw
Faculty Ethics Officer

Appendix 9: ADCS approval letter

ADCS
Leading Children's Services

Christine Cocker
University of Glasgow and University of East Anglia
Department of Psychiatry
Caledonia House
Royal Hospital for Sick Children
Yorkhill
Glasgow
G3 8SJ

By email
4 February 2015

Dear Christine,

Request for ADCS research approval – University of Glasgow and University of East Anglia - The Impact of the Introduction of the Strengths and Difficulties Questionnaire (SDQ) on Looked After Children and their Social Workers

ADCS ref: RGE150130

I write on behalf of Sue Wald, Chair of the ADCS Research Group regarding your request for research approval for the above named project.

The Research Group has considered your request and given its approval believing that the results of the project will be useful to local authorities. We would be grateful if when contacting local authorities you would quote the reference above.
The Group's encouragement to respond to the survey will be communicated to ADCS members in local authorities in England in the next edition of the ADCS weekly e-bulletin which is produced and circulated on Friday afternoons. A list of approved research projects can be found on the ADCS website. The Research Group wishes you well with the project.

As mentioned in the ADCS Guidelines for Research Approvals, please send the Research Group a copy of the full report and the summary of your main findings when the research is complete.

If you have any queries about this feedback, please contact me in the first instance.

Yours sincerely

Gary Dumbarton, **on behalf of Sue Wald, Chair of the ADCS Research Group**

Appendix 10: The Parent/Carer SDQ   P 4-17

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name ....   Male/Female

Date of Birth...

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Please turn over - there are a few more questions on the other side

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

• How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

• Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

• Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	

• Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

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