National Children's Bureau

# Measuring the wellbeing of children in care

## Views from the frontline and opportunities for change

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# Glossary of terms

**Looked after children (LAC)** - this is a legal term describing children for whom a local authority has, via a court order, assumed parental responsibility (see section 2.1.1). We only use this term when citing legislation and literature which refers to this group.

**Children in care** - this report focusses on measuring the wellbeing of children who have been looked after for significant periods of time and may have experienced abuse, neglect and/or trauma. We use the term 'children in care' to refer to these children rather than those who may be 'looked after' for shorter periods or for other reasons (see section 2.1.1). We use the term to refer to children and young people up to the age of 18.

**Measure** - a way of measuring something (in this case, wellbeing) this can include informal ways of measuring (see section 7.7) as well as the use of specific tools and proxy indicators such as educational attainment.

**Tool** - something that is used to aid the measurement of wellbeing such as a questionnaire or checklist (see sections 2.2.3 and 2.2.4).

**Specialist mental health services** - mental health treatment or therapy provided by trained medical professionals as part the NHS. Whilst this is often referred to as CAMHS (Child and Adolescent Mental Health Services), we do not use this term as it can also refer to the wider support children and young people's mental health from schools and local authorities.

**Designated doctor/nurse** - designated doctors and nurses for looked after children are appointed by each clinical commissioning group (local NHS commissioning body) in England. Guidance recommends that their role should be to assist clinical commissioning groups at a strategic level to improve the health of looked after children (Department for Education and Department of Health, 2015).

**Named doctor/nurse** - named doctors and nurses for looked after children work in health provider organisations and act as a principal contact in that service for children's social care (Department for Education and Department of Health, 2015).

**Independent Reviewing Officer** - an employee of the local authority, independent of the day to day provision of the child's care, who is responsible for monitoring a local authorities performance of their duties towards that child and chairing reviews of the child's care plan.[1]

**Independent Visitor** - a person, normally a volunteer and independent of the local authority, who visits, advises and befriends children in care. Local authorities have a statutory duty to provide an independent visitor for a child when they deem that it is in that child's best interests.[2]

**Children in care council** - a group of children in care convened by (or on behalf of) a local authority to inform the improvement of local services.

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[1] Sections 25A, 25B of the Children Act 1989

[2] Section 23ZA of the Children Act 1989

# Executive Summary

Taking a child into care is major step, and one which places a responsibility on the child's new corporate parents to ensure that that child grows up healthy and happy. To this end, local authorities have a legal duty to safeguard and promote the welfare of children in care, including through the promotion of physical, emotional and mental health.[3] In 2017, this duty was complemented by the introduction of statutory corporate parenting principles, which require local authorities to consider wellbeing in all of their interactions with children in care.[4]

Children in care are more likely than their peers to experience mental health problems and related negative outcomes (Meltzer et al, 2003; Department for Education, 2014). This makes measurement of their wellbeing all the more critical for informing the planning of their care. Measuring wellbeing can also help to assess how well children are being supported to move on from any trauma they have experienced prior to entering care, and to hold corporate parents to account for their contribution to this. However, concerns about current approaches to wellbeing measurement have led to calls for improvements.[5]

With funding from The J Paul Getty Jnr Charitable Trust, the National Children's Bureau (NCB) conducted research exploring the measurement of wellbeing of children in care. We gathered the views of 114 professionals working with children in care, as well as those of children and young people themselves through five children in care councils.

In line with the diverse literature on this subject, professionals suggested a range of definitions of wellbeing. They generally considered wellbeing to be a holistic concept that encompassed many different areas of children's experiences. Whilst this included aspects of physical and mental health, professionals thought that wellbeing was a broader concept.

Professionals said that they measured children's wellbeing at all ages and stages throughout their journey through care.  They did this for a variety of purposes, including for care planning, and to measure progress and outcomes. They explicitly acknowledged the value of doing this to help improve the lives of the children they worked with.

We found widespread use of the Strengths and Difficulties Questionnaire (SDQ), which reflects the requirement on local authorities to report results of the SDQ to Government each year. Whilst participants were aware of a number of other tools, very few reported having used any of them regularly.

There were mixed views on how well the SDQ worked in practice. Challenges included:

- Reliance on a positive trusting relationship between the child and the person administering the questionnaire, which did not always exist;
- The questionnaire not being flexible enough to work for children with particular communication needs and experiences; and
- The questionnaire not taking account of some indicators of wellbeing, such as involvement in afterschool clubs or engagement in exercise, which were seen as important by professionals.

Consequently, many professionals relied on their own bespoke and informal measures and proxy indicators to inform their work with children in care. The SDQ was seen by some as a 'tick box exercise'.

The SDQ's suitability as a wellbeing measurement tool is also undermined by the way it is administered. Participants confirmed findings from previous research which found that the questionnaire is not always administered at the point of entry into care, so cannot provide a baseline. We found that carers and young people filled out the questionnaire in most instances, with some social workers and health professionals also completing it. Carers and social workers in

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[3] Section 22 of the Children Act 1989
[4] Section 1 of the Children and Social Work Act 2017
[5] This includes emerging evidence published since we carried out our field work by the Expert Working Group on Improving Mental Health Support for Children in Care (Milich et al, 2017)

particular may be reluctant to engage with the SDQ if it is likely to be used to judge the quality of care they were providing.

The SDQ was designed as a screening tool for emotional and behavioural problems. Unsurprisingly, therefore, professionals were keen that SDQ scores be used to inform planning of children's care and, when required, access to specialist mental health services. We heard, however, that there was mixed practice around the extent to which this happened. Professionals expressed frustration about wellbeing scores not leading to any changes. Some young people we heard from were also sceptical about results being used in a positive way. There were particular challenges around access to specialist mental health services. Services would, for example, apply their own referral criteria (in addition to the SDQ) or delay treatment whilst they waited for payment from the child's placing authority.

Based on these findings we recommend that the Government takes a number of steps to improve the measurement of the wellbeing of children in care. Current work the Government is leading provide opportunities to make progress. The Government has committed to piloting new approaches to mental health assessments for children entering care and is carrying out a consultation on proposals set out in its recently published Green Paper, *Transforming children and young people's mental health provision* (Department for Education and Department of Health, 2017).

We recommend that the Government:

- Pays particular attention to the needs of children in care in the implementation of its proposals in *Transforming children and young people's mental health provision*. This should include ensuring that at least one the proposed Trailblazers focuses on the needs of these children.

- Uses planned pilots of new approaches to mental health assessment to explore:
  - Options for creating a baseline measure of children's wellbeing on entry to care whilst ensuring assessment of wellbeing is seen as an ongoing process
  - How access to specialist mental health services for children who need them could be made simpler

- In consultation with children, carers and professionals, develops a definition of wellbeing and clear guidance on what this looks like for children in care

- Reviews, tailors and supplements the SDQ to create a suite of tools that can fulfil the distinct functions of screening for mental health conditions and measuring wellbeing more effectively

- Creates a comprehensive outcomes framework for children in care that reflects the breadth of topics that relate to children's wellbeing, building on existing published data and proxy indictors.

Regardless of any, professionals, local authorities, and health commissioners should uphold and promote good practice within the current framework. In particular:

- Local authorities should ensure results of screening tools such as the SDQ are always taken into account in care and placement planning

- NHS England and Clinical Commissioning Groups should work with mental health service providers to improve processes for children in care accessing mental health treatment

- Local authorities should use a range of sources of evidence to assess the quality of care they are providing, including the views of children in care councils and professionals who do not have core responsibility for a child's care.

# 1 Introduction

Past experience of abuse, neglect and difficult familial relationships present serious challenges to the mental health and wellbeing of many children in care[6]. The process of being taken into care can also be traumatic for children, as can some in-care experiences such as being moved between different foster or children's home placements regularly or at short notice (Munro and Hardy, 2006).

The risks posed by these experiences are borne out, for example, by higher prevalence of mental health problems amongst children in care. Indeed, the last major prevalence study (Meltzer et al, 2003) found children in care to be over five times more likely than their peers to have a mental disorder.

Local authorities are 'corporate parents' (Department for Education, 2015a, p15) of children in their care. They are, in most cases, the bodies which took the decision to apply to court to remove these children from their birth families. They can therefore be seen as having a responsibility to promote the child's wellbeing, to ensure that they grow up happy and healthy. As such, local authorities have a legal duty to safeguard and promote the welfare of these children, including through the promotion of physical, emotional and mental health.[7] The role of local authorities has also recently been strengthened through the introduction of corporate parenting principles (see policy context, below).

Given this responsibility and duty, it is important that local authorities have some means of measuring the wellbeing of children in care. However, no wellbeing measures are adopted or used consistently at the national or local level. As a consequence, it is difficult to track outcomes related to wellbeing of children in care. This in turn hinders any attempt to assess the extent to which care is helping children to progress or to plan improvements to services based on this. This has led to calls for the Government to measure and report annually on children in care and care leavers' wellbeing (Alliance for Children in Care and Care Leavers, 2016).

With funding from The J Paul Getty Jnr Charitable Trust, the National Children's Bureau (NCB) conducted research exploring the measurement of wellbeing of children in care. The research aimed to explore:

- How professionals and children and young people in care define wellbeing;
- What indicators, tools and/or measurements are used in wellbeing assessments of children in care in England;
- How indicators of wellbeing work in practice; and
- What works and any challenges associated with indicators of wellbeing.

The research consisted of a literature review, online survey and telephone interviews of professionals as well as consultation with five children in care councils.

The online survey was distributed between August 2016 and January 2017 to a wide range of professionals working with children in care. A total of 114 people responded to the survey. Nearly two fifths (39 per cent) were designated, named or other specialist nurses working with looked after children, whilst 11 per cent were social workers. Other respondents included children's rights workers, researchers, project/support workers and virtual school staff. Fourteen of the professionals who completed the survey also took part in follow-up interviews by telephone.

For more information on the research methodology see Appendix A.

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[6] It is important to acknowledge that the reasons why children are looked after are complex and varied. They range from abuse and neglect, through to a need to offer parents or children a short break because of severe disability. However, the primary reason why social services become involved with a child is due to abuse or neglect (61% in 2015; Zayed and Harker, 2015). Family-related issues make up the majority of the rest of cases, with reasons including child or parent illness and/or disability, familial stress, low income and family dysfunction (Zayed and Harker, 2015).

[7] Section 22 of the Children Act 1989

The remainder of this report is structured as follows:

**Chapter Two** describes what the existing evidence tells us about wellbeing and the measurement of wellbeing for children in care and sets out the policy context in which this research has been carried out.

**Chapters Three to Six** outline the findings from our primary research. Topics include how professionals define wellbeing, the specific tools and measures they use, how, when and by whom this is done, and how results are used.

**Chapter Seven** discusses the key challenges in measuring the wellbeing of children in care, as identified by study participants. It also explores some of their reflections on what needs to be done to this effectively.

Our **conclusions and recommendations** include actions for national government, local authorities and their partners, and professionals.

# 2 Literature review

## 2.1 What is wellbeing and why is it important to children in care?

This chapter explores the evidence on the wellbeing of children in care, why measurement of it is important and the approaches currently used to do this. It also explores the current policy context, highlighting developments which may present opportunities for a new national impetus on this issue.

### 2.1.1  The experiences of children in care

At the end of March 2017 there were 72,670 looked after children. This is higher than any point since 1985 (Department for Education, 2017a). This figure includes disabled children accessing short breaks and children in youth detention accommodation as well as those who have been taken into care for significant periods due to abuse, neglect and other family problems.[8]

Meltzer et al (2003) considered the prevalence of mental disorders in looked after children and found them to be over five times more likely than their peers to have a mental disorder. This included higher rates of emotional disorders such as anxiety and depression, conduct disorders such as oppositional defiance disorder and hyperkinetic disorders such as attention deficit hyperactivity disorder (ADHD). Looked after children are also more likely to have lower academic attainment, be excluded from school, or be convicted of a criminal offence(Department for Education, 2014).

The wellbeing needs of those in care are often greater than those of children in the general population. This is because they face a number of challenges that children in the general population generally do not. These include issues relating to attachment, instability, trust, abuse, neglect and trauma(NSPCC, 2015; Garcia Quiroga and Hamilton-Giachritsis, 2016; Munro and Hardy, 2006). Children in care are also more likely than their peers to have special educational needs and disabilities (SEND). The proportion of looked after children with identified SEND is 57 per cent, compared to just 14 per cent with identified SEND in the general population(Department for Education, 2016).

The relationship between children's wellbeing, their experiences that led to being in care and their experiences within the care system are complex. Studies have shown that children who remain in care, rather than being returned to their family, have greater wellbeing (Farmer and Lutman, 2012; Wade *et al.*, 2011). The increased risk of mental health and wellbeing problems for looked after children cannot solely be attributed to maltreatment or neglect bytheir birth families. Biological, social and psychological factors all play a part in different children's responses to adversity. When factors such as deprivation are taken into account, the difference in rates of mental health problems is less pronounced. Even then, looked after children are over three times more likely to have a mental health problem than their peers (Bazalgette, Rahilly and Trevelyan, 2015).

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[8] A child is legally defined as 'looked after' through three different routes:
- If they are subject to a care order, which gives the local authority parental responsibility for the child (Sec 22, Children Act 1989). These are granted by courts if they agree with the local authority that a child is suffering, or is likely to suffer, significant harm attributable to their parent(s) not being able care for them or their being beyond parental control (Section 31, Children Act 1989).
- If they are being provided with accommodation by the local authority, as part of its social services function, for a period of 24 hours or more (Section 22, Children Act 1989). This includes children subject to emergency protection orders, as well as short break provision for disabled children (Section 22 of the Children Act 1989; Schedule 1 of the Local Authority Social Services Act 1970).
- If they have been remanded in youth detention accommodation (Sentencing and Punishment of Offenders Act 2012).

### 2.1.3 Defining wellbeing

In order to measure wellbeing, it is important to be clear from the outset about the form of wellbeing being measured (Warr, 2012). There are, however, multiple definitions of wellbeing and no consensus as to what 'wellbeing' actually is (Selwyn and Wood, 2015). Whilst this research does not use a specific definition, it is worthwhile exploring some of the theories of what constitutes wellbeing and how these may relate to the experiences of children in care.

Seligman's (2011) PERMA model, for example, outlines five core elements of wellbeing and happiness

- Positive emotions -feeling good;
- Engagement -finding flow;
- Relationships -authentic connections;
- Meaning -purposeful existence; and
- Achievement -a sense of accomplishment.

Many children in care experience difficulties in forming healthy attachments and trusting relationships. This suggests that supporting them to address these difficulties should be a focus of efforts to promote their wellbeing. Having been separated from their birth family, experiences of these children will also differ from their peers in terms of developing identity and meaning in their lives. Understanding a child's potential and helping them to achieve it will present challenges for carers and services. This is particularly so given the traumatic experiences from which many children in care are recovering and the relatively poor longer-term outcomes associated with being in care.

There is a lack of consensus in the literature on how wellbeing relates to mental health. The Office for National Statistics (2015) contends that there is a clear distinction between mental health and mental wellbeing:

Mental ill health refers to a person experiencing a clinically diagnosable illness with a defined set of symptoms, such as anxiety or depression….

Mental wellbeing is more about how individuals feel about their lives and whether they believe they are worthwhile.

Office for National Statistics (2015: 3)

However, the World Health Organisation (2004) proposes the following definition of *mental health* describing it as the 'foundation for wellbeing':

A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

World Health Organisation (2004: 10)

Wellbeing can also be defined in broader terms. Guidance from the National Institute for Health and Care Excellence (2013) describes three elements of wellbeing: emotional, psychological and social wellbeing. Alternatively Katherine Weare (2015), a leading academic in the field of child wellbeing and mental health, defines social and emotional wellbeing as:

A state of positive mental health and wellness. It involves a sense of optimism, confidence, happiness, clarity, vitality, self-worth, achievement, having a meaning and purpose, engagement, having supportive and satisfying relationships with others and understanding oneself, and responding effectively to one's own emotions.

Weare (2015: 3)

Emotional and mental health are key aspects of wellbeing and are particularly pertinent in

delivering support for children in care. A focus on emotional and mental health should not mean measuring just mental illness or its absence, however. Luke *et al.* (2014) also stress that research on looked after children should have a greater focus on positive outcomes, and less on problems, with children in care wanting studies about them doing well "on their own terms" (2014: 17).

Measures that relate to emotional and mental health, including those with a clinical focus, will therefore provide a useful, if only partial, insight into the wellbeing of children in care. The rest of this literature review and the discussion of the research findings will therefore consider emotional and mental health as an important part of the wider wellbeing of children in care. Definitions of wellbeing were explored further in the survey element of the research (see 4.2).

### 2.1.4 Policy context

The duties placed on local authorities and their partners provide a clear rationale for the development of wellbeing measures for children in care. In addition to this, recent policy developments and announcements suggest that there may be new opportunities to take this forward.

Local authorities and their partners have a duty under the Children Act 2004 to promote the wellbeing of all children residing in their area.[9] Local authorities also have a range of duties specifically towards children looked after by them. This includes an overarching duty to safeguard and promote the welfare of these children.[10] Clinical Commissioning Groups and NHS England are required to cooperate with local authorities in fulfilling this duty.[11]

More specific requirements placed on local authorities include an assessment of children's physical, emotional and mental health needs when they enter care, and regular review of those needs (every six months for children aged under five and annually for others) (Department for Education, 2015a). Guidance from Department for Education (DfE) and Department of Health (DH) (2015) on promoting the health and wellbeing of looked after children emphasises the need to consider both emotional and physical health.

All local authorities in England are required to return a range of data relating to children in their care annually to DfE (DfE, 2015b). This includes scores from a screening tool for emotional and behavioural problems, the Strengths and Difficulties Questionnaire (SDQ). The SDQ is completed for all children in care for 12 months or more. The use of the SDQ for measuring wellbeing is discussed in 2.2.3, below. The annual statistical release includes aggregated SDQ results alongside statistics on the number of placements children have had during the year, academic attainment and school absences (DfE, 2016; 2017a).

Data from the SDQ is also used to form the basis of a national indicator of the emotional wellbeing of children in care. This indicator is part of the Public Health Outcomes Framework which consists of a range of indicators designed to help services understand how well the health of the whole population is being promoted and protected (Public Health England, 2017).

Reform of mental health support for children and young people has been high on the political agenda in recent years.

In December 2017, the Government published *Transforming Children and Young People's Mental Health Provision: a Green Paper* (DfE and DH, 2017). This set out plans for:

- Incentives and support for schools to have a **senior member of staff who leads on mental health**. These leads would be linked with specialist mental health services which can provide rapid advice, consultation and signposting
- New **Mental Health Support Teams** to provide extra capacity for early intervention and

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[9] Section 10 of the Children Act 2004.

[10] Section 22 of the Children Act 1989.

[11] Section 27 of the Children Act 1989.

ongoing support. These would be linked to groups of schools and colleges to provide interventions to support those with 'mild to moderate needs'.

- A trial of **four-week waiting time limits** for specialist mental health services.

The Green Paper commits to £300 million to improve mental health services in schools and colleges. Funding for mental health support in schools is set to start in 2019 and the changes including Designated Senior Leads, Mental Health Support Teams and reducing waiting times are to be rolled out to 20-25% of England by the end of 2022/23. Mental Health Support Teams will be implemented initially in a number of 'trailblazer areas' which will be evaluated. The Green Paper states that this approach will help build understanding how the reforms' 'benefits can extend to all children and young people, including the most vulnerable' (DfE and DH 2017: 4). The Government is currently consulting on the detail of how these reforms should be implemented

The publication of the Green Paper followed shortly after other initiatives to reform and invest in children's mental health. *Future in Mind*, published by the Children and Young People's Mental Health Taskforce in March 2015 (DH and NHS England, 2015), made a number of recommendations for improving children's mental health and related services. These included action on 'promoting resilience, prevention and early intervention' and more integrated support for the most vulnerable children, including those in care. The Government allocated £1.4bn to be spent on improving children and young people's mental health services over five years from 2015 to 2020. (HM Government, 2017). However, there is some evidence that this money is not being invested in mental health services as expected (Frith, 2016).

There have also been a number of developments relating specifically to children in care. In spring 2016, for example, the Government commissioned the Social Care Institute for Excellence (SCIE) to develop a range of recommendations on improving the emotional and mental health of children in care. This project was informed by an expert working group led by Dame Christine Lenehan and Professor Peter Fonagy OBE and concluded in November 2017. The final report (Milich et al, 2017) recommended the introduction of a mental health lead for children in care in each local area, the use of additional assessment tools to understand children's mental health needs and for such assessment to be viewed as an ongoing process. It also made a number of recommendations relating to staff and carer training as well as local service planning and accountability.

In November 2016 the Government committed to piloting an integrated approach to mental and physical health checks for looked after children. These pilots are currently in the early stages of planning. However, the Government has suggested that there are likely to be six to ten pilots across the UK and, once started, they are expected to run for two years (Lord Nash, 2016).

The Children and Social Work Act 2017 introduced a set of corporate parenting principles. These principles set out key considerations that local authorities must keep in mind when providing services for (or any other interactions with) children they look after. Notably, they include a requirement for local authorities to have regard to the need to promote both the 'physical and mental health and well-being' of these children.[12] The Department for Education has recently consulted on statutory guidance for local authorities in relation to these principles (DfE 2017b).

### 2.1.5 Criticism of the care system's approach to wellbeing

The promotion of wellbeing is a key part of good support for children in care. However, literature suggests that there should be stronger accountability for how the care system delivers this.

The National Audit Office (2014) has raised concerns over the lack of indicators on the efficacy of the care system. It argued that indicators of effectiveness are needed to ensure that the £2.5 billion spent on the care system achieves the Government's stated objectives of improving the quality of care and stability of placements.

If the wellbeing of children in care were to be measured and analysed then this may would help us to understand what works in care and drive improvements. There would also be a stronger

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[12] Section 1(1)(a) of the Children and Social Work Act 2017.

incentive for local authorities and health services to work together to promote the wellbeing of children in care. Recently, however, both the Care Quality Commission (2016) and the Education Select Committee (2016) have raised concerns that children in care are being let down when it comes to support for good mental health and wellbeing.

The Children's Commissioner for England (2017) has highlighted the detrimental impact that instability can have on the outcomes of children in care, including their ability form secure relationships and achieve their potential at school. The Commissioner has led the development of a stability index which records the number of placement moves, school moves and changes in social worker a child experiences. A pilot of the index indicated that 69 per cent of children in care had experienced at least one such change in the 12 months to 31st March 2016.

A number of organisations have called for a greater focus on wellbeing within the care system, and, as part of this, better approaches for measuring wellbeing. For example, a recent NSPCC (year) report said:

> Governments must take action to ensure that the mental health and emotional wellbeing of looked after children is a clear priority for our care systems. They should define clear requirements for local authorities' collection of outcome measures to track children's progress.

<div align="right">Bazalgette, Rahilly and Trevelyan (2015: 6)</div>

This priority was echoed in a recent call by the Alliance for Children in Care and Care Leavers (2016) for the Government to:

> Measure and report annually on looked after children and care leavers' wellbeing. This should combine available data and tools, including clinically validated measures and subjective measures based on children's own views about how their lives are going.

<div align="right">Alliance for Children in Care and Care Leavers (2016: 3)</div>

## 2.2 Ways of measuring wellbeing

This section reviews the evidence on how wellbeing can be measured, what the key challenges are and tools currently used to measure the wellbeing of children in care.

### 2.2.1 Approaches to measuring wellbeing and associated challenges

The personal nature of wellbeing makes measurement complex. Selwyn and Wood (2015), citing Hicks (2011), distinguish between subjective wellbeing (defined by the individual) and objective wellbeing (defined outside of the individual). Subjective and objective wellbeing are measured differently:

- **Objective measures** require researchers to make assumptions about what is required for wellbeing and set indicators to assess how far these requirements are satisfied. Such indicators may be economic, related to quality of life, or environmental. A number of studies have identified what these might be for children (see domains of wellbeing, below)

- **Subjective measures** ask individuals to assess their own wellbeing based on how they feel. The relative *subjectivity* of these measures comes from focusing on what a person feels e.g. life satisfaction, happiness, rather than the fact that it is self-reported.

Researchers have made a number of observations about how attempts to measure children's wellbeing can play out in practice:

- Children are more likely to provide repetitive responses or extreme answers (Matza *et al.*, 2004)

- They are also more likely to respond with the intention of pleasing the interviewer, and

answer questions they do not understand, in order to appear competent (Matza *et al.*, 2004).

- They may have limited understanding of key terms. For example, Taylor *et al.* (2010) note that children have been found to confuse the terms 'satisfactory' and 'satisfaction', with not all children aged ten to 15 having a full understanding of the concept of satisfaction.

- Research on the psychological (i.e. subjective) measures of wellbeing consistently notes the value of including multiple informants, particularly parents (Nakamura *et al.*, 2009).

These observations point to two key considerations in measuring the wellbeing of children in care. Firstly they highlight the need to have age-appropriate questions and interview processes. This important for ensuring that children understand what they are being asked and have the confidence to answer honestly. Secondly, careful consideration needs to be made of who, in addition to children themselves should inform assessments of wellbeing for children in care. For many children in care, particularly those in short term placements, foster carers and residential care workers may not be best placed to comment on their wellbeing.

Tarren-Sweeney, Hazell and Carr (2004) concluded that where a child is in long-term placement, foster parents or teachers would be well placed to comment on most aspects of their wellbeing. They stressed however that they would still have limited insight into how the child feels. Subjective, self-reported wellbeing measures may offer the opportunity to deepen understanding of a child's own perspective and feelings, particularly those who are not in stable or long-term placements.

Organisations developing their own measure of the wellbeing of children in care have also noted that children's communication needs can vary based on their age and any additional needs they may have (Selwyn and Briheim-Crookall, 2017; NCB and Research in Practice, 2017, p17). These organisations therefore developed different versions of their measurement tools and adapted methods of administration, for example, by asking a trusted adult to fill out a questionnaire alongside any children who were unable to do this by themselves.

Further work is needed to help understand how comparisons can be made to measure any progress or outcomes. Hannon *et al.* (2010) and Sebba *et al.* (2015) argue that, due to different experiences, it is unfair to compare outcomes for looked after children with children who are not looked after or in need. Sebba *et al.* (2015) believe a fairer comparison is to look at children who are in need but live at home as they provide an additional, and in some cases more suitable, comparison group. They also argue for a greater examination of progress when in the care system as a means of judging the effectiveness of care.

As such, an assessment of wellbeing would be made at the start of the care process. The child would then be regularly assessed as they move through the care system and beyond. By analysing this data, there would be a greater understanding of the effectiveness of the care system and, along with other indicators, what contributes to any success. This research will contribute to an understanding of how wellbeing is measured currently and whether any improvements can be made to improve the quality of care.

### 2.2.2   Domains of wellbeing for children

Many factors from several aspects of life may have a bearing on a child's overall sense of wellbeing. These 'domains of wellbeing' form the basis of objective measures that can be used with children.

The Children Act 2004, for example, places local authorities and their partners (such as health services and schools) under a duty to cooperate to improve the wellbeing of children in their local area in relation to five particular areas. These were referred to the 'five outcomes' when this legislation was first enacted as part of the 'Every Child Matters' agenda (Department for Children, Schools and Families, 2003)[13]. They are:

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[13] Every Child Matters was launched by the Labour Government in 2003, partly in response to the death of Victoria Climbié. The initiative covered England and Wales and had five outcomes for every child to: stay safe, be healthy, enjoy and

- physical and mental health and emotional well-being;

- protection from harm and neglect;

- education, training and recreation;

- the contribution made by them to society; and

- social and economic well-being.

According to Selwyn and Wood (2015), at the time of their research many local authorities were still using the 'Every Child Matters' framework to assess the wellbeing of children in their care.

Children and young people's views of what makes positive wellbeing is a relatively recent topic for published research (Rees, Goswami and Bradshaw, 2010). The aims, methods and findings of four projects, two of which focused specifically on children care, are outlined in Table 1. Each of these domains can be measured through more specific questions relating to children's experiences. ONS's'(2015) Measuring National Well-being (MNW) programme, for example, developed 31 measures to assess children's wellbeing. These include: quarrelling with parents, talking to parents about things that matter, happiness with family and friends, satisfaction with time use, desire to go on to further education, and considering the things that one does are worthwhile. They also cover more general measures of life satisfaction and happiness.

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achieve, make a positive contribution, and achieve economic well-being. It covered children and young adults up to the age of 19, or 24 for those with disabilities. The three papers on Every Child Matters led to the Children's Act 2004.

**Table 1. Domains of wellbeing for children as identified by four UK studies**

| Project/ Organisation and Aims | Domains of wellbeing identified |
|---|---|
| The Childhood Wellbeing Research Centre (see Holder *et al.*, 2011)<br><br>----<br><br>Develop a self-report wellbeing outcome measure for use in economic evaluations of children's services<br><br>[For all **children**] | Eight domains were identified:<br>• Provision for **physical needs**, including food and drink, warmth and shelter, clean and adequate clothing<br>• Feeling **safe and secure**<br>• Whether children and young people can **go to school** and do the best that they can<br>• Receipt of **help and encouragement** to be confident, to make friends, to do well at school and to deal with problems and pressures<br>• **Being able to express yourself**, being given the opportunity to have your say (by adults, such as a parent) and being able to challenge decisions<br>• **Being listened to**, able to make choices and have your views taken into account<br>• Having **enough time** to do the things you want to do after school and at the weekend<br>• **Relationships** with family and relationships with friends |
| New Philanthropy Capital, in collaboration with The Children's Society (see Heady and Oliveira, 2008)<br><br>----<br><br>Develop a measure of children's subjective wellbeing for charities to prove their impact and improve the development of their services<br><br>[For all **children**] | Ten domains were identified:<br>• **Physical** well-being including physical health and fitness<br>• **Psychological** well-being including mood and level of worry<br>• **Behaviour** including feelings towards others and any risky behaviours or conflict<br>• **School** including happiness and safety at school and any trouble with school work<br>• **Family** including happiness at home, the amount of quality time with parents and feelings about whether parents care about them or not<br>• **Friends** including feelings towards friends, fun with friends and level of loneliness<br>• **Resilience** including outlook and capability to overcome problems<br>• **Living** environment including safety and feelings towards their house and neighbourhood<br>• **Subjective** well-being including self-esteem and satisfaction with life<br>• **Material** including economic background compared with national baseline and perception of living comfortably/having enough |

| Project/ Organisation and Aims | Domains of wellbeing identified |
|---|---|
| NSPCC 'Achieving emotional wellbeing for looked after children' (see Bazalgette, Rahilly and Trevelyan, 2015)<br><br>----<br><br>Engage with local authorities and their health partners to learn more about 'what works' in terms of meeting the mental health and wellbeing needs of looked after children and to investigate how local services can be improved.<br><br>[Specifically for **children in care**] | Ideas of what 'good' and 'poor' emotional wellbeing looked like were very **different for each child in care**. Each child requires an individual response In terms of wellbeing support but there are also some important themes about what works in promoting good wellbeing. Young people defined both 'good' and 'poor' emotional wellbeing according to their;<br><br>• **Feelings,**<br>• **Thoughts**,<br>• **Behaviours**,<br>• **Activities and achievements**,<br>• **Relationships,** and<br>• **Safety** and **stability**. |
| Bright Spots (2013-present)<br><br>Coram Voice and Hadley Centre for Adoption and Foster Care Studies at the University of Bristol (see Coram Voice and University of Bristol, 2015)<br><br>----<br><br>To give local authorities a better understanding of what contributes to a positive care experience<br><br>[Specifically for **children in care**] | Four domains emerged from the first part of the research:<br>• **Relationships** (Support our relationships): keeping and developing the relationships that are important<br>• **Rights** (Support our rights): Participating in decisions, understanding rights and being free from abuse and discrimination<br>• **Resilience building** (Build our abilities): learning how to manage the challenges in life<br>• **Recovery** (Make us feel better): coming to terms with what has happened and feeling valued<br><br>'Your Life, Your Care' revealed that the majority of young people felt that being in care had improved their lives and was a positive intervention. |

## 2.2.3 The Strengths and Difficulties Questionnaire

The Strengths and Difficulties Questionnaire (SDQ) is a brief tool for screening emotional and behavioural problems in children and young people aged three to 17. It consists of 25 statements to which the respondent is asked, on three point scale, to what extent they agree. This results in five sub scores covering:

- hyperactivity/inattention symptoms;
- emotional symptoms;
- conduct problems;
- peer relationship problems; and
- pro-social behaviours (i.e. strengths).

From this, a single summary figure is produced for each child, the 'total difficulties score', ranging from 0 to 40. Scores are banded into three categories: a score of under 14 is considered normal; 14-16 is borderline cause for concern; and 17 or over is considered a cause for concern.

The questionnaire is designed for administration by trained practitioners. It its original form, it includes versions for completion by parents, teachers and children aged over 11 years (Whyte & Campbell, 2008).

Since 2008, local authorities have been required to collect information about children's emotional and behavioural health through the SDQ. Authorities submit SDQ data to the DfE alongside outcomes data on themes such as  placement changes, educational attainment, substance misuse and offending (DfE 2015a, DfE and DH 2015).

Government guidance recommends that local authorities do not treat the SDQ just as a data collection exercise but also use it to:

- Inform a child's initial health assessment and health plan;
- Identify specific emotional and behavioural difficulties that may warrant specific intervention; and
- Help quantify the needs of the children in care to inform population-wide strategies for health services. (DfE and DH, 2015 pp10,17,30).

When implemented properly, the SDQ has been found to be effective as a screening tool for socio-emotional difficulties (Luke *et al.*, 2014) and psychiatric disorders (Brown et al., 2006). Its subject matter and widespread use also make it an obvious source of insight into the wellbeing of children in care and the quality of support they are receiving. However it does have number of limitations, particularly in its current form:

- Local authorities are only required to submit SDQ data for childrenwho have been cared for continuously for at least 12 months. Consequently the questionnaire is not always conducted at the point of entry into care and therefore, for many children, **does not provide a baseline** (DfE 2015a, Bazalgette, Rahilly and Trevelyan, 2015)
- The requirement to submit data **does not apply with regard to children under four or over sixteen** years of age (DfE 2015a)
- Even allowing for the criteria above, there are significant gaps in the data. In 2016 no score was submitted for a quarter of eligible children, and 12 local authorities returned results for less than half of local eligible children (DfE 2016). This suggests that there are a **large number of children in care for whom the questionnaire is not completed at all**
- Total difficulties scores provide **only limited information about the level and type of need** a child has - in 2016 49 percent of children's scores were classed as normal, 13 per cent borderline and 38 percent concern. Of those 51 percent borderline or concern children may have a wide range of different needs and specialist mental health services may only feel able to support small proportion of them (see 2.1.3 and 7.2)
- **It is focussed on emotional and behavioural problems so can only give insight into these**

**specific aspects of wellbeing**. It does not include key domains featuring in the studies described in 2.2.2. It does not cover life satisfaction, achievement or aspirations for the future, for example.

Research has also identified a number of obstacles to its effective use. For example:

- Approaches to completing the SDQ are **not consistent** across the country (Cocker 2016), suggesting it would be difficult to make comparisons across time and place
- There is often **no local process in place for regular monitoring** (Bazalgette, Rahilly and Trevelyan, 2015; Cocker, 2016) and DfE does not use the total difficulties scores submitted to track changes in individual children over time
- There is evidence that its use **is not universally supported amongst the workforce.** Selwyn and Wood (2015), for example, argue that, in some cases, social workers are reluctant to use scales and questionnaires as they are viewed as "too deterministic". Carers may also be concerned that measures are being used as a way of assessing the care they provide

The SCIE expert working group (Milich et al, 2017), which published its report since we carried out our fieldwork, also identified problems with the use of the SDQ to inform care planning. It noted that the SDQ did not detect post-traumatic stress disorder (PTSD), attachment disorganisation and developmental issues such as autistic spectrum condition. It therefore recommended that other assessment tools should be used alongside the SDQ to identify individual mental health needs.

Participants in this study shared their insight into these and other challenges from their experience of using the SDQ. These are discussed in 4.2 and 7, below.

### 2.2.4  Other tools

Guidance states that other screening or diagnostic tools can be used to monitor the emotional/mental health of children in authorities' care (although SDQ assessments must be completed) (DfE and DH, 2015). Selwyn and Wood (2015) summarised a number of communication tools and guides that local authorities have used. These include: Talking Mats, inmyshoes, incentiveplus, as well as indicators developed with looked after young people (for example, Essex County Council's 'The Pledge').

A number of metrics and systems have also been used to measure and quantify the mental health and wellbeing of children including those in care. Some of the better-known examples include:

- **Assessment Checklist for Children** - a checklist completed by carers and other professionals which explores emotions, behaviours and their physical affects;
- **Children's Global Assessment Scales** - asks professionals how well children are doing at home, at school etc.;
- **Emotional Behaviour Scale** - asks children whether various hypothetical situations are 'more like me' or 'less like me';
- **Warwick Edinburgh Mental Well-being Scale (WEMWBS**) - completed by young people aged 13 and over by rating how often they experience certain feelings and thoughts.

Annex 1 summarises these and many other tools for measuring wellbeing. This shows the breadth of measures used by the system to monitor wellbeing, though it is unclear how much these measures and tools inform understanding of the effectiveness of care or affect young people's care journey.

# Chapter conclusion

This chapter has discussed what the current evidence and policy and practice context tells us about measuring the wellbeing of children in care.

There is no consensus on what wellbeing is, but there are some common themes in the definitions and domains of wellbeing that have been proposed. These include resilience, developing and maintaining healthy relationships and achievements as well as the extent to which a child feels

happy or positive about their life. These have a special relevance to children in care, who may face particular problems with emotional health and relationships, for example.

There is a clear onus on local authorities and their partners to promote the wellbeing of children in care, and this is underpinned by legislation and guidance. Evidence suggests, however, that approaches for monitoring of children's wellbeing are poorly developed.

Children's mental health and wellbeing, including that of children in care, is receiving significant political attention. This includes, most notably, the recent publication of the Government's Green Paper, *Transforming Children and Young People's Mental Health Provision* (DfE and DH, 2017).

There are many challenges involved in effectively measuring the wellbeing of children in care. These relate to developing questions about subjective wellbeing that everyone can understand, deciding which people are best placed to comment on a child's wellbeing, and being able to assess changes in a child's wellbeing over time.

There are a range of tools for measuring the wellbeing of children. Local authorities have a legal duty to use the Strengths and Difficulties Questionnaire (SDQ) which ensures widespread use of this particular tool. The SDQ, however, was designed as a screening tool for emotional and behavioural problems and is not carried out in a way that allows the effective monitoring of children's wellbeing.

# 3 Defining wellbeing

Numerous definitions of wellbeing have been offered by the World Health Organisation, NICE and other researchers, as outlined in Section 2.1.2. This chapter will outline what participants in our study believed wellbeing meant, drawing on data from the survey, interviews and questions asked through children in care councils.

## 3.1 Definitions

Participants largely agreed that wellbeing was a particularly "grey" and "vague" area, without an accepted definition locally or nationally. Participants reflected that wellbeing was an open and subjective concept that could be "everything and nothing" at the same time.

Some of participants said that wellbeing was not a word that was "ever used" in their day to day practice or by their organisation. Most, however, were aware of attempts to define wellbeing, for example by the World Health Organisation or NICE. Despite this, many participants used their professional experience to develop their own understanding or terminology of what wellbeing meant for them and the population they worked with.

These definitions of wellbeing offered by participants largely centred on positive concepts (see Figure 1).

**Figure 1. Definition of wellbeing: themes from the open responses[14],[15]**
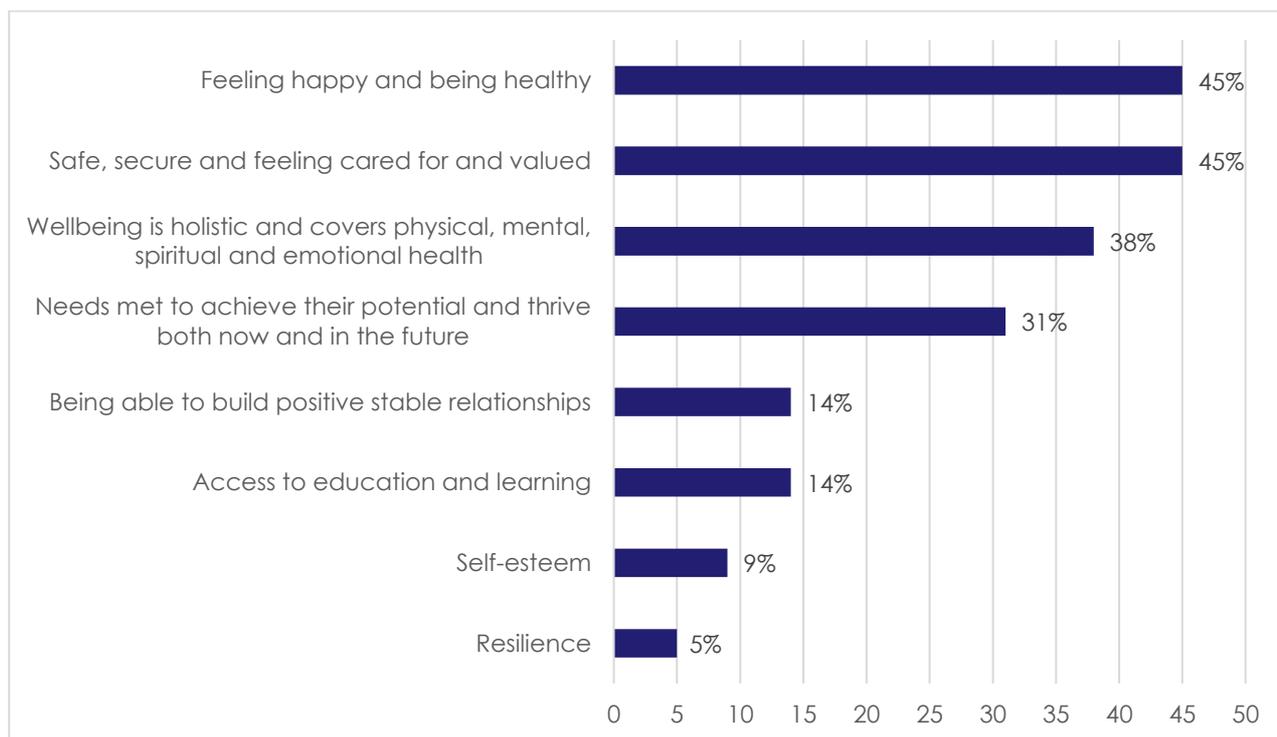


Nearly half of survey participants cited wellbeing as feeling happy and healthy (45 percent), with the same proportion believing it was about feeling safe, secure and cared for. Interview participants elaborated on this:

> "My definition is about keeping well emotionally and physically, enjoying your childhood and having a happy life…"

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[14] Source: Survey of professionals (n = 111)
[15] Respondents open responses were coded into the different themes their definition covered. One open response answer could encompass more than one theme, so percentages total more than 100.

> "Having good mental and physical health…includes weight, eating habits and confidence, social skills, mental health."

<div align="right">Interview participants</div>

Just under two fifths (38 percent) of survey participants felt wellbeing was a holistic concept that covered numerous aspects of health. This includes all aspects of health, as reflected by one interviewee:

> "Health on every single level of health outcomes; physical health, mental health, social health, spiritual health, emotional health, sexual health."

<div align="right">Interview participant</div>

Participants also felt wellbeing was concerned with people thriving (31 percent), looking to the future and having access to educational opportunities (14 percent). Interview participants shared these views and there was consensus that wellbeing is more than doing "just fine". Participants felt it was important that children had the motivation and opportunities to make progress academically and to build their aspirations for the future. One interview participant said:

> "Emotional wellbeing needs to be a concept of flourishing; a basis from which a child is able to feel themselves and be in a position to flourish, to have a resilient and strong starting point."

<div align="right">Interview participant</div>

Smaller proportions of participants felt wellbeing was strongly related to positive relationships (14 percent) and self-esteem (9 percent). Some interview participants felt that these social and relational aspects of wellbeing were of increased importance for children in care. They explained that these children were more likely to have been socially isolated and so lack the confidence, social skills or positive relationships to help them achieve a sense of wellbeing.

Children participating in this research through children in care councils had similar views to professionals about what wellbeing meant for them. Many children in care cited aspects of health including looking after their body, feeling fit and eating well as central to wellbeing. Slightly fewer also felt wellbeing encompassed feeling happy, confident, and cared for.

Some professionals thought that wellbeing was sometimes a difficult concept for children to interpret, which could make asking them about it difficult. As such, the professionals acknowledged that children and young people's understanding of their own wellbeing and the term as a whole is key for the definition of wellbeing as a concept.

## 3.2 Distinction between health and wellbeing

Whichever definition professionals and/or children and young people were using, there was a distinction between mental and physical health and wellbeing. Physical and mental health were recognised as separate, but important, aspects of a holistic concept of wellbeing. This is consistent with the ONS's (2015) view that there is a clear distinction between mental health and wellbeing.

It was acknowledged that good mental health did not always mean higher levels of wellbeing and vice versa. One participant mentioned a study within their hospital demonstrating how looked after children had been shown to have poor mental health (scoring highly on the SDQ), but high levels of wellbeing (as demonstrated through high Warwick Edinburgh Mental Well-being Scale [WEMWBS] scores).

Professionals praised changing attitudes in the sector and the attention to both children's health (physical and mental) and their wellbeing. While some participants felt they and/or their organisation had always seen emotional wellbeing and health as interrelated, there was a feeling that perceptions had changed. In a relatively short period of time, they had moved from an understanding of physical health (e.g. health assessments focusing on if children are registered with a doctor or have attended dental appointments) to a much more nuanced understanding,

encompassing aspects of wellbeing such as the ones described in section 2.2.2.

## Chapter conclusion

These findings demonstrate that there is no clear, widely accepted definition of wellbeing. Professionals held various definitions, based upon their experiences and the characteristics of the children they worked with. However, there was a degree of consensus that wellbeing is a holistic concept that encompasses many different things, including aspects of physical and mental health. Nevertheless, these were not seen as synonymous with wellbeing.

# 4 Measures of wellbeing

Survey respondents were asked whether they measured the wellbeing of children in care. The vast majority (82 percent) of the 114 respondents reported that they did measure the wellbeing of children in care, whilst just under a fifth did not (18 percent). Similarly, all interview respondents who worked directly with children in care measured wellbeing in some way. This could be through informal means such as talking or observing children or more formally through a tool developed within their organisation.

This chapter will outline findings from the survey and interviews about approaches to measuring wellbeing. This includes what measures they use including both standardised and bespoke tools, and proxy measures for wellbeing.

## 4.1 Awareness and use of standardised measurement tools

Survey respondents were asked about a range of standardised tools and whether they used them to measure wellbeing. For most of the tools presented, most respondents either did not answer the question or said they had not heard of the tools in question, which suggests that they were not being used.

By a large margin, the tool most frequently cited as being used with children in care was the Strengths and Difficulties Questionnaire (SDQ): 83 percent of respondents indicated that they currently or had previously used it with children in care. This high level of use reflects the duty on local authorities to report annually the wellbeing scores of children in care, using the SDQ, to the DfE.

Whilst current or previous use of other measures was much lower in comparison to the SDQ, respondents had substantial awareness of a wide range of alternative measures (see Figure 2). Just under half of respondents were aware of the Assessment Checklist for Children (45 percent) and just over a quarter were aware of the Emotional Behaviour Scale (29 percent), the Children's Global Assessment Scale (27 percent) and the Warwick Edinburgh Mental Well-being Scale (25 percent).

**Figure 2. Awareness of measures of wellbeing[16]**



| Measure | Percentage |
|---|---|
| Strengths and Difficulties Questionnaire (SDQ) | 88% |
| Assessment Checklist for Children (ACC) | 45% |
| Emotional Behaviour Scale (EBS) | 29% |
| Children's Global Assessment Scale (CGAS) | 27% |
| Warwick Edinburgh Mental Well-being Scale (WEMWBS) | 25% |
| Behavioural and Emotional Rating Scale (BERS-2) | 22% |
| Child Behaviour Checklist (CBCL) | 21% |
| Resiliency Scales for Children and Adolescents (R-...) | 20% |
| Assessment Checklist for Adolescents (ACA) | 20% |
| Outcome Rating Scale (ORS) | 19% |
| Revised Child Anxiety Depression Scale (RCADS) | 17% |
| Daily Life Stressors Scale (DLSS) | 15% |
| Behavioural and Emotional Reactivity Index (BERI) | 15% |
| Development and Wellbeing Assessment (DAWBA) | 13% |
| Emotion Expression Scale for Children (EESC) | 10% |
| BERRI developed by Dr Silver | 10% |
| Affect and Arousal Scale (AFARS) | 10% |

## 4.2 Perceived effectiveness of standardised measurement tools

Given the relatively low numbers of respondents using most standardised measures, it is difficult to draw conclusions on how professionals found using them in practice. The SDQ, which was more widely used, presented mixed results in terms of how respondents believed it worked in practice. Interestingly, 35 percent (of 89 respondents) believed it worked well or very well, whilst 34 percent thought it did not work very or at all well. (A further 29 percent did not believe it worked either well or not well.) These mixed results were also reflected in the qualitative data, where there appeared to be variation in practice and use of the SDQ. Furthermore, interviewees mentioned practical difficulties in using SDQs with specific groups of children and young people, which will be discussed further in section 7.6.

Other tools mentioned during interviews included the Warwick Edinburgh Mental Well-being Scale (WEMWBS) which was found to work well at opening conversations about wellbeing.

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[16] Awareness was calculated by combining "Currently or previously used with children in care" and "Know about but not used with children in care" responses (n = 105). Awareness of measures at <10% have not been included in the graph.

# 4.3 Bespoke measurement tools

Survey respondents were asked about any bespoke tools that they or their organisation had developed. Nearly a fifth of the 110 respondents (17 percent) revealed that they and/or their organisation had developed their own measure of wellbeing.  Many of those who went on to describe them talked about the use of a bespoke measurement tool. Of these, six of the tools developed by respondents had been subjected to an independent review or research to critically assess or validate them. However, respondents gave few details of how or by whom. These six tools included the outcomes framework for advocacy[17], a CAMHS screening tool[18], an emotional and social assessment, communication of emotional wellbeing, an outcomes framework developed by Barnardo's and the health assessment review.  Further details can be seen in Table 2.

**Table 2. Measures that have been developed by organisations and independently validated**

| Measures of wellbeing organisations have developed for children in care | Brief details about how they were developed |
|---|---|
| Outcomes framework for advocacy. | Through working with university staff, young people and advocates. |
| Emotional Social Assessment which covers a range of developmental areas including relationships, play, sense of agency and sense of identity. | Arose from a search for something more than an assessment tool that was comprehensive and was able to capture small steps. This was put together by a team of professionals including residential care managers and psychotherapy staff. |
| Communication of emotional wellbeing. | Developed through monitoring and advocacy standards. |
| The LAC health assessment questionnaire. | Developed in response to social care requesting awareness of the health of LAC that are in their care - an audit to identify aspects of a child's wellbeing e.g. physical health, learning needs. lifestyle indicators etc. |
| Barnardo's outcomes for children and young people used throughout Barnardo's services. | The outcomes used for measuring well-being are generic with services choosing 1 to 5 of the most relevant outcomes for any specific service. |

Other bespoke tools mentioned in interviews included a measure of the emotional and social progress of students, developed by a residential school for children in care. This tool encompassed "a lot about relationships" and "children developing a sense of independence". A healthcare professional discussed a health assessment tool they had developed themselves which encompassed six health dimensions (physical, mental, social, spiritual, emotional and sexual). Another health professional developed a form to look at wellbeing, asking questions about whether young people were settled in their placement, if they got on with the people they lived with, who they talked to about their worries/feelings and what they needed to improve their mood. Many of these components are consistent with the domains of wellbeing identified by recent research, outlined in Table 1 in section 2.2.2.

Taken together, this suggests that professionals and organisations appeared to be committed to finding measures of wellbeing that worked for them and the population they worked with. More examples of (non-validated) tools, developed by respondents, can be found in Appendix C.

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[17] Published by the National Development Team for Inclusion: https://www.ndti.org.uk/uploads/files/Advocacy_framework.pdf

[18] This has not been included in the table as no further information was given.

## 4.4 Proxy indicators for wellbeing

Survey participants were also asked if they used any other indicators, such as educational attainment, as a proxy for wellbeing. Just under a third of the 109 respondents (32 percent) reported that they did use other indicators as a proxy measure for wellbeing.

Over three quarters (77 percent) of those using other indicators said these indicators related to education. The indicators they specified included attendance at school, attainment, engagement with learning, behaviour at school, involvement with peers and participation in after school activities. Respondents also highlighted the value of using employment and training as a proxy measure, especially for care leavers.

The use of indicators as a means to measure wellbeing was also spoken about in interviews. There was a general view that any standardised measure was only ever an indicator of wellbeing; as such, interviewees used many different proxy and informal, less standardised tools and/or methods to look at wellbeing. One foster carer talked about measuring wellbeing based on whether the child had walked into school with their head held high or was getting more invitations to friends' houses. An Independent Reviewing Officer also used more informal measures, stating that they looked for eye contact, communication, observation among other things. As professionals, it was felt they had many different tools to use, as well as their own professional and personal experiences to draw upon:

> "I guess we have a lot more tools than we know we have that we use, they're just not written down, it's being a social worker I suppose, you just learn…you know what good looks like and you're looking for that; it's a combination of things and they're not on a piece of paper."
>
> Interview participant

> "Wellbeing is measured by the authority I work for, but I have no idea what it is called, if indeed it has a name…although I have not devised a written measure of a child's wellbeing, I feel I have a very good feel for it from my years as a member of a very large extended family, a mother, a teacher and foster carer."
>
> Survey respondent

Whilst interview participants recognised the value in proxy and more informal measures of wellbeing, they also noted difficulties with using these. One participant highlighted these challenges:

> "We talk about wellbeing all the time in various guises; emotional, spiritual, we ask them whether they go to church…but capturing that in assessments, provable, measurable, trackable outcomes, is difficult."
>
> Interview participant

## Chapter conclusion

The main tool used was the SDQ, which reflects the requirement for local authorities to report on total difficulties scores to DfE as part of their looked after children annual data return. Whilst the SDQ was most commonly used, participants were also had awareness of a number of other formal and informal measures. Other formal measures that respondents were aware of included the Assessment Checklist for Children, Emotional Behavioural Scale, Children's Global Assessment Scale and the Warwick Edinburgh Mental Well-being Scale. There were mixed views on how well the SDQ worked in practice. However, not enough participants had used other tools for us to make any meaningful comparisons

More informal and/or bespoke measures developed by individuals and organisations were also used when looking at wellbeing. Proxy measures were often used by professionals to help understand wellbeing as a holistic concept. These proxy measures included school attendance, attainment and membership of after-school clubs.

# 5 Practicalities of measuring wellbeing

## 5.1 Introduction

In addition to understanding what wellbeing measures and tools are being used within the sector, the survey and interviews sought to explore the practicalities around measuring wellbeing. This included the age of children when they have their wellbeing measured, at what point in children and young people's journey through care wellbeing is measured, and who is involved in completing assessments.

## 5.2 Age of children

Survey respondents were asked about the ages of children in care who have their wellbeing measured (see Table 3). The majority of respondents reported that wellbeing was measured for children aged between 4 and 18 years (34 percent) or between birth and 18 years (33 percent). A smaller proportion of respondents measured the wellbeing of children between 4 and 16 years (16 percent) or between 11 to 16 years (10 percent). Some of these answers may reflect the role of the survey respondent, such as those working only with children of a certain age.

**Table 3. Age of children at the time of wellbeing measurement[19]**

| Age | Count | Percent |
| --- | --- | --- |
| Ages 4 to 18 years | 30 | 34% |
| Aged 0 to 18 years | 29 | 33% |
| Ages 4 to 16 years | 14 | 16% |
| Ages 11 to 16 years | 10 | 11% |

Interviewees highlighted that collecting wellbeing scores (using the SDQ total difficulty scores) was statutory. As such, there were minimal differences in terms of which children in care had their wellbeing measured.

In interviews, however, details regarding the tools used to measure wellbeing at certain ages revealed differences. One Trust said that WEMWBS was used in combination with the SDQ, for young people aged over 14. This suggests that, in addition to the SDQ, some local authorities tried to tailor the assessment of wellbeing for different age groups of children.

## 5.3 When wellbeing was measured

Respondents were asked about when children had their wellbeing measured. The findings revealed that professionals measured children's wellbeing at multiple points during their time in care (see Figure 3).

The most common time to measure children and young people's wellbeing was at the point of the annual review of their care plan (66 percent). Over half also measured wellbeing at the point of initial assessment (54 percent) and 39 percent measured wellbeing more than once a year as a part of the children and young people's placement.

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[19] (n = 89). Only responses to the four main categories of ages, by individuals who reported that they or their organisation measured the wellbeing of children in care, have been included in this table. Responses to individual ages have been excluded due to small base sizes.

**Figure 3. Timing of wellbeing measures[20]**
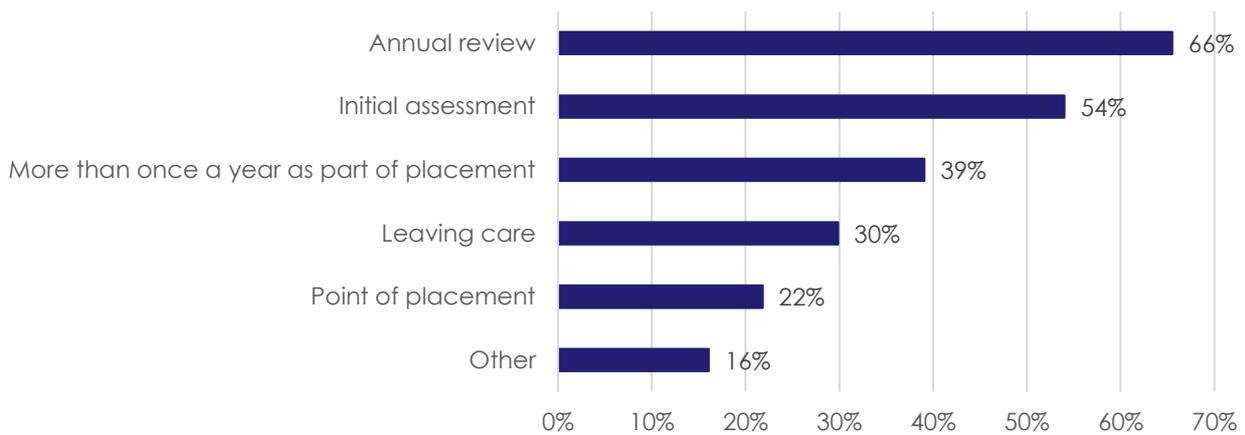


Interview participants gave further examples of when they measured wellbeing. This included the start and end of a service or intervention (e.g. counselling). One nurse stated that their Trust screened children after they had been in care for 6 months, whereas another interviewee screened children when they first entered care for a baseline to allow them to more accurately monitor any changes.

Interviewees also highlighted challenges around the timing of wellbeing assessments. Indeed, where measures were completed during periods of transition, such as changing placement or leaving care, then it was felt that the results were likely to show lower levels of wellbeing. As such, the timing of assessments was noted to have an effect on the results.

## 5.4 Who completes measures of wellbeing

Survey respondents were asked to give more detail about who completed measures of wellbeing used for assessments. There were a wide variety of individuals that were involved in completing wellbeing measures (see Figure 4).

Respondents indicated that carers were most commonly involved in completing measures of wellbeing (87 percent), closely followed by self-reports of children and young people in care (83 percent). Half of the respondents reported that other professionals were also involved in assessments; this included teachers, school staff, residential workers and psychologists.

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[20] Respondents who indicated they or their organisation did not measure wellbeing of children in care and those that responded 'N/A' have been excluded from the analysis (n = 87).

**Figure 4. Individuals involved in completing wellbeing assessments[21]**
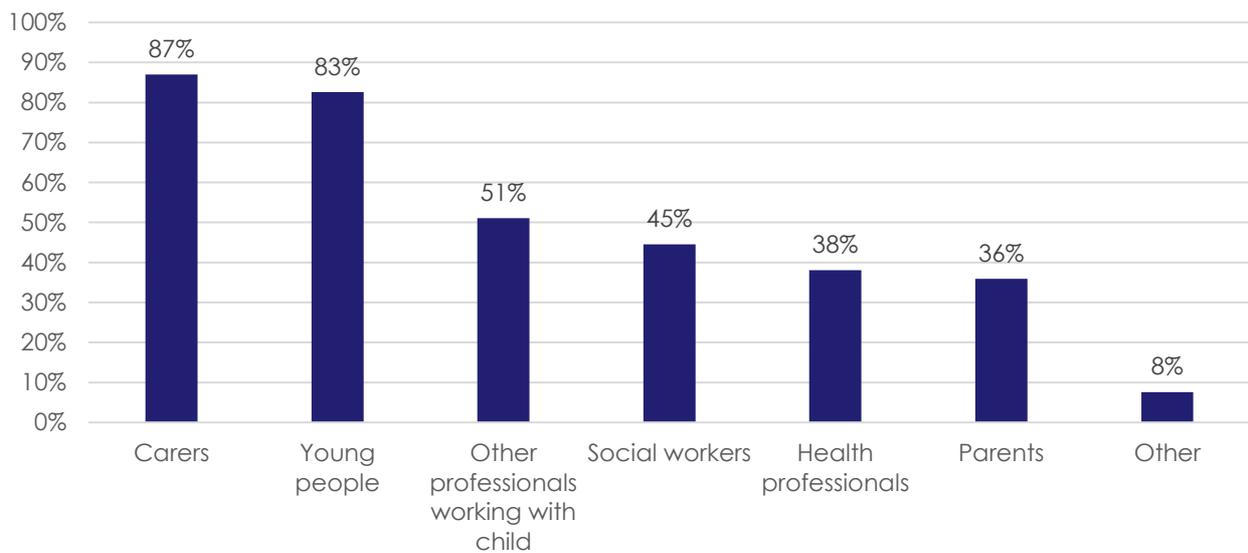


## Chapter conclusion

This chapter has discussed the practicalities around wellbeing assessments including the time points children are assessed at, children's ages and who completes the measures. The data revealed minimal differences in the ages of children in care that had their wellbeing measured, with most organisations measuring it at least for all children in care aged 4-16 years old. This was done at multiple time points throughout their journey in care, including at annual reviews, initial assessments and as part of their placement.

The findings also highlighted that different people were involved in completing, or helping to complete, measures of wellbeing. Carers and young people were most commonly involved in completing these assessments, in addition to other professionals working with the child, social workers and health professionals.

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[21] Respondents who indicated they or their organisation did not measure wellbeing of children in care have been excluded from the analysis (n = 92).

# 6 Results of wellbeing measures

As discussed in chapters one and two, there a several uses to which wellbeing measures can be put. This chapter will cover how professionals use the results of wellbeing assessments, who the results are shared with and for what purpose.

## 6.1 How results are used

Survey respondents were asked how they used the results of wellbeing assessments (see Figure 5). 80 percent of respondents selected more than one response, indicating that they used wellbeing scores for multiple purposes. Approximately three quarters of respondents used the results from wellbeing assessments to inform care planning (76 percent) and to measure children and young people's progress (73 percent), with slightly fewer using the scores to measure outcomes (70 percent).

**Figure 5. How professionals use results from wellbeing assessments[22]**
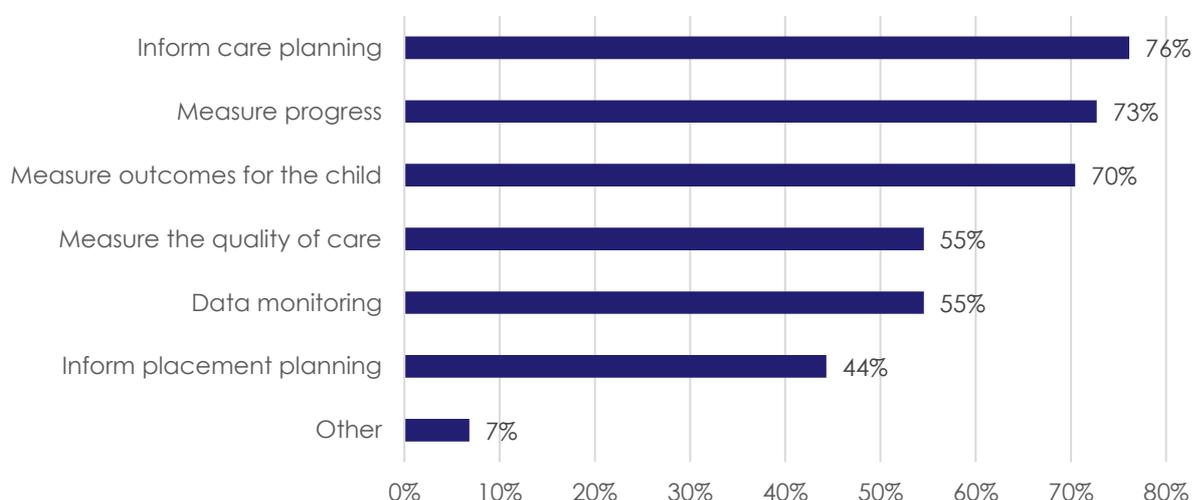


Whilst professionals highlighted a number of uses of the wellbeing assessment scores and how they were used, interviewees often felt that assessments (in particular the SDQ) were used because it "has to be", but results were not used for wider purposes such as care planning. The challenges around this are discussed in more detail in section 7.3.

Other interviewees had a more positive experience of organisations using results. Some talked of using results on wellbeing to inform commissioning, as it allowed them to explore which services were needed for children in care. Assessments meant they could commission based on need, rather than guessing what needs might be.

## 6.2 Information sharing

Given the number of different professionals involved in wellbeing assessments and the numerous uses of the data generated, interviewees were asked how information was shared. Organisations structured the sharing of information differently; this included who they shared information with and the practicalities of sharing. Information was regularly shared when referring to specialist (mental health) services, but the picture for sharing the results of wellbeing assessments more generally was mixed.

One explanation for this variation was the variety of systems available to assist with the sharing of information. One designated doctor spoke of issues with transferring paperwork from social services

[22] (n = 88)

within the local authority to the health team at the local hospital. Indeed, there were multiple teams within the local authority involved with children in care, all of whom had their own administrative support which spread out responsibility for this sharing information and complicated the process.

Where respondents reported that information sharing was going well, however, there were a number of things that enabled this process. During the interviews, health professionals spoke of the benefits that a clinical computer system had brought to their service, allowing them to share information in a more efficient way. This allowed them to more easily monitor health changes in looked after children over time and report on the health of the looked after population as whole. The clinical records computer system had also allowed one named nurse to develop a looked after child audit template, recording:

> "A wide variety of things about physical health, such as their height and weight, and emotional health, like if the child is being bullied"

<div align="right">Interview participant</div>

Other interviewees relied on face to face sharing of information. Some had weekly or monthly meetings with other teams and/or organisations to discuss SDQ scores. A residential school reported having review meetings with parents/carers and social workers, as well as other professionals involved with the child to discuss wellbeing after measurement to explore what measures could be put in place.

Interviewees also talked about sharing information on wellbeing with young people themselves. They discussed how tools such as the SDQ or Development and Wellbeing Assessment (see Annex 1) opened up conversations and allowed them to talk to young people about any concerns they might have. This was similar to the independent reviews, which focused on asking young people how they were and whether they needed anything further from their care.

Questions on who results are shared with and why led to discussions of referral pathways. Interviewees were concerned that sometimes measures of wellbeing were completed, but nothing happened if the score indicated there might be a problem. To this end, many health professionals spoke of establishing initiatives to ensure that if a child scored over a certain amount on a completed SDQ for example, then they were automatically referred to a service.

To illustrate this problem, a designated nurse felt that carers were "fatigued" at completing SDQs "because they don't expect anything to happen as a result of them filling it in". In the past, the local authority sent foster carers an SDQ report, but nothing happened if the score was high. The trust then changed their approach to link SDQs to health assessments, with the person completing the health assessment having a duty of care towards the child. This meant action was taken if any child scored highly. Action included referrals to CAMHS, discussions with the school nurse, home visits or notifying the supervising social worker.

# Chapter conclusion

The findings from the research highlighted that professionals used results from wellbeing assessments for a variety of purposes, including for care planning, and to measure progress and outcomes for children in care. There was mixed practice around who professionals shared results with, and how this was done; this was largely dependent on the organisation. Whilst some professionals were able to give good examples of wellbeing scores being used and shared appropriately, others expressed frustration about wellbeing scores not leading to any changes.

# 7 Challenges and reflections

The majority of participants firmly believed that wellbeing measurements and resulting scores should always inform the delivery of better outcomes for children in care. They shared a range of views and reflections on how this could be realised more fully than is currently the case and provided additional insight into some of the issues identified in our literature review. This chapter will discuss the key themes highlighted, including several challenges encountered by professionals.

## 7.1 The role of standardised measures

The introduction and literature review set out the importance of monitoring the wellbeing of children in care to hold corporate parents to account and inform improvements in the care system.

Some participants felt that a national standardised measure would enable comparison of outcomes for children in care across the country. They suggested that this would enable lessons to be learnt about what works within the care system:

> "There needs to be a national measure to compare and contrast 'wellbeing' of LAC in localities/regions and be able to learn lessons."

> Survey respondent

Without a standardised measure, some felt it was difficult to comment on children's wellbeing, especially when children had complex needs:

> "I'm required to comment on children's wellbeing but with no standardised measures in place, especially for children with little or no communication and complex disabilities, this is difficult."

> Survey respondent

Participants also found that a lack of standardisation presented challenges for the use of wellbeing measures as screening tools. This was particularly the case when children placed out of area needed specialist mental health services. Professionals suggested that assessment and commissioning arrangements differed across the country, which meant that not all children had the same level of assessment or access to services.

## 7.2 Assessing individual needs

Professionals felt that they had an "ethical" obligation and a responsibility to children in care to not just assess their wellbeing, but for this to translate into something that would make a difference. They acknowledged and welcomed recent changes in guidance relating to children in care, which specify that local authorities should provide holistic assessments of health and wellbeing for children in care (DfE and DH 2015). Professionals were of the view that "there's no point screening, if you don't do anything".

However, it was felt that, in reality, wellbeing assessments often did not have a clear relationship with care planning or onward referrals. Professionals repeatedly talked about wellbeing measures being completed and viewed as a "tick box" exercise, driven by processes and targets:

> "The SDQ is predominantly the measurement tool in use in my area of work, but this is completed by the social worker annually. There is often no comment or action plan. It feels like a tick box exercise rather than being meaningful."

> "They're done, they go to an administrator, who marks them, and the total score goes onto a spreadsheet to prove it's been done…and because it's a target it's become a process rather than a tool in any way to help the child's wellbeing."

> Interview respondents

This was part of a wider view expressed by participants that the reporting protocol for the SDQ did not have children's wellbeing at the heart of it. To counteract this, some local authorities put in place schemes to ensure wellbeing scores were "more than just a number". Such schemes involved thresholds of scores that dictated an outcome; for example a home visit, a further conversation or referral to an intervention.

Even in areas where scores on wellbeing measures were used to inform change or intervention for children in care, this was not always simple. Professionals acknowledged the burden that was on services, particularly specialist mental health services, which mean a referral would not necessarily lead to timely support.

Referrals and access to other services were further hindered for children placed out of area. External services had different thresholds and different funding streams which complicated processes for these children in care. One participant gave the example of a child whose score on a wellbeing assessment necessitated the involvement of specialist mental health services. However, as the child was placed in a neighbouring local authority, their access to treatment was delayed whilst the relevant health commissioners for the placing and host local authorities agreed how it was to be funded. Such processes made it much harder for children to access services, even in instances where there was a commitment to act on wellbeing assessments.

# 7.3 Shared understanding and responsibility

Participants felt more needed to be done to define wellbeing in order to measure it objectively. Survey respondents elaborated on the varied level of understanding of wellbeing and the problems this causes. One respondent reflected that "the lack of a definition makes progress difficult".

Participants reflected that wellbeing for children in care was often measured through very simplistic indicators such as academic attainment. Survey respondents also suggested that the subjective nature of wellbeing combined with the use of these simplistic measures could result in very different interpretations of a child's wellbeing depending on who was interpreting the results:

> "Results can be misinterpreted e.g. although a child is achieving in school they may be struggling emotionally/socially. What one person sees as a problem someone else may see as resilience - having clear ways of measuring child wellbeing would aid collaboration."

> Survey respondent

Academic attainment is an example of a proxy measure focussing on particular domain of wellbeing identified by several studies highlighted in the literature review. We heard mixed views from survey respondents, interviewees and children and young people on the appropriateness of the use of such measures. Foster carers in particular did not feel local authorities paid enough attention to holistic wellbeing and were too focussed on placement breakdown and/or educational attainment. Some of these carers did, however, believe these things to be intrinsically linked. An interview participant who worked in a specialist residential school expressed a view that educational attainment is a poor indicator of how children are doing in care. This was also reflected in comments from young people themselves, where one young person said:

> "If the local authority feel that you are doing well in education they assume that everything else in your life is okay."

> Young person in care

Further indicating a perceived lack of a holistic approach to wellbeing, participants felt that each professional or each service acted as though they were only responsible for one specific part of wellbeing. It was felt that no organisation or individual had an understanding of, or responsibility for a child's overall wellbeing. For example, nurses were responsible for physical health, specialist mental health services for mental health etc. As such, children were felt to be more likely to fall in

between the gaps - depending on which subjective understanding each service was coming from and the number of services involved in each child's case.

## 7.4 Appropriateness of current tools

Some participants viewed the SDQ as providing a standard framework for discussion of wellbeing. The use of a form was also considered helpful if young people were not comfortable talking about their feelings and was felt to enable more accurate and reliable responses:

> "Previously children and young people would have been asked general questions, like 'how are you feeling?' or 'anything you are worried about?', but the SDQ gives a bit more structure and ensures that all LAC nurses ask the same questions. Also, having the SDQ means that young people can complete it without having to verbalise how they are feeling and this can mean that they are more honest in their responses."

Some interviewees, however, highlighted a challenge of their being a lack of understanding amongst professionals in social care about what the SDQ was originally designed to do. Those who believed themselves to have a better understanding of this tool highlighted that the SDQ is **not** a wellbeing measure. Whilst it encompasses some elements of wellbeing, the SDQ is a mechanism for assessing mental health difficulties and helps clinicians to make judgements. One participant reflected:

> "SDQ is all we have currently and there is very little understanding in social care about its use, just a figure to collect for annual returns. It is a blunt instrument but at least helps people to think more about mental health."

<div align="right">Survey respondent</div>

Professionals who responded to the survey and those who were interviewed recognised that children in care had been through trauma prior to their entry to care, which can have mental health and wellbeing impacts throughout the life course. As such, some professionals questioned whether the current tools that were in use were the best way of assessing wellbeing. Instead of "ruling in' any issues related to wellbeing, there was a view that the sector should instead adopt a 'ruling out' approach to justify why children in care do not need certain interventions.

Other participants were concerned that the SDQ did not capture everything they wanted it to. They noted that it did not address wider indicators of wellbeing such as involvement in afterschool clubs or taking part in exercise. Subsequently, many participants had been in discussions with their organisations about how to supplement or complement the information that is captured in SDQs, to better understand children and young people's wellbeing.

Some organisations accompanied SDQ measurements with other assessments to give a better overall picture of wellbeing. More specifically, WEMWEBS was seen as useful for use with adolescents to capture other aspects of wellbeing and allow more follow up questions, resulting in a more open dialogue. Whilst professionals agreed that no one tool was optimal for assessing wellbeing, tools were viewed as useful for starting and opening up conversations into wellbeing.

## 7.5 Making reliable measurements

Professionals acknowledged that they did not always know how honest or accurate responses to wellbeing assessments were; especially where professionals used more formal measures or did not have an established relationship with the child.

Professionals felt that more formal measures, especially paper based assessments, hindered responses from children and young people. Professionals felt that children in care had everything about them written down, which could act as a barrier to children and young people opening up

to professionals and talking about their emotions. Instead, it was felt that more informal measures or innovative methods of gathering wellbeing information (such as smartphone apps) had the potential to elicit more honest responses.

Relationships between children and assessors were also viewed as important for the process of gaining reliable responses. Participants tried hard, where capacity allowed, to build up relationships with children and young people in care. It was not always possible, however, to have the same person complete a wellbeing assessment each time.

Children and young people said that they wanted their wellbeing measured by people whom they knew, and who knew them. This included foster carers, doctors, school nurses, or teachers. Whatever role they held, children and young people placed importance upon assessments being done by "someone who knows [them] well".

It was these relationships that were felt to affect the honesty and quality of responses to wellbeing questions. One young person, who was a part of a children in care council, admitted that they were not always honest in assessments as they did not always feel anyone cared about their responses or how they were really feeling. Children and young people stressed how difficult it was talking to a stranger, or someone they had known for only a short time, about issues related to wellbeing. This suggests that a positive relationship with someone who they believe cares about them will elicit a more accurate insight into how children and young people feel and their overall wellbeing:

> "It is up to you how much you share, I am not always honest as I feel no one really cares."

> "I tell my social worker what I think that she wants to hear as I have not known her that long and I don't know how long she will be my social worker."

<div align="right">Children in care</div>

These findings suggest that professionals need more time to build up relationships with children in care, prior to doing formalised assessments of wellbeing. However, it is not just the length of time that is important for young people, it is also the quality of the relationship. Participants cited cases where the children's and the assessors' personalities clashed, leading to a high SDQ score which professionals did not feel reflected the child's wellbeing.

As such, it was suggested that triangulating the SDQ, in particular, between carers, teachers and young people could provide more reliable results. Guidance (DfE and DH, 2015) recommends that such triangulation should be carried out if the scores from the carer suggest the child may need additional help. Some professionals who were interviewed believed it was "pointless" to only get the carer to complete the SDQ; this triangulation approach provided a more nuanced understanding of children's wellbeing. They noted, however that it placed additional time pressures on professionals.

## 7.6 Informal measures

While some participants called for more standardised approaches, others saw children in care as a very diverse group whose wellbeing could not be measured by standardised tools or assessments.

Addressing the example offered above of a child with complex needs, not all participants agreed that a standardised tool would make an assessment of wellbeing any easier. Those who thought this did not believe that a "one size fits all" approach was suitable in these situations. They felt that standardised measures did not and could not reflect the complexity of children's experiences and their needs. While this challenge was applicable to all children in care, it was particularly pronounced for children in care with especially complex needs or with certain past experiences such as human trafficking. This problem was articulated for one such group, unaccompanied asylum seeking children (UASC), by a participant:

> "SDQ is statutory responsibility, so we do try to get [it] completed even for disabled young people or UASC, but questions aren't really relevant for them, but they still have to get forms completed. Some of them are severely disabled and can't speak, and unaccompanied asylum seeking children have post-traumatic stress disorder, which SDQ doesn't cover."

In addition to other standardised measures, more informal reviews or indicators of wellbeing were thought to be important. There were many proxies for wellbeing and indicators which were less formal, such as children being seen walking into school 'with their head held high' or getting regular invitations to friends' houses. Similarly, there were also felt to be more informal intervals of measurement, in addition to the standardised annual intervals for the SDQ. For example, participants highlighted that every child in care has a written care plan which the social worker would update every six months; minutes of their review would be submitted and the care plan would be updated based on an assessment of the child's needs, including their wellbeing.

In addition to measurements that were "written down", professionals had an array of tools related to their professional judgement, to help them monitor children in care's wellbeing:

> "I guess we have a lot more tools than we know we have that we use. They're not just written down. It's being a social worker I suppose, you just learn."

Interview Participant

Despite this, professionals called for more resources and tools to help them effectively and meaningfully measure wellbeing for children in care.

# Chapter conclusion

This chapter has discussed the reflections that participants shared regarding some overarching challenges and considerations in measuring the wellbeing of children in care.

Some participants explicitly acknowledged the value of measuring wellbeing to inform improvements in the care system. However, there was also concern that when problems are identified regarding a particular child's wellbeing, this should lead to action to address that child's needs.

The importance of standardised approaches was highlighted by several respondents, particularly for the purposes of comparing different local areas and children with diverse needs. However, it was also highlighted that the specific tools used to gather information should be flexible in response to the diversity of children's experiences and communication needs.

Participants highlighted a range of challenges in relation to collecting reliable information from children. This includes ensuring the child trusts the person asking them about their wellbeing, feels able to open up about their feelings and understands questions put to them. The relationship that the child has with anyone asking them questions about their wellbeing was thought to be a critical factor in all of these.

Professionals suggested that triangulation of SDQ scores provided by carers, teachers and young people themselves could make for more reliable measurements. Several thought that the use of informal measures such as ongoing observation of the child's behaviour and social interactions could also make a valuable contribution.

# 8 Conclusions and recommendations

This report has set out findings from research conducted by the National Children's Bureau into what tools, measures or indicators are used to assess the wellbeing of children in care. We spoke to professionals working with children in care, as well as asking questions of children and young people in care. We have outlined the background to the research from existing literature and the policy and legislative context, set out what our findings say about defining and measuring wellbeing, and explored professionals' reflections on making this process successful and useful. This chapter summarises these findings and presents recommendations for policy and practice.

## 8.1 An important task that needs greater attention

Measurement of wellbeing is particularly important for children in care. Evidence demonstrates that these children are more likely to face a number of problems with emotional health and relationships, for example. (Melzer, 2003; Munro and Hardy, 2006 as discussed in 2.1).

Professionals reported that they measured children's wellbeing at all ages and stages throughout their journey through care. They did this for a variety of purposes, including for care planning, and to measure progress and outcomes for children in care as well as collecting information required by the Department for Education.

We found mixed practice, however, regarding how the results of wellbeing assessments were shared and acted upon. Some professionals expressed frustration about wellbeing scores not leading to any changes for children in care. Some of the young people we spoke to also suggested that they did not think the results of any assessment would be acted on.

Our findings indicate widespread use of the Strengths and Difficulties Questionnaire (SDQ) amongst professionals. They also highlight, however, the SDQ's limitations in terms of its scope: Being focussed on behavioural and emotional problems, it cannot provide insight into other aspects of wellbeing to inform individual care planning, direct improvements to services, or hold corporate parents to account. In practice, it also often fails to facilitate access to specialist mental health services for children with identified needs. Furthermore our findings highlight that, even within its limited scope, it is not implemented in a way that allows assessment of the quality of care services. These challenges and their implications are discussed in more detail in the sections below.

The report of the Expert Working Group on improving mental health support for children in care, commissioned by the Government and developed concurrently with this research, echos several of our findings (Milich et al, 2017). It made a number of important recommendations focussing on access to mental health support for looked after children.

Taken as a whole, this evidence suggests that the way the wellbeing of children in care is measured could be improved. The Government's current focus on children's mental health and wellbeing, outlined in the Green paper, *Transforming Children and Young People's Mental Health Provision*, presents opportunities to improve access to support for children in care, as well as for children in general:

- Piloting new mental health assessment pilots for children in care, testing new approaches, potentially beyond the SDQ.
- "Trailblazer" areas with new mental health support teams to help children with mild and moderate mental health problems to access support at school.
- Piloting waiting time targets for accessing specialist support.

**Recommendation: In consulting on plans set out in *Transforming Children and Young People's Mental Health Provision*, the Department of Health and Department for Education should pay particular attention to the needs and experiences of children in care. This should include:**

- **Ensuring that at least one of the proposed trailblazer areas focuses on children in care and care leavers.**
- **Committing to reviewing national policies and providing resources to implement change based on:**
    - **findings from the trailblazers;**
    - **findings from the mental health assessment pilots;**
    - **recommendations of the Expert Working Group; and**
    - **recommendations of this report.**

# 8.2 Acting on individual results

Local authorities are required to assess children's emotional wellbeing and regularly review it to inform care planning for individual children they look after (DfE, 2015a). Participants in our study told us that when assessments identify needs this rarely leads to action to address those needs.

We found mixed results amongst our study participants in terms of how well the SDQ worked in practice as well as variation in how the SDQ was carried out. They acknowledged particular challenges in obtaining reliable results (see 'getting a full picture', below).

We heard that results of SDQs were sometimes discussed amongst professionals directly involved in the day to day care of the child. However, the experiences of both professionals and young people suggested that, in general, there was no clear link between wellbeing assessment and care planning.

Some participants noted the limited scope of the SDQ, which may be one reason why it is not used to inform children's whole care package. However, results did not even appear to be used for screening emotional and behavioural problems.

We heard that in some local authority areas, a score above a certain level would trigger a referral or further investigation. However, professionals working in other areas reported that having an SDQ score that caused concern (total difficulties scores of 17 and over) did not lead to any specific action. We heard that where referrals *were* made to specialist mental health services, there were then further delays or obstacles to treatment. Services would apply their own referral criteria, or wait for funding to be agreed before commencing treatment, for example.

The individual results of wellbeing assessments need to be more consistently acted upon to ensure that children in care receive the support that they need. This means effective screening for problems that may require the intervention of specialist mental health services. It should also include the assessment of the child's wider wellbeing to inform placement and day to day care planning. For children returning to their birth family or young people leaving care, information should be shared, with their permission, with other relevant services. This might include services supporting disabled children or adult mental health services, for example.

Further investigation is needed into how alternative assessment tools and approaches can facilitate this. Whilst there are a wide range of alternative tools available, our findings did not enable us to make any meaningful comparisons between tools in terms of their effectiveness or ease of use.

**Recommendation: The Government should use mental health assessment pilots to explore how the results of the SDQ and other tools can better translate into action by services supporting children in care. This should include the development of consistent protocols for following up on results that cause concern.**

**Recommendation: NHS England and Clinical Commissioning Groups should work with mental health service providers to improve access to specialist mental health services for children in care.**

They should ensure that when a child's SDQ score causes concern they have prompt access to further assessment by a specialist mental health professional.

**Recommendation: Local authorities should ensure that the results of screening tools such as the SDQ are always taken into account in care and placement planning. They should follow good practice identified in this research by carrying out further investigations and making referrals to specialist services for children that need them.**

More robust and consistent local protocols and policies for acting upon the results of wellbeing assessments could be encouraged by updating relevant statutory guidance. The Department for Education (2017b) has recently consulted on statutory guidance for local authorities and their relevant partners on implementing the corporate parenting principles. Government have also suggested that, following the publication of the findings of the expert working group, they may review statutory guidance on promoting the health and wellbeing of looked after children (DfE and DH, 2015; 2016).

**Recommendation: The Government should clarify that if children are assessed as having mental health or wellbeing needs, they must have timely access to appropriate support. To achieve this, the Government should update statutory guidance to outline the responsibilities of Clinical Commissioning Groups and NHS England towards children assessed as needing support.**

# 8.3 Informing improvements in the care system

Reflecting their role as corporate parents, local authorities and their partners are expected to promote the wellbeing of children in care. This is underpinned by legislation and guidance including the recently introduced Corporate Parenting Principles. [23] Effective monitoring of the wellbeing of children in care would enable local authorities to assess how well they are fulfilling their duties to children in care. It would also be invaluable in informing the development of services that better meet children's needs. Participants explicitly acknowledged the value of measuring wellbeing to inform improvements in the care system.

The SDQ, by far the most commonly used tool amongst our professional participants, was designed as a screening tool for emotional and behavioural problems. It therefore provides limited insight into children's wellbeing as a whole. It does not address life satisfaction, achievement or aspirations for the future, for example. Partly for this reason, some professionals have developed their own informal measures of wellbeing to inform their work with children in care.

The way in which the SDQ is administered also does not make it suitable for assessing the quality of care. It often relies on the input of carers and social workers who may be reluctant to give honest answers if they think the results will be used to judge the care that they provide. Additionally, it is not always conducted at the point of entry into care, so does not provide a baseline. Professionals also suggested that whilst completion of the SDQ was seen as a one-off tick box exercise, it was common to assess a child's wellbeing (using whatever tool or method) several times a year as part of a child's placement. Professionals' concerns that that an assessment on a specific day or carried out by one specific person may not give a fair reflection of a child's wellbeing are also important note. They highlights the importance of wellbeing assessment being seen as an ongoing process.

The planned pilots of new approaches to mental health assessment may provide an opportunity to seek solutions to these particular challenges.

**Recommendation: Government should use the mental health assessment pilots to explore options for a baseline measure of children's wellbeing on entry to care as well as ways of making sure that assessment is carried out on an ongoing basis.**

Professionals we spoke to also highlighted difficulties in using the SDQ with particular groups of

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[23] Section 22 of the Children Act 1989; Section 1(1)(a) of the Children and Social Work Act 2017; DfE and DH (2015)

children and young people. These centred on its reliance on children's consistent understanding of questions - particularly subjective questions where children may have different understandings of what constitutes 'normal'. Some professionals believed that it would not reflect marginal gains in wellbeing for children in particularly challenging circumstances. They acknowledged the impact that trauma experienced by children before entering care can have on their needs, and the importance of a measurement tool that took account of this.

More work needs to be done to develop a measure of wellbeing that can be used to inform the development of services and hold corporate parents to account. Whilst the Government expects the SDQ to combine fulfilling this purpose with that of informing individual care planning (see above) this does not appear to be working in practice. A combined approach can avoid additional assessment and reporting processes that place a burden on professionals and children in care themselves.

**Recommendation: The Department for Education should review options for improving, tailoring and supplementing the SDQ to create a tool or suite of tools for measuring the wellbeing of children in care. Particular attention should be paid to ensuring that the multiple functions for which the SDQ is currently used can be delivered more effectively in the future.**

## 8.4 Developing a common definition

Our findings demonstrate that there is no clear, widely accepted definition of wellbeing. We found that professionals defined it in various ways depending on their own experience and the needs of the particular children they worked with. However, there was a degree of consensus that wellbeing was a holistic concept that encompassed many different things, including aspects of physical and mental health. This is consistent with the findings of other studies which suggest there are some common themes including: resilience, developing and maintaining healthy relationships and achievement, as well as the extent to which a child feels happy or positive about their life. Developing a clear, shared understanding of wellbeing could help professionals and carers better work together to improve outcomes for children in care. It should be the first step in the development of better wellbeing measures for children in care.

**Recommendation: To inform the development of better wellbeing measures, the Department for Education should develop a definition of wellbeing with clear guidance about what this looks like for children in care. It should draw on the findings of this research and other studies identified in our literature review. It should consult with children and young people with experience of the care system as well as professionals and carers supporting them.**

## 8.5 Standardised measures, flexible tools

The importance of standardised approaches was highlighted by several respondents, particularly for the purposes of comparing different local areas and children with diverse needs. However, it was also highlighted that the specific tools used to gather information should be flexible in response to this diversity. Evidence from existing literature and the professionals we spoke to underlined the importance of being flexible to meet a range of communication needs. Children in care are much more likely to have special educational needs or disabilities which may contribute to such communication needs. The best way of assessing a child's wellbeing may, in particular, depend on the quality of relationship they have with the various people involved in their care. Participants suggested that the use of innovative approaches such as smartphone apps could elicit more candid responses from those children that are not comfortable discussing their feelings with professionals. The practice of using differentiated assessment tools to produce results on a common metric is well established conceptually. The SDQ itself and other tools such as the Bright Spots 'Your Care Your voice' survey are carried out in multiple formats, for example. This approach may need be deployed more extensively to gather meaningful information about the wellbeing of all children

in care.

**Recommendation: In reviewing the SDQ, the Government should pay particular attention to the diversity of experiences and communication needs amongst children in care. This could include, for example, the development of a suite of tools and training for the professionals that will use them. It should include investigation of how technology can help children to share their feelings.**

## 8.6 Getting a full picture

Our findings indicate that no one single, person, measure or tool can provide a complete assessment of a child's wellbeing.

Professionals suggested that triangulation of SDQ scores provided by carers, teachers and young people themselves could make for more reliable measurements. Concerns about social workers and carers being asked to 'judge themselves' mean it may be appropriate to seek information from a wider range of professionals. This might include, for example, systematically seeking the views of school teachers, GPs and independent visitors for children in residential care. Children in care councils are also an important source of views and experiences that can help to inform the improvement of services.

As discussed in sections 2.1.2, 2.2.2 and chapter 3, there are many aspects of wellbeing that manifest in different domains of a child's life. Several participants described their efforts to take account of this through the use of informal measures such as ongoing observation of the child's behaviour and social Interactions. Some also found proxy measures including school attendance, attainment and membership of after-school clubs useful.

For the purposes of assessing the quality of care in any local area, or indeed across the country, it could be helpful to draw these sources of information together in a more routine and consistent way. The range of aspects of wellbeing, coupled with the need to use several source to get an accurate picture, creates a case for a wide ranging outcomes framework for children in care. In practice, this would mean building on the Department for Education's statistical releases on looked after children with new measures and proxy indicators of wellbeing. It should also incorporate indicators of stability in children's care such as placement moves, school moves and changes of social worker experienced by children in care.

**Recommendation: The Government should work with children in care, professionals and carers to develop an outcomes framework for children in care. This would include:**

- **Subjective measures which directly ask children about their emotional wellbeing and how they think the care they have received has affected this**

- **Existing statistics such as those on educational attainment and placement moves**

- **New subjective measures and proxy indicators reported by professionals and carers, including those who do not have core responsibility for the child's care such as teachers, GPs, independent visitors and children in care councils.**

## 8.7 Continuing and sharing good practice

It is important to note that we did hear examples of encouraging practice. The professionals we spoke to were also very committed to promoting the wellbeing of the children they worked with.

It is of course good practice for professionals to use all the tools at their disposal, in addition to formal measures of wellbeing such as the SDQ, to develop a deeper understanding of how children are getting on. Local authorities should ensure that there is consistency for all children in their care and that, as far as possible, any approaches to measuring wellbeing are evidence

based. In doing this they should draw on the practices and approaches that many professionals are already using. Similarly, in advance of a national outcomes framework for children in care being developed, local authorities should use the full range of sources of information to reflect on the quality of care they are providing for children.

**Recommendation: In developing a more consistent and evidence based approach to the measurement of wellbeing, the Government and local authorities should draw on approaches already developed and used by the many committed professionals working with children in care.**

**Recommendation: In advance of the development of a national outcomes framework for children in care, local authorities should continue to adopt a flexible, listening, approach to assuring themselves of the quality of care. This should include taking on board the views of children in care councils and seeking and analysing feedback from professionals working with the child who do not have core responsibility for their care.**

# Annex 1: Wellbeing measurement tools

**Measures of mental health and wellbeing summarised from Nakamura *et al.*, 2009; Haggerty, Elgin and Woolley, 2011; Tsang *et al.*, 2011; Luke *et al.*, 2014**

| Measure | Population | | Age | Type of reporting | | | | Constructs measured | | | | | | Scale | Example of measures | Developed by |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | General | looked after | | Self (CYP) | Carer | Teacher | Other professional | Positive affect[i] | Negative affect[ii] | Emotions | Behaviour | Physical affects | Relationships | | | |
| **Affect and Arousal Scale (AFARS)** | ✓ | | | ✓ | | ✓ | | ✓ | ✓ | | | ✓ | | 4- point (0-3): 'never' to 'always true' | Physical affect items: 'I have trouble getting my breath'; 'My heart beats too fast' | Chorpita *et al.* 2000; Daleiden *et al.* 2000 |
| **Affect Intensity and Reactivity Scale for Youth (AIR-Y)** | ✓ | | | ✓ | | | | | | ✓ | | | | | 'Sad movies deeply touch me'; 'My friends might say I'm emotional' | Jones *et al.*, 2009 |
| **Assessment Checklist for Children (ACC) and Assessment Checklist for Adolescents (ACA)** | | ✓ | | | ✓ | | ✓ | | | ✓ | ✓ | ✓ | | | 'Causes herself to vomit'; 'Distressed by traumatic memories'; 'Easily influenced by other children/young people' | Tarren-Sweeney, 2007; Tarren-Sweeney, 2013a; Tarren-Sweeney, 2013b |
| **Behavioural and Emotional Rating Scale (Version Two) (BERS-2)** | ✓ | | | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | 4-point (0–3); (e.g.) 'not at all like the child' to 'very much like the child' | 'Trusts a significant person'; 'accepts criticism'; 'attends school regularly' | Epstein, 1999; Buckley & Epstein, 2004; Epstein *et al.* (2004) |

| Measure | Population | | Age | Type of reporting | | | | Constructs measured | | | | | | Scale | Example of measures | Developed by |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | General | looked after | | Self (CYP) | Carer | Teacher | Other professional | Positive affect[i] | Negative affect[ii] | Emotions | Behaviour | Physical affects | Relationships | | | |
| **Behavioural and Emotional Reactivity Index (BERI)** | ✓ | ✓ | | ✓ | | | | | | ✓ | ✓ | | ✓ | | How young adults behaviourally respond to emotion-evoking situations in relations with their parents | Bartle and Sabatelli, 1995 |
| **BERRI (B**ehaviour, **E**motional wellbeing, **R**isk to self and others, **R**elationships, **I**ndicators of a developmental /psychological condition) | | ✓ | | | ✓ | ✓ | | | | ✓ | ✓ | | ✓ | Designed to help assist staff in completing a comprehensive assessment of a child or young person's needs, and in tracking how these needs change over time. | | Dr Miriam Silver |
| **Bright Spots** | | ✓ | | ✓ | | | | ✓ | | | | | ✓ | Measures quality of care experience and wellbeing | | Coram Voice and the University of Bristol |
| **Child Behaviour Checklist (CBCL)** | ✓ | ✓ | 4-18 | ✓ | ✓ | ✓ | | | ✓ | | ✓ | ✓ | ✓ | | About how many close friends does your child have? 'Acts too young for his/her age' 'Gets teased a lot' | Achenbach, 1991 |

| Measure | Population | | Age | Type of reporting | | | | Constructs measured | | | | | | Scale | Example of measures | Developed by |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | General | looked after | | Self (CYP) | Carer | Teacher | Other professional | Positive affect[i] | Negative affect[ii] | Emotions | Behaviour | Physical affects | Relationships | | | |
| **Children's Depression Inventory (CDI)** | ✓ | | | | | | | | ✓ | | ✓ | ✓ | | Covers nine symptoms for major depressive syndrome in children. Children's responses are based on a 3- point scale, from 0 to 2, with 2 being the most severe | | Kovacs, 1981 |
| **Children's Global Assessment Scale (CGAS)** | ✓ | ✓ | 4-16 | | | | ✓ | | | | ✓ | | ✓ | Extremely impaired (score 1-10) to doing very well (91-100) | Consider how child functions: at home with family; at school; with friends; during leisure time | Shaffer *et al.*, 1983 |
| **Child Psychosocial Distress Screener (CPDS)** | ✓ | | 8-14 | ✓ | | ✓ | | | | ✓ | ✓ | | | Descriptors are levels of functioning, which range from 'doing very well ' to 'extremely impaired' | 'Did you experience any aversive events?'; 'Have you been distressed by these events' | Jordans *et al.*, 2009 |
| **Children's Sadness Management Scale (CSMS)** | ✓ | | | ✓ | ✓ | | | | | ✓ | ✓ | | | 3-point: (1): 'hardly ever'; (2) 'sometimes'; (3) 'often' | 'I hold my sadness in'; 'I whine and fuss about what's making me feel sad'; 'I try to calm down with what is making me feel mad'. | Zeman *et al.*, 2001 |

| Measure | Population | | Age | Type of reporting | | | | Constructs measured | | | | | | Scale | Example of measures | Developed by |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | General | looked after | | Self (CYP) | Carer | Teacher | Other professional | Positive affect[i] | Negative affect[ii] | Emotions | Behaviour | Physical affects | Relationships | | | |
| **Development and Wellbeing Assessment (DAWBA)** | ✓ | ✓ | 5-16 | ✓11+ only | ✓ | ✓ | | | ✓ | ✓ | ✓ | | | | 'Are you specially attached to the following adults?'; 'Have you not wanted to go to school in case something nasty happened to your attachment figures while you were at school?' | Goodman *et al.*, 2000 |
| **Devereux Early Childhood Assessment (DECA)** | ✓ | | | | ✓ | ✓ | | | | | ✓ | | | All items start with 'During the past 4 weeks, how often did the child . . ' followed by a question about an observed behaviour. Assessors are asked to rate on 5-point: 'never' to 'very frequently' | Observed behaviour examples include: 'hurt or abuse animals'; 'set or threaten to set a fire?' | Reddy, 2007 |
| **Devereux Student Strengths Assessment (DESSA)** | ✓ | | | ✓ | ✓ | ✓ | | ✓ | | ✓ | ✓ | | ✓ | All items start with 'During the past 4 weeks, how often did the child...' followed by a question about an observed behaviour. 5-point (0–4): 'never' to 'very frequently' | Behavioural descriptors regarding strength, such as 'try to do his or her best?', 'respect another person's opinion?' | Nickerson & Fishman, 2009 |

| Measure | Population | | Age | Type of reporting | | | | Constructs measured | | | | | | Scale | Example of measures | Developed by |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | General | looked after | | Self (CYP) | Carer | Teacher | Other professional | Positive affect[i] | Negative affect[ii] | Emotions | Behaviour | Physical affects | Relationships | | | |
| **Daily Life Stressors Scale (DLSS)** | ✓ | | | ✓ | | | | | | ✓ | | ✓ | | 5-point (0–4): from (0) 'not at all stressful'; to (4) 'very much stressful' | 'It is hard for me to get up in the morning' ; 'I feel uncomfortable at lunchtime' | Kearney et al., 1993 |
| **Emotional Behaviour Scale (EBS)** | ✓ | | | ✓ | | | | | | ✓ | | | ✓ | 12 situations in printed descriptions; dichotomized choices of 'more like me' or 'less like me' with spaces for written responses | 'I never feel upset for long'; 'I am cheeky' | Clarbour & Roger, 2004 |
| **Emotion Expression Scale for Children (EESC)** | ✓ | | | ✓ | | | | | | ✓ | | | | 5-point: from (1) 'not at all true'; to (5) 'extremely true' | 'I often do not know why I am angry'; 'I prefer to keep my feelings to myself' | Penza-Clyve & Zeman, 2002 |
| **Levels of Emotional Awareness Scale for Children (LEAS-C)** | ✓ | | | ✓ | | | | | | ✓ | | | | 5 levels scoring: (0) no responses; to (5) complex blends of emotions | 12 evocative interpersonal scenarios 'How would you (the other person) feel?' | Bajgar et al., 2005 |
| **New Philanthropy Capital wellbeing questionnaire** | ✓ | | 11-16 | ✓ | | | | | | ✓ | | | ✓ | | Self (including self-esteem, resilience and emotional wellbeing); Relationships (peers and family); Environment (schools and community/neighbourhood) | Heady and Oliveira, 2008 |

| Measure | Population | | Age | Type of reporting | | | | Constructs measured | | | | | | Scale | Example of measures | Developed by |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | General | looked after | | Self (CYP) | Carer | Teacher | Other professional | Positive affect[i] | Negative affect[ii] | Emotions | Behaviour | Physical affects | Relationships | | | |
| **Outcome Rating Scale (ORS) and Child Outcome Rating Scale (CORS)** | ✓ | ✓ | ORS 13-17 CORS 6-12 | ✓ | | | | | | ✓ | | | ✓ | Based on a line of smiley faces | Rate how well they feel they have done individually, interpersonally, socially and overall | Miller and Duncan, 2000 |
| **Positive and Negative Affect Scale (PANAS-C)** | ✓ | | | ✓ | | | | ✓ | ✓ | | | | | This scale consists of a number of words that describe feelings and emotions. 5-point (1–5): 'very slightly' or 'not at all' to 'extremely' | Interested; sad; frightened; alert; excited | Laurent et al., 1999 |
| **Emotional Regulation Q-Scale (Q-Scale)** | ✓ | | | ✓ | | | | | | ✓ | | | | 9-point (1–9): ranging from 'extremely characteristic' to 'extremely uncharacteristic' | 'Can recover from stress'; 'Is easily irritated' | Shields & Cicchetti, 1997 |
| **Resiliency Scales for Children and Adolescents (R-Scales)** | ✓ | | | | | | ✓ | ✓ | | ✓ | | | ✓ | 5-point (0–4): from 'never' to 'almost always'; | 'My life will be happy'; 'I'm good at figuring things out'; 'I can learn from my mistakes' | Thorne & Kohut, 2007 |
| **Revised Child Anxiety Depression Scale (RCADS) and also Parent Version (RCADS-P)** | ✓ | ✓ | 8-18 | ✓ | ✓ | | | | | ✓ | | | | Rates each of the items according to its frequency -Never; Sometimes; Often; Always | 'Nothing is much fun anymore'; 'I worry that something bad will happen to me' | Chorpita et al., 2000 |

| Measure | Population | | Age | Type of reporting | | | | Constructs measured | | | | | | Scale | Example of measures | Developed by |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | General | looked after | | Self (CYP) | Carer | Teacher | Other professional | Positive affect[i] | Negative affect[ii] | Emotions | Behaviour | Physical affects | Relationships | | | |
| **Strengths and Difficulties Questionnaire (SDQ)** | ✓ | ✓ | | ✓ 11+ only ; | ✓ | | | | | ✓ | ✓ | ✓ | ✓ | 3 -point (0–2): from score = 0, 'not at all'; 1 = 'somewhat true', to 2 = 'certainly true' | 'I try to be nice to other people. I care about their feelings'; 'I fight a lot. I can make other people do what I want' | Goodman, 1997 |
| **Warwick Edinburgh Mental Well-being Scale (WEMWBS)** | ✓ | | 13 and up | ✓ | | | | | | ✓ | | | | Rate feelings and thoughts in relation to statements from none of the time to all of the time' There is also a shortened version of the measure (SWEMWBS). | 'I've been feeling optimistic about the future'; 'I've been feeling useful | Tennant *et al.*, 2007 |

[i] Positive affect describes positive emotions, such as enthusiasm, comfort and excitement

[ii] Negative affect describes negative emotions, such as distress, anxiety, depression and nervousness

# Annex 2: Other wellbeing measurement activity developed by organisations

| Wellbeing measurement activity organisations have developed for children in care | Brief details about how it was developed | Effectiveness of measures |
|---|---|---|
| Routine regular meetings with a cross section of professionals who look in detail at the child/young persons, emotional health, physical health and education attainment to identify any shortfalls | Developed by social care team. | Very well |
| Physical and emotional wellbeing is assessed through health outcome measures individually and as a group of local looked after children | A data collection tool has been devised based on the DH checklist tool and other health indicators. Following a statutory health review this information is inputted on System One. Health interventions can then be targeted and can track any improvements. | Well |
| Health assessment tool which continues to evolve to provide ongoing holistic assessment | Developed by local specialist nurses and reviewed regularly. | Well |
| Child assessment forms that are used in school nursing | Modified the child assessment forms used | Well |
| Working with care team to identify children and young people's individual goals and assess achievements on a monthly basis | | Well |
| Better methods of asking about emotional wellbeing at the Review Health Assessment revised the IHA and the RHA forms. We do not have a tool as such it is more a pictorial representation of how they are feeling and asking the young person more about their feelings and self-esteem. | A whole service and partner agency half day. Away creative afternoon facilitated to ask how the young people want to be consulted. | |
| Measuring efficacy targets in relation to education, emotional wellbeing, contact, permanence etc. | Developed by a previous manager to use signs of safety scaling to measure how positive elements of a child's wellbeing and care is delivered | Neither well nor not well |
| Review with managers/team about what progress children have made whilst in their care | Reflective practice | Not at all well |
| Local authority has been working on a holistic assessment for young people aged 16 years+ | Currently in the final stages of development and has included multi-agency working | Don't know |

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