The mental health needs of looked after children in a local authority permanent placement team and the value of the Goodman SDQ

Lin Richards, Nola Wood and Luisa Ruiz-Calzada investigated the current level of emotional and behavioural need and pre- and post-care experiences for children placed in one local authority social care department permanent placement team. A cohort of 41 looked after children was assessed by foster carers, teachers and young people aged 11–16 years themselves, using the Goodman Strengths & Difficulties Questionnaire (SDQ). The results were related to a number of factors taken from each child’s individual historical experiences as understood from their social work files. The results supported the growing body of research indicating that the mental health needs of looked after children are significantly higher than those of the general population. A range of factors was found to reach statistical significance in relation to increased mental health difficulties. The research highlighted the complex and multi-factorial nature of the experiences of the looked after cohort that contribute to overall emotional well-being and positive mental health. The study also sought to identify a suitable screening tool for the early identification of mental health need and Goodman’s SDQ is discussed in this light.

Background

Local perspective

Based in a busy Essex town, generic and specialist childcare social work teams work with looked after children. The responsibility for long-term looked after children rests primarily with the children with disabilities team, the asylum seekers team and the permanent placement team (PPT). At the time of research there were 270 children looked after by the local authority and the average number of children whose names were on the Child Protection Register was 65, over three-quarters of whom were registered under the category of neglect.

A senior registrar in public health had been seconded to the local authority to undertake specific objectives relating to looked after children. One objective was to identify a suitable screening tool for early identification of mental health need and the Strengths & Difficulties Questionnaire (SDQ) (Goodman, 1997) was chosen for this purpose (Munday and Atherton, 2000).

At the same time, the authors’ perception was that those in long-term care were not being identified as in need of a mental health service; there was potentially unmet mental health need within the PPT. Infrequent referrals from this team compared to other social work teams contributed to this perception.

A brief review of research

McCann et al (1996) undertook one of the first systematic studies of the rates of psychiatric disorders in an adolescent population of looked after children. Higher mental health need was identified in the population studied. It was further noted that mental health needs often went unrecognised and accessing services was difficult. Meltzer et al (2003) found significantly higher levels of classification of mental health problems in looked after children ‘as based on the diagnostic criteria using the ICD-10 classification of mental and behavioural disorders with strict impairment criteria’ (Meltzer et al, 2003, p 7). Kelly et al (2003) cite research which indicates that conduct disorder is the most common difficulty, but that it is the co-morbidity and complexity of these children’s needs which impacts on all aspects of their lives, emotionally, socially and educationally.

McCarthy et al (2003, p 14) found that carers’ experience in looking after
these children related directly to the high levels of behaviour problems displayed by the children. In a Community Care article (2004), White and Stancombe’s research discovered that while carers did report higher levels of mental health difficulties and challenging behaviour, the young people themselves did not.

Many looked after children experience multiple forms of harm, the symptoms of which are often difficult to relate to specific cause and are affected by the child’s age and stage of development (Oliver, 1988; Cicchetti and Toth, 1995). Children who enter the care system later in life have been found to experience more difficulties than children placed as infants (Berridge and Cleaver, 1987; Hodges et al, 2003; Howe and Fearnley, 2003). Placements of children aged six and over have been found to be more likely to break down (Berridge and Cleaver, 1987; Byrne, 1997).

Contact with relatives may help the child to resolve identity issues resulting from their abusive experiences and the ‘loss’ of their birth family by providing an additional source of information on their past (Neil et al, 2003). Placement with a sibling may enhance the child’s ability to make lasting, stable attachments, and provide an additional coping resource and assist in placement stability (van Meeuwen, 1997).

Study aims and objectives
Our research was jointly commissioned by the local Department of Social Care and the Child and Adolescent Mental Health Service (CAMHS). Its purpose was to identify and highlight the mental health needs of looked after children in a permanent placement social work team (PPT) and to identify a suitable screening tool for the early identification of mental health need.

From our reading, as identified in the above review, we anticipated finding higher mental health need within the looked after population. Based on previous research, it was expected that pre- and post-care experiences and educational experiences would have a significant effect on children’s emotional and mental health needs. It was also expected that the significant harm experienced by the child, together with other pre-care experiences such as parental mental health or substance misuse issues and domestic violence, would result in higher mental or emotional health needs.

It was hypothesised that children who had experienced unsuccessful reunification would have increased mental and emotional health needs, alongside those who had experienced a number of placement moves and breakdowns. Educational factors such as multiple numbers of school moves, fixed-term exclusions and Statements of Special Educational Need were envisaged to be associated with increased mental and emotional health need.

Previous research findings further led to the expectation that direct contact with birth family would lead to lower emotional and mental health needs, as would residence with a sibling. Therapeutic support was also expected to result in reduced emotional and mental health needs.

In addition to explaining these hypotheses, to our knowledge, this is one of only a few research papers that uses the SDQ tool to compare the views of all three SDQ participants: carers, teachers and young people themselves. This is important because this instrument is increasingly used by practitioners to assess the psychosocial development of children in need. We also had the distinct advantage of viewing social work files to consider the impact of life experiences on looked after children’s mental health.

The following sections of this report describe the methods used, followed by results. We then move on to discussion and conclude with recommendations for the development of local and national practice and policy.

Methods
We sought and obtained agreement for this research project from the South Essex Local Research Ethics Committee. This included the complex matter of gaining multiple parental responsibility and informed consent across the 4–16 years age range.

We chose to approach the population...
of the PPT because the local authority and CAMHS both wanted to pilot the use of the SDQ in a team where there were perceived concerns about referral rates to CAMHS. The PPT works with children for whom the permanent plan of care usually excludes a return to birth parents. This population was also chosen because it was thought that, unlike other social work teams, the children were more likely to be in relatively stable placements, with legal and other matters having been settled. Participants were not pressured to participate and were made aware that they could withdraw from the research at any time without having to give a reason or facing any negative consequences.

The SDQ is a standardised questionnaire, chosen for its well-researched validity (Meltzer et al., 2000) and located within the Department of Health Framework for the Assessment of Children in Need and their Families (2000). It assists all professionals in monitoring early identification and intervention of mental health need. It has been found to be effective in distinguishing psychiatric cases from controls and in detecting difficult behaviours identified in interviews with parents (Goodman and Scott, 1999). A main strength of this two-page questionnaire is its simplicity, with 25 tick-box answers regarding mental health difficulties to complete on the first page, and further tick-box questions related to the impact of difficulties on page two. The SDQ scoring framework allows for outcomes of low, some and high mental health needs. It has separately designed questionnaires for parents/carers of children aged 4–16 years, teachers of children in the same age range and young people themselves aged 11–16. Given the remit of our study, information came from page one of the SDQ form.

Specific pre- and post-care experiences were collected from discussions with social workers and reviewing social work files. The data included child’s age upon entry into care, the nature of significant harm and whether or not there was known parental substance misuse or mental health issues. Placement-related variables were also investigated; for example, the length of time in care, whether unification to birth family had been attempted, number of placements and breakdowns, and whether the child was residing with at least one sibling. Data were gathered regarding educational experiences including number of school moves, number of fixed-term exclusions and whether or not the child was the subject of a Statement of Special Educational Needs. The level of direct contact with birth family and whether or not there had been therapeutic support were also recorded.

Of the 270 children looked after by the local authority at the time of the research, 75 were known to the PPT. The SDQ’s focus on those aged 4–16 years led to seven children/young people being eliminated from the study. A further seven were in adoptive placements and we decided not to approach these families. A sample of 61 children aged between four and 16 years was therefore identified.

All the children were white, of British origin, except one who was of other white origin. This is not a representative sample of the ethnic origins of the local looked after population. At the time of the research, minority ethnic groupings of looked after children were represented within other social work teams.

Through the process of gaining informed consent, six adults on behalf of children and 14 young people (38.89%, 8 males, 6 females) aged 11–16 years chose not to participate. Children and young people aged 11 years and over were initially approached by their social worker to explain the research and request their participation. The researcher visited the foster home to assist if necessary in the completion of the parent report and 11–16 years self-report SDQs. Participants completed the questionnaires in writing unless difficulties precluded this, when the SDQ was filled in verbally with the researcher. Otherwise the researcher’s role was to answer queries regarding the questionnaire and the research project. A teacher SDQ was sent to school heads with an accompanying letter asking that it be completed by the teacher who best knew the child.


Results

The research population focused on 41 looked after children (67%), the age range being 4–16 years, and the mean age being 10.4 years (SD = 3.9). Of the population, there were 21 children under 11 years old (14 males, 7 females) and 20 aged between 11 and 16 years (11 males, 9 females). Participants were the child’s main carer or key worker (N = 41), a teacher who knew the child best (N = 41) and those children aged 11 years and over considered able to participate themselves (N = 20).

An overview of the carer, teacher and self-rated strengths and difficulties (SDQ) scores for the 41 looked after children is shown in Table 1.

When the SDQ total difficulties scores for the looked after children participants were compared to the SDQ norms for the general population, identified needs were higher for the looked after group (see Table 2).

The self-reporters consistently cited lower difficulties than those perceived by their carers and teachers. Eighteen of the carers’ total difficulties scores and 19 of the teachers’ scores placed the looked after children within the category identified as high mental health need. Of the 20 who self-reported only three perceived themselves within the high need category and 13 within the low need. There were significant positive correlations between carer-rated and teacher-rated SDQ total scores (p = <0.0005), carer-rated and self-rated SDQ total scores (p = <0.0005) and teacher-rated and self-rated SDQ total scores (p = 0.006).

Pre-care experiences were analysed in relation to carers, teachers and self-rated SDQ total difficulties scores. Data taken from the social work files were as follows:

- The children’s ages upon entry into care ranged from birth to 12 years, the mean age being 4.76 years (SD = 3.25).
- It was known that 23 had been physically abused, 18 sexually abused and 21 emotionally abused.
- Thirty-three were known to have at least one parent with mental health difficulties.
- Thirteen children had a parent with substance misuse difficulties.
- Thirty-three of the 41 had lived with domestic violence.

There was a statistically significant relationship in the teachers’ total SDQ scores and parental substance misuse (p = 0.044).

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1 Data were collected from social work files and SDQ scores. The data were analysed using the SPSS version 11. Independent t tests were used to measure a number of variables and SDQ total difficulties scores. Pearson’s product-moment correlation and Spearman’s Rho were used to look at the relationship between SDQ total difficulties scores and a number of variables; for example, placement breakdown, fixed-term school exclusion.

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Table 1
The categorised SDQ total difficulties scores of looked after children

<table>
<thead>
<tr>
<th></th>
<th>Low need</th>
<th>Some need</th>
<th>High need</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% N</td>
<td>% N</td>
<td>% N</td>
</tr>
<tr>
<td>Carer rated</td>
<td>43.9 18</td>
<td>12.2 5</td>
<td>43.9 18</td>
</tr>
<tr>
<td>Teacher rated</td>
<td>39.0 16</td>
<td>14.6 6</td>
<td>46.3 19</td>
</tr>
<tr>
<td>Self-report</td>
<td>65 13</td>
<td>20 4</td>
<td>15 3</td>
</tr>
</tbody>
</table>

Table 2
The SDQ total difficulties scores of looked after children compared to the general population

<table>
<thead>
<tr>
<th>Grouping characteristic</th>
<th>Looked after children</th>
<th>General population</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean N</td>
<td>Mean N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer rated</td>
<td>14.83 41</td>
<td>8.4 10,298</td>
<td>5.76</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>Teacher rated</td>
<td>14.00 41</td>
<td>6.6 8,208</td>
<td>6.71</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>Self-report</td>
<td>12.60 20</td>
<td>10.3 4,228</td>
<td>1.68</td>
<td>ns</td>
</tr>
<tr>
<td>Males</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer rated</td>
<td>15.56 25</td>
<td>9.1 5,153</td>
<td>4.96</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>Teacher rated</td>
<td>14.68 25</td>
<td>7.8 4,073</td>
<td>5.61</td>
<td>&lt;0.0005</td>
</tr>
<tr>
<td>Self-report</td>
<td>13.45 11</td>
<td>10.5 2,135</td>
<td>1.88</td>
<td>ns</td>
</tr>
<tr>
<td>Females</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carer rated</td>
<td>13.69 16</td>
<td>7.8 5,145</td>
<td>2.89</td>
<td>0.011</td>
</tr>
<tr>
<td>Teacher rated</td>
<td>12.94 16</td>
<td>5.3 4,135</td>
<td>3.63</td>
<td>0.002</td>
</tr>
<tr>
<td>Self-report</td>
<td>11.56 9</td>
<td>10.0 2,093</td>
<td>0.64</td>
<td>ns</td>
</tr>
</tbody>
</table>
Post-care experiences were also analysed in relation to the SDQ scores of carers, teachers and self-reporters. In addition, the following was obtained from social work files:

- Thirty-six children were subjects of a care order or interim care order (sections 38 & 31, Children Act, 1989) and five were accommodated (section 20).
- Twenty-four children were residing outside the local authority boundary.
- The number of placements children had experienced ranged from one to 23, with a mean of 4.5.
- The current placements ranged from two months to 14 years.
- The length of time in care ranged from under one year to 14 years.
- The number of placement breakdowns ranged from 0 to 13.
- Reunification to birth family had been attempted with 11 of the 41 children.
- Sixteen of the population were residing with at least one sibling.
- Thirteen had direct contact with birth family on at least a weekly basis, 18 at least a monthly basis and 39 at least annual direct contact.
- Thirty children and young people had received therapeutic support and 20 were known to the local CAMHS team. A further two were receiving support at regional centres.
- In the six months following the research a further four of the 41 children were appropriately referred to the local CAMHS team.

The relationship between level of direct contact with birth family and carer-rated total difficulties scores was statistically significant (p = 0.027), as was the relationship between levels of direct contact with birth family and self-report total difficulties scores (p = 0.003). In both cases higher levels of direct contact were associated with a lower total difficulties score.

Carer-rated reports indicated a significant effect, with those children who had received therapeutic support having higher mean total difficulties scores than those who had not: a total score of 16.4 (SD = 5.99) compared to a mean of 10.55 (SD = 8.5). This effect was statistically significant (p = 0.018). There was also statistical significance (p = 0.045) in the relationship between placement moves and teacher-rated SDQ.

Educational experiences were also analysed in relation to SDQ scores and information from social work files revealed the following:

- The number of school moves outside normal transitions ranged from one to seven.
- Eight of the 20 self-reporters and three of the under-11-year-olds had been subjects of at least one fixed-term exclusion. Fifteen of the research population were subjects of a Statement of Special Educational Needs, seven for learning, seven for emotional and behavioural reasons and one for both.

Teachers gave children with a statement for emotional and behavioural needs a much higher conduct score than was the case for those without a Statement, and a similar emotional score to both. The 11 to 16-year-old self-reporters with a statement for behavioural and emotional needs rated their conduct scores no higher than those 11 to 16-year-olds without a statement. The teacher and self-reporters rates for emotional and/or conduct difficulties were no different to those for children and young people without statements.

The relationship between teacher-rated SDQ scores and fixed-term exclusions did reach statistical significance (p = 0.050) and, more specifically, there was statistical significance between the teacher SDQ conduct difficulties and fixed-term exclusion (p = 0.08).

**Discussion**

**Study limitations**

We identify two limitations of the study, the first of which concerns the size and nature of the sample. Low numbers may have led to a lack of statistical signifi-
cance. In addition, the research may not accurately represent all looked after children within the local authority. The research population was located within a PTT operating to a permanency plan, so tended to be in stable placements, schooling and contact arrangements. This may mean that their mental health needs would have been more easily identified than those who have not yet achieved the same level of permanency and stability. The 20 who did not participate may also have influenced the result. It was known that some of the young people who chose not to participate were having placement difficulties. It is possible that had they been included in analysis greater levels of difficulty might have been identified.

Secondly, we believe it is difficult to attribute causality to the information from social work files. The data were retrospective and variables could not be measured in terms of specific experiences. Social work files were accumulated over a long period of time and over a number of allocated social workers, which may have affected the quality and quantity of information recorded.

Study strengths
Despite these limitations, the results confirmed previous research findings about the significantly higher mental health needs of looked after children compared to children in the general population. The research also identified a number of factors that reached statistical significance with the emotional and mental health needs of looked after children. The choice of the SDQ as a research tool and using it with all three respondent types was viewed as an additional strength. New information regarding direct contact, therapeutic support, placement moves, school exclusion and Statements of Special Educational Needs was also gathered. A further practical benefit of the study was the closer working relationship between the PTT and the local CAMHS.

Specifically, our findings support research regarding the number of looked after children identified as being in ‘high need’ (McCann et al, 1996; Nicol et al, 2000), though they were not identified as such by the 11–16-year-olds themselves (see below). Like McCann’s research, our study received a high response rate from the research population, including the self-report group of 11–16-year-olds. Other research demonstrates this can be a difficult age group to engage in research.

The current research covered a wider age range of children and, as would be expected, the average age at entry into care was much younger (4.78 years/9.2 years) than in the McCann study, though, interestingly, the range in terms of number of placements was very similar, as was the range of time in care.

Unlike Nicol et al, the current research population was primarily located within non-specialist foster care placements. However, both studies showed high levels of education/learning need and school exclusion rates for its respective populations. There have been previous studies where the SDQ has been used (McCarthy et al, 2003; Sinclair and Wilson, 2003). However, the current research used SDQ information from all three respondent types in combination with life histories obtained from social work files.

The research demonstrates that young people consistently report lower levels of difficulties than do their carer/teacher. This supports other recent research findings (Mount et al, 2004). Indeed, the young people themselves did not rate their needs to be significantly higher than those of the general population. This is consistent with previous findings that many children and young people attending a mental health clinic rated themselves as having low or moderate needs, while their parents and/or teachers felt their needs to be in the high range (Goodman et al, 1998; White and Stancombe, 2004). Young people’s self-perception of mental health needs may be one factor that discourages their engagement in traditional CAMHS community services (Nicol et al, 2000).

The results suggested significant agreement between carer, teacher and self-report ratings, with higher scores from one source likely to be associated with higher scores from the other two, indicating the total SDQ total scores have good inter-subject reliability. This important
finding showed an agreed correlation between the three respondent groups. Other significant findings show that adults who have differing relationships with the same looked after population sample viewed the children and their mental health needs differently.

Contact The level of direct contact with birth family members had a significant relationship with carer ratings and self-report ratings. A higher level of direct contact was associated with lower total difficulties, which appears to support the work of Neil et al (2003) in that more positive relationships with birth family members contribute to continuing positive emotional and mental health. However, another explanation may be that those children with more positive emotional mental health are more able to sustain higher levels of direct contact. Contact that took place on a daily to weekly basis was often informal and unsupervised.

Therapeutic support Those children who received therapeutic support were rated by their carers as having significantly higher difficulties than those who had not. Of the SDQ scores that totalled 20 or more, indicating high mental health need, over 80 per cent had received some such support. This implies that the majority of children with the highest emotional and mental health needs were being recognised and attempts at therapeutic support had been made.

Number of placements The number of placements since entering care showed a significant relationship with teacher-rated SDQ scores. Placement moves are likely to have an adverse relationship on the emotional and mental health needs of those children whose lives have been disrupted by yet another change of carer. This significance suggests that children who had more placement moves were rated by teachers as having more difficulties within the school environment.

Educational needs A high proportion of children (36.6%) were the subject of Statements of Special Educational Needs. Of those with a Statement for emotional or behavioural difficulties, teachers appeared more likely to view difficulties as conduct based. The self-reporters’ SDQ scores showed low conduct but significant emotional difficulties. Teachers may not be consistently recognising children’s outward conduct difficulties as an indicator of underlying emotional problems.

Teachers’ total difficulties ratings and conduct difficulties ratings were both higher for those children who had been the subjects of fixed-term exclusions than for those who had not. This may be because children enact their difficulties at school but not in the home (or in a very different way within the home). The two environments are very different: school is a catch-all environment with a variety of sanctions available, including exclusion, whereas foster placements constitute a care-specific environment. Children may act out at school because of extra demands placed on them in that setting, including higher social skills, difficulties maintaining peer relationships, compliant behaviour and the challenges of academic work. Issues may also relate to specific school environments and the manner in which the child’s behaviour is perceived. The relationship of teacher SDQ scores and parental substance misuse may have been statistically significant because this subject is more likely to be identified as a primary cause of family difficulty and more easily recorded.

The SDQ provides a snapshot of mental health need. This is one of its strengths, alongside the fact that it has been well researched. We were pleased to have used the SDQ knowing that in likelihood it was to become the routine mental health screening tool for the local looked after population. In our view, within the resources available, the SDQ was able to provide a concise working tool, using clear language and instruction. Its ease of completion for non-CAMHS professionals was complemented by its relative ease to score. The tick-box format could be said to have helped positively guide decisions regarding completion. We had been aware of difficulties with the take-up rates of previous research and believe that the use of the SDQ contributed greatly to our 100 per cent response. However, the SDQ cannot on its own
provide a retrospective, comprehensive view of the mental health needs of the looked after population. It is best used as a tool within a wider, holistic assessment that encourages young people's participation in that process.

Review of the research aims and objectives
Our original view that there was unmet mental health need within the PPT was not found, given that of the cohort of 41, at least 30 had received therapeutic support at some time. Mental health need had been identified, considered and addressed earlier in the child's care history.

Our prior concern that pre- and post-care experiences would be seen in the context of higher mental health needs was not statistically proven. Many children experienced at least two types of significant harm, which made it very difficult to separate out the effects of specific aspects of such abuse. A similar difficulty arose from the facts that more than 75 per cent of the research population had a parent with mental health difficulties and over 75 per cent of children had experience of living with domestic violence. Of the children whose parent(s) had substance misuse issues, more than 75 per cent were under 11 years at the time of the research. There were 11 unsuccessful reunifications and placement moves ranged from one to 23. None of these relationships reached statistical significance but we do not dismiss these powerful numbers.

Conclusion
It is our strong view that additional mental health needs for looked after children cannot be attributed to a single variable or even easily explained by an interaction of variables. Rather, it is highly likely that the mental and emotional health needs of looked after children arise from a complex interaction of both pre- and post-care experiences, which makes it difficult to measure the effects of specific experiences. One example of our population was a nine-year-old who had been in nine different care placements, with nine different primary caregivers, and this after being removed from the birth family and suffering significant harm(s). One factor is inadequate to explore unmet mental health need and suggests the multi-factorial complexities of pre-care experiences, as well as the local authority decision-making of the day.

In conclusion, the experiences of each looked after child are unique. These children clearly need co-ordinated multi-agency working to address the multiple factors that contribute to the persistence of their emotional and behavioural difficulties. As a main principle of the Children Act 2004 we welcome:

...[the] duty of Local Authorities to make arrangements to promote co-operation between agencies...in order to improve children's well-being...and a duty on key partners to take part in the co-operation arrangements. (Department for Education and Skills, 2004, p 5)

We also welcome 'being healthy' as one of the five outcomes that children and young people have identified for themselves as key to their well-being in childhood and later life. We would wish to see earlier identification and intervention of the mental health needs of looked after children and more effective, specialist multi-agency working to find creative solutions to complex needs that no single organisation can provide.

The following recommendations are suggested:

1. Future research to involve more participants in order to increase the likelihood of identifying key results
The sample should be more broadly representative of looked after children, for example, in terms of ethnicity and children who are at different stages of the care system. We would also suggest the use of a larger sample to try and identify the impact of individual factors such as placement breakdowns. The information gained from this broader, larger sample would inform multi-agency decision-making in respect of the looked after population. A study of the younger age range of our population who remain in care rather than those who follow the adoption route would also be useful.
2. The use of the impact scores and information from the SDQ and other measures in addition to the SDQ

This would contribute to a comprehensive picture of the child’s needs, for example, interviews with participants or qualitative components to the research. Interviews would assist in interpreting the participants’ understanding of the subjective ratings used in the SDQ.

3. To research separately the views of teachers in relation to the mental health needs of looked after children

The results of this study indicate some statistically significant relationships between teachers and independent variables. This is worthy of further exploration as positive educational experiences play a significant role in promoting the mental health of looked after children.

4. The use of a screening tool to promote earlier identification of the unmet mental health needs of looked after children

The research began following discussions with the local authority about the regular use of SDQ via the looked after children’s reviewing system. We continue to recommend the use of the above screening tool.

Finally, we recommend effective multi-agency working relationships, to include foster carers, teachers (particularly those with LAC responsibility), adult and child social care workers together with child, adolescent and adult mental health professionals, that work towards a shared understanding of the mental health needs of looked after children.

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