

**Young people in care's perspective on their psychological adjustment as an
addition to the BERRI questionnaire**

by

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Abstract

Children Looked After (CLA) are known to be a vulnerable group with high levels of psychological need and potential for adverse adult outcomes. Given these factors and the ever-increasing demand and pressures on children's social care, the need for effective mental health provision for this group has never been more evident. An integral part of such provision is outcome measurement. Outcome measures are tools that can be used to identify and quantify psychological need, understand the effectiveness of interventions and services, and hold practitioners to account. There are a range of measures currently used across the sector, but many have significant shortcomings when it comes to their use with care experienced young people. BERRI is a tool that was designed by clinical psychology professionals specifically for use with the CLA population. However, its current design relies entirely on perspectives of parents or carers, rather than eliciting the perspective of the young person themselves. This is at odds with increasing awareness and policy focus regarding the inclusion and empowerment of CLA voices in decisions made about their care. The present study therefore aimed to gather care experienced perspectives on their psychological adjustment as an addition to the BERRI questionnaire. The specific research question was: What observable markers do young people in care think indicate strengths or improvement/deterioration in their psychological wellbeing? After consultation with a care-experienced panel, semi-structured interviews were conducted with eight individuals who were either currently in care or recent care leavers. Thematic analysis was conducted on the interview transcripts and five superordinate themes were created: Strong and Stable Relationships, Coping with Adversity, A Sense of Agency, Control of Emotions and Behaviour and Interests and Talents. These findings are discussed in the context of the existing literature and their implications for practice and future research.

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List of Abbreviations

ACEs	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
APA	American Psychological Association
BAME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CANS	Child and Adolescent Needs and Strengths
CGAS	Children’s Global Assessment Scale
CLA	Children Looked After
CORC	Child Outcomes Research Consortium
GAF	Global Assessment of Functioning
HoNOSCA	Health of the Nation Outcome Scales for Children and Adolescents
LAC	Looked After Children
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer+
NSPCC	National Society for the Prevention of Cruelty to Children
PEP	Personal Education Plan
PTSD	Post-Traumatic Stress Disorder
RCADS	Revised Children’s Anxiety and Depression Scale
ROM	Routine Outcome Measurement
SWB	Subjective Wellbeing
SDQ	Strengths and Difficulties Questionnaire
UASC	Unaccompanied Asylum Seeking Children
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations International Children’s Emergency Fund

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Introduction and Background

A Picture of Children's Social Care

Children and young people in care are known to be a vulnerable group with high levels of psychological need (Herwig, 2022; Tarren-Sweeney, 2008). Statistics show that 66% of Children Looked After (CLA) are in care due to risk of abuse and neglect (Department for Education, 2022). It is well established that exposure to such Adverse Childhood Experiences (ACEs) can have significant and long-lasting impacts on mental health and emotional wellbeing (Felitti et al., 1998; Merrick et al., 2018). It is therefore not surprising that half of all children in care meet the diagnostic threshold for a mental health condition and a further 25% have significant mental health needs (Tarren-Sweeney, 2008).

Young people leaving care also tend to have poorer outcomes in later life in comparison with their peers. For example, care leavers are more likely to be unemployed, homeless or involved in the criminal justice system (Fortune & Smith, 2021; Gaskell, 2010; Smith, 2017). The transition out of care itself is often associated with the onset or recurrence of mental health difficulties, which have been shown to intensify rather than decrease over time (Dixon, 2008; Fortune & Smith, 2021). Care leavers are four times more likely to attempt suicide in adulthood compared with the general population (Children and Young People's Health Outcome Forum, 2012; Smith, 2017).

The picture of CLA's mental health need must also be positioned in the context of a system that is increasingly struggling to meet demand. The number of CLA is currently at its highest since the early 1990s (MacAlister, 2022). There was a 24% rise of the number of children taken into care in England between 2010 and 2020 (Action for Children, 2022) and this upwards trajectory is expected to continue with 100,000 children estimated to be in care within the next ten years (MacAlister, 2022).

Unsurprisingly, rising numbers across the sector are accompanied by an increase in costs: local authorities spent £9.93 billion on children's social care in 2019 to 2020 in comparison to £6.65 billion in 2009 to 2010 (Foster, 2021). More than eight in ten councils in England responsible for children's social care reported overspends in 2019 to 2020 despite an increase in budget of £535 million that year (Local Government Association, 2021).

At the time of writing, the stability of children's social care and the lives of those that rely on it are particularly precarious. There are concerns that the current cost of living crisis will lead to spiralling costs of care provision and higher numbers of children in the system as families are faced with

extreme financial pressures (Sacks-Jones, 2022). This is on top of the potential longer-term consequences of the Covid-19 pandemic, which is said to have led to a decline in children and young people's mental health and new pressures on an already over-stretched system (Ofsted, 2022).

The Use of Outcome Measures

With the significant mental health need of CLA, potential for adverse adult outcomes and the increasing demand, costs and pressures on children's social care, the need for effective mental health provision has never been more evident.

An integral part of such provision is outcome measurement (Department of Health & Social Care, 2022; Kwan & Rickwood, 2015; Miller et al., 2015). Outcome measures are tools that can be used to "quantify aspects of an individual's health, safety and wellbeing" (Hood et al., 2020, p. 319). When used with children and young people in care, outcome measures allow practitioners, researchers and policy makers to identify psychological need, understand how young people are progressing, assess the suitability of placements, motivate staff and hold care providers to account (Quinn, 2021).

Outcome measurement has long been identified as a priority for children's health and social care services (Department for Education & Department of Health, 2004; Department of Health & NHS England, 2015; Department of Health & Social Care, 2022). For example, the National Service Framework for Child and Adolescent Mental Health Services (CAMHS) - Every Child Matters - recommends that services should be monitored and evaluated via the use of Routine Outcome Measurement (ROM) to ensure that they are operating at the highest possible standard (Department for Education & Department of Health, 2004). It has been suggested that commissioners should be spending as much as 3 to 5% of budgets in children's mental health services on outcome measurement (Wolpert et al., 2008). More recently, the Department of Health and Social Care (2022) have highlighted the 'life-saving' use of data during the COVID-19 pandemic and called on services to ensure this remains central to care planning, commissioning and service improvement in the post-pandemic world.

It is therefore not surprising that there is a large number of outcome measures currently employed across children's health and social care. A systematic review identified 113 unique measures being used in the area of children's psychological wellbeing and mental health (Wolpert et al., 2008). Common measures used within CAMHS include the Revised Children's Anxiety and Depression Scale (RCADS), the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and the

Children's Global Assessment Scale (CGAS) (Batty et al., 2013; Waldron et al., 2018). Since 2008, Local Authorities in England have been required to submit annual scores on the Strength and Difficulties Questionnaire (SDQ) for all CLA in their care (Department for Education & Department of Health, 2015).

Despite this large number and range of possible outcome measures, the vast majority are initially designed with children and young people from the general population in mind (Wolpert et al., 2008). Some efforts are being made to design tools for this population, for example the Child and Adolescent Needs and Strengths Assessment (CANS) (Praed Foundation, 2023). However, given the specific needs and potential vulnerabilities of CLA, there is an argument for more widespread development and implementation of measures and tools tailored for this population.

BERRI

BERRI is a clinical evaluation tool for identifying, tracking and improving the outcomes of children with complex needs (BERRI, 2023). It was designed by clinical psychology professionals with experience of working with CLA and specifically with this population in mind. It has been shown to be a reliable and valid way to gain an understanding of children and young people's psychological wellbeing (Harris, 2019)¹

BERRI is structured around an 88-item questionnaire which is split into five domains: Behaviour, Emotional wellbeing, Relationships, Risk (to self and others) and Indicators of underlying psychiatric or neurodevelopmental conditions. These domains were originally produced via thematic analysis of data from focus groups conducted with residential care staff, foster carers, link workers and other professionals in the sector (BERRI, 2023).

BERRI also collects information about the circumstances and recent stressors, or 'Life Events', currently surrounding the child or young person concerned. As such, scores on the measure are given context which can be particularly useful when considering possible interventions or tracking change over time.

At present, BERRI is used across a range of private care providers, fostering agencies and local

¹ At the time of writing, several papers regarding the development and use of BERRI are under peer review by academic journals. These include studies that evidence the reliability and validity of the tool as well as testing its structure through factor analysis.

authorities across the UK. The BERRI questionnaire is filled in by professionals and carers working with children and young people and is designed on the principle of providing useful information and outputs for those that use it, rather than acting as simply a reporting or data collection system.

The current design of BERRI gathers the perspectives of care givers and professionals but does not ask for the child or young person's input on their psychological wellbeing. Research on the use of outcome measures suggests that practitioners value measures that are completed by children and young people themselves more than those completed by professionals (Batty et al., 2013). In addition, anecdotal feedback on BERRI from current users has highlighted that including the young person's voice in the measure would significantly enhance the level of understanding that the tool provides.

Young Person's Voice

This feedback on BERRI is aligned with the increasing emphasis in policy on the importance of the child's perspective and building personalised services (Department for Education & Department of Health, 2015; MacAlister, 2022). The right of a child to have their opinion accounted for in decisions about their lives is enshrined in Article 12 of the UN Convention on the Rights of the Child (1989). The introduction of this legislation marked a shift from an approach where children were seen as the subject of a decision towards one where they are considered an active participant (Cashmore, 2002). This is echoed in the Children Act (1989) which stipulates that local authorities should consider the child's views before making decisions about their care. More recently, the National Service Framework has recommended that all Child and Adolescent Mental Health Services evaluate outcomes from the perspective of users (Department for Education & Department of Health, 2004).

Despite this legislation and an increasing awareness of the importance of inclusion, the views and opinions of young people are still often neglected. In a review of 38 national surveys undertaken by the Department of Health in England, children and young people under 16 accounted for less than 0.6% of respondents across 10 years (Hargreaves and Viner, 2012). Children and young people in care feel particularly neglected when it comes decisions about their care (MacAlister, 2022).

This issue of participation is particularly salient for looked after children and young people (Cashmore, 2002). As Thomas and O'Kane (1999) note, this population tend to have a larger number of important decisions made about their lives, by a greater number of adults and professionals around them, than the general population. There is also evidence that links placement stability with

the degree to which children feel they have been listened to (Lindsay, 1995). Giving young people who have been abused or neglected a sense of agency in the decisions regarding their lives is also likely to facilitate development of self-esteem and confidence (Cashmore, 2002).

In addition, cultural narratives about this population tend to be constructed by others, often those in positions of higher power. Messages from the media and the government, for example, often paint young people in care as vulnerable or fragile, a portrayal which is at odds with the traits of strength and resilience that many care leavers identify with (Lensvelt et al., 2021). As such, there is a risk of diverging understandings, priorities and interests between those working in the system and those that it is designed to serve and protect.

An Introduction to the Present Study

As discussed above, the inception and increasingly widespread use of BERRI across the country marks an important and innovative step in understanding and addressing the needs of some of the most marginalised young people in society. However, its current design is inconsistent with the increasing emphasis on including CLA perspectives in the planning, monitoring and delivery of their care. As such, there is an opportunity for further development of the tool. This research was therefore embarked upon as the initial step in the design of an element of BERRI which elicits the young person's voice. A more detailed discussion of the rationale and aims of the present study will be provided at the end of the literature review, given its role in shaping the lines of enquiry and specific questions this research aimed to address.

Literature Review

As part of this project a literature review was conducted to collect and summarise material that was relevant to the topic. This helped to inform the rationale for the research, refine research questions and identify the extent of and gaps in pre-existing knowledge. Literature was largely sourced from the APA PsychINFO database which was searched using variations of terms relevant to the research topic. This ensured that the research reviewed was predominantly from high quality peer reviewed journals. Reference lists of key papers identified during this search were also examined and additional reading identified where applicable. Key government and charity websites were also searched to ensure policy documents and knowledge from non-academic publications was considered.

Children Looked After

Defining Children Looked After

In the UK, children or young people under the legal care of a local authority are known as 'Children Looked After' (CLA)². As per the Children Act (1989), CLA come under the care of the state when their parents are unable to provide stable or sufficient care. This decision can be made through a court ruling or by a family requesting support from the local authority.

Once they have been taken into care, CLA may be placed with alternative family members, foster carers or in residential homes, either on a temporary or permanent basis (NSPCC, 2023). When a child or young person returns home, becomes adopted or turns 18 they are no longer legally classified as being in care. However, local authorities are now required to support care leavers until the age of 21, and many young people will remain with foster carers³ or move to semi-independent living as they transition out of care (Department for Education, 2022; NSPCC, 2023).

In England, 56% of the current CLA population is male and 44% are female, marking a slight over-representation of males in comparison to the general population (51%). CLA also tend to be older, with 10- to 15-year-olds accounting for 39% of those in care, and 16- to 18-year-olds accounting for a further 25%. Children from Black, Mixed and Other ethnic groups are also over-represented in the care system, with 10% being from Mixed or Multiple ethnic groups, 7% are Black African, Caribbean or Black British and 5% are Asian or Asian British (Department for Education, 2022).

The Psychological Needs of CLA

Whilst the individual backgrounds and stories of CLA are unique and diverse, as a group they are generally considered some of the more vulnerable people in society. A significant and well documented aspect of this vulnerability is the high level of psychological need amongst CLA (Ford et al., 2007; Herwig, 2022; Tarren-Sweeney, 2008).

Research suggests that CLA are far more likely than their peers to have significant psychopathology

² Until recently, convention has been to refer to this group as 'Looked After Children', echoing the language used in the Children Act (1989). Alternative phrases used to describe this group include 'Children in Care' and 'Care Experienced'. However, young people themselves have reported a preference for 'CLA' (Community Care, 2020) and this term is being used with increasing frequency in legislation and practice. As such, CLA will be the predominant term used in this paper.

³ The Children and Families Act (2014) introduced legislation that enables fostered young people to 'Stay Put' with their foster families until the age of 21. This is facilitated and monitored by local authorities. Young people leaving care may also be supported by a Personal Advisor up until the age of 25.

(Ford et al., 2007). Over half of CLA meet the threshold for a diagnosable mental health condition such as anxiety, depression and PTSD and a further 25% have significant mental health need (McCann et al., 1996; Tarren-Sweeney, 2008). CLA are also known to have higher levels of neurodevelopmental disorders such as ADHD (Ford et al., 2007; Willis et al., 2017) and behavioural problems such as conduct disorder (Harman et al., 2000; McAuley & Davis, 2009). Such difficulties have been shown to be related to the age at entry into care, with those coming into care later showing higher levels of need (Milan & Pinderhughes, 2000; Tarren-Sweeney & Hazell, 2006).

Experiences before, during and after the care journey are seen as major contributors to the aetiology of this psychological need (Chambers et al., 2010; Dixon, 2008; Martin et al., 2014). Whilst exact figures vary, the experience or risk of abuse and neglect is generally considered the most common reason for young people to become looked after (Chambers et al., 2010; Department for Education, 2022). Chambers et al. (2010) examined a representative sample of 52 young people coming into the Australian care system and found that 69% had experienced neglect, 48% had experienced physical abuse, 37% had experienced emotional abuse and 23% had experienced sexual abuse. Other reasons for coming into care can include poverty, parental illness, no available parents (in the case of Unaccompanied Asylum Seekers), parental drug and alcohol abuse or parental domestic violence (Chambers et al., 2010; Department for Education, 2022).

Experiences like these, often termed Adverse Childhood Experiences (ACEs), are known to have long term consequences on both physical and mental health. In their seminal study, Felitti et al. (1998) explored the association between childhood experiences of abuse, neglect and adverse family circumstances on health outcomes later in life. They found that the more of these ACEs in childhood, the greater the risk of developing a range of physical and mental health issues and experiencing social difficulties in adulthood. Replications of this research across a wider range of countries and more varied samples have yielded similar results, showing a robust link between ACEs and later psychological need (e.g., Bellis et al., 2016; Burke et al., 2011; Spratt & McGavock, 2016).

For many CLA, ACEs are not something that disappear upon coming into care. In fact, the transition into care can be an adverse experience in itself due to separation from loved ones, significant changes in physical and social environments and subsequent feelings of loss, uncertainty and a lack of control (Leeson, 2007; Stanley, 2007; Winter, 2010). For many young people, coming into care limits their ability to use strategies and assume roles which may have formed part of their coping mechanisms and identity formulation whilst in their family home (Winter, 2010).

Experiences once in care are varied: some young people report an overall positive experience of the care system and show improvements in their mental health and wellbeing over time (Tarren-Sweeney, 2017). For others, however, their care experience is characterised by a cycle of deteriorating mental health, problems accessing appropriate care, placement breakdowns, educational difficulties and social exclusion (Baldwin et al., 2019; Kerker & Dore, 2006). Young people in unregulated care settings are a particularly vulnerable subgroup: often living in unsafe accommodation without appropriate mental health support and at an increased risk of criminal exploitation (Commission on Young Lives, 2022). Whilst these types of services are becoming more rigorously legislated by Ofsted (Department for Education, 2023), there remains concerns about such settings providing low levels of supervision for vulnerable young people (Become, 2023).

The transition out of care represents another moment of vulnerability for CLA. Whilst efforts are made to support care leavers with their psychological wellbeing, the transition into adult life is often associated with the onset or recurrence of mental health difficulties (Dixon, 2008). In some cases, these difficulties will be compounded by the difficult transition from child to adult mental health services which occurs concurrently for many CLA (Broad et al., 2017). Without appropriate support or intervention, psychological need of care leavers has been shown to increase over time (Dixon, 2008). Sadly, care leavers are four times more likely to attempt suicide in adulthood compared with the general population (Children and Young People's Health Outcome Forum, 2012; Smith, 2017).

Whilst CLA are not a homogenous group, it is clear to see that emotional, behavioural and mental health difficulties are a common feature of the lives of many young people in care and those leaving care. Unfortunately, protection from harm by removal into care is not sufficient to facilitate wellbeing and, in some cases, it is the experience of being in care itself which leads to high levels of psychological need (Akister et al., 2010). Working to alleviate psychological distress, provide support for behavioural and neurodevelopmental conditions and promote early intervention for young people and their families requires multidisciplinary strategy, expertise and resource. One such element of this strategy is the use of effective and routine outcome measurement.

Current Measurement Practices

Defining Outcome Measures

In an extensive review of children's mental health outcome measures, Wolpert et al. (2008) define these as "any questionnaire, measure or approach to measurement that seeks to provide

measurement of mental health in children and young people” (p. 16). Similarly, Hood et al. (2020) define the outcome measures used by social workers in child protection work as “professional tools that quantify aspects of an individual’s health, safety and wellbeing” (p. 319). Kwan and Rickwood (2015) provide a more specific definition, tying outcome measures to the concept of change or progress in response to an intervention and how this can be used to monitor and evaluate a service.

Unsurprisingly, the precise definition of an outcome measure is likely to vary depending on the context within which the measure is designed and used. Wolpert et al. (2008, p.6) highlight several ways in which outcome measures can be defined and can differ from one another, some examples of which are detailed below:

- 1) The population: some measures are designed to gather survey type epidemiological data regarding the general population. Others target specific populations, perhaps those known to be at risk of developing mental health problems, to expand knowledge or inform opportunities for early intervention. Others, usually those administered in clinical settings, are designed with a specific mental health presentation in mind and assess the magnitude of change due to an intervention.
- 2) The scope: measures used across different settings and purposes can vary significantly in their scope. Broad screening measures can give a general indicator of wellbeing or psychological distress in an individual or population by assessing a range of behavioural and emotional factors. They are often easy to administer but may not be suitable for assessing the presence or change in symptoms of specific psychological conditions. More specific measures are designed to give a thorough profile in relation to a particular mental health presentation. These are often used in specialist settings with children who have been diagnosed or are at risk of particular mental health conditions (Kwan and Rickwood, 2015).
- 3) Who provides the data: questionnaires can be designed to be completed by one or a combination of parents or carers, clinicians or other professionals and the young person themselves. Each of these informants is likely to be able to provide information unique to their expertise yet also have limitations in the scope of their perspective (Deighton et al., 2014). As such, many outcome measures now include multiple versions, each designed to elicit a different perspective, or are administered as part of a battery of other measures that capture viewpoints across the social and support network.
- 4) The administration: traditionally, outcome measures have been administered manually, either face to face if requiring input from a trained professional or via the phone or post in the case of more survey-like measures. Over the last couple of decades, the proliferation of

information technology has enabled outcome measures to be sent via email or even hosted on specialised platforms or applications and accessed remotely (Deighton et al., 2014). The mode of administration is likely to be dictated by several factors but often comes down to questions of resource, including financial costs and consideration of clinician and respondent time.

- 5) The purpose: the data generated from an outcome measure can be used for many different purposes. As mentioned above, some measures are designed to assist in understanding a mental health presentation or identify areas of strength or need in an individual or population. Others are designed to monitor how a presentation may change over time to assess the effectiveness of an intervention or the performance of a particular practitioner or service.

Given the several dimensions by which outcome measures can differ from each other, it is perhaps unsurprising that Wolpert et al. (2008) were able to identify 113 unique measures of child mental health. However, the next stage of their review involved an extensive filtering process that assessed the psychometric properties and ease of implementation of each identified measure. Information was gathered on factors such as the content validity, the reproducibility, the existence of norms and the length of time to administer. The authors of this review arrived at a list of just 12 measures that were assessed as high quality against these criteria. As Kwan and Rickwood (2015) posit: “to be useful, mental health outcome measures must be valid and reliable, sensitive to change, comparable across relevant client groups and service types, and meaningful to both clients and clinicians.” (Kwan and Rickwood, 2015 p. 2). Therefore, in defining outcome measures one must also consider the importance of a robust evidence base, including the analysis of psychometric properties, and the utility of a measure in terms of how easily it can be implemented across different contexts.

Why Are Outcome Measures Used?

Outcome measurement has long been identified as a priority for children’s health and social care services (Department for Education and Skills, 2004; Department of Health & NHS England, 2015). For CLA, the Children Act (1989) and The Care Planning, Placement, and Case Review Regulations (2010) emphasize the need for regular reviews and assessments regarding the wellbeing of young people under the care of their local authority, including the use of outcome measures. Within Child and Adolescent Mental Health Services (CAMHS), the National Service Framework - Every Child Matters - recommends that services should be monitored and evaluated via the use of Routine Outcome Measurement (ROM) to ensure that they are operating at the highest possible standard

(Batty et al., 2013; Department for Education and Skills, 2004; Department for Education & Department of Health, 2004). It has been suggested that commissioners should be spending as much as 3 to 5% of budgets in children's mental health services on outcome measurement (Wolpert et al., 2008). In sectors where budgets are notoriously limited, it is helpful to consider the rationale behind such a considerable focus on measuring the outcomes of CLA.

Outcome measurement is used in the assessment of psychological need which, as discussed in previous chapters, is significant amongst the CLA population. Measurement in the care system has traditionally focused on numbers of children entering and leaving the system or timeframes for decisions being made (Axford and Little, 2006; as highlighted by Selwyn et al., 2017). However, more recent efforts have seen a shift in using measurement to understand the psychological needs of individual children. Mental health outcome measures can offer a standardised way of assessing and comparing young people to others in care and their counterparts in the general population. Mental health and psychological need are broad constructs, but outcome measures often break these down into meaningful categories that can be easily interpreted and used in work with children with no disorder as well as those with a diagnosis or where early prevention is deemed necessary (Kwan and Rickwood, 2015).

As well as providing a snapshot of mental health and wellbeing of CLA, outcome measures can be used to monitor change and progress of individuals over time and, by extension, inform decision making around placement planning and mental health support. Tracking change in psychological need over time and comparing scores to norms of CLA in different settings can enable care organisations to assess effectiveness of an intervention and guide decisions related to care provision such as step downs, permanency planning or transitions to semi-independent living. This is particularly important for CLA to reduce risks of placement breakdowns by ensuring children are not moved from or into a new placement before they are ready or, conversely, remaining in high-cost residential placements when their needs could be met more effectively in foster care (Quinn, 2021).

Outcome measures are not only used to understand progress and outcomes in individual CLA but are also used to monitor service provision across the sector. Selwyn et al. (2017) note that given the huge expense of the care system, there are very few indicators of its efficacy. The increasingly widespread use of outcome measures is, at least in part, helping to combat this. Measuring outcomes at the service level can take the form of monitoring a specific intervention or work of an individual clinician over time or reporting on the effectiveness of a service as a whole (Kwan &

Rickwood, 2015). As such, outcome measures can hold professionals to account and there is evidence to suggest that this can motivate staff (Hood et al., 2020) and lead to more collaborative practice (Law & Wolpert, 2014). The work of Miller et al. (2013, 2015) on Feedback Informed Treatment has found that practitioners who seek routine feedback from their clients are more effective in their work. By monitoring service-level outcomes, evidence can also be provided to stakeholders and policymakers about what yields the best outcomes for CLA and ultimately result in more optimal resource allocation across the sector.

It is clear to see that outcome measurement forms an integral part of the evidence-based practice movement within children's health and social care. As Hood et al. (2020) describe, evidence-based practice is that which is informed by up-to-date, high-quality research about what works, and what doesn't, for service users. In the UK, the Child Outcomes Research Consortium (CORC) was founded by a group of mental health professionals who advocate for the use of high-quality outcome measurement tools as an integral part of using evidence to enable effective and child-centred support across mental health and wellbeing services (CORC, n.d-a).

Examples of Outcome Measures

A review of all major mental health outcome measures currently used within children's health and social care is beyond the scope of the current review. However, an overview of some of the most commonly used measures is provided below, each also selected to demonstrate the degree of variation in measures that are currently on offer for use with CLA. This helps to ensure that any efforts towards the development of a new measure or new sub-scale of a measure are made in the knowledge of what is currently available and used within the sector.

Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a screening tool that can be used with 2 to 17-year-olds. It consists of 25 items on psychological attributes, grouped into the 5 domains of emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and pro-social behaviour (Goodman, 2001). There are several versions of the SDQ that each elicit different perspectives (e.g., parent, teacher and self-report) and cater for different age groups.

The SDQ is widely used across children's health and social care. In fact, it is the only measure routinely used to examine the wellbeing of individual CLA in England. If a child has been Looked After for more than 12 months and is between the ages of 5 and 16, carers are required to complete

an annual SDQ, the scores of which are collated by the Department for Education (Selwyn et al., 2017). The rationale for this usage comes from a large evidence base showing that it has strong psychometric properties (e.g., Stone et al., 2010) and is used in successful intervention planning with children entering the care system (e.g., McCrystal & McAloney, 2010). Some studies suggest that the majority of practitioners using the SDQ report that they find it useful for their work (Wolpert et al., 2008).

However, there are several criticisms about the SDQ and its use with the CLA population. The practitioners interviewed by Wolpert et al. (2008) reported that it focuses heavily on behavioural problems over psychological need and lacks sensitivity to change. Notably, it is often viewed as too broad a measure and has limited sensitivity for CLA because score comparisons are made against the general population and not against similarly complex and marginalised groups (Selwyn et al., 2017).

The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)

The HoNOSCA is an assessment tool that is used to measure and evaluate the mental health of 4 to 18-year-olds. It comprises 13 items that assess different areas of functioning associated with mental health conditions including specific symptom presentations, behaviour, social relationships and physical health (CORC, n.d-b). There is a self-report version of the tool that can be filled in by 13 to 18-year-olds alongside the version filled in by clinicians or parents.

The HoNOSCA is designed for use with young people who are using mental health services, rather than specifically for use with CLA. Batty et al. (2013) note that this measure is the most used of all CORC recommended measures within CAMHS. However, feedback from practitioners using the tool is mixed, with reports that the measure does not produce useful data, can minimise the complexity of problems and does not capture change in more complex populations such as CLA. The self-report version of the HoNOSCA is seen as particularly limited as it can only be used with a small age range and lacks a strong evidence base (CORC, n.d-b; Wolpert et al., 2008).

The Child and Adolescent Needs and Strengths Assessment (CANS)

The CANS is a tool that assesses the risk, needs and strengths of children and young people across several health and care sectors, including those in care and those using mental health services (Praed Foundation, 2023). The tool takes the form of a questionnaire that covers six core domains: behavioural and emotional needs, caregiver needs and resources, cultural factors, life functioning, risk behaviours and strengths. As such, it provides a comprehensive view of wellbeing, development

and mental health in a way that has been shown to be reliable and valid (e.g., Anderson et al., 2003).

The CANS is underpinned by a theory of communimetrics. This means it designed with a view to aid communication and decision making between relevant stakeholders, rather than to diagnose or infer a cause of distress. Measures designed within a communimetrics approach aim to provide immediately useful data that can be used to develop shared insight and common objectives amongst a child, their carers and their clinicians (Lyons, 2009).

However, the CANS must be administered by a professional or someone with specific training. It does not currently have an option for a self-report assessment to be filled out by a young person nor an option for a family member to directly report their assessment. Whilst collaboration and consultation with carers is encouraged, Accomazzo (2014) notes there is no formal way of recording such collaboration. As a result, opportunities for clinician bias can arise and impact the psychometric properties of the measure. Research also suggests that practitioners value measures that are completed by children and young people themselves more than those completed by professionals (Batty et al., 2013). The author also notes that the language used across the CANS seems to be heavily aligned with diagnostic labels rather than assessing observable symptoms, perhaps risking the adoption of informal diagnoses.

Limitations of Outcome Measures

Unsurprisingly, with the proliferation of outcome measurement tools comes an increasing awareness and discourse around their limitations, both in terms of their use in particular contexts or with specific populations, and in a broader sense in terms of their relevance, scope and utility in a complex landscape of health and social care provision. The examples of outcome measures outlined above touch on some of the common limitations of measures when used with CLA. Elaboration of some of these limitations will further elucidate why striving for developments in the field of outcome measurement is an important and timely endeavour.

As can be seen in the brief overviews of the SDQ and the HoNOSCA, a common critique of outcome measures is their questionable relevance to the care experienced population. Similar critiques exist for other commonly used measures across the sector, including the Children's Global Assessment Scale (Blake et al., 2007; Shaffer et al., 1983). Using the same measures and comparing outcomes of young people in care with their non-care experienced counterparts is arguably "overly simplistic and counter-productive" (Hannon et al., 2010; back cover), and using benchmarks from the general

population can lead to a view of the care system and those within it as failing against an arguably irrelevant control group and set of standards. These comparisons can also lead to unrealistic expectations and pressure on services if, for example, large proportions of CLA are meeting score thresholds that make them eligible for support, but such support is not appropriately funded or resourced.

Of particular concern is the lack of trauma-informed approaches to measurement and interpretation within the field. As previously discussed, CLA are likely to have been exposed to traumatic experiences prior to their entry into the system. In light of this, the practitioners surveyed by Ryder et al. (2017) questioned whether the tools currently available to them were the most appropriate way of assessing wellbeing for this group. Many believed that the questions on the SDQ lack relevance to young people in care who may have experienced trauma or have related disorders of attachment. This was reinforced by Milich et al. (2017) who found that the SDQ was inadequate in detecting post-traumatic stress disorder (PTSD) and attachment disorganisation. Blake et al. (2007) assessed the reliability of the Global Assessment of Functioning (GAF) scale and the Children's Global Assessment Scale (CGAS), two of the most used measures of children's mental health in the USA. They found that neither scale was reliable in measuring functioning in children who had been exposed to trauma. There is also an emerging evidence base to suggest an over diagnosis of ADHD in children in care, which some believe is linked to poor measurement and understanding of the impact of trauma on how young people are presenting and expressing their needs (Brown et al., 2017).

Related to this is the critique that outcome measures often are overly clinical and pathologizing. Ryder et al. (2017) argue that outcome measures which focus solely on concepts of 'mental health' or potential diagnoses provide a valuable but incomplete picture of the wellbeing of young people in care. This view, as Selwyn and Wood (2015) argue, is held by much of the workforce who see the measures available to them as "too deterministic" (p. 45). Similarly, Luke et al. (2014) believe that research and measurement of outcomes with children in care should focus less on problems and more on positive outcomes which are described and determined by care experienced young people themselves.

Of course, outcome measures are only useful if they are actually completed. Much of the criticism surrounding measures is their limited usability and utility, particularly in the context of ever stretched budgets and limited time available for practitioners to administer measures and decipher their results in a way that can meaningfully impact care. Professionals often see the measures they use as little more than mandatory reporting and assessment fuelled by government-led agendas

which have limited direct impact on the lives of those in care (Ryder et al., 2017). This is perhaps reflected in the fact that, in 2016, SDQ scores weren't reported for over half of eligible children in 12 local authorities in England (Department for Education, 2016). Duncan and Murray (2012) conducted a systematic review of outcome measurement by Allied Health Professionals and reported those measures that did not inform practice were a barrier to them being used. Professionals also critique the usability of measures with a view of the preferences of the young people they work with. For example, those surveyed by Ryder et al. (2017) noted that children in care are used to having everything about their lives written down, and that more innovative approaches to collecting information need to be offered if young people are going to be motivated to engage with them. Crucially, Batty et al. (2013) found that practitioners value measures that are completed by children and young people themselves more than those completed solely by professionals.

Effective and appropriate outcome measurement is evidently a complex pursuit, and the critiques provided above will not be revelatory to those with knowledge of the field. In fact, some efforts have already been made to provide more appropriate means of measuring outcomes for CLA. One such example is the CANS-Trauma tool. This later iteration of the CANS tool was designed to assess young people's trauma experiences, their responses to trauma and their strengths (Kisiel et al., 2018). However, the criticism of lack of inclusion of the young person's voice still stands with this trauma informed version of the CANS. Whether it is a lack of understanding of trauma, an overly clinical approach or limited utility, more effective inclusion of young people's perspectives in these measures is arguably likely to add value, practicality and relevance to the data that they produce and the care that they inform.

Considering CLA perspectives

The Rationale

Whilst children may once have been expected to be 'seen and not heard' there is an increasing awareness of the importance and value of listening to children and young people when it comes to measuring their outcomes and making decisions about their lives. However, such efforts are arguably still rarely seen as integral parts of research or care planning practices and are often tokenistic or simply tagged on to otherwise adult governed processes (Aldgate & Statham, 2001; Cashmore, 2002). Careful examination of the rationale for considering CLA perspectives is an important step to ensure their voices are not only elicited, but also valued in research, outcome measurement and decision-making processes.

The last few decades have seen widespread introduction of policy and legislative requirements to ensure children and young people participate in decisions that impact them (Cashmore, 2002). Many of these requirements are underpinned by Article 12 of the UN Convention on the Rights of the Child (1989) which dictates that children and young people have the right to express their opinions on matters concerning their lives and to have these views considered by the adults around them. For CLA in England and Wales, this right is upheld by the Children Act (1989) which requires local authorities to take children's wishes into account, facilitate informed decision making and dedicate clearly defined complaints procedures for young people. In addition, the National Service Framework has recommended that all Child and Adolescent Mental Health Services (CAMHS) evaluate outcomes from the perspective of service users (Batty et al., 2013; Department for Education & Department of Health, 2004). In a practical sense, UNICEF recommend that children should actively shape the processes and questions in data collection and surveys conducted about their lives and wellbeing (Hudson & Kuhner, 2016).

There is also a well-established narrative from young people themselves who express the importance of having their views elicited and their voices heard. For example, the latest Good Childhood Report (2022) found that feeling listened to was one of the strongest predictors of reported wellbeing yet was one of the aspects of schooling that young people felt least satisfied with. Young mental health service users spoken to by Badham (2011) expressed a wish to have their voices heard in intervention decisions and therapy and many saw outcome measurement as an important feature in this process. In one of their formative early pieces of research, Become Charity (then known as the 'Who Cares?' Trust) surveyed 600 young people in care, nearly all of whom said that there were "areas of their lives where they needed more say and involvement." In addition, "nearly half of the young people in foster care surveyed felt that they had no say in daily decisions" (Fletcher, 1993; Lansdown, 1995, p.30 as quoted in Cashmore, 2002). Similar themes persist in more recent literature, for example in the 2014 Children's Care Monitor, CLA highlighted the three areas of their lives they wanted more of a say in as: decisions about their placements, contact arrangements and conversations about their future (Children's Care Monitor, 2014). In addition, Bromley et al. (2020) reported that CLA using mental health services felt there was a need for more age- and CLA-appropriate feedback processes.

There is also evidence to link involvement in decision making to the wellbeing and mental health of CLA (Winter, 2010). Prilleltensky et al. (2001) propose that allowing children to have more power in decision making has a significant impact on their general health, resilience and experience of

problems later in life. Much of the literature highlights how having choice and agency can facilitate the development of confidence, self-esteem and a positive sense of identity for CLA (Bromley et al., 2020; Eide & Winger, 2005; McLeod, 2007). This is likely to be of particular importance due to the histories of abuse and neglect amongst this group and the abrupt transition to independence facing many young people leaving care (Cashmore, 2002). In addition, as Lindsay (1995) highlights, CLA may experience more placement stability when they have been able to have some say in placement planning. Aldgate and Statham (2001) propose that those CLA in placements that have been imposed on them or who have had decisions made against their will may express resistance and contribute to placement breakdowns, the negative mental health impact of which is well documented (e.g., Cullen et al., 2022).

Sometimes the views of CLA differ or even directly contradict reports from the adults around them (Haselgruber et al., 2020). Whilst this introduces some complexity into CLA involvement in decision making, it is arguably a further demonstration of the importance of eliciting the young person's perspective to ensure fully informed decision making. Davies and Wright (2008) highlight the lack of evidence to suggest that parents can accurately represent their child's views, and that further exploration is needed as to how accurate representation may be particularly difficult in the case of foster carers. One example of differing perspectives is highlighted by Stanley's (2007) account of the perceptions of self-harm amongst CLA and residential staff. Whilst residential staff and carers viewed self-harm as a high risk and difficult to manage behaviour, young people who self-harmed conceptualised the behaviour as a coping mechanism and an explicable response to distress. As Haselgruber et al. (2020) note, previous efforts to minimise or see discrepancies between child and carer reports as measurement errors have been replaced with an awareness of the meaning that these discrepancies may carry and a curiosity to understand them.

As McLeod (2007) posits, really listening to CLA may challenge the status quo of adult-led authority and requires an openness to alternative possibilities in care planning and research practices. Stanley (2007) argues that the current predominance of diagnosis and the medical model in the field of CLA mental health means that the voices of young people are rarely sought or considered. Bakketeig et al. (2020) warn that these problem-focused lenses that do not elicit the young person's perspective risk political and professional discourses becoming stigmatising. This is also highlighted by Lensvelt et al. (2021) who note that cultural narratives about CLA in media and government discourse often portray young people in care as vulnerable and fragile. Whilst this can be the case, it is often at odds with the ideas of strength and resilience that feature in narratives coming from care leavers

themselves. For example, some of the female care leavers spoken to by Colbridge et al. (2017) saw themselves as survivors and viewed their resilience and resourcefulness as an integral part of their identity. As such, eliciting young people's perspectives is an important step in addressing power dynamics at the individual level between a young person and their carers, but also at a societal level in terms of reducing stigmatising narratives surrounding CLA and becoming more aligned with the narratives of strength often coming from CLA themselves.

The Challenges

Despite the well documented need to include and consider perspectives of CLA, this population consistently report that they do not feel listened to or understood by adults and the systems responsible for their care (e.g. Coram Voice, 2021; Davies & Wright, 2008; Rehill et al., 2022). Indeed, a considerable amount of the literature surrounding decision making, research and outcome measurement with CLA recognises the significant challenges in eliciting the views and opinions of young people (e.g. Bradbury-Jones et al., 2018; Bromley et al., 2020; McLeod 2007). Even where young person 'self-report' is a viable option, often carers, social workers or academics will provide information or responses as a proxy for voices of young people themselves (Bromley et al., 2020). To move towards a convention of CLA perspectives and experiences being routinely considered and held in high regard it is important to explore the factors currently preventing this.

Difficulties including CLA voices in care planning often centre on legal questions and developmental perspectives regarding the capacity of young people to make decisions (Munro, 2001). As Schofield (2005, p.29) posits, there can be tension between the right to be heard and the right to be protected, particularly in instances where the wishes of the young person are in opposition to the professional judgement of the adults around them. Where the UNCRC (1989) highlights the need to consider children's perspectives, it stipulates that this should be done according to the age and maturity of the child in question. Within UK law a young person is deemed to have capacity at the age of 16 (Mental Capacity Act, 2005). However, a child under this age may be deemed 'Gillick competent' if they display sufficient maturity and understanding of the implications of their decisions (NSPCC, 2022).

Determining what constitutes such maturity requires a multidisciplinary approach but is often underpinned by cognitive and neuroscientific theory (Grootens-Wiegers et al., 2017; Schofield, 2005). It is generally accepted that young people around the age of 12 possess an ability for abstract thinking, accurate self-perception and self-regulation (Flekkøy & Kaufman, 1997; Grootens-Wiegers

et al., 2017). This is due, in part, to continuing development in how the control and reward systems in the brain – the prefrontal cortex and the ventral striatum - interact. However, Miller et al. (2004) argue that these capabilities are dependent on contexts such as the emotional salience of the decision and the availability of adult support. These are particularly important factors when considering capacity of CLA, many of whom will experience delayed cognitive and socioemotional development and have limited trusted adults to scaffold decision making (Davies & Wright, 2008; Golding et al., 2006).

When it comes to research, there are a number of practical barriers that can prevent routine gathering of CLA perspectives. The busy lives of young people and potential mismatch between researcher and young person schedules is one such barrier (Wilson et al., 2020). In addition, many researchers may lack training in how to make their processes accessible and developmentally appropriate (Chapman et al., 2004). This is reflected in the fact that young people often report that research is complicated, boring and can be generally unmotivated to participate (Wilson et al., 2020). In addition, people with experience of care are underrepresented in academic and research institutions. This is likely to have an impact on young people who may feel more motivated to be involved in research run by individuals that have first-hand experience of care and therefore allowing for more equal power relations during the process.

The ethical complexities of involving CLA in research projects are another factor. The significant vulnerabilities of CLA and the potential risks of research participation can introduce warranted complications into ethical approval processes (Bradbury-Jones et al., 2018; Dale & Watson, 2010). Ethical considerations for research with CLA can include: navigating unequal power dynamics, gaining informed consent, issues around remuneration and implementing safeguarding procedures (Chapman et al., 2004; O'Reilly & Dogra, 2017). Questions regarding the need for parental consent and risk of participation are particularly pertinent when working with a population where carer responsibility is held across multiple adults and agencies. Leeson (2007) provides an account of the complexities of dealing with gatekeepers when recruiting CLA into research projects. She argues that professionals can be “over-protective and counter-productive” (p. 270) in their approach to research and that this can risk perpetuating the view that young people do not need to be involved in research that concerns them.

Whilst not insignificant, the barriers discussed above are arguably surmountable with appropriate planning, resource and young person-centred approaches to research, outcome measurement and

decision making. However, these processes require motivation from carers and professionals and an appreciation of why eliciting young people's perspectives is important. Wadman et al. (2019) interviewed mental health researchers who felt that research with young people was not taken as seriously or held in as high regard as research with adults. In addition, Kendal et al. (2017) argue that many researchers still do not view young people as experts of their own experiences. When it comes to care planning and decision making, Shemmings (2000) found that many professionals were reluctant to involve young people, often failing to see the nuance between young people making the decisions alone and young people being involved in the decision-making process.

CLA Perspectives – What is Known

As discussed in previous chapters, seeking care experienced people's perspectives in research, outcome measurement and placement planning is important but often deprioritised and challenging to carry out effectively. Whilst significant gaps and questions remain regarding the care experience, there is a small but growing body of literature surrounding CLA perspectives on their wellbeing. Terminology used within this area is broad and "conceptually muddy" (Morrow & Mayall, 2009; p. 221) with concepts such as 'wellbeing', 'mental health' and 'psychological adjustment' often not being clearly defined or distinguished from one another. This is made more complex by the fact that these are adult defined constructs, which often do not translate effectively into young person-centred narratives. In addition, a large number of clinical studies which claim to have explored CLA experiences focus more on the prevalence of mental health diagnoses, rather than the more subjective experiences of psychological wellbeing (Stanley, 2007). This chapter therefore aims to disentangle some of these concepts and provide an overview of what is known about CLA perspectives on their wellbeing. The literature reviewed only includes that which has explicitly asked young people themselves as part of the research process, largely via interview or survey techniques.

The Practicalities of Care

A lot of research that centres CLA perspectives is focused on gathering accounts of their circumstances and the more practical features of care itself, often grounded within a social work context (Winter, 2010). This is perhaps unsurprising, given the infrastructure increasingly embedded within social work practice to elicit young person voices as is the case in LAC (Looked After Child) reviews and PEP (Personal Education Plan) meetings (Pert et al., 2017; Thomas, 2011). Whilst arguably somewhat dated, the work of the Who Cares? Trust (Shaw, 1998) is repeatedly cited across the relevant literature. This survey remains one of the largest of its kind whereby some 2000 young

people in the UK were asked about their experiences of care, the findings of which persist across more recent research (e.g., Rehill et al., 2022; Staines & Selwyn, 2020). Common themes discussed within such literature include: children's views on coming into care, placement and contact arrangements and relationships with social workers.

A significant portion of the research reports CLA's views on placement moves. However, young people repeatedly report that the first move into care is the hardest and carries the most significance (e.g., Mitchell & Kuczynski, 2010). Much of this experience is characterised by confusion and not knowing what is happening until their move is imminent (Morgan, 2010; Shaw, 1998). The majority of the CLA spoken to by Holland et al. (2010) reported that they were not aware that they were being taken into care in advance of being moved from their families and were rarely provided with information regarding the reasons for being moved, what would happen once they were in care and how long they would be there for. Schofield et al. (2012) interviewed 20 young people who were in foster care to understand their experiences of coming into care. Some of the participants in this study commented on the small factors that could make the process easier, for one young person this was a photograph of her new foster family and house prior to the move which made her feel more at ease with coming into care.

There has also been some exploration of CLA views of 'every day' life once in placement. Of course, experiences vary dramatically but a recurring theme from children is a desire for more freedom and control over seeing friends, pocket money and what time they go to bed (Shaw, 1998). There is a sense from a lot of young people of having less freedom on such matters than their peers and a frustration that decisions that were freely made by birth parents must be checked and monitored by social workers once a child is in care (McLeod, 2006). Young people in care report being left out of social events and even educational opportunities like school trips as a result (Blueprint Project, 2005).

When it comes to contact arrangements, one third of the respondents in the Who Cares? Survey said they wanted to see more of their birth family. This was echoed by Munro (2001), who reported on a study commissioned by a local authority to understand the views of children in their care. In this study, a total of 15 CLA were asked about their experiences via unstructured interviews to allow for the young people to guide the discussion and raise topics which were important to them. Most of the children in this study also raised contact with birth families as an important determinant of their satisfaction with their care. Two of the 15 interviewed reported having stable and satisfactory

contact but the rest of the sample were dissatisfied with either the frequency of the contact or their involvement in deciding how it would look.

Relationships with social workers is also something raised by CLA as a highly notable aspect of their care experience. All children interviewed by Munro (2001) mentioned the importance of their social worker, commenting that the quality and continuity of this relationship had a powerful impact on their lives. The care leavers spoken to in Holland et al.'s (2010) research reflected on the frequent unexpected changes in social worker whilst in care, and the sense of loss and rejection that can come from this. CLA perspectives on social workers are often linked with issues of trust and confidentiality due to their social workers' limited availability and their tendency to pass on information that CLA did not feel comfortable others knowing (Buchanan, 1995; Duncalf, 2010). McLeod (2006) found that young people frequently experienced social workers over-riding or ignoring their wishes, leading to outcomes which rarely reflected young people's preferences.

Subjective Wellbeing

Stepping away from accounts of the more objective features of the care experience, much of the literature that has sought care experienced views has done so through exploring subjective wellbeing (SWB). Whilst there is no single agreed definition of SWB, it is generally considered to be a self-reported measure of wellbeing, focusing on how people experience and evaluate their own lives (Diener, 2009) rather than more objective wellbeing outcomes such as income, literacy and life expectancy (Das et al., 2020). By their very nature, therefore, measures of SWB require eliciting the voice of the young person. However, as Goswami et al., (2016) note, the domains explored on SWB measures have often originated from adult-defined measures of wellbeing and should not be assumed to be relevant for children.

Enhancing the SWB of children and young people is a specified goal of governments across the globe (UNICEF, 2021). In the UK, the work of The Children's Society in publishing their annual Good Childhood Report (The Children's Society, 2022) helps to identify and explore indicators of SWB for young people (Wood & Selwyn, 2017). Their most recent report, for example, highlighted that children (aged 10 to 17) were on average most happy with their family situation, their health and their home. The issue that children were most unhappy with was their education and how much they felt they were listened to at school. Young girls frequently reported being unhappy about how they looked, a domain which has seen increasing dissatisfaction over time. Children also reported being most worried about the environment when discussing a range of global issues presented to

them (The Children's Society, 2022).

Unsurprisingly, there has been much less research into the SWB of the CLA population (Staines & Selwyn, 2020). Holder et al. (2011; p. 25) conducted a review of CLA perspectives on their wellbeing and held focus groups to gather feedback on nine domains they had identified from the literature. These domains included: physical care, feeling safe and secure, school support, help and encouragement, feeling understood, recreation and leisure, and relationships with family and friends. However, some of the young people in the focus groups had difficulty understanding some of these adult-defined domains and, as argued by Wood and Selwyn (2017), the researchers decided not to include some additional factors highlighted by the participants on the basis they lacked relevance to their pre-defined domains. This decision has been criticised by others who claim the research lacked appreciation of CLA views and was biased towards negative and objective measures of wellbeing (Selwyn et al., 2017; Wood & Selwyn, 2017).

As Wood and Selwyn (2017) argue, it should not be assumed that the domains used to measure the SWB of children in the general population translate to those that are important for children with experience of care. Theirs was the only study identified that enabled CLA participants to define what mattered to their subjective wellbeing, rather than asking for feedback on predefined categories. Another strength of their research was the large number of participants, with 140 CLA taking part across 18 separate focus groups. This research uncovered four domains that were important to the subjective wellbeing of the CLA interviewed. The first domain was relationships, the indicators of which included the sensitivity of carers and relationships with pets. Second was rights, which young people said involved being free from abuse and feeling involved in decisions. Resilience building was another domain, which involved feeling a sense of belonging, enjoying school and having a key trusted adult. Finally, the domain of recovery was detailed which corresponded to having a second chance if they make mistakes and feeling that life is getting better over time. As Wood and Selwyn (2017) note, the domains uncovered by their research were partially similar to those in research conducted with the general population but the indicators and emphasis differed for CLA, reiterating the need for further exploration of CLA perspectives on their SWB.

Mental Health and Psychological Wellbeing

As discussed above, the literature surrounding SWB can offer valuable insight into the perspectives of CLA. However, whilst psychological wellbeing and mental health are sometimes explored as part of SWB, these concepts are rarely emphasised or given particular focus. In addition, as Stanley

(2007) notes, much of what is known about the mental health of CLA is based on clinical studies exploring the prevalence of certain diagnoses, rather than the perspectives of CLA on their psychological wellbeing. As Mullan et al. (2007, p.422) write, mental health can be an “abstract concept” and many researchers therefore do not attempt to gather young people’s perspectives in this area. However, given the extensive psychological and mental health needs of CLA, it is important for researchers, carers and clinicians to work to elicit and understand CLA perspectives on these specific domains.

In attempts to understand CLA perspectives in this area, research participants are often asked to define what mental health means to them. Across multiple studies, mental health is defined by CLA in what adults perceive as negative terms, using phrases such as “being mad”, “not right in the head” or “crazy” (Beck, 2006; Mullan et al., 2007; Tatlow-Golden & McElvaney, 2015). Mullan et al. (2007) note that very few CLA define their feelings, emotions or behaviours in terms related to mental health. However, Roose et al. (2003) argue that children and young people do indeed have a sophisticated understanding of mental health but that it may simply differ from that of their parents and carers. This was highlighted by Beck (2006) who found that carers were more likely to view the difficulties of those in care as behaviour-related problems. Young people, in contrast, viewed their difficulties as primarily related to their relationships and were more likely to discuss emotional difficulties than their carers. Common experiences of these CLA included reporting having low self-confidence, feeling down, experiencing anxiety and having little control over their temper.

Where CLA have contact with mental health services, there is an increasing awareness of the need to explore their experiences within these. In 2008, Davies and Wright conducted a review of children’s views on mental health services but found that very few studies elicited CLA voices, despite the overrepresentation of this population in CAMHS and their frequently expressed wishes for more choice and control when receiving support (Bromley et al., 2020; Davies & Wright, 2008; Stanley, 2007). The young people spoken to by Tatlow-Golden and McElvaney (2015) reported that they found CAMHS services inflexible and lacking in appropriate ways of engaging young people in care. This was echoed by the youth in Beck’s (2006) study who cited practical barriers in accessing mental health support such as transport and timetable clashes with schooling. When asked for their suggestions, CLA recommended that services needed to feel more relaxed, work to offer more timely support and listen to their wishes and feedback more effectively. However, the care experienced youth that Bromley et al. (2020) spoke to reported that even the tools and processes used to provide feedback in such services were inaccessible and inappropriate for them to have their

voices heard, leaving them little hope that things would change.

Another recurring theme across the literature is the significant impact that stigma from being in care has on the psychological wellbeing of CLA. The young people in Stanley's (2007) paper highlighted the negative attitudes and assumptions of their peers at school and the emotional pain this causes them, impacting their ability to form trusting relationships with friends who are not in care. Tatlow-Golden and McElvaney's (2015) participants highlighted how being in care and suffering from mental health difficulties can carry double stigma. This, they reported, caused them to feel shame and compromised their willingness to be open with people, ultimately impacting their relationships with peers and highlighting feelings of difference. As Stanley (2007) notes, this stigma facing many CLA is a prime example of the social context of their psychological wellbeing and is something that can best be understood by hearing care experienced voices on the subject rather than relying on clinical or diagnosis lead narratives.

In contrast to the more negative tone often used when discussing mental health with CLA, psychological wellbeing is often discussed via narratives of coping, tackling challenges and recognition of strengths. Whilst some of the young people in Tatlow-Golden and McElvaney's (2015) study reported using drugs or self-harm to cope with difficult emotions, almost all had learned how to use positive distraction. Listening to music, writing a diary or going for a walk were activities that these CLA said they had learned could help improve their mood. Bakketeig et al. (2020) attempt to unpack psychological wellbeing for young people in care by asking what 'doing well' means for them. In doing so, they argue, they are centring young people's own definitions of wellbeing within the context of their care experience, rather than assuming the same positive outcomes associated with children in the general population will apply. The young people in this study emphasized a life that feels good and happy for them is often one that is in many ways mundane, ordinary and easy for them to control.

Rationale and Aims for the Research

The literature reviewed has helped to identify gaps in current understanding related to the research area and build the rationale for the present study. It is evident that outcome measurement is an important factor in effective provision for the psychological needs of CLA, a population who are known to be particularly vulnerable and have complex psychological needs (Herwig, 2022; Kwan & Rickwood, 2015). However, the measures currently in widespread use across the sector have a number of limitations. These include but are not limited to: being designed with the general

population in mind, arguably ill-equipped to identify and measure trauma, having an overly pathologizing approach and lacking usefulness for practitioners and young people themselves (Hannon et al., 2010; Ryder et al., 2017).

As previously highlighted, BERRI was designed with a view to address some of these common shortcomings of mental health outcome measures used with CLA (BERRI, 2023). It has, for example, been designed specifically with this population in mind and produces interpretive reports that aim to provide immediately useful information for the care network around the young person. However, the current design of BERRI does not include an option for young people to offer their perspective on their psychological needs.

This is a common shortcoming of measures currently in use across the sector. Where self-report versions do exist, there are often issues with the reliability or usability of such measures (Ryder et al., 2017; Wolpert et al., 2008). This means that some outcome measurement practice is misaligned with the increasing awareness and emphasis in policy on the importance of considering the perspectives of young people (Department for Education & Department of Health, 2015; MacAlister, 2022). A review of the literature in this area revealed multiple compelling arguments as to why young people in care should have their perspectives included in care planning, research and outcome measurement. This includes the confidence building benefits of decision making (Bromley et al., 2020), parental inability to accurately represent their child's views (Davies & Wright, 2008) and the important role children's voices play in challenging stigmatising narratives surrounding CLA (Lensvelt et al., 2021). However, there are several distinct challenges and barriers preventing the effective inclusion of young voices in these processes and many young people in care are still left feeling as though they are not listened to.

Therefore, a clear rationale is evident for further development of effective and accessible methods of eliciting the voices of young people in care. This research therefore aimed to gather care experienced young people's views on their psychological adjustment to inform the development of an addition to the BERRI questionnaire that could be completed by young people themselves, to complement the existing tools that are completed by carers and professionals. The specific research question was: What observable markers do young people in care think indicate strengths or improvement/deterioration in their psychological wellbeing?

Understanding young people's perspectives on their wellbeing is a relatively recent topic for published research (Rees et al., 2010; as highlighted by Ryder et al., 2017). Particularly within

psychological research, terminology remains largely adult defined and is often aligned with efforts to understand the experiences of mental health conditions (Stanley, 2007). The present study has therefore chosen to use the terms 'psychological adjustment' and 'psychological wellbeing' within the research title and question. This is with a view to capture strengths and signs of resilience as well as any discussions of mental ill-health or deterioration. This was believed to be particularly important given the findings from the literature review that CLA's narratives of wellbeing often feature their strengths and stories of overcoming challenges, contradicting the picture of vulnerability which is often the focus of media and political discourse (Lensvelt et al., 2021).

Research Design and Methodology

Epistemology

This research employed a critical realist stance (Bhaskar, 1975; Collier, 1994) which is often seen to offer a middle ground in social science between the opposing approaches of positivism and idealism (Pilgrim, 2019; Wiltshire & Ronkainen, 2021). A critical realist philosophy acknowledges both ontological realism and epistemological relativism. It therefore follows that an objective reality exists independent of what is known or thought about it, but that different versions of the truth are constructed through discourses that vary across time, place and people (Pilgrim, 2019). In addition, a critical realist position argues that powerful structures across economic, social and biological systems are responsible for socialising the individuals within them (Willig, 1999).

Ussher's (1999) commentary on why critical realism is appropriate for use in feminist psychology resonates here. She argues that assuming the existence of an objective reality is important in understanding and validating the experiences of individuals involved in research. However, recognising that identities are constructed within a wider social context also acknowledges the structures of power at play in people's lives, a particularly important consideration when working with those from marginalised groups. She also argues that critical realism does not limit researchers to the constraints that can be associated with strictly quantitative or qualitative enquiry. This is an appropriate consideration for the present study as, whilst the research is being conducted via qualitative interviews, it is ultimately being used to aid the creation of a questionnaire that will quantitatively measure psychological wellbeing. Finally, Ussher claims that the critical realist approach values "lay knowledge" (p. 45) no less than that of researchers and academics, an appropriate stance for research which aims to truly understand and value the perspectives of young people in care.

Conducting this research within a critical realist framework therefore required consideration of how

social relationships and societal norms impacted the young people's narratives of psychological wellbeing and determined what they chose to discuss within the research (Pilgrim, 2019; Sims-Schouten & Riley, 2018). In practical terms, this meant that the accounts provided by participants were validated as true by the researcher but were also interpreted as having been constructed through language and memory, and influenced by participants' emotional circumstances, their experience of the interviews, the research context and a range of wider socio-political factors (Collier, 1994). Participants were also seen as experts in their own lives and identities, facilitated by the use of flexible, semi-structured interviewing and ongoing work by the researcher to reflect on how their assumptions as someone from an academic and clinical background would be shaping the research.

Research Design

A qualitative research approach was used for this study to enable an in depth understanding of care-experienced young people's perspectives on their psychological wellbeing. Qualitative approaches enable researchers to understand the natural phenomena in the social world and uncover the meaning, experiences and views of research participants (Al-Busaidi, 2008; Mays & Pope, 2000). Qualitative methods are said to be exploratory and descriptive in nature and support an inductive approach where hypotheses can be generated from data collected (Kvale & Brinkmann, 2009). This is in contrast to the deductive, confirmatory approach often associated with quantitative research (Barker et al., 2015). In addition, qualitative exploration is often advised as a preliminary stage in questionnaire development in order to define and operationalize constructs of interest (Barker et al., 2015).

Qualitative data in the form of audio recordings, transcriptions, participant's photographs and researcher fieldnotes were collected. This multi-layered approach enabled the research to move beyond superficial interpretations and towards the type of "thick description" that Geertz (1973) argues is necessary for in-depth qualitative enquiry and advanced understanding.

Central to the qualitative method, particularly within a critical realist context, is an awareness of the relationship between the researcher, the research topic and participants, and the situational constraints that shape inquiry (Denzin, 2005). As such, reflection and consideration of researcher bias and power relations between the researcher and care experienced participants was a key consideration during the research design, data collection and analysis. In practical terms, steps to address unequal power dynamics and limit researcher bias included: a bracketing interview between

the researcher and a colleague, seeking advice from an advisory panel on how to make interviews accessible and reiterating to participants that they did not have to answer any questions or discuss any topics they did not feel comfortable with.

Care Experienced Advisory Panel

Whilst the researcher and supervisors of this project had academic knowledge and clinical experience working with CLA, they did not have first-hand experience of the care system. As such they recognised the limitations of their knowledge and lack of understanding about what the experience of participation may be like for a care experienced young person. For a project about hearing the voices of CLA, it was deemed imperative that these voices were incorporated in the design of the research itself.

Therefore, in the initial stages of the project, two care experienced advisors were consulted. These individuals were known to the researcher through previous professional relationships and approached after ethical approval was obtained to ask if they were interested in advising on the present study. Two consultations occurred over Zoom lasted around 90 minutes each. During these consultations, the panel were asked to provide feedback on the research proposal and procedure. Draft interview questions were asked, and potential further topics of conversation were discussed. These consultations were audio recorded and listened to by the researcher when updating and adapting the materials. Written informed consent was gained prior to the consultations and the panel were remunerated for their time and expertise.

Recruitment and Participants

To recruit participants for the study itself, a purposive sampling strategy was used. This was deemed suitable due to the exploratory nature of the research, there being a specific population of interest and the known complexities of recruiting CLA for research (Mezey et al., 2015). Participants were recruited from organisations and services already using or known to BERRI to enable a more efficient and prompt recruitment process.

For participants in the younger age range (15-18), care providers and organisations were initially approached regarding the project via email, or over the phone (Appendix A). To any interested parties, information was provided on the research background and protocol, inclusion and exclusion criteria for participants and project flyers (Appendix B). Organisations directly contacted included local authorities, independent fostering agencies, residential care settings, supported

accommodation and adoption services. A total of 32 care organisations were directly contacted and meetings were scheduled with 7 organisations after expressions of interest were received. Following these exchanges, 6 services agreed to advertise the project to suitable young people within their organisations and facilitate initial contact with the researcher.

Care providers were asked to screen potential participants against the inclusion criteria at their discretion. The researcher advised that such screening was done prior to advertising the research to prospective participants to avoid feelings of disappointment or rejection in those that did not meet the criteria. Specific inclusion criteria and rationale were as follows:

- 15-18 years of age: to reflect a midpoint of the ages it is anticipated the prototype tool will be used with.
- Known to organisations currently using BERRI: to facilitate ease of recruitment and aid with screening and debriefing processes.
- Current or recent experience of being 'Looked After' outside of the family home: to ensure relevance to the population the prototype tool will be used with.
- No current significant emotional distress, significant current vulnerability or severe learning disability: to protect against further distress being caused by participation and ensure participants were able to engage with the language and reflective functioning required to discuss psychological wellbeing.

Five participants were recruited through this method. In order to represent the views of a larger sample, ethical approval was sought and granted to extend the age range of participants. An additional age range of 18-25 was chosen. The lower limit of this was selected on the basis of the participants being able to provide informed consent without scaffolding or support from carers. The upper end of this was chosen to reflect the age at which formal state support (by means of access to a Personal Adviser) ends in the UK (Foley et al., 2022). The same recruitment protocol was employed for these participants, although interested individuals were asked to contact the researcher directly and screened against the inclusion criteria by the researcher instead of their carers.

In line with recommended sample criteria for exploratory research, the researcher aimed to include between 10 and 15 young people in the project (Emmel, 2013). Samples in qualitative research do not intend or claim to be representative of their populations (Barker et al., 2015). However, CLA are far from a homogenous group and there is evidence to suggest that, for many young people, their care experience intersects with other minoritized identities (Bywaters et al., 2016; Department for

Education, 2022). As such, the researcher aimed to achieve a heterogenous sample and anticipated the possible use of positive action to prioritise the inclusion of diverse voices where appropriate if the study became oversubscribed. However, as is often the case in research with CLA (Wilson et al., 2020), recruitment processes faced a number of challenges and the total number of interested participants did not exceed the preferred minimum sample size. It was therefore not possible to construct the sample using positive action. The final sample did, however, consist of a range of voices and experience, including that of some marginalised groups such as LGBTQ+ and racially minoritized individuals.

The final sample consisted of eight care experienced young people, aged between 15 and 25 years old at the time of interview. Further demographic data is presented below (Table 1).

Demographic	Details
Age	Range: 15-25, Mean: 18.6
Gender	Male: 2 Female: 5 Non-binary: 1
Race/Ethnicity	White British: 6 Mixed or Multiple Ethnic Groups: 2
Geographical Location (England)	North West: 2 Midlands: 1 South East: 4 South: 1
Community	Urban: 2 Suburban: 4 Rural: 2
Type of Care Experience (Current)	Foster Care: 2 Semi-Independent Living: 4 Care Leaver: 2

Table 1: Sample demographics

Central to the research design and the purpose of this study was valuing the experiences and expertise of young people in care. In addition, many participants were of working age and were giving up valuable time to participate and offer their meaningful contributions to the study. Therefore, a financial inducement of a £20 voucher was deemed appropriate for those who

participated.

Data Collection

Primary data collection consisted of eight interviews with young people in care, supported accommodation or care leaving services. Young people were given the choice of having the interview face to face in a location they felt comfortable or via video conferencing. Five chose to have their interviews face to face in their place of residence, three chose to have their interviews conducted remotely. The participants also had the choice to have a trusted adult present, an option which two chose to opt for.

The interviews were semi-structured and used open ended questions to facilitate flexibility and allow participants to have a level of control over what was discussed (Alderson et al., 2019). As a group, CLA often report not being listened to by adults and professionals, so time was taken during the interviews to build rapport, show genuine interest and facilitate the sharing of perspectives in multiple ways.

The interviews were designed to gain an in-depth, nuanced understanding of young people's subjective perspectives on their psychological adjustment and what they deemed to be indicators of improvements or deteriorations in their wellbeing. Schedules were informed by the literature review, conversations with the research supervisors and feedback from the care experienced advisors. Schedules can be found Appendix C. Topics covered included: how life looks and feels when things are going well and less well, a time recent time they felt proud of themselves, feedback on some concepts of psychological wellbeing and their thoughts on the current BERRI questionnaire.

Young people were encouraged to bring photographs of recent 'good' or 'bad' days to their interviews to aid with discussions of the indicators of their psychological wellbeing. As Bakketeig et al. (2020) note, the use of such creative methods can encourage participation, enhance data richness and disrupt the rigid format of conventional research interviews which often serve to uphold power imbalances between interviewers and marginalised groups. As advised by the care experienced panel, this was optional and not a necessary requirement for participation in case any participants did not feel comfortable with sharing their photographs. For those that did share photographs, they were encouraged to keep these anonymous by focusing on pictures of places or things with no identifiable information.

Four of the eight participants chose to use photographs as a part of their interviews. Three of these were shown on their smartphone (either from their recent camera rolls or social media posts) and one was via 'memory books' that were created by the young person's foster carer as a way of documenting memories from their time together and from their birth family. Examples of the type of photographs used included a young person outside their new workplace on their first day, animals seen on a recent visit to a wildlife park and a meal made by a young person with some friends at the weekend. Discussions that followed were led by the participant, but usually involved a description of what was happening in the photograph, how the young person was feeling when the photograph was taken and what 'signs' there were in the photograph to suggest they were having a 'good' or 'bad' day.

Data Analysis

The data was analysed using Braun and Clarke's method of thematic analysis (Braun & Clarke, 2006). This method has become increasingly popular and widely used in qualitative research across disciplines since it was first published in 2006 (Clarke & Braun, 2018). It is known for its clarity and usability and is therefore deemed an appropriate choice for early career researchers as was the case in the present study (Maguire and Delahunt, 2017). However, with such widespread use, Braun and Clarke warn against the misuse that can arise from a lack of clear understanding or oversimplification of their approach (Braun & Clarke, 2016; Clarke & Braun, 2018).

For example, whilst Braun and Clarke do not tie thematic analysis to a specific epistemological stance, they emphasise the importance of making epistemological assumptions explicit and clearly defining these ahead of analysis (Braun & Clarke, 2006). They also refute efforts that align thematic analysis with what they perceive as more positivist stances through the use of predefined coding frameworks or sample size calculations (Braun & Clarke, 2016). In their more recent work, they refer to their approach as reflexive thematic analysis, marking their commitment to acknowledging researcher subjectivity and the role of the researcher in knowledge generation (Braun & Clarke, 2021).

These factors were therefore considered during the present study to ensure rigour and quality of the analysis. For example, the analysis was conducted within a latent, or 'interpretive' level to be aligned more with a critical realist approach. This means that the analysis did not focus just on what was being said, but the ideas and assumptions that were shaping this (Clarke & Braun, 2018). In addition, the thematic analysis was conducted through a deductive or theoretical approach (Braun & Clarke,

2006). As such, it was driven by the specific research questions rather than the data itself (as is the case in a 'bottom up' or inductive approach). This was to ensure that the analysis was closely aligned with the specific research questions and assisted with the clear aim of understanding CLA perspectives on their psychological adjustment. However, to limit the influence of researcher pre-conceptions and bias, open coding was used. As such, no codes were set or pre-determined but were developed throughout the analysis process.

The thematic analysis followed the six steps identified by Braun and Clarke (2021), adapted from the first iteration in their original 2006 paper. Whilst these steps are not rigid and are expected to merge with one another, Braun and Clarke (2021) recognise how providing a protocol can increase the ease of accessibility of their method for less experienced researchers. The steps that were followed are outlined below:

- 1) Familiarising yourself with the dataset: interviews were audio recorded using a Dictaphone and transcribed by the researcher (Appendix D). This process was an effective way of immersing the researcher in the data, given the focus and time required for accurate transcription. Draft transcripts were then read alongside listening to each audio recording to check for accuracy and allow for further familiarisation. Field notes were made as soon as possible after each interview to document researcher reflections and any information which may not have been captured via audio recordings. These notes were reviewed by the researcher during this stage (Appendix E).
- 2) Coding: transcripts were printed, read and initial codes considered. These initial codes were in the form of annotations based on what stood out to the researcher in the interview data (Appendix F). This was first done seeing each interview as a separate entity. In later readings, codes were added relating interviews to one another where applicable. The approach here was deductive in that annotating and constructing of codes was related to and driven by the research question.
- 3) Generating initial themes: these codes were compared and highlighted across transcripts (Appendix G). They were then arranged in the form of lists and mind maps of codes considered related or linked to each other (Appendix H). These lists were reviewed, adjusted and, when appropriate, given labels that represented initial draft themes.
- 4) Developing and reviewing themes: at this stage, to ensure quality and credibility of the analysis, the project supervisor was given a transcript to code (Nowell et al., 2017;

Yardley, 2017). The supervisor and researcher met to discuss and compare their thoughts on the transcript, example codes and candidate themes. Similarities and discrepancies were noted and discussed, as were reflections on the assumptions and biases shaping the analyses (Appendix I).

- 5) Refining, defining and naming themes: notes from the above discussion were considered alongside revisiting the codes and entire data-set in order to produce a final refined list of themes and subthemes. As recommended by Braun and Clarke (2018), the researcher aimed to go beyond producing simple 'domain summaries' to create themes that capture patterns and shared meaning across the data.
- 6) Writing up: these themes and subthemes were then written up as can be seen in the findings chapter of this thesis. Quotations are heavily embedded in the write up in order to evidence the strong link between the data and themes and to tell the "story" of the data, rather than just providing a summary (Clarke & Braun, 2018; p.109; Yardley, 2017). A write up of researcher reflections is also offered to evidence the role of the researcher in shaping and defining these themes (Braun & Clarke, 2021).

Member Checking

The themes identified, along with some draft questionnaire ideas were then developed. This was shared with research participants via a process of member checking (Lincoln & Guba, 1985).

Member checking is the process of getting feedback from research participants about the data or interpretations from the research in order to increase credibility of results (Birt, 2016; Motulsky, 2021). Member checking is also seen as a way of involving respondents in the later stages of the research and analysis (Birt, 2016).

Participants were sent a copy of the themes via email, presented in writing and in image form to make them accessible for the range of ages and reading abilities within the sample (Appendix J). They were asked to fill in an anonymous online feedback form consisting of 3 questions rated on a Likert scale, and one free response question for additional feedback (Appendix K). Based on feedback from the care experienced panel, participants were also offered to feedback verbally over the phone if they preferred. The results of this feedback were analysed via descriptive statistics and free response answers were recorded. It was deemed beyond the scope of the present study to conduct comprehensive analysis of this data, but reference to what was recorded and the implications of this is offered in the discussion chapter of this thesis.

Ethical Considerations

Given the potential vulnerable nature of this group, the sensitivity of topics discussed and the power relations between adults (particularly those known in a professional capacity) and young people in care, ethical considerations were of paramount importance to this research.

Ethical approval from Canterbury Christ Church University Ethics Panel was granted in November 2022 (Appendix L). An amendment to the ethics approval was submitted and granted to extend the age range of participants up to 25 given the challenges experienced recruiting younger participants. This was applied for and granted in March 2023. Some organisations acting as gatekeepers also conducted their own independent ethical review of the research prior to advertising to potential participants.

Informed consent was gained from all young people participating in the study through the production and distribution of clear and accessible information sheets at the recruitment stage, during onboarding and at the beginning of the interviews (Appendix M). Consent forms were also provided to explain use and storage of data, confidentiality (and the limits of confidentiality), privacy and the right to withdraw (Appendix N). This was deemed particularly important for this research as it has been shown that young people can have difficulty withdrawing from activities run by those in perceived positions of power (Masson, 2014).

Due to the nature of qualitative data analysis, there were limits to the extent to which participants could withdraw from the research once the analysis had begun. This was communicated to participants via information sheets and consent forms, and a two-week post-interview timeframe for withdrawal was detailed. This gave scope for participants to reflect on their involvement and advise the researcher if they wished to withdraw. If request for withdrawal occurred within two-weeks, the participant's data would have been removed in its entirety from the data set. If they chose to withdraw after the timeframe, it was communicated that any identifiable information would be removed from project storage and the dataset.

Due to the age of the participants, the researcher did not require parent or carer consent for participation. Gillick competence was listed as a consideration in the inclusion criteria discussed with care organisations during the recruitment phase. Potential participants were, however, encouraged to discuss their participation with a trusted adult and have them present during the interview should they wish.

Discussion of wellbeing had the potential to raise historic trauma or current distress for the participants. Exclusion criteria of no current significant distress acted to screen out potential participants who may be particularly vulnerable at the time of interview. The researcher was clear to all participants at the beginning of the interview that they did not have to discuss anything that they would find distressing and could take breaks whenever they wished. As advised by the care experienced panel, fidget tools (for face-to-face interviews) and opportunities for movement were made available during the interview to alleviate any symptoms of post-traumatic stress surfacing from the discussions (van de Kamp et al., 2019).

Interview schedules also included time for post-interview debriefs. All participants were offered space for reflection and the opportunity to raise any concerns that had surfaced as a result of the interview. Advice on accessing support was given at the end of the interview in a debriefing document, as well as researcher's professional details to contact with any questions arising after the interview (Appendix O).

Reflexivity

McCabe and Holmes (2009) note that ethical approaches to research involve a reflexive approach to examine the power that the researcher may hold due to professional or social position and the impact this may have on research participants. In addition, the use of thematic analysis and the critical realist stance of this project required reflexivity about researcher interpretation, impact, ethical obligations and transparency about assumptions prior to and during the research process (Braun & Clarke, 2021; Collier, 1994).

Researcher reflexivity is not just an ethical consideration but also one of quality. Yardley (2017) argues that researcher reflexivity is central to achieving the "Sensitivity to Context" and "Transparency" (p. 295) necessary to ensure the validity of qualitative research. As such, the researcher in the present study worked to develop an awareness of the sociocultural context of the research and ensured transparency regarding the impact of this – both in way they interacted with participants and thorough reporting of how knowledge was constructed from the study.

To facilitate an awareness of the power the researcher may hold and mitigate the effects of this, a bracketing interview was conducted prior to data collection. There are a number of definitions of bracketing and a lack of consensus on a specific method of when, how and by who it should be done

(Tufford & Newman, 2012). However, bracketing is largely viewed as a way of facilitating researcher reflexivity, limiting the impact of researcher preconceptions and protecting against any emotional distress arising from the research (Rolls & Reff, 2006; Tufford & Newman, 2012). Rolls and Relf (2006) draw comparison between bracketing interviews and clinical supervision, arguing that the process of reflecting a researcher's personal and professional experiences will enhance the overall quality of their work. As advised by Tufford and Newman (2012), the bracketing interview was conducted by a fellow early career researcher who was known to the researcher in a non-clinical and non-managerial context. The interview followed a similar format and areas of discussion to that detailed by Rolls and Reff (2006) in their account of bracketing.

The bracketing interview took place via video conferencing and lasted around 30 minutes in duration. The colleague chose some questions at random from the discussion guide to ask the researcher. The researcher answered first as themselves and second brainstormed some ideas of what they thought would come up in the interviews with their participants. The interview was recorded and later transcribed by the researcher, and the colleague made notes of their observations throughout. Both of these documents were revisited and referred to by the researcher throughout the research process.

Findings

This chapter will detail the main findings of the research by presenting a set of themes and corresponding subthemes that were generated from the thematic analysis detailed previously. Given the critical realist stance of this research, these themes are not presented as concrete or as truths that have been extracted from the data. Rather, they must be interpreted as the creations of the researcher based on the data and therefore subject to social and cultural influence (Braun & Clarke, 2016). Reflections on this will be detailed later in this chapter.

In order to understand young people in care's perspectives on their psychological adjustment, the research question aimed to explore what the participants saw as strengths or improvement in their psychological wellbeing separate from that which indicated deterioration. Across the eight interviews the young people more readily spoke about strengths and improvement rather than weaknesses or deterioration. Where deterioration in wellbeing was discussed, it was often framed as the direct opposite or absence of the indicators of improvement or strengths. As such, the themes detailed below are framed predominantly within the context of strengths and improvements in

psychological wellbeing, with exploration of their opposites detailed where identified in the data to offer an understanding of the indicators of deterioration.

An overview of the five identified superordinate themes and subthemes is provided in the table below (Table 2). Quotations are labelled with names in order to demonstrate the spread of data across the eight participants. However, each of these names are given as pseudonyms in order to preserve anonymity. Any other identifying information, such as names of Local Authorities or friends, have also been changed or redacted.

Superordinate theme	Subtheme	Illustrative Quotation(s)
Strong and Stable Relationships	Feeling like I belong	<i>I know people who are in foster care and I think they've got similar experiences [to me]...And cause of the way they are, most of them have problems like me... (Luke)</i>
	Building and maintaining relationships	<i>I feel like obviously if you move placements a lot, you feel like you matter less because like you go somewhere, then you move again. I feel like it's quite difficult to feel like you matter to people, if like, you know, you're just being moved a lot... (Alex)</i>
	Relationships rupture but can be repaired	<i>....If I had an issue, I don't know, with the foster carer at home then I'd go in school and snap at the teacher or refuse to do work...all because of something that has gone on. So it was just...I'd then spoil that relationship for myself, but then I would go and obviously apologise... it was just yeah, a cycle I guess... (Sally)</i>
Coping with Adversity	A strong sense of self and story	<i>I'm normally very caring, quite friendly. I am funny, sometimes not all the time. Mostly sensible. But at that point I was teasing everybody, not getting along very well, drinking underage. It just wasn't me. (Emma)</i>
	Resilience	<i>...so I always had those was of dealing with it...I just kind of took it with a pinch of salt, like, alright, I just</i>

		<i>get on with my life and there's not much more you can do that that. (Daniel)</i>
A Sense of Agency	Feeling listened to and heard	<i>I guess does your carer actually listen to you..? That's quite a big one... (Emma) Well, you get ignored all the time... (Alex)</i>
	Having an appropriate level of independence	<i>By 16, because I'd had so much, well, the social worker felt I had a lot of experience in kind of, looking after myself so I was moved out. Do you know, I, I think back and I'm like how the how the heck did they decide like a 16-year-old could live by themselves? (Sally)</i>
	Having structure, routine and plans	<i>Charlotte: I'm going college in September Researcher: What are you going to study? Charlotte: Um, health and social...I want to look after [the] elderly...</i>
Control of Emotions and Behaviour	Ability to regulate and reflect	<i>...on a good day, I'm alright, but like on a bad day it can be a bit...when I was younger it used to be really bad, but I've learnt to control it. (Charlotte)</i>
	Cycles of low mood and withdrawal	<i>...I just don't leave when I'm having a bad day. I don't move anywhere...I just sit here... (Mia)</i>
	Lack of control links to risk	<i>...one of my best friends as well... like her and her foster carer were like really bad, like in terms of relationships. So she would have went out late with her friends and stuff, and felt like peer pressured into doing like drugs and alcohol, stuff like that, and then instead of her foster carer kind of, like, supporting her emotionally....she was just doing the opposite like yelling and screaming (Daniel)</i>
Talents and Interests	Being good with people	<i>Louise: I kind of want to like, run for Prime Minister when I'm older. Researcher: Why do you think you'd be a good prime minister? Louise: Because I understand people's needs.</i>

	Creativity	<i>I guess I'm the creative type...I'm very artistic, quite like to make my own music and all that stuff.</i> (Emma)
	Access to animals and nature	<i>Researcher: Why do you think you like animals?</i> <i>Louise: They're so, like, non-judgemental. They don't let us have animals here. I keep harassing the owners and being like, please, I just want a bunny or something.</i>

Table 2: Superordinate themes, subthemes and illustrative quotations

Theme 1: Strong and Stable Relationships

Relationships with others were something that all the young people spoke about as having an important impact on their mood and wellbeing. Whether with carers, friends, birth families or social workers, feeling as though their relationships with others were strong and stable was a clear indicator of things 'going well' in their lives, and these were important sources of support when things were going 'less well'.

Subtheme: Building and maintaining relationships

Complex situations with birth families and frequent changes of home and school meant that a lot of participants spoke about difficulty building and maintaining relationships. The disruption of relationships when taken into care was a particular focus:

I literally never leave the house. There's nothing to do because I don't live near any of my mates anymore... (Louise)

So I then was moved to like a really remote placement in the middle of nowhere... and I was like where are my friends?... it was like, maybe like a 40-minute drive away from where I was living. (Daniel)

Trying to build new relationships when in care or maintaining existing relationships was a difficult experience for the participants:

I found myself really kind of having this desperation to make friends because essentially from 16, I was pretty much spending like birthdays and Christmases alone. So you just find yourself

in situations, making friends with anyone and you don't realise how that person or those people then influence you. (Sally)

...We were all going to go to the same school, but now it's too far for me to go. (Louise)

...And it meant, like, my relationships are starting to break down with my friends. Obviously they'd all go into town after school and stuff like that. And I couldn't. (Daniel)

For Daniel, building a network of relationships was an integral part of success and stability in a placement, and was something he felt adults should prioritise and had a responsibility to facilitate:

I know, there's like a focus on those in care, and like counselling and prioritizing them. But I don't think necessarily, or, like, it should be more of a focus on, like, building, like good relationships around them. So, like making sure that foster carers are using their extended family and make sure that they're included in the family and stuff like that, and having like longer placements like mine, so that you're more a part of the community and stuff like that. Rather than just like, throwing them at counselling. (Daniel)

For Emma, this network came from a prolonged involvement with her fostering agency, even after she had moved into semi-supported living. Relationships with staff and young people at this agency offered some stability and continuity as she moved into adulthood:

So like, they quite recently got together all as a company. So you can either meet the new carers or you can have communications with the old ones. You never really lose touch...it's like one big family...I'm definitely sad that I'm not in it now. But [staff member] has offered that I can go still to their game days and all that, so I'm waiting on the next one. (Emma)

The ability to build and maintain relationships, both old and new, was necessary for placement stability and important for feeling supported when moving across settings. This could therefore be seen as an indicator of psychological wellbeing for these participants.

Subtheme: Feeling like I belong

Meaningful relationships were integral for these young people to feel like they belong in their placements and wider social spheres.

I like playing football because it's doing team things. Part of something. And it's just fun to go out with your mates and just mess around... (Luke)

Strikingly, the majority of conversation around this area focused on friends or romantic partners, rather than carers or parents. Friendships with people who understood them or were going through similar experiences were important for these young people to feel that they belong:

With my friend group, I belong. Sometimes honestly, I don't feel like I belong because of just stressful situations, which puts me out of it really, I don't think I've had the same upbringing as nearly everyone else I've known. And it kind of makes me feel a bit left out. But with my group, we've had similar circumstances of some things that have happened in our life... (Emma)

...there's another foster kid like me who runs away and goes out, he'll run away...cause most of the people that are in care, most of them are like me [they've] got kind of the same issues...it means they'll understand me because otherwise I struggle to make friends cause I prefer younger kids as friends cause I'm scared of like older kids... (Luke)

...that's how [me and my friend] met, because the workers here kept saying we'd be good friends and I was like, oh, just give her my Instagram. We're very similar. Like, she can be very quiet...I guess we're both in, like, similar situations because we're both in the same housing (Louise)

Adults, on the other hand, could sometimes make the participants feel isolated and different. Daniel gave the example of what happened when he had a change of social worker:

...you don't know who they are...you're the last kid sitting at school, looking out for the car...other kids went off with their parents and you're just kind of sitting there going, right, when's this person going to arrive? What does their car look like? And then reception staff are going like "when are you going to be picked up?", or there's parents walking past going like, "are you okay, why are you sitting here?" and I just get that keep that constant reinforcement... like oh, I'm a foster kid and these people know it. (Daniel)

Feeling as though they belong in their placements, schools and friendship groups could therefore be seen as an indicator of psychological wellbeing, facilitated by strong relationships with people who young people feel understand them and their situations.

Subtheme: Relationships rupture but can be repaired

Relationships with friends, family and carers were all vulnerable to rupture. Examples of conflict and falling out were often features of 'bad days':

...the time I was having an argument with my sister over the phone...that was absolutely terrible... it just made me feel angry. Because she was saying all these things I just know weren't true. And I don't like people lying to me, because you don't know if you can trust them later on... (Emma)

Well when me and [foster carer] fall out, because obviously sometimes we do, I just kind of lock myself in my room... (Luke)

However, there were very few examples of relationships being permanently damaged. In fact, most examples of conflict were followed by corresponding stories of how the conflict was resolved and the relationship was repaired:

...and then because I'm a very, like, self-conscious person, I always feel guilty afterwards. I'd say sorry...And I try not to do it again. (Emma)

I listen to my music and calm down... and I'm meant to say sorry, I talk to my friend and he tells me to go and say sorry and have a chat about it, and then we do. (Luke)

Relationships rupturing was therefore a distressing but common feature of these young people's lives and could be seen as an indicator of deterioration of psychological wellbeing. However, the ability to repair relationships and, in some cases, learn from this experience was a clear strength.

Theme 2: Coping with Adversity

Being able to cope with what life had thrown at them was seen as a strength and indicator that things were going well for the young people in this project. As with many CLA, the participants shared that they had been through some difficult times. However, their focus tended to be not on

the 'what' they had been through, but more on the 'how' they had coped with this adversity and come through the other side.

Subtheme: A strong sense of self and story

Participants had a clear sense of who they were and an understanding of their journey through life and through the care system. For them, who they were and their stories were things they felt proud of, could depend on and return to in times of adversity:

[Getting the keys to my flat] made me feel proud of myself...like I could achieve something cause like obviously it's a big thing isn't it? Not many 18-year-olds can say that they've done it. (Mia)

And I did try and stick true to myself and be myself. That happened for the first three years or so...I was starting to become popular then which is my bad choice...It's not until one of my friends said you're being rude... I actually stopped and said you know what, this isn't me... And then I tried going back to myself again... Now I'm happy again, I'm myself again. (Emma)

So all the people in care, we should like listen to them because we've all got different stories to tell, different things we've been through that have made us who we are...(Mia)

For some young people, building and maintaining this sense of self and story was aided by consciously making memories and keeping records of happy or significant moments:

Louise: So we do a house meeting every month. And we order Dominos.

Researcher: That's nice. And you put that on Instagram?

Louise: Mm hmm. Yeah. I try and do it because, like, I have a little highlight, so I can look back at my year and it helps me remember the good times.

Similarly, Luke spent time taking the researcher through his life story books which included records of key moments from his time in care and pictures of his birth family. For someone with mild learning and communication difficulties, these books allowed Luke to share his story with the researcher and were, according to his foster carer, an important part of aiding his identity development and understanding of being in care.

Subtheme: Resilience

A recurrent theme of these participants' life stories was their ability to adapt, bounce back and overcome difficult situations. For Sally, this was shown in her learning to adjust to repeated changes in her placement arrangements:

I think you just learn to be adaptable from being in the foster care system because sometimes it just doesn't work out and it's either, you know, they don't know how to meet your needs or it's just a complete breakdown of a relationship. So, I guess you learn to be malleable and expect things to change...You learn to kind of integrate within each environment... (Sally)

When asked what had helped them to get through difficult experiences, most participants initially focused on their own internal strength and resource, rather than external sources of support:

Without resilience, I don't think I'd be here today. Because I've had to come up against loads of things that pulled me back. I think it's also perseverance. And also I have a very, very strong opinion. When someone thinks I can't do something, I have to tell them that I can and I show them that I can. So that's pulled me through, yeah. (Emma)

Participants often gave examples of how they had developed or turned things around for themselves when faced with adversity. Sally reflected on how she had grown throughout her different placements:

...through time you learn to build a lot of confidence and self-belief because I didn't have anyone else to support that. So I guess even though it may have taken a lot longer than most children, I guess you, you become intuitively attuned to your own inner voice and you can be more trusting of yourself... it's like being a self-starter and yeah, this kind of champion for your own cause...

Resilience was therefore seen as a point of pride and a key feature of these young people's identities. An ability to recognise one's strengths and to adapt when faced with challenges can therefore be seen as a strength and indicator of psychological wellbeing for these participants.

Theme 3: A Sense of Agency

For the young people in this research, having a sense of agency and a level of control over their lives was often seen as an important facilitator of psychological wellbeing, and something they were able to harness and make the most of when things were 'going well', and felt frustrated and stuck with when things were going 'less well'.

Subtheme: Feeling listened to and heard

The participants often had clear ideas, preferences and a confidence that they knew what was best for them. Having these opinions listened to was therefore important for fostering a sense of agency. Distinctions were made, however, between adults making genuine efforts to listen and more tokenistic examples:

...carers they can say they listen to the child, but if the child doesn't feel like they're listening... it's a completely different story.. (Emma)

Emma spoke about her involvement interviewing prospective carers at her fostering agency as an example of being listened to and *heard*, as she could see her ideas having an impact:

...we make up three questions that we want to ask them...and we basically write down whether we think they're good or not, what good qualities they had, what bad qualities they had, and it actually goes to the proper council, and whatever we decide does actually influence their decision... (Emma)

Not being listened to or feeling ignored was something that could cause frustration and distress. Examples of this were often centred around placement preferences and living arrangements:

...this is a two placement house.... We all don't want another kid to come here because I've been here for two years. I'm settled. It takes me a long time to settle down. And last time, it just threw everything off... (Alex)

Despite repeatedly communicating their preferences to their social worker and local authority, Alex felt they had been ignored and was still having to argue their case:

[Local Authority] ignored it. They were like: "Oh, no, you'll be fine." So then I got an advocate, sent in a stage one complaint and then we like summarised everything and they're like: "We don't see how this would affect you." Even though I just sent in a full-blown complaint with all of the things that would... (Alex)

Louise also expressed her frustrations around having to fight to have her preferences considered at her placement:

They don't let us have animals here. I keep harassing the owners and being like: "Please, I just want a bunny or something." But they keep saying no. I think they used to have a policy, but, um, there were like, so many problems. So I rewrote their policy and sent it to them....If they say no I'm like why? The problem before was the policy, I rewrote it perfectly. (Louise)

For Sally, a disclosure of abuse was met with a prompt response from the adults around her but one she felt had not actually taken what she said into account:

I obviously opened up...about sexual abuse that happened as a child and their initial reaction was to call the police, so they just went ahead and called the police into the school. Even though I identified to them that, you know, this happened some time ago and now I just wanted to get help and that, not the police...that was very overwhelming...there definitely wasn't an understanding...(Sally)

For these young people, therefore, 'being' listened to was not an adequate facilitator of psychological wellbeing alone, given the lack of action or common misinterpretation from adults that usually followed. It was 'feeling' listened to and heard that enabled young people to have a sense of agency and therefore can be seen as an indicator of psychological wellbeing.

Subtheme: Having an appropriate level of independence

Some of the participants felt stifled by the rules and regulations they associated with being young and in care:

We had to spread [Valentine's Day] across three days...because parents... parents are weird and they like to show that they still have control. So, like, intentionally plan over days like that...they're like: "You see, we still have 100% control of what you can do." (Alex)

I've been to some of the other [name of care organisation] houses. I think this is the best one...they don't lock our living room at night...I'm not a child. If I can't sleep, I want to come down here. But I couldn't there. (Louise)

As such, gaining more independence was aspirational and often seen as an achievement. This was the case for Mia who had recently started her new job:

Researcher: Can you tell me about a time recently that you felt proud?

Mia: Um, when I got a job...I was just so happy cause I've achieved something. For myself.

Her new job opened up the possibility for her to move out of her semi-supported accommodation into her own flat:

Researcher: Can you tell me about a good day that you've had recently?

Mia: When I got the keys for my flat...it's because everything was just like, it was a new chapter.

However, this excitement soon turned to stress when she found herself managing alone for the first time in her life and was left feeling as though she had been “*dumped*”:

[It's] fucking stressful...the gas is always messing up, the electric's just the same. It's just stressful...I'm just on my own half the time... (Mia)

Sally had similar experiences when she moved out of her foster carer's home into her own flat and found the support she had been promised did not materialise:

...pretty much the day after my birthday [I] moved into my own flat... And I just had like a person that was...coming out to see me like three or four days a week...essentially their job was to stay with me in the night, teach me how to, to kind of do budgeting and things like that. But that never happened. Essentially what she did was leave the iPad, went home and came back the next morning. (Sally)

Having a level of independence was important for these young people to feel empowered and in control of their lives. However, when this independence was not adequately supported, it became associated with feelings of isolation, overwhelm and stress and indicated deterioration in psychological wellbeing.

Subtheme: Having structure, routine and plans

For some of the young people interviewed, having control over their daily routines important for their agency and wellbeing. For Daniel, this was compromised when the pandemic began:

...I developed like really bad anxiety, which I never had before...once all my kind of group projects ended...I kind of didn't know what to do with myself.... (Daniel)

For Sally and Louise, losing control over their routine and feeling disorganised was often a sign that things weren't going well:

I noticed when I'm really chaotic like I have no, I have no ability to organise. I can't, it would be all, you know, my organisation skills from the way I dressed, to doing my hair, that would all be neglected if I was in a bad state of mind, to brushing my teeth. And there was one point where I went like a whole two months without brushing my teeth or my hair. (Sally)

[To be in a better place] I'd have to care about myself more...like having a regular get up time, general routine...like a sense of purpose. (Louise)

Others found routine and structure through their education or employment. They were often keen to share their hardworking tendencies and recent successes at work or school:

...I'm just a hard working girl, I think. I've got a job... in a nursery...it's good to have something to do with myself... (Mia)

...I'm a good student. I get good grades. In science it's stupidly high... so I'm getting like 8s and 9s on everything... (Alex)

These achievements were also often seen as steps towards a longer-term plan. Many of the young people interviewed had specific ideas of what they wanted to do when they were older:

I'm going to be hopefully, a social worker... (Daniel)

Charlotte: I'm going college in September

Researcher: Ah nice, what are you going to study?

Charlotte: Um, health and social...I want to look after the elderly

Sally recommended that asking young people in care about their future plans would be an important way of gauging a young person's wellbeing or vulnerability to risk:

I guess specifically you'd want to ask is... do you have a solid education plan?...what's your prospects for the future? What's your desires for the future? What's your outlook? What's your plan for how your life will be in the next five years? You know, where do you see yourself going? (Sally)

Emma's involvement in the Cadets and Alex's plan to work in the police force were also examples of these young people seeking out routine and structure, both in terms of having clear future plans and their association with regimented and formal organisations:

Depending on the grades, I want to either be a vet or go into the police force...probably end up being a dog handler...You have to do like one year training and then one year I think it's on the family side, one year is front lines and then you have to apply. (Alex)

If you're going into [the] army, you need to a lot of leadership skills if you want to actually remain part of the team... I got quite into it. (Emma)

These young people therefore were arguably drawn to routine and structure as a way of tolerating uncertainty. In terms of their daily lives, having a routine was seen as an indicator of psychological wellbeing, something that was often lost when things were going 'less well'. It was also important for these young people to see structure in the longer term, often finding comfort and hope in planning and imagining their future.

Theme 4: Control of Emotions and Behaviour

Where indicators of deterioration were spoken about in this research, it was largely in the context of emotional dysregulation and subsequent impact on behaviour. Examples were sometimes given via

stories from friends or other young people they knew in care, rather than detailing their own experiences. This was likely, however, to be due to the personal and sensitive nature of these topics rather than them not being relevant or applicable.

Subtheme: Ability to regulate and reflect

When speaking about 'bad days', anger and aggression were most commonly spoken about, rather than feeling sad or upset:

[When I have a bad day] it's frustrating and like yeah, it's really frustrating and I just get angry and yeah...hard to control. (Charlotte)

[My sister] sees my mood changing. I get dead aggy...it just puts everyone in a bad mood, cause of my attitude. (Mia)

Feeling unable to regulate these emotions was a common experience:

As you'd expect, just like moody and I guess more aggressive and stuff like that. It was hard to control it. (Daniel)

I wanted to punch something. Like a very, very strong urge to punch her or somebody or something... (Emma)

And I just can't contain it. Because I'm one of those people that holds my emotions in when I'm having a bad time, and then sometimes it just explodes because I can't keep my emotions in or out actually. So sometimes I take out suddenly and very badly on people. (Emma)

Physical sensations were often used as a way of explaining anger, and why it was hard to control:

A lot of tension. And like I always used to feel hot, I don't know why. I know that sounds really silly, but I used to feel really hot and kind of just like...really tight and seized up inside...I didn't know what to do with it...(Sally)

Despite these powerful emotions and sensations being difficult to control, participants could reflect on their origin and impact and many had taught themselves strategies for regulation:

I didn't [punch her]...But I just can't get my emotions out. I don't know if that's anything to do with the past or not but I just find it hard to I think... (Emma)

I would always act in autopilot and not necessarily do things because I thought them through... did it out of reaction because of fight or flight, you know? (Sally)

I mean I have squishy toys and fidget toys, but sometimes I use them it depends. If I'm not that angry, I just listen to my music, but sometimes I play with my squishy toys and music...and sometimes I punch my teddy. My big teddy. If I'm angry I punch it. (Luke)

As such, feeling angry, frustrated and aggressive were clear indicators of bad days. The ability to reflect on and regulate these emotions was therefore seen as a strength and an indicator of psychological wellbeing.

Subtheme: Cycles of low mood and withdrawal

When low mood was mentioned, it was often spoken about in terms of staying at home and socially withdrawing:

Louise: I don't leave my room. I just keep it to myself.

Researcher: Why do you think that is?

Louise: They don't understand...

Researcher: What about the other young people you know in care. If they're having a bad day, what might you notice?

Louise: They don't talk as much. And they stay in their rooms.

When things were going less well I definitely um... I didn't leave the house. (Sally)

I'm quiet. But I'm never normally quiet, that's one way to symbolize I'm having a bad day. (Emma)

Unlike using this alone time to self-regulate as was often the case when angry or frustrated, staying inside when feeling low was associated with tiredness and a loss of motivation, with some participants recognising this as a cycle:

Ummm. I don't talk [on a bad day]... I would, but I'd probably fall asleep sleep mid-sentence.
(Alex)

So again, it's that withdrawal. I felt low so I stopped going to college... I wouldn't really express how I'd feel, but I'd cry a lot in private...I didn't really involve myself again and would just shutdown (Sally)

Just feel like giving up. I don't have many motivations. I [don't] really feel emotionally invested in anyone. I just want to sit in my bed and sleep. Most of the time. Yeah, trying to sleep the problems way even though it's not gonna work. Have to face it. (Emma)

Emma and Sally also reflected on their 'brains' in these moments and the role of their thoughts in maintaining these cycles:

I mean I'd start getting in these really deep, kind of, thoughts, yeah, and just spiralling... when I felt really bad, I'd think of that same thought or that that same situation really intensely, to the point where that was just so amplified. And it was hard to let anyone else in.
(Sally)

Heavy? Kind of, like, tired. I guess my body feels tired when it happens. And very stupid. My brain turns stupid...it's telling you one thing, but you know it's not true and like, but your brain wants you to think that it is... (Emma)

In contrast to the earlier themes of belonging and feeling involved, the social withdrawal that was linked to feeling low, and the impact this had on tiredness and motivation can be seen as an indicator of deterioration of psychological wellbeing.

Subtheme: Lack of control links to risk

These young people did not see engaging in behaviours associated with risk as an inevitability or simply 'part of being in care'. When young people spoke about underage drinking or drug taking, for example, they did so with an awareness of the context of these behaviours and usually felt as though they could have been prevented with appropriate support. Some of the participants directly associated risk taking with feeling out of control:

I was spiralling, emotionally. I then found myself creating really bad friendships in terms of, it was kids that weren't necessarily...I would say I was definitely taken advantage of. And I would sometimes find myself with people in my house that I didn't want to be in my house, and they were doing drugs. I think yeah, because things internally weren't going well. (Sally)

This was similar for Luke, who told the researcher how he would run away or try to escape over fences in response to conflict, unable to control his emotions:

Luke: I ran away and went up to the park...I went to meet someone and play football...

Carer: But you didn't know she was going to be there did you, you just went...

Interestingly, however, Luke's carer had encouraged him start climbing lessons which had reduced his tendency to climb and escape when feeling distressed:

He used to find it very challenging to stay in school, so he would climb. And he is very, very good at it. So, you know, a 6 foot fence, he would be over it in less than 30 seconds. And he would then go. (Luke's Carer)

As seen here, adults had a role to play in managing or exacerbating some of these young people's engagement in risk. A lack of support from adults was often cited as a contributor to young people feeling out of control and engaging in potentially dangerous activities:

But I did start to drink at like 16 as well, you know, but for a short period of time. But yeah. Yeah, I think because there was a lack of support. There was a lack of direction. I needed direction. That was subsequently, I just did whatever and with whomever that came that wanted to be there... (Sally)

Behaviours associated with risk were therefore often related to feeling out of control and a lack of support from carers. Feeling supported and in control of behaviours that are associated with risk could therefore be seen as an indicator of psychological wellbeing.

Theme 5: Interests and Talents

All eight young people interviewed were encouraged to speak about their strengths, an opportunity which many of them embraced. The researcher fieldnotes repeatedly mention the degree of ease

with which the participants spoke about their range of passions and things they were good at. Having opportunities to express and build on these interests and talents, and feeling motivated to do so can be seen as an indicator of psychological wellbeing.

Subtheme: Being good with people

A number of the participants took pride in their ability to get on with people, understand others and care for the people around them:

I guess my ability to like build relationships has always been like, my one of my strengths. So I've been able just to talk to anybody, like I've been told that I can just talk to a brick wall...(Daniel)

Caring....Listening...Communication. Uh, just respectful really. (Mia)

I help my grandma cause she lives in [a care home] and I, I just feel bad that some old people don't get the help, so it's nice to care for them (Charlotte)

The young people in this sample were often working, or had aspirations of working in, caring professions such as social work, care homes or nurseries. Getting on with and caring for others was often seen as a skill and something they wanted to develop further. For many, it was linked with being in, or aspiring to, positions of leadership and responsibility:

I've been able to, like, through my voluntary commitments with like, different youth organizations...been able to learn to use those relationship skills to network with them...So I guess, one of my key skills is to like, represent others. (Daniel)

I like forest school things. I'm tryna' help, like try and be a leader, sort of things. (Luke)

For some reason, kids and animals adore me.... every single year since I was in year 8, it's happened, like some random kid who won't leave me alone. So I just have like a herd of lower year groups...(Alex)

[My teachers would] probably say I'm passionate...the boys in my class...they were like really racist and homophobic, so I'd be like educating them. (Louise)

I give like the best advice...sometimes when [me and my friends] don't know what we're doing, and I just bring up something and we all end up doing it... (Charlotte)

It's clear to see these young people were affable, caring and natural leaders. Opportunities to exhibit and develop these traits were seen as an important facilitator of psychological wellbeing. Given their clear conceptualisation of this as a strength, this is a related but distinct theme from 'Strong and Stable Relationships', the building of which was spoken about as more of a response to difficult circumstances.

Subtheme: Creativity

The participants frequently mentioned creative activities as things they enjoyed and were good at. A range of creative pursuits were mentioned throughout the interviews, from origami and painting, to playing the guitar and learning to cook:

Sometimes [I cook]. Try new recipes. I made some for the worker as well. It's very easy like, all you do is just wash kale, and then add salt and like seasoning. And then put it on a tray for 15 minutes in the oven. (Louise)

Sometimes, the participants used their creative talents to make gifts or express care towards others. Alex took pride in telling us about the present they had carefully made for their girlfriend:

For Valentine's Day, I made an origami bouquet of flowers, and all cards are handmade...The flowers took so long... I did six lavender, six lilies and six roses. And they, the roses in total took, like, 20 minutes each. Then the lilies, it took around 3 hours in total to make... (Alex)

Creativity was also sometimes spoken about as a way of expressing or letting out difficult emotions:

I like to do art, like draw and paint my emotions out and stuff like that, because that really helps... I think it's because all the different colours I can use, and I can just literally wreck the paper with stuff...especially when I'm in a happy mood, I use vibrant colours. Whereas when I'm in a bad mood, I use all the dark, gloomy colours with a bit of red. Symbolise danger. (Emma)

Creativity was arguably a strength for many of these young people. Access to creative activities and the ability to use these activities to build relationships or cope with difficult emotions was an indicator of psychological wellbeing.

Subtheme: Access to animals and nature

Many of the participants were passionate about animals and nature, contact with which was a key feature of accounts of good days or coping mechanisms. In fact, the researcher noted that 7 of the 8 participants mentioned their care and love for animals in their interviews:

Researcher: Is there anything in particular that has helped you through some hard things that you've been through?

Alex: Animals.

Researcher: What's your favourite animal?

Alex: I don't have one. I just like them all.

Animals always make me happy anyway, because they're just so innocent and cute, even though they can be predators. Especially the White Wolf. Always gets me. I love the White Wolf. (Emma)

For some, coming into care had meant saying goodbye to the pets they had at home, something that was associated with feelings of sadness and loss:

I've always had pets, at my mums I had five cats...a bunny, guinea pig, dogs, chickens. I miss them now. It's so hard. I did have my own dog as well. (Louise)

Others spoke about animals more in the context of being outside and in nature. Luke and his carer reflected on their favourite thing to do at the weekend:

Carer: He likes [location] because it's a big park, lake, lots of places to ride around and lots of swans and ducks

Luke: Swans and ducks and geese and trees!

Carer: It's a very calming place to go.

It follows that this park was where Luke could sometimes be found when things got difficult at home:

If I'm angry, sometimes I go down there, because they've got like a big lake and they've got little streams on the edge...and I sit on the benches next to the streams and just watch the world go by. (Luke)

This was also the case for Daniel, who found that being outside allowed him to engage in the physical activity he deemed important for managing his mood:

The way I dealt with [feeling down] was I live in quite a rural area. I'm surrounded by mountains and like, the sea and stuff. So, I used to go kayaking with one of my friends and I used to go hiking. And we went loads of walks around the countryside. And so, I dealt with it that way just kind of went out and did exercise. And I always love, like, nature in general. (Daniel)

Similarly, Luke reflected on the impact of his recent move from mainstream education into his "Forest School":

...it's outdoors. So there's like less pressure... it's more better, cause I don't get angry cause it's outside anyway. And it's not like a lot of people in the room. It's only like 10, 20, well not even 20 but 10...so it's less crammed. (Luke)

It is clear to see that many of these young people were passionate about animals and the outdoors. Access to and active engagement with animals, nature and physical activity were related to one another and often clearly articulated as important indicators of psychological wellbeing.

Participant Feedback

As previously mentioned, these themes were presented to the participants in a process of member checking to increase the validity and credibility of the results. At the time of writing, five of the eight participants have provided their feedback. The questions and corresponding answers are detailed below:

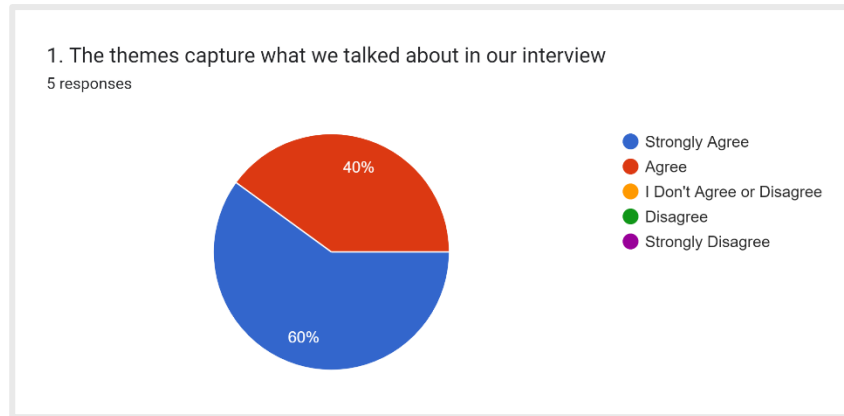


Figure 1: Participant responses to Question 1 on the feedback questionnaire

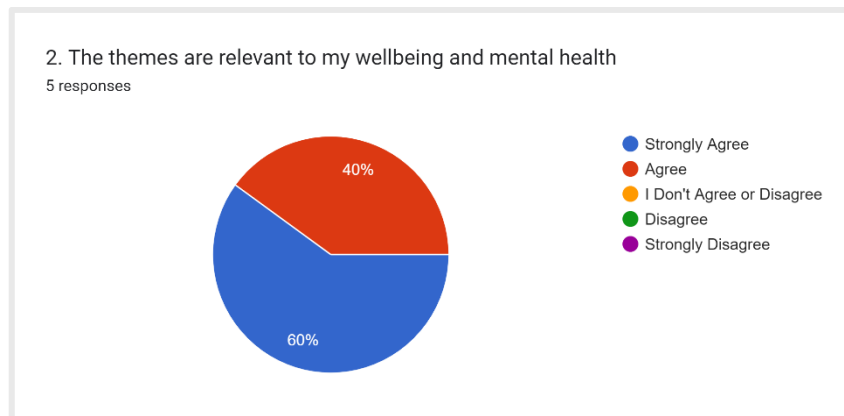


Figure 2: Participant responses to Question 2 on the feedback questionnaire

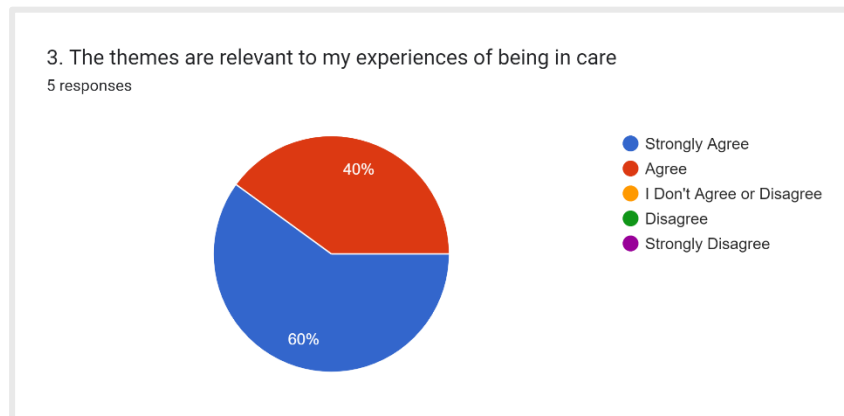


Figure 3: Participant responses to Question 3 on the feedback questionnaire

One response was recorded to the free response question: "Is there anything you think we've missed, or any other comments?". One participant responded with the following:

"We felt that Theme 3 - Sense of "Agency", the term Agency is confusing as this is often used to refer to the fostering agency and not the YP's feelings, and would be better written as "Sense of Control" (Anonymous Participant)

Researcher Reflections

As previously discussed, high quality and ethically sound qualitative research requires reflections from the researcher as to their role in shaping the process and findings (McCabe & Holmes, 2009; Yardley, 2017). This is particularly important when using thematic analysis and conducting research within a critical realist epistemological stance (Braun & Clarke, 2020; Collier, 1994). I am detailing the reflections below in first person to provide a summary of my reflective process throughout the project, facilitated by the bracketing interview and reflective journal.

I believe it is important to note that I do not have care experience. I had secure and stable relationships with my birth family throughout my childhood and these have continued into my adult years. I am a white, middle-class person with university education. Any experiences I have of disadvantage or marginalisation are related to my LGBTQ+ identity and experience of mental health difficulties, but these have been relatively small and moderated by significant privilege in other areas of my life.

This means there is likely to have been a limit to how much I could relate to the experiences of my research participants. In practical terms, this means I may not have followed up some topics of conversation, understood the significance of certain experiences or even misinterpreted some of what my participants shared. Following advice from the care experienced panel, I often shared with the participants that I did not have care experience which may understandably have impacted their readiness to share their experiences or thoughts. However, trying to hold this privilege in mind may have meant that I over-compensated during the interviews and sometimes unintentionally disempowered my participants by making assumptions about what they were willing or able to discuss, rather than letting them assert their boundaries themselves when needed.

In addition, I also approached this research from background in academic and clinical psychology. I have experience talking to young people in care, but this is predominantly in a professional context conducting psychological assessments for Local Authorities. I have also worked with the organisation who developed BERRI and been involved in rolling out this tool in its current form. This means that my understanding of young people in care has been developed predominantly in the context of mental health research and clinical practice. This is likely to have impacted my interpretation of these results and compromised my ability to understand and discuss psychological wellbeing truly in these young people's terms. I also knew from the outset that this data would be used in the formation of a new element of the BERRI tool, so may have interpreted the results in a way that I

thought would be most useful with this goal in mind, rather than driven purely by the data itself.

These reflections are not exhaustive neither do they impact the credibility of the research. Presenting them in the findings section of this thesis is hopefully a reminder that the findings cannot be separated from their social, cultural and political context and should be interpreted with these in mind.

Discussion

Discussion of findings

The responses and themes derived from the interviews present a unique and informative insight into CLA perspectives on their psychological wellbeing. The results from the member checking process suggest that the themes created by the researcher reflect what was discussed in the interviews and resonate with participants' experiences of being in care, their wellbeing and their mental health. Each theme will now be discussed further in terms of its relevance to existing literature that has focused on the perspectives of CLA. As Holland (2009) notes, some of the principal theories drawn on in research and practice with CLA are attachment and resilience. Although these are adult defined concepts, discussion of how the present study relates to these theories is likely to further contextualise and demonstrate the value of the findings.

The ability to build and maintain strong relationships was seen as a key indicator of psychological wellbeing amongst these young people. Frequent placement disruptions made this a difficult but necessary endeavour. Across the literature, CLA often report that they wish to stay within their community or, at least, keep established connections with family and friends after being taken into care as these are viewed as their most reliable and trustworthy relationships. This is often the case regardless of the circumstances in which young people are taken into care (McAuley & Young, 2006; Shaw, 1998). Frequent placement moves are viewed by CLA as having a negative impact on their emotional wellbeing (Gaskell, 2010; Holland et al., 2010), something that has also been repeatedly evidenced across studies quantitatively assessing mental health of CLA (e.g. Courtney & Barth, 1996; Cullen et al., 2022). In addition, strong and stable friendships are seen as an important factor in promoting positive outcomes when leaving care (Dixon, 2008).

It is appropriate here to consider attachment theory, which suggests that all humans are born with a need to form a close emotional bond with a primary caregiver (Bowlby, 1969; 1988). When a child receives a consistent, caring response from their caregiver, they are given a secure base from which to explore and develop and this is considered to have a significant impact on later development.

Neglected children or those whose carers are inconsistent may feel anxious and insecure. These feelings can continue and impact the way individuals view themselves and others later in life (Bowlby, 1969; South et al., 2016). Many young people in care are likely to have experienced disruption in their attachment to their caregivers (Munro, 2001). Efforts are therefore often made to facilitate the building and maintaining of stable attachment relationships, and the benefits of this in terms of mental wellbeing, positive self-esteem and even educational outcomes are well documented (Cullen et al., 2022; Perry, 2006; White et al., 2009).

However, whilst attachment theory often focuses on a single birth parent, research has shown that multiple attachments are common and can even be beneficial, particularly for young people in care (Schofield & Beek, 2009). In the present study, this is demonstrated in the participants' limited mention of birth families and their focus on friendships when discussing relationships. Young people with insecure attachments have been shown to opt for their peers as their primary attachment relationships (Freeman and Brown, 2001). The CLA spoken to by McMurray et al. (2011) felt their friends were important sources of emotional support and people that they could be their real selves around. The adults in their lives, by contrast, were seen as transient figures who they were less motivated to build relationships with. Where young people in care do form attachments with adults, this is often only seen as possible within consistent and long-term relationships with carers or social workers (McMurray et al., 2011).

Strong relationships with peers were also important for the young people in this study to feel a sense of belonging. This was often most salient when they had friends with similar experiences or with people who 'understood' being in care. Belongingness is considered a basic human motivation but usually remains unconscious until one notices its absence (Bengtsson & Luckow, 2020; Bennett, 2014). As Biehal (2012) argues, CLA may have to continuously construct a sense of belonging as they move between families and repeatedly build "identification with one's social, relational and material surroundings" (May, 2011; p.368, as quoted in Bengtsson & Luckow, 2020, p.107). In addition, young people in care often experience high levels of social exclusion and stigma (Bromley et al., 2020). The young people spoken to in focus groups by Stanley (2007) cited relationships with other CLA and confiding in people with similar experiences as a significant part of reducing the stigma of being in care. For the young people in the present study, it is therefore easy to see why an ability to build, maintain and repair their relationships with key attachment figures was a significant indicator of psychological wellbeing.

The individuals in this research had a strong sense of themselves and their life stories, and saw this as a strength and facilitator of psychological wellbeing. Similar findings are echoed across literature that elicits care experienced perspectives on identity formation. For example, the black and minority ethnic (BAME) care leavers in Lensvelt et al.'s study (2021) on identity formation discussed their journeys of becoming themselves, including recognising certain pivotal moments and an appreciation for how the past had impacted their current sense of self. Lensvelt et al. (2021) comment on the "meaning-making process" (p. 44) that took place in their interviews and the way in which participants would make sense of the present through discussing the past and vice-versa. These findings arguably align with the increasing emphasis in care planning guidance on carrying out life story work with CLA and awareness of the importance of enabling these young people to explore and develop their own sense of story and identity (Sanders, 2020).

A common thread in these stories from participants was their ability to adapt to change, overcome challenges and bounce back from adversity. Labelling this subtheme as 'resilience' requires some discussion of the literature surrounding this term. Resilience is a widely used but vaguely defined concept and confusion often arises as to whether it is an individual trait, a desirable outcome or an adaptive process (Antcliff et al., 2011). Considering these different meanings and understandings of resilience, Antcliff et al. (2011; p. 6) offer a definition which arguably resonates with the stories from the young people in this research: "Strength in the face of adversity. The capacity to rebound from stressful life events, strengthened and more resourceful."

Lensvelt et al. (2021) argue that further exploration and research is needed to explore how resilience relates to CLA. There are not many examples of CLA discussing the concept of 'resilience' across the literature. However, accounts from CLA do often feature stories of strength, coping and adapting, similar to the participants in the present study. For example, the care leavers in the studies by Lensvelt et al. (2021) and Colbridge et al. (2017) saw themselves as survivors and often mentioned how they identified and developed their strengths whilst going through difficult experiences. Drapeau et al. (2007) interviewed young people in foster care about their pathways to resilience and found that they saw self-efficacy, the ability to reflect and being exposed to new opportunities as important factors in their journeys. For the CLA spoken to by Ungar (2001), the opportunity to have control over their lives and placement decisions was key to their constructions of themselves as resilient individuals.

The young people in this research also highlighted having a sense of agency as a key indicator of psychological wellbeing, echoing a key theme from the literature review. Central to this was being

listened to and heard, which was contingent on seeing adults take action in response to their views and wishes. Similar findings exist in literature spanning across decades. For example, Sinclair (1998; p.139) concluded that “while social workers may think they are listening, children do not feel they are heard.” Some twenty-five years later, the children spoken to in the Good Childhood Report (2022) cited not feeling listened to as the aspect of their lives they were least satisfied with. Feeling listened to has been directly linked to psychological wellbeing, both from the direct perspectives of CLA and in adult defined theory and research. For example, the young people spoken to by Bazalgette et al. (2015) saw this as one of the most important influences on their emotional wellbeing, citing the importance of having their feelings acknowledged and the need for adults to facilitate varied and alternative means of communication. Cashmore (2002) argues that feeling listened to is particularly important for the psychological wellbeing of children and young people who may have been abused or neglected, enabling them to build self-esteem and confidence. This was arguably the case for the participants in this study.

Participants also saw having independence as a key facilitator and indicator of psychological wellbeing. This was something that many felt had been taken away from them upon coming into care, or that was stifled through rules impressed on them during placement. Care experienced young people in other studies often discuss their frustration towards navigating and negotiating new rules and boundaries when moving placements (Mullan et al., 2007; Thomas & O’Kane, 1999). Across the lifespan, self-determination and independence are associated with the development of resilience and positive mental health, particularly for marginalised groups (Nelson et al., 2001; Prilleltensky et al., 2001). However, by contrast, the transition into semi-independent living was associated with a sudden expectation of independence that the young people in this research felt underprepared for. As Cashmore (2002) notes, one of the difficulties facing CLA leaving care is the abrupt and early transition into adulthood. This is coupled with a lack of opportunity to safely explore independence and make their own decisions whilst younger and in care. Too often, care leavers are experiencing many of the ‘firsts’ of growing up without appropriate support and guidance (King & Ndure, 2019). This is likely to be a contributing factor to the well documented mental health difficulties facing many care leavers (Dixon, 2008).

The participants in this study viewed having structure, plans and routine as important indicators of psychological wellbeing. On first consideration, this seems to contradict the frustration surrounding stifling rules and regulations evident from CLA in other research. However, for participants in the present study, being able to make and stick to their own plans and routines was an important part of creating a sense of agency. Howe (2017) and Golding (2008) posit that this need for control and

certainty could be driven by anxiety related to insecure attachment relationships and living in unpredictable environments that are common experiences for many CLA. Building and sustaining a daily routine is also thought to require and promote psychological resilience, particularly when individuals have been exposed to stress (Hou et al., 2019; 2020). This was evident amongst care leavers in Bakketeig et al.'s (2020) study, who emphasized the "importance of the everyday" (p. 6) and that engaging in the "mundane" (p. 5) aspects of daily life such as cooking and cleaning were signs that they were "doing well" (p. 1). When it comes to having longer term plans as an indicator of psychological wellbeing, the findings of the present study echo a common theme in the literature that positive future aspirations can contribute to resilience and act as a buffer against negative outcomes (Beal and Crockett, 2010; Sulimani-Aidan, 2015).

The participants in this study usually discussed deterioration in their psychological wellbeing in terms of losing control over their emotions and behaviour. Similar themes have been found in research that has explicitly asked CLA about their mental health. For example, the young people spoken to by Mullan et al. (2007) told researchers that the externalising behaviours they associated with difficult mental health experiences included anger and hitting out, self-harm and alcohol and drug use. The experience of withdrawing when dealing with difficult emotions is also documented, with Singer et al. (2004) finding that significantly more foster children than birthchildren reported hiding their emotions from carers and were less likely to try and induce empathy from adults by sharing how they were feeling. In addition, Powell et al. (2021) noted that CLA showed a lower level of help-seeking behaviours than their non care experienced counterparts, citing concerns around a lack of understanding from adults and mental health services as a reason for not seeking help.

As Antcliff et al. (2011) remark, difficulties in regulating emotions and behaviours are common for children who have experienced prolonged exposure to stress and an absence of support. However, the ability of the young people in this study to reflect on their difficulties with emotional and behavioural regulation and draw links between their engagement with risk-taking behaviour and a lack of control shows a remarkable level of insight into their psychological wellbeing and is arguably in itself an indicator of resilience. As Mullan et al. (2007) note, the difficulties in emotional and behavioural regulation in this population should not necessarily be seen as pathological, rather a sign of being under the care of a system that is not always equipped to provide appropriate support for traumatised young people.

The young people in this research embraced the opportunity to discuss their talents and interests and saw their motivation to engage in and develop these as a key strength and indicator of

psychological wellbeing. Understanding these participants' interests and talents within the existing literature has been challenging given the limited research directly exploring CLA perspectives on their strengths. This alone is an interesting point of discussion for the present study and arguably furthers the rationale for challenging the predominance of deficit-based narratives in this area of research.

Where talents and interests of CLA are explored in the literature, they are often contextualised within resilience theory. In fact, "Talents and Interests" is also one of the six domains that Daniel and Wassell (2002) argue contribute to building resilience. Whilst research in this area focusing on CLA in particular is sparse, there is a small but growing body of evidence that directly links young people's creativity, physical activity and proximity to nature with resilience related concepts such as self-confidence, self-esteem and a sense of belonging (Gillespie & Allen-Craig, 2009; McCormick, 2017; Zarobe & Bungay, 2017). There are also believed to be therapeutic benefits of physical activity, exposure to nature and engaging in the creative arts for young people who have been exposed to trauma (Hunter & Rosevear, 2011; St Thomas & Johnson, 2007; Tillman et al., 2018).

Similar themes exist across the literature when it comes to animals (e.g. Purewal et al, 2017), and this is an area where perspectives from CLA themselves are often more prominent. For the young people spoken to by Wood and Selwyn (2017), pets were seen as one of the key relationships in their lives and central to their subjective wellbeing. They felt that they could speak to pets in confidence without fearing their response and thought that animals were always happy to see them. Holland et al. (2020) found that young people in care who self-harmed listed animals as one of the top three sources of support that they found useful in reducing their distress. This was not the case for non-care experienced young people who were self-harming.

Many of the young people in this research discussed their ability to get on with and understand others as a considerable strength. This echoes a key theme from the care leavers in Lensvelt et al.'s (2020) research who said that they connected with the role of helping others and often had future aspirations of working in caring professions. Empathy, pro-social behaviour and general social competence are seen as contributors to building resilience (Daniel & Wassell, 2002) and there is evidence to link such behaviours to positive outcomes in adulthood (Caprara et al., 2000; Daniel & Wassell, 2002). This is of particular interest within this population due to the likely early experiences of abuse and neglect which are sometimes linked to aggressive behaviour or a delay in development of empathy and prosocial behaviours (Antcliff et al., 2011). However, Heller and LaPierre (2012) posit that children in adverse family circumstances often learn to survive by deprioritising

themselves and attending to the needs of others. They argue that, by inviting other people to rely on them, these young people may be managing their fears around rejection and expressing their needs. Therefore, for the young people in this research, their ability to understand and get on with others is a remarkable display of strength and development in the face of adversity, but further understanding of whether this links to suppressing their own needs is likely to be of interest.

Limitations

Whilst the present study has some considerable strengths in elucidating CLA perspectives on their psychological adjustment, there are a number of limitations that should be highlighted. As Ross and Zaidi (2019) comment, researchers across all disciplines have a responsibility to the academic community to accurately reflect and report on the limitations of their work. For a research project which had aimed to place the rights and interests of CLA at its centre, reporting on limitations is arguably also important for the young people involved in the research and those who may be impacted by its findings.

Primarily, the findings of this research should be interpreted with an awareness of the limitations of qualitative research. Unlike quantitative research, qualitative research is exploratory in nature and is designed to generate hypotheses rather than test them (Barker et al., 2015). The findings of this research, whilst rich and insightful, cannot claim to hold true for all CLA and should not be seen as generalisable. Rather, they represent the opinions and experiences of the young people spoken to in this particular project. In addition, as is appropriate to consider within a critical realist position, the impact of the researcher in qualitative research cannot be ignored. As Smith and Elger (2012, p.18) highlight, interviews are “necessary for accessing human thought, meaning and experience” but warn against seeing them as “an adequate basis for analysing the multiplicity of factors at play in social relations.” Potential areas of influence arise from the assumptions that a non-care experienced researcher may hold about CLA, shaped by the social and political context they live and work in. This could have influenced, for example, what questions were asked in the interview and how responses were interpreted in the analysis. In addition, the participants may well have seen the researcher as akin to the professionals that regularly exert power over their lives, impacting what they chose to discuss.

The methods used to recruit participants in this research are likely to have introduced significant bias into the sample interviewed. Using care providers as gatekeepers had advantages in terms of ensuring appropriate screening for emotional distress and suitability for the study. However, this

may well have meant large groups of children and young people will not have had the research advertised to them and their experiences and opinions are therefore not likely to be represented in the findings. As Ward et al. (2005) note, this is common with research in the CLA population and final samples can be biased towards those with better outcomes, fewer emotional and behavioural difficulties and therefore more positive overall experiences of care. This, in part, could be reflected in the fact that the participants in the present study found it easier to discuss improvements in their psychological wellbeing and times when things were 'going well' than they did the more negative or difficult aspects of their psychological wellbeing.

The potential bias in this sample also comes from the fact that some key demographics within the CLA population are not represented by the participants. Whilst some of the young people in the sample had experienced brief stays in residential care, none were currently in under-18 residential accommodation nor had experienced previous extended stays in residential care settings. Where residential placements were represented, this was in the form of semi-independent living placements which were held by those over the age of 16 who had been in foster care prior to this. Whilst the majority of the care population are in foster care (Department for Education, 2022), CLA in residential care typically represent those with higher levels of need, higher incidence of offending behaviour and worse overall outcomes (Strijbosch et al., 2015).

Another subgroup of CLA not represented in the sample is Unaccompanied Asylum-Seeking Children (UASC), which currently represent around 7% of the CLA population (Department for Education, 2022). Given the circumstances from which these young people are coming to the country, they are likely to have particularly high levels of need, some of which will be unique to their UASC status. Limited expertise in engaging young people from other cultural backgrounds and limited financial resource (e.g. for translators) in the research team meant that it was not viable to include UASC in the present study. The findings of this research should therefore be considered in light of the regrettable exclusion of UASC.

A strength of the present study was arguably the participation of care experienced advisors during the research design process. However, given the early career of the researcher and the known vulnerability of the population it was deemed appropriate to gain ethical approval before such involvement was sought, by which stage the initial structure of the study was in place and the timeframes of the research schedule would not permit complete restructuring of the proposal. Whilst this was not what the panel advised in this case, true care experienced involvement would

have involved consultation from the outset. Given the power dynamics between researchers and participants, particularly those from marginalised groups (Bradbury-Jones et al., 2018), those consulted may have felt pressured or expected to give positive feedback on the methodology and design of the research presented to them, rather than being able to fully engage and offer their honest thoughts and ideas. As Percy-Smith and Thomas (2009) note, true participatory research with young people is best achieved when they have been involved in all stages of the research, from planning through to evaluation.

Similarly, alternative research methodologies and design consideration could have had been more participatory in nature and led to more equal power dynamics between researcher and participants. As McLeod (2007) notes, a research interview is likely to have similarities from the many official reviews and meetings that CLA attend and therefore the same power dynamics and high stakes may be presumed. Although steps were taken to explain the research and provide clarity that their participation would have no direct impact on their care, this familiarity in format may have impacted the young people's motivation or ability to reflect on their experiences in the interview. The initial plan for the present study involved focus groups to offer young people to offer a more novel way of communicating, more control over what was discussed and to facilitate the expression of a range of views (MacDougall & Fudge, 2001). However, all of the participants opted for semi-structured interviews when given the choice of how they would like to participate.

Potential other methodologies could have included Photovoice (Gruman et al., 2017; Wang & Burris, 1994), a participatory action methodology used to elicit and empower the voices of marginalised groups and communities through the capturing, discussing and displaying of photographs from participants. Whilst this methodology was considered during the design phase, the research aims of the present study were deemed too specific to be answered by Photovoice methodology, and the time needed to collect and display the photos was potentially beyond the scope of the project. Photo elicitation (Collier, 1957) was instead used to offer some of the same creativity and alternative options of expression that are possible with Photovoice.

The rationale and importance of eliciting CLA perspectives has been previously discussed. Given the focus on self-report methods in this study, both in terms of the research interviews and the tool that will be designed as a result, a reminder of the limitations of self-report is also appropriate. A particular example for the present study is that the young people may have felt pressured to give socially desirable responses about their psychological wellbeing, particularly to an unknown

researcher in a position of relative power. They may also have not felt comfortable to ask for clarification of any questions or concepts discussed in their interviews. In addition, younger participants may have limited introspective ability and potentially have been inconsistent in their perception of their psychological or behavioural difficulties (Wolpert et al., 2008).

The limitations discussed above do not render the present study invalid or unusable. Rather, as Ross and Zaidi (2019) note, awareness and discussion of limitations of research ultimately enhances the strength of the work and highlights opportunities for further exploration of a topic. Understandably, some of these limitations echo the earlier highlighted challenges of eliciting CLA perspectives. Prioritising and valuing the voices of marginalised communities within research is arguably something of an ongoing paradigm shift, one fraught with challenges which require understanding and motivation from academics and, most importantly, effective collaboration with those who guide and participate in research.

Implications and Conclusion

This research aimed to get young people in care's perspectives on their psychological adjustment to inform the design of a new element of the BERRI questionnaire. This was deemed a timely and necessary endeavour given the significant psychological need of CLA coupled with the lack of opportunity and paucity of measures designed to elicit the perspectives of young people in care.

In terms of implications for further research, consideration must now be given regarding how to successfully translate these themes into the design of a new element of the BERRI questionnaire. The use of qualitative methods to aid the subsequent design of questionnaires is an established method (Barker et al., 2015). However, as Ricci et al. (2019) argue, details of how findings from qualitative analysis are converted to the design of a questionnaire are poorly recorded. At the time of writing, a draft of the questionnaire has been created (Appendix P). Draft question items were written based on the themes identified and, where possible, echoed language that was used by participants across the interviews. Four questions were derived from each of the five themes and then placed in a randomised order. The next steps of development could include eliciting feedback from CLA on the wording of items and form design. In addition, a small-scale pilot study could take place, with cognitive interviews to understand the practicability of administering the questionnaire with varying ages and abilities (Holder et al., 2011). This could be followed by a larger scale pilot study to assess the psychometric properties of the measure and assess how scores from the young person's questionnaire relate to that from the adult versions of the questionnaire.

In terms of implications for practice, it would be naïve to think that any measure designed as a result of this research will be the solution to the well documented challenges of including CLA perspectives in care planning and decision making. It is notable that care experienced young people's need for agency was both a feature in the rationale for this research, and also a finding of the analysis. This cycle can be found across the literature in this area spanning a number of years, where it is repeatedly revealed that care experienced young people want to feel more in control and have more of a say in the decisions that impact their lives (e.g. Holder et al., 2011; Shaw, 1998; Wood and Selwyn, 2017). There is arguably therefore a disconnect here between what CLA are telling us in research, and what is being done about this in practical terms. Crucially, there is still need for a significant shift in how adults – from practitioners to policy makers and parents – include and act on the voices of care experienced young people.

The findings from this research offer an insight into what care experienced young people view as signs of strength, improvements and deterioration in their psychological wellbeing. Some of the superordinate themes and subthemes echo well established findings or fit neatly within existing psychological theory or frameworks. For example, the ability to build and maintain relationships in spite of frequent placement moves is mentioned frequently by CLA across the literature and can be understood through the lens of attachment theory. Other findings from the present study offer a more novel and nuanced insight; For example, the act of engaging in routine, everyday tasks as an important indicator of psychological wellbeing, or the ability to understand and care for others as clear strength for the participants in this study.

There remains, however, a clear discrepancy between the wishes of CLA to be listened to, and the ability or motivation of adults to hear what is being said. Finding solutions to this problem may be aided by more research regarding how adult defined concepts such as resilience and attachment are viewed by and related to care experienced young people. Developing deeper understandings of how both practitioners and CLA view the use of outcome measures, and the barriers to their effective implementation may also be of value. In addition, further exploration of how a shift from deficit to strength-based narratives may be implemented within the field is likely to be beneficial. These efforts are necessary to challenge the view of CLA as entirely vulnerable and passive recipients of care and move towards seeing CLA as potentially strong individuals who are experts in their own needs and collaborators in their care. A higher quality of care provision and an overall improvement in the psychological wellbeing of CLA, both when in care and in life after care, are likely as a result.

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Appendices

Appendix A: Example initial approach to care providers

From: **Amy Malone** <[REDACTED]>
Date: Fri, 2 Dec 2022 at 08:00
Subject: BERRI Research Project: Getting young people's perspectives on their psychological adjustment
To: [REDACTED]

Good morning [REDACTED],

I hope you are doing well. I am just getting in touch regarding a research project we are conducting at BERRI in conjunction with Canterbury Christ Church University. The title of this project is: Getting young people's perspectives on their psychological adjustment as an addition to the BERRI questionnaire.

As you will know, the current design of BERRI gathers the perspectives of caregivers and professionals, but does not ask for the child or young person's input on their psychological adjustment. Feedback from our users has highlighted that including the young person's voice in the measure would significantly enhance the level of understanding that the tool provides.

As such, we are conducting this research with the aim of designing a new element of the BERRI questionnaire which will be filled in by the young person. To do so, we are looking to carry out some interviews with care experienced young people to get their perspectives on their psychological wellbeing.

I have attached a briefing document with more information on the project. We would be grateful if you could take a look and let us know if this is something you think would be suitable for some of the young people known to your organisation to participate in. If that was the case, we would then arrange a call to answer any questions and discuss next steps.

Thank you in advance for your time.

Kind regards,

--

Amy Malone
Assistant Psychologist / Fieldworker

BERRI Ltd.
<https://berri.org.uk/>

Provider initial information: Getting young people in care's perspective on their psychological adjustment as an addition to the BERRI questionnaire

Background to the project

The current design of BERRI gathers the perspectives of care givers and professionals, but does not ask for the child or young person's input on their psychological adjustment. Feedback from our users has highlighted that including the young person's voice in the measure would significantly enhance the level of understanding that the tool provides and ensure that young people feel involved in the monitoring and planning of their care.

As such, we are conducting this research in conjunction with Canterbury Christ Church University with the aim of designing a new element of the BERRI questionnaire which will be filled in by the young person. To do so, we are looking to carry out some focus groups and 1 to 1 interviews with care experienced young people to get their perspectives on their psychological wellbeing, and how such a tool should be designed.

The task(s)

Interviews

Participants: 1 to 1 interviews with researcher

Task: 60 minute informal interview with researcher, discussing the young person's perspectives on psychological wellbeing. In the month before the interview, they will be asked to take a small number of photographs across their daily lives (excluding any identifiable data e.g. faces) and bring these to the interview. There will be a small follow up form to fill out online/via post roughly three months later.

Logistics: Can be done face to face or via zoom. Researcher can travel to local to the participant. Travel expenses will be reimbursed and £20 voucher will be sent after the feedback form is sent back.

Example Questions and discussion points

- What does the term psychological wellbeing mean to you?
- How does it feel inside when things are going well or less well?
- If we were to try and get your perspective on your emotional wellbeing on BERRI, what questions would you like us to ask?

The participants

Inclusion criteria:

- Age: 15-18 at time of participation
- Current experience of being 'Looked After' outside the family home
- Known to an organisation using BERRI
- Willing to engage in the full research project and contribute to discussions about psychological wellbeing

- No current significant emotional distress, significant current vulnerability or learning disability

We are aiming to recruit from a range of placement types and services known to BERRI: in-house fostering, independent fostering agencies, residential care settings, supported accommodation and adoption services. We are also keen to hear a wide range of voices across race, sex, gender identity and disability status. Due to the nature of the project, participants must not have any current significant distress or vulnerability or learning disability.

We will be asking our contacts within provider organisations to discuss the project with young people that meet these criteria and facilitate initial contact with the research team if they would like to be involved.

Ethical Considerations

This project has been granted ethical approval by the ethics committee at Canterbury Christ Church University. It is being supervised by academic staff at the university and Dr Miriam Silver at BERRI. We are consulting an expert by experience in the design of the project to ensure we our design is sensitive, appropriate and engaging for our participants.

Full information sheets and consent forms will be provided to participants across the project. Usage and storage of personal data will be in line with GDPR regulations and participants will have the right to withdraw up to the point of data analysis.

The research is being carried out by an Assistant Psychologist with experience of working with looked after children and in NHS mental health services. She has a full and up to date enhanced DBS check. Full and thorough debriefing will be provided for participants including signposting and the offer of a one-off psychology session with clinical staff at BERRI if the research raises any emotional distress.

Would you like to have your voice heard in research?



We are looking for 15 to 18 year olds with experience of being in care to take part in some research. We are interested in hearing your ideas about well-being and mental health.

The aim of this research is to design a new element of the BERRI questionnaire which will (in the future) be filled out by young people themselves, rather than just their carers.

What would it involve?

The research will involve talking to our researcher for about an hour, either in a group or just you – whatever you'd prefer. We can travel to you or meet you at a place you choose.

We will ask you some questions about your wellbeing and your experience of being in care. We might also show you some existing questionnaires and ask for your feedback. Some example questions might be:

- Tell me about something you are good at...
- What words would your friends use to describe you?
- Tell me about a good day you've had recently

You might also be asked to take some photos in the weeks before we meet to show us what your life looks like. We will also ask for your feedback at the end of the project – either using a short online form or a quick call/video call. You will be given a £20 amazon voucher after this is finished.

Who is doing the research?

My name is Amy (pictured here with my dog, Scarlett). I am doing this research with help from my workplace (BERRI) and a university (Canterbury Christ Church). I have lots of experience working with young people and hope to make the research a fun and rewarding thing to be involved with!



What do I do if I want to take part?

If you are interested in taking part, please let your carer or key worker know, and they will be able to give you some more information.

Appendix C: Interview schedule

INTERVIEW GUIDE – 1 to 1

Introduction (5 minutes)

- Thank you for agreeing to take part
- Reminder of information sheet and consent form
- Reminder of privacy, confidentiality and limits of this
- Reminder of audio recording
- Movement and fidget tools
- Breaks and pauses whenever you need
- No right or wrong answers – want to get an understanding of their experiences
- Don't have to discuss anything that may cause distress and can stop at any time
- Feel free to ask me questions as well, at the end we will talk about next steps

Section 1 – When things are going well (10 minutes)

- **I'd like you to think back to a 'good day' you've had recently or a day you felt good...**
 - Can you describe it to me?
 - Where were you? Who were you with?
 - What happened to make it 'good'?
 - What colour (show colour cards) would you associate with this day?
 - Why is that?
 - What were you feeling on the inside?
 - How did this feel 'emotionally'?
 - How did this feel 'physically'?
 - Would people around you have known you were having a 'good' day?
 - If so, how could they tell?
 - When would they notice?
 - If not, why not?
 - Who would notice, who wouldn't notice?
 - Your friends? Carers? People at school?
- **So we've looked at a specific day that went well. Can you tell me about your life when things are going well more generally, perhaps when you're having a good week?**
 - What does this feel like on the inside?
 - What does it look like on the outside?
 - What might your friends notice?
 - What might your carers notice?
 - What might your teachers notice?
- **I asked you to bring some photos with you today, are you okay to show me some of them now? Let's look at some of the photos you took on 'good days'...**
 - What can you tell me about this photograph?
 - How were you feeling when you took this photograph?
 - What, if any, signs are there in this photo that you were having a good day?
- **I'd like you to think about other young people you know in care – friends or people you have lived with....**
 - When things were going well for them, what might you notice?
 - How, if at all, could you tell if they were having a good day?
 - How, if at all, might they have shown you or told you that they were having a good day?

Section 2 – When things are going less well (10 minutes)

- **I'd like you to think back to a 'bad day' you've had recently...**
 - Can you describe it to me?
 - Where were you? Who were you with?
 - What happened to make it 'bad'?
 - What colour (show colour cards) would you associate with this day?
 - Why is that?
 - What were you feeling on the inside?
 - How did this feel 'emotionally'?
 - Would people around you have known you were having a 'bad' day?
 - If so, what would they have noticed?
 - When would they have noticed?
 - If not, why not?
 - Who would notice, who wouldn't notice?
- **So we've looked at a specific day that didn't go well. Can you tell me about your life when things aren't going well more generally, perhaps when you're having a bad week?**
 - What does this feel like on the inside?
 - What does it look like on the outside?
 - What might your friends notice?
 - What might your carers notice?
 - What might your teachers notice?
- **When things are going less well, what might you do to make yourself feel better?**
 - What, if any, coping mechanisms do you have?
 - Who, if anyone, might you talk to?
 - What advice or tips would you give to help other young people feel better on their bad days?
- **I'd like us to look at some more of the photos you have brought with you, if that's okay. This time, let's look at the photos you took on 'bad days'...**
 - What can you tell me about this photograph?
 - How were you feeling when you took this photograph?
 - What, if any, signs are there in this photo that you were having a bad day?
- **I'd like you to think about other young people you know in care – friends or people you have lived with....**
 - When things were going less well for them, what might you notice?
 - How, if at all, could you tell if they were having a bad day?
 - How, if at all, might they have shown you or told you that they were having a bad day?

Section 3 – Your Strengths (10 minutes)

- **Tell me about a time recently you felt proud of yourself...**
 - When was this?
 - What happened?
 - How did it make you feel?
- **I'd like to spend some time talking about your strengths. What would you say some of your strengths are?**
 - What are you good at?
 - What are your favourite things about yourself?
 - What would you say has got you through some of the hard things you've been through?
 - When you're in a stressful or difficult situation, what helps you to get through it?
- **What would other people say your strengths are?**
 - If I were to ask your carer, what would they say your strengths are?
 - If I were to ask your friends, what would they say your strengths are?
 - If I were to ask your teachers, what would they say your strengths are?

Section 4 – Specific concepts regarding wellbeing (10 minutes)

- **What does the word wellbeing mean to you?**
 - What about 'psychological' wellbeing?
 - What about 'mental health'?
- **Some of the things we've read tell us that it is important for young people in care to feel like they belong/matter. I'd like to get your thoughts on this.**
 - Do you feel like you belong/matter?
 - How often do you feel like you matter?
 - If so, who do you matter to?
 - If not, what makes you say this?
 - What does belonging/mattering or not belonging/mattering feel like?
 - What do you think belonging/mattering to someone looks like?
 - How important is it for you to belong/matter to someone?
 - How important do you think it is for other young people in care to belong/matter?
- **What does the term psychological wellbeing mean to you?**
 - Can you give me a definition?
 - Prompt – What does the word 'wellbeing' mean to you?
 - Prompt - What does the word 'psychological' mean to you?

Section 5 – Questionnaire Design (5 minutes)

I've been asking you some questions to understand your perspective on psychological wellbeing/mental health/wellbeing (use as appropriate), and how things look when things are going well or less well for you. We are designing a questionnaire to ask young people in care about their psychological wellbeing/mental health/wellbeing.

- Do you have any ideas about what we might want to include on this questionnaire to understand young people's psychological wellbeing?
 - Is there anything you wouldn't want to be asked?
- Do you have any ideas about what we might want to include on this questionnaire to ask young people about their strengths?
- If there was one thing you wish adults knew about being in care, what would it be?

Debrief (10 minutes - adjusted as needed)

- Is there anything else you would like to add to the discussion we've had today?
- How have you found our conversation today?
 - Is there anything we've spoken about that you are worried about?
 - Is there anything we've spoken about that you will be thinking about later?
 - Who might you talk to if you are feeling worried/sad/upset after our conversation today?
- Give debrief document with avenues for support
- Next steps
- Thank you for taking part

Appendix D: Example transcript excerpt

Researcher Could you tell me a little bit about a bad day you've had recently?

Participant Well, recently, probably the time I was having an argument with my sister over the phone. That was the only recent one that I've had. But that was absolutely terrible.

Researcher Really? Was that happening here?

Participant Yeah, actually I don't know. It kind of carried on from when I was at the hospital waiting for [name]. Until, like, late in the evening...

Researcher Okay. Okay. Yeah. And how does how did that feel that day emotionally, on the inside?

Participant Well it just made me feel angry. Because she was saying all these things I just know weren't true. And I don't like people lying to me, because you don't know if you can trust them later on. And she's supposed to be someone that's quite close to me because she's my family but she wasn't showing it then. But we have made up now.

Researcher Okay. Okay.

Participant But I'm still a bit wary.

Researcher Yeah. Yeah. Understandable. And in your body? How did that feel that day?

Participant Oh, like I wanted to punch something. Like a very strong urge to punch her or somebody or something. I didn't.

Researcher Yeah. And would people around you have known you're having a bad day?

Participant Yes. Because I was taking out on them, which I did apologize for at the end of the day,

Researcher What does that look like? If you're taking out on someone?

Participant Just if they're trying to make me feel better, I'll start an argument up. I try and make an argument out of the littlest things they did wrong, and probably sound a bit angry when I'm talking. And then because I'm a very, like, self-conscious person. I always feel guilty afterwards. I'm like, I'd say sorry. I know that. And I try not to do it again.

Researcher Yeah. Being self-conscious. How do you think that kind of plays out in your life?

Participant It definitely used to a lot because I was at school and all that and people look for certain things that they want in a friend and all that. And I did try and stick true to myself and be myself. That happened for the first three years or so. And I just got into the thing. I was starting to become popular then which is my bad choice.

]

- 1 -

And I started becoming one of the popular people. It's not until one of my friends said you're being rude like being a B I T C H really. These past couple of weeks, I actually stopped and said you know what, this isn't me. And then I tried going back to myself again, while sticking to some of the popular people just because they aren't they weren't close friends. I just became someone I totally didn't remember. So I just cut ties with them. Now I'm happy again, I'm myself again.

Researcher Yeah, that's nice. That's really nice to hear. When you say you feel yourself what does like what do you think is more yourself now?

Participant

I'm normally very caring, quite friendly. I am funny, sometimes not all the time. Mostly sensible. But at that point I was teasing everybody, not getting along very well, drinking underage. It just wasn't me.

Researcher Yeah. Yeah. When you're having a bad time, kind of more generally, kind of what was that was a specific day with your sister. How does that, again similar questions, how does that feel? On the inside? If you're going through a more like a bad period of time? What does that feel like?

Participant Just feel like giving up. I don't have many motivations. I really feel emotionally invested in anyone. I just want to sit in my bed and sleep. Most of the time. Yeah, trying to sleep the problems way even though it's not gonna work. Have to face it.

Researcher Yeah, yeah. What does that feel like in your body? Physically, when you're having a bad time?

Participant Heavy? Kind of, like, tired. I guess my body feels tired when it happens. And very stupid. My brain turns stupid.

Researcher Really? Yeah. What do you mean by that?

Participant Normally, when I'm having a bad time, I don't actually think before I say anything. Sometimes it can be hurtful, sometimes it can be really stupid. And sometimes it just doesn't make any sense whatsoever and have to repeat myself.

Researcher Yeah, yeah. Makes sense. And how would people here or staff here know if you're having a bad week?

Participant I probably won't ever come out from my bedroom. And if I do, most likely, I'll try and start a little argument and then take myself away and be like no. I'm not doing that. So I go upstairs.

]

- 2 -

18/02/23

Interview with R

Me: Nervous - stressed interview wasn't giving me much. But calmed over conversation about cat.

R: one word answer at first. but very happy to talk about interests. Liked showing off photos about job.

I wonder if wasn't too happy talking about harder times, shared over this and didn't want to answer question about a recent bad day. How to make participants more comfortable

Take away thoughts / themes:

- !!!
- Animals
- ↳ talking about what good at
- Anger > sadness
- Friends > family

27/08/25

Interview with E

Me: much better. having time to have tea + ask "normal" questions helped.

E: Very "shiny", very happy - v articulate. Wonder if her experiences are like other? Didn't have photos of bad days - found that a funny reveal.

Take away thoughts / themes:

- Birth family is vulnerable point.
- Repairs relationships
- Control vs dysregulation.
- photography, art, music - creative!

Appendix F: Annotated transcript excerpt

Researcher: Could you tell me a little bit about a bad day you've had recently?

Participant: Well, recently, probably the time I was having an argument with my sister over the phone. That was the only recent one that I've had. But that was absolutely terrible.

Researcher: Really? Was that happening here?

Participant: Yeah, actually I don't know. I kind of learned on from when I was at the hospital waiting for [name]. Until, like, later in the evening.

Researcher: Okay, yeah. And how does now did that feel that day emotionally, on the inside?

Participant: Well, it just made me feel angry. Because she was saying all these things I just know weren't true. And I don't like people lying to me, because you don't know if you can trust them later on. And she's supposed to be someone that's quite close to me because she's my family but she wasn't showing it then. But we have made up now.

Researcher: Okay, okay.

Participant: But I'm still a bit wary, not as easy as I used to be.

Researcher: Yeah, yeah. Understandable. And in your body? How did that feel that day?

Participant: Oh, like I wanted to punch something. Like a very strong urge to punch her or somebody or something. I didn't know.

Researcher: Yeah, and would people around you have known you're having a bad day?

Participant: Yes, because I was taking out on them, which I did apologise for at the end of the day.

Researcher: What does that look like? If you're taking out on someone?

Participant: Just if they're trying to make me feel better, I'll start an argument up. I try and make an argument out of the littlest things they did wrong, and probably stand a bit angry when I'm talking. And then because I'm a very, like, self-conscious person, I always feel really awkward. I'm like, 'I'd say sorry, I know that. And I try not to do it again.'

Researcher: Yeah, being self-conscious. How do you think that kind of plays out in your life?

Participant: It definitely used to a lot because I was at school and all that and people look for certain things that they want in a friend and all that. And I did try and stick true to myself and be myself. That happened for the first three years or so. And I just got into the thing, I was starting to become popular then which is my bad choice.

Researcher: And you're trying to be in a way of making up.

Participant: Yeah, I always feel really awkward. I'm like, 'I'd say sorry, I know that. And I try not to do it again.'

Researcher: Yeah, yeah. Makes sense. And how would people here or staff here know if you're having a bad week?

Participant: Probably, yeah, because I was at school and all that and people look for certain things that they want in a friend and all that. And I did try and stick true to myself and be myself. That happened for the first three years or so. And I just got into the thing, I was starting to become popular then which is my bad choice.

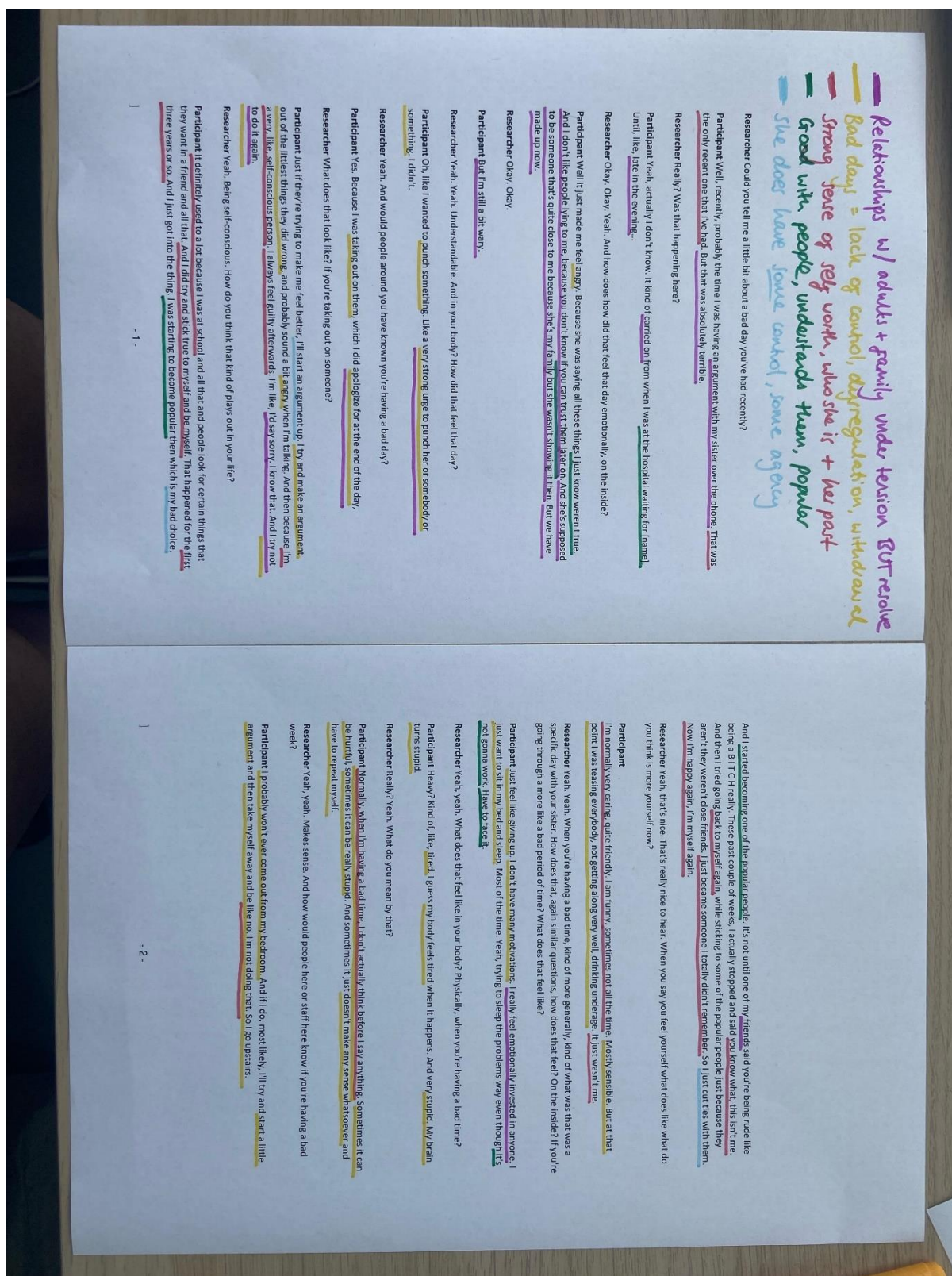
Researcher: Yeah, yeah. Makes sense. And how would people here or staff here know if you're having a bad week?

Participant: Probably, yeah, because I was at school and all that and people look for certain things that they want in a friend and all that. And I did try and stick true to myself and be myself. That happened for the first three years or so. And I just got into the thing, I was starting to become popular then which is my bad choice.

Researcher: Yeah, yeah. Makes sense. And how would people here or staff here know if you're having a bad week?

Participant: Probably, yeah, because I was at school and all that and people look for certain things that they want in a friend and all that. And I did try and stick true to myself and be myself. That happened for the first three years or so. And I just got into the thing, I was starting to become popular then which is my bad choice.

Appendix G: Highlighted transcript excerpt



Relationships w/ adults + family under tension BUT resolve
 Bad days = lack of control, dysregulation, withdrawal
 Strong sense of self worth, who she is + her part
 Good with people, understrands them, popular
 she does have some control, some agency

Researcher Could you tell me a little bit about a bad day you've had recently?

Participant Well, recently, probably the time I was having an argument with my sister over the phone. That was the only recent one that I've had. But that was absolutely terrible.

Researcher Really? Was that happening here?

Participant Yeah, actually I don't know. It kind of carried on from when I was at the hospital waiting for [name]. Until, like, late in the evening...

Researcher Okay, Okay. Yeah. And how does how did that feel that day emotionally, on the inside?

Participant Well it just made me feel angry. Because she was saying all these things. I just know weren't true. And I don't like people lying to me, because you don't know if you can trust them later on. And she's supposed to be someone that's quite close to me because she's my family but she won't show up. Then, but we have made up now.

Researcher Okay, Okay.

Participant But I'm still a bit wary.

Researcher Yeah. Yeah. Understandable. And in your body? How did that feel that day?

Participant Oh, like I wanted to punch something. Like a very strong urge to punch her or somebody or something. I didn't.

Researcher Yeah. And would people around you have known you're having a bad day?

Participant Yes, because I was taking out on them, which I did apologize for at the end of the day.

Researcher What does that look like? If you're taking out on someone?

Participant Just if they're trying to make me feel better, I'll start an argument up. I try and make an argument out of the littlest things they did wrong, and probably sound a bit angry when I'm talking. And then because I'm a very, like, self-conscious person, I always feel guilty afterwards. I'm like, I'd say sorry, I know that. And I try not to do it again.

Researcher Yeah. Being self-conscious. How do you think that kind of plays out in your life?

Participant It definitely used to a lot because I was at school and all that and people look for certain things that they want in a friend and all that. And I did try and stick true to myself and be myself. That happened for the first three years or so. And I just got into the thing, I was starting to become popular then which is my bad choice.

- 1 -

And I started becoming one of the popular people. It's not until one of my friends said you're being rude like being a B I T C H really. These past couple of weeks, I actually stopped and said you know what, this isn't me. And then I tried going back to myself again, while sticking to some of the popular people just because they aren't they weren't close friends. I just became someone I totally didn't remember. So I just cut ties with them. Now I'm happy again, I'm myself again.

Researcher Yeah, that's nice. That's really nice to hear. When you say you feel yourself what does like what do you think is more yourself now?

Participant

I'm normally very caring, quite friendly, I am funny, sometimes not all the time. Mostly sensible. But at that point I was teasing everybody, not getting along very well, drinking underage. It just wasn't me.

Researcher Yeah. Yeah. When you're having a bad time, kind of more generally, kind of what was that was a specific day with your sister. How does that, again similar questions, how does that feel? On the inside? If you're going through a more like a bad period of time? What does that feel like?

Participant Just feel like giving up. I don't have many motivations. I really feel emotionally invested in anyone. I just want to sit in my bed and sleep. Most of the time. Yeah, trying to sleep the problems away even though it's not gonna work. Have to face it.

Researcher Yeah, yeah. What does that feel like in your body? Physically, when you're having a bad time?

Participant Heavy? Kind of, like, tired. I guess my body feels tired when it happens. And very stupid. My brain turns stupid.

Researcher Really? Yeah. What do you mean by that?

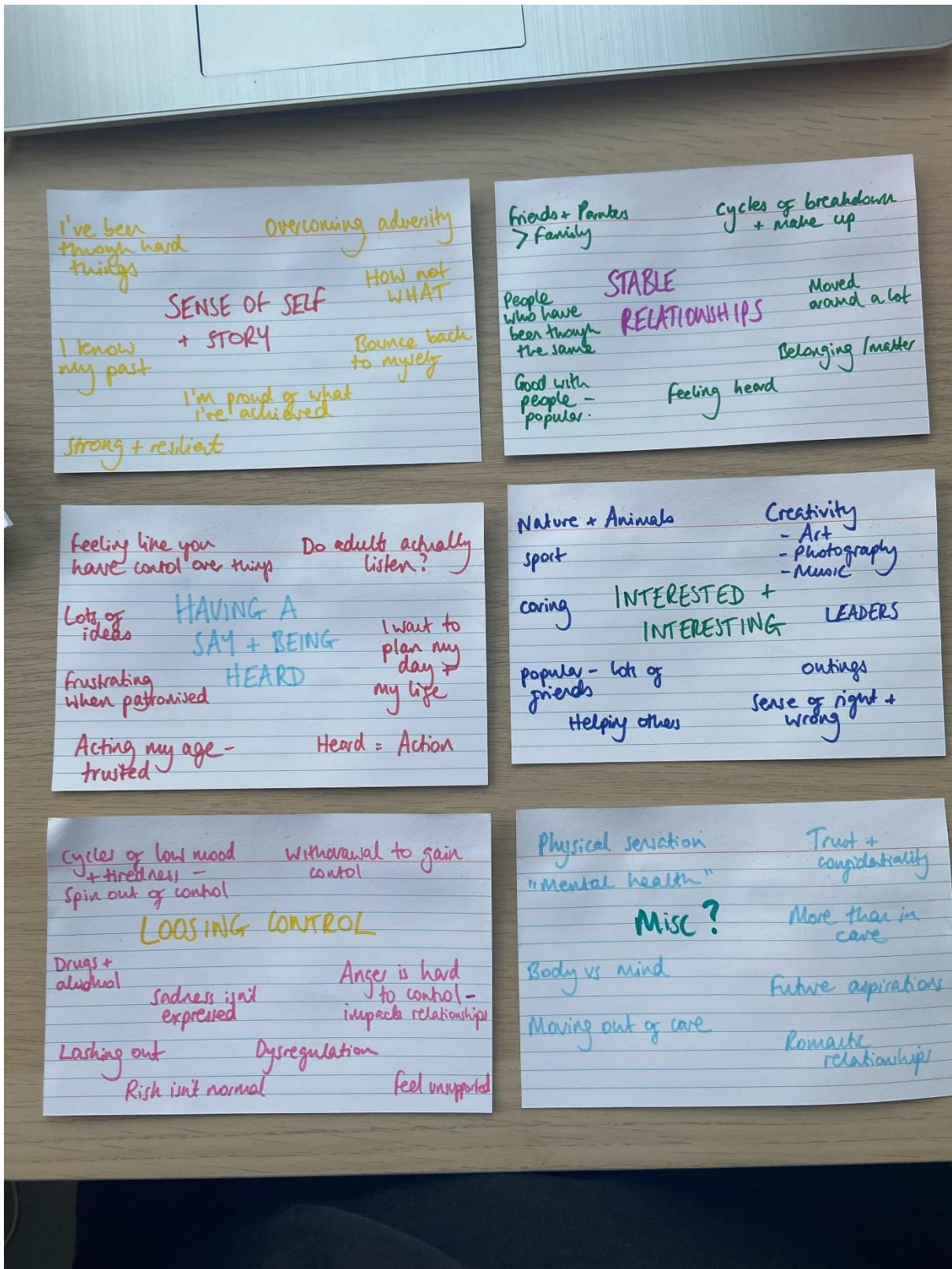
Participant Normally, when I'm having a bad time, I don't actually think before I say anything. Sometimes it can be hurtful, sometimes it can be really stupid. And sometimes it just doesn't make any sense whatsoever and have to repeat myself.

Researcher Yeah, yeah. Makes sense. And how would people here or staff here know if you're having a bad week?

Participant I probably won't ever come out from my bedroom. And if I do, most likely, I'll try and start a little argument and then take myself away and be like no, I'm not doing that. So I go upstairs.

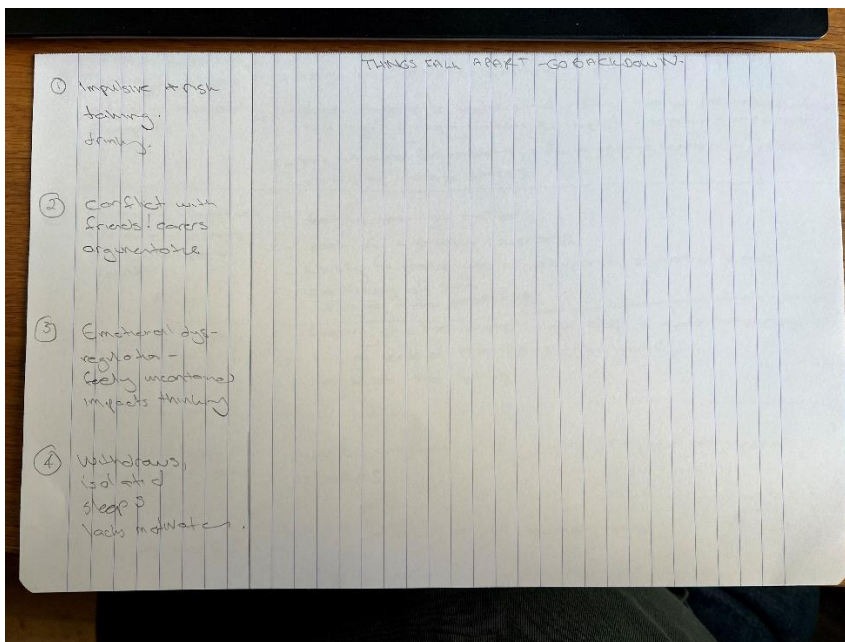
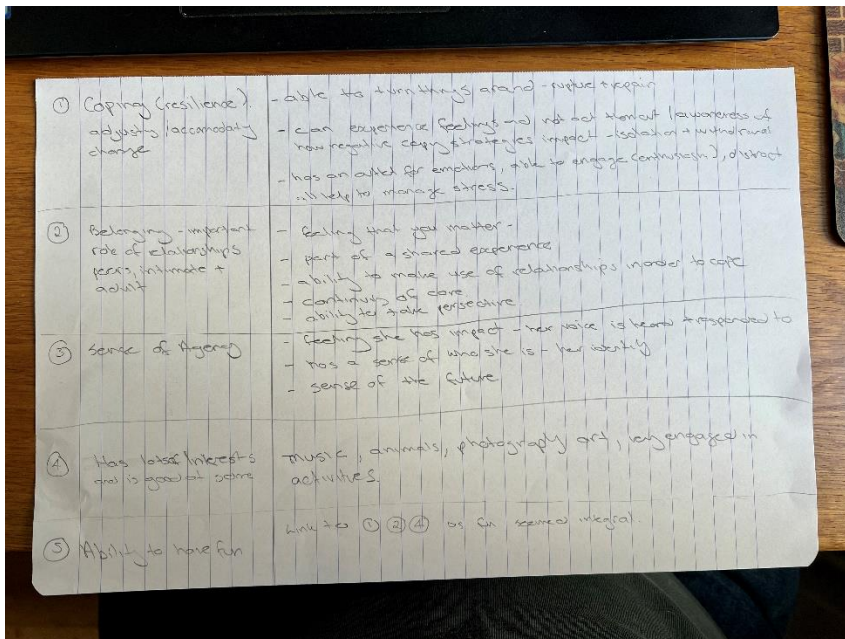
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Appendix H: Initial theme mind maps



Appendix I: Summary of analysis comparison conversation

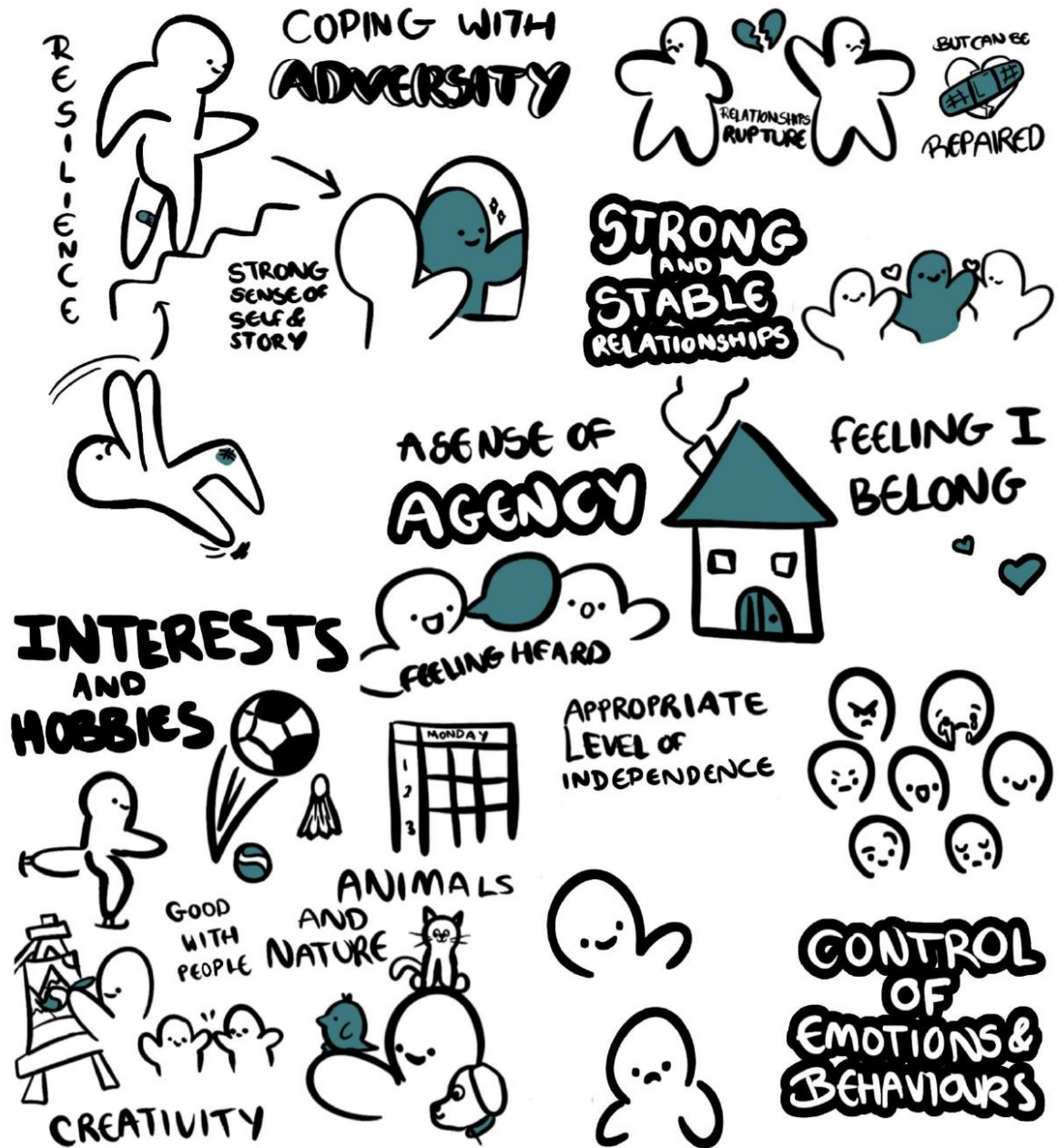
Supervisor Ideas:



Key thoughts:

- Much more here on indicators of improvement and strengths
- Is deterioration just the opposite / absence of the above
- Make sure you tie into the research question
- Struck by focus on strengths – presumed it might be difficult to get people to talk about what they were good at – opposite was true. Shows assumptions of CLA as vulnerable.
- Lots here to think about in terms of relation to resilience

Appendix J: Themes sent to participants



Theme 1: Coping with Adversity

You told us that you have coped with some hard things in your life.

- A strong sense of self and story: you know who you are, what you've been through and feel proud of yourself for what you can achieve.
- Resilience: you can get through hard times and bounce back when things have been difficult.

Theme 2: A Sense of Agency

You told us it's important for you to feel that you have some control over your life:

- Feeling listened to and heard: you want to feel that that the people around you are listening to what you say, and considering your opinion when they are making decisions.
- Having an appropriate level of independence: you want to be able to do things without having to ask permission from adults. However, you want to know you have their support when you need it.
- Having structure, routine and plans: having a daily routine is an important sign of your wellbeing. It's also important for you to have an idea of what you want to do in the future.

Theme 3: Control of Emotions and Behaviour

Sometimes it can be hard to feel in control of your emotions and behaviour

- Ability to regulate and reflect: being able to control of your emotions and talking about how you're feeling can be a sign of things 'going well'.
- Cycles of low mood and withdrawal: you told us that when you feel sad you often spend time in your room and don't want to do much.
- Lack of control links to risk: sometimes, losing control of your emotions or not having support could lead to you getting involved in dangerous situations.

Theme 4: Strong and Stable Relationships

You told us about some of your relationships with the important people in your life. You feel these relationships are important for your wellbeing.

- Feeling like I belong: it's important to have friendships and relationships with people who understand you and know what it's like being in care, this helps you feel like you belong where you live.
- Building and maintaining relationships: sometimes coming into care or changing placement can make it hard to keep in contact with people you care about. It's important for you to be able to keep in contact with these people, but also to build new relationships once you've moved.
- Relationships aren't always easy and there are some arguments, but you are good at making up with people and fall outs don't often last for long.

Theme 5: Talents and Interests


You told us lots about your interests and hobbies. You feel it's important for you to do things you enjoy and get the chance to show people what you're good at.


- Being good with people: you have lots of friends, play team sports or are natural leaders. People often come to you for advice.
- Creativity: you enjoy things like photography, music and making things. Sometimes this helps you to cope with difficult emotions.
- Access to animals and nature: animals are important to you and can be comforting. Getting the chance to be outside is also important.

Appendix K: Member checking questionnaire

Research Feedback

We would love to get your feedback on the findings of our research. Everything is anonymous, so we won't know who said what. When you have finished, please email amy@lifepsychol.co.uk to arrange your £20 amazon voucher.

amy@lifepsychol.co.uk [Switch account](#) 

 Not shared

Section 1: Themes

Please give your feedback based on the themes you were sent by email.

1. The themes capture what we talked about in our interview

Strongly Agree

Agree

I Don't Agree or Disagree

Disagree

Strongly Disagree

2. The themes are relevant to my wellbeing and mental health

Strongly Agree

Agree

I Don't Agree or Disagree

Disagree

Strongly Disagree

3. The themes are relevant to my experiences of being in care

Strongly Agree

Agree

I Don't Agree or Disagree

Disagree

Strongly Disagree

4. Is there anything you think we've missed (or any other comments!)

Your answer _____

Appendix L: Ethics approval letter



Salomons Institute for Applied Psychology

Amy Malone
Trainee Clinical Psychologist
Canterbury Christ Church University

17 November 2022
Direct line 01227 927094
E-mail Margie.Callanan@canterbury.ac.uk
Our Ref V:\075\Ethics\2019-20

Dear Amy,

Outcome: Full Approval

Young people in care's perspective on their psychological adjustment as an addition to the BERRI questionnaire.

Thank you for addressing the points raised by the Ethics Panel so thoroughly, we are pleased to offer you approval for your proposed study.

We look forward to receiving a short report on progress and outcome on completion of the research, in order to complete our file. The report should be the same one that is provided to your participants. Please note that any changes of substance to the research will need to be notified to us so that we can ensure continued appropriate ethical process.

We wish you well with your study and hope that you enjoy carrying it out.

Yours sincerely,

A handwritten signature in blue ink that reads "Margie Callanan".

Professor Margie Callanan
Chair of the Salomons Ethics Panel

Cc Alex Hassett



Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG

www.canterbury.ac.uk/appliedpsychology

Information about the research

Getting young people in care's perspective on their psychological adjustment as an addition to the BERRI questionnaire

Hello. My name is Amy and I am a masters student at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you.

We encourage you to talk to others about the study and your decision to take part.

Part 1 of this sheet tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the how the study will be conducted.

PART 1

What is the purpose of the study?

We are conducting this research to understand care experienced young people's perspectives on their psychological well-being. We are doing this with the aim to create a draft questionnaire which will be added to BERRI. BERRI is an online questionnaire filled in by carers to help understand young people's mental wellbeing and needs. By carrying out this research, we hope to create a version of the tool which is filled in by young people themselves so they can let us know how things are going for them in their own way.

Why have I been invited?

You have been invited to take part in this study because you are known to an organisation already using BERRI, and a professional at this organisation thought you might be interested in taking part. We are aiming to talk to a total of 15 young people as part of this study.

Do I have to take part?

It is up to you to decide whether to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw up to two weeks after your interview, without giving a reason.

What will happen to me if I take part?

Participants in this study will be required to take part in an interview carried out our lead researcher, Amy Malone. These will last a maximum of 60 minutes. In the month before your interview you will be asked to take some photos that represent your day to day life. The information we gather from the interviews will then be used to create a draft of a questionnaire. Once this is created, we will send this to you along with a form to get your thoughts and feedback on it, this is likely to be a few months after your original interview.

Expenses and payments

We plan for the interview to take place at your place of residence or an alternative location nearby if you prefer. If you need to travel for any reason to take part, you will be reimbursed. You will be given £20 as a thank you for participation.

What will I be asked to do?

If taking part in an interview, you will be asked to attend for 60 minutes. The interview will be a one to one session between you and the researcher. Prior to the interview, you may be asked to take some photographs that represent your life (on your smartphone or another device) on good days and bad days. We will ask you to share these during the interview. In the interview we will ask you about what psychological wellbeing means to you and what your life may look like in times when things are going 'well' and when things are going 'less well'.

All interviews will be audio recorded. Interviews can include any breaks you need and time for a debrief. Exact dates and times will be confirmed after recruitment, but participants will not be expected to travel from their place of residence.

What are the possible disadvantages and risks of taking part?

Talking about your experiences of care and your psychological wellbeing has the potential to cause some upset or psychological distress.

What are the possible benefits of taking part?

We cannot promise the study will help you directly but we hope that the information we get from this study will help to understand and improve the lives of young people in care.

What if there is a problem?

Any complaint about the way you have been treated in the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will information from or about me from taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. There are some rare situations in which information would have to be shared with others. The details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

PART 2

What will happen if I don't want to carry on with the study?

You are able to withdraw at any point before your interview. If you would like to withdraw after your interview, you will need to do so within two weeks by informing the researcher (in person, on the phone or by email).

If you wish to withdraw two weeks after your interview, we will make every effort to remove your data from the project, but this may be difficult. At the very least, any identifiable information we hold about you will be anonymised.

What if there is a problem?

Any complaint about the way you have been treated in the study or any possible harm you might suffer will be addressed quickly and sensitively. If you wish to make a complaint, please use the contact details below.

Concerns and Complaints

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number 01227 927070. Please leave a contact number and say that the message is for Amy and I will get back to you as soon as possible. If you would like to complain to the academic supervisor of this project, please call 01227 927093 or write to alex.hassett@canterbury.ac.uk. If you remain dissatisfied and wish to complain formally, you can do this by contacting Professor Margie Callanan - margie.callanan@canterbury.ac.uk.

Will information from or about me from taking part in the study be kept confidential?

Collection and processing of your personal data during this project will follow GDPR. We will record your name, contact information and care organisation you are associated with so we can contact you regarding the study. Any personal data you provide during your interview will be audio recorded and later transcribed. This data will be coded and pseudonymised at the earliest opportunity after collection. Identifying names of people or places will be changed on transcribing of interviews and audio recordings will be erased after transcription. All data from the study will be stored electronically and securely, and paper copies will be shredded at the earliest opportunity.

Only authorised persons will be able to view your data – this is limited to the researcher, academic supervisor, examiner and any regulatory authorities. It will be retained for five years after the study is completed and securely disposed of after this time. Your data will be stored securely for five years after the study is completed.

You have the right to access the data we hold about you, check the accuracy of data held and correct any errors at any time.

The only time when I would be obliged to pass on information from you to a third party would be if, as a result of something you told me, I were to become concerned about your safety or the safety of someone else.

What will happen to the results of the research study?

After the data collection phase, a draft questionnaire will be created and shared with you. We will send this to you via email and include a short online form where we will ask for your thoughts and feedback on the questionnaire.

The results of the research study will be submitted to Canterbury Christ Church University, a report of the thesis will be on the University's public website and results may be published in a scientific journal. Anonymised quotes from the interviews will be used in final and published reports, however participants will not be identified in any report or publication.

All participants in the research will be sent a copy of the master's thesis and any academic journal articles produced as a result of this research. You will not be identified in any write up of this research.

Who is sponsoring and funding the research?

This research is being supervised by Canterbury Christ Church. It is being carried out as part of a Masters by Research degree. The fees of this are being paid by BERRI LTD.

Who has reviewed the study?

This research has been approved by the Canterbury Christ Church Research Ethics Committee.

Further information and contact details

If you would like any further information about this project, please contact Amy on am2109@canterbury.ac.uk. You can also leave a message for me on a 24-hour voicemail phone line at 01227 927070. Please say that the message is for Amy Malone. You may also wish to speak with your carer or a trusted adult about your decision regarding participation.

Appendix N: Consent form



Salomons Institute for Applied Psychology
One Meadow Road, Tunbridge Wells, Kent TN1 2YG

CONSENT FORM

Title of Project: Getting young people in care’s perspective on their psychological adjustment as an addition to the BERRI questionnaire.

Name of Researcher: Amy Malone

Researcher contact: am2109@canterbury.ac.uk

Please put your initials in each box if you consent:

- 1. I confirm that I have read and understand the information sheet dated..... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- 2. I understand that my participation is voluntary and that I am free to withdraw up to two weeks after the interview or focus group without giving any reason.
- 3. I understand that data collected during the study may be looked at by the lead supervisor [Professor Alex Hassett]. I give permission for this individual to have access to my data.
- 4. I consent to use of audio-recording, with possible use of verbatim quotation
- 5. I agree that anonymous quotes from my interview and other anonymous data may be used in published reports of the study findings
- 5. I agree that any anonymous photographs that I have chosen to share with the researcher may be used in published reports of the study findings
- 6. I agree for my anonymous data to be used in further research studies
- 7. I agree to take part in the above study.

Name of Participant _____ Date _____

Signature _____

Name of Person taking consent _____ Date _____

Signature _____

Appendix O: Debriefing document



Getting young people in care's perspectives on their psychological adjustment as an addition to the BERRI questionnaire.

DEBRIEFING DOCUMENT

Thank you for taking part in our research. The purpose of this research is to get understand care experienced people's perspectives on their psychological wellbeing. This research study is being conducted at Canterbury Christ Church University (CCCU) by Amy Malone as part of an MSc project. Please refer to the project information sheet for further details on the project. You can contact Amy Malone on am2109@canterbury.ac.uk if you have any questions after your participation.

Background

We are conducting this research to understand care experienced young people's perspectives on their psychological well-being. We are doing this with the aim to create a draft questionnaire which will be added to BERRI. BERRI is an online questionnaire filled in by carers to help understand young people's mental wellbeing and needs. By carrying out this research, we hope to create a version of the tool which is filled in by young people themselves so they can let us know how things are going for them in their own way.

Dissemination of results

This study will be written up as part of an MSc thesis and will therefore be published in the CCCU library. The findings may also be written and published in peer reviewed academic journals. The questionnaire drafted as a result of this research may be further developed and incorporated into the online BERRI system, which is used by care professionals, parents and young people.

Process for withdrawing consent to participate

You are free to withdraw your consent to participate in this research project up to two weeks after your participation. without having to give a reason.

You may read further information on your rights relating to your personal data at the following link: Research Privacy Notice - <https://www.canterbury.ac.uk/university-solicitors-office/data-protection/privacy-notices/privacy-notices.aspx>

Further Support

We hope that participating in this project has been an enjoyable and worthwhile experience. However, we are aware that sharing your experiences of being in care and talking about your psychological wellbeing could potentially have caused you some discomfort or distress.

If this is the case, please speak with a trusted adult or a member of the research team to discuss any support we may be able to provide. The team at BERRI are able to offer a one-off session with a qualified psychologist for psychological support. If you would like to arrange this, please speak with Amy Malone or email am2109@canterbury.ac.uk.

If you would prefer support from another organisation, or further support after your session, please see the details of other organisations below. We would also advise you to speak with your carer(s), teacher, social worker or GP if you would like to access other services.

Support and Resources:

Child line: <https://www.childline.org.uk/>

Offers support for young people on the phone or online.

Mind: <https://www.mind.org.uk/information-support/for-children-and-young-people/#youngperson>

Provides information on young people's mental health and where to get support.

On My Mind: <https://www.annafreud.org/on-my-mind/>

Aims to empower and educate young people to make informed choices about their mental health and well-being.

The Mix: <https://www.themix.org.uk/>

Support service for young people, offering a free confidential helpline and counselling service. They provide support on a range of issues from mental health to money, from homelessness to finding a job and from break-ups to drugs.

Place2be: <https://www.place2be.org.uk/>

Provides information about young people's mental health and links to websites with more specific information.

Samaritans: <https://www.samaritans.org/>

Support via phone, email, letter or self-help app. Also offer support for anyone worried about someone else.

Shout: <https://giveusashout.org/>

A free, confidential 24/7 confidential text messaging support service for anyone struggling.

Young minds: <https://www.youngminds.org.uk/young-person/>

Provides information on young people's feelings and experiences, mental health and where to get support. A range of guides on topics from supporting friends to dealing with abuse.

Support for Care Experienced People:

Become Charity: <https://becomecharity.org.uk/>

Support, information and community for young people in care and care leavers

Coram Voice: <https://coramvoice.org.uk/>

Support and advocacy for young people in and leaving care

Barnardo's: <https://www.barnardos.org.uk/what-we-do/supporting-young-people/leaving-care>

Area of website dedicated to support and information for care experienced young people

Difference and Diversity:

Action for Kids: <https://www.afkcharity.org/>

Support and advice for children and young people with disabilities.

National Autistic Society: <https://www.autism.org.uk/about.aspx>

Information and advice on challenges facing autistic people.

Mosaic Trust: <https://www.mosaictrust.org.uk/young-persons>

Information and support for LGBTQ+ young people.

Mermaids: <https://mermaidsuk.org.uk/parents/>

Supports transgender and gender diverse children, young people and their carers through online communities, resources and helpline.

The Black, African and Asian Therapy Network: <https://www.baatn.org.uk/>

Psychological support informed by an understanding of intersectionality.

Voice of the Young Person

Instructions: Your social worker and placement would really like to hear your view on how things are going for you at the moment. Please pick an answer for each question by sliding the circle from side to side to match most how you feel.

1.

What I've been through has made me strong What I've been through has made me vulnerable


2.

I have people in my life who get me I feel lonely and misunderstood


3.

People listen to me and care about my opinion I am ignored and my opinion doesn't matter

4.


I stay indoors and don't move my body enough I get outdoors and move my body enough

5.


I am calm and relaxed I am moody and snap at people

6.


I feel proud of what I have achieved I have let myself and others down

7.


I feel like I belong where I am I feel unsettled and isolated

8.


I have control over my life Other people have control over my life

9.


I have contact with nature and animals I don't have contact with nature and animals

10.



I am in control of my emotions and actions

My emotions are in control of me

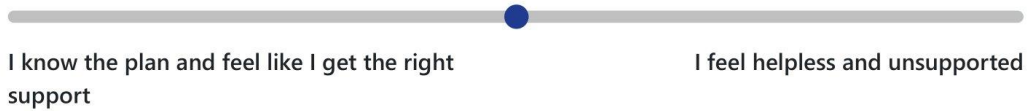
11.



12.



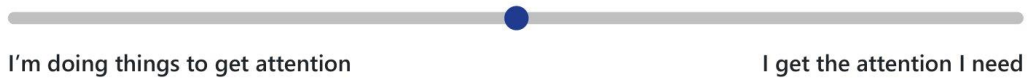
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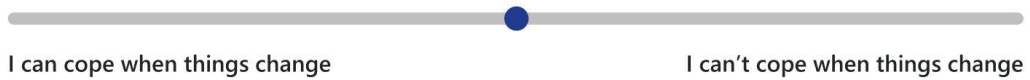
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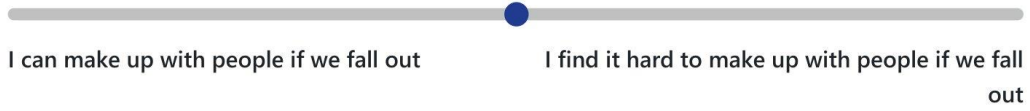
15.



16.



17.



18.



19.



20.



Is anything really troubling you that you'd like us to know about?

Anything else you'd like to share?

Instructions: Click the button below to save your responses. It can take a while to save the data, but PLEASE only click the button once!

Submit

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