University of Glasgow

A critical evaluation of the usefulness of the SDQ in social workers' assessments of looked after children's mental health.

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The Project: Why is this an area of importance for research?

- Two reasons:
  - *Prevalence figures are high for looked after children.*
  - *Performance data: the Strengths and Difficulties Questionnaire (SDQ), is completed annually for looked after children living in England aged between 4-16 who have lived in care for 1 year or longer.*
- This offers an opportunity to find out about mental health within the looked after children population, including whether there is a statistically significant relationship between the SDQ data collected on c23,000 children annually, and other outcomes listed in the SSDA903 data for these children.

So what is the Strengths and Difficulties Questionnaire (SDQ)

- Comprises 25 questions that can be broken down into 5 scales
- Applies to children aged 4-16.
- a 'general difficulties' score is identified by adding together the scores from the first 4 categories (www.sdqinfo.org).
- The range of scores overall is between 0-40.
- The scoring of the SDQ classifies results into one of three categories:
  - normal (score is between 0-13);
  - borderline (score is between 14-16);
  - abnormal (score is between 17-40).
- There is a second part to the questionnaire that gives an idea of the impact of the difficulty on daily life, where answers are rated.
- There are 3 versions of the questionnaire – carer, teacher and self report version for young people over 11
- It's quick to complete, cheap to use and easy to score.

My Study

Mixed methods design:

- Systematic literature review using PRISMA
- Quantitative: Analysis of 6 years of non-aggregated data about looked after children (n = 161,474) collected annually by the Department for Education, including 4 years data on SDQ scores for (n = 95,101) children
  - *Question:* ***Does the introduction and annual use of the Strengths and Difficulties Questionnaire affect other outcomes for looked after children***
  - ***If there are differences then why? If there aren't any differences then why?***
- Qualitative: Focus groups or individual interviews with social workers (n = 56) and CAMHS workers (n = 26)
  - *Question:* ***Has the introduction of a common mental health assessment tool (SDQ) influenced the way social workers work with looked after children? If so, how?***

Conclusions from lit review:

1. Rates of MH problems in this population of children are high, often alongside other health and developmental issues

2. The quality of placements is key – the relationship between the foster family and child is important.

3. The research evidence is mixed about the abilities of SWs to identify MH problems and intervene effectively

4. There are a number of questions that need to be asked (and answered!)

    Now we know there is a problem, what do we do about it?

    What works with this population of children?

5. There are ideological differences between social and medical approaches to this area of practice.

Quantitative study:

- Took 2 years to get permission for data release from DFE and a further 4 years to get it all – last of it sent in Oct 2014.
- Information from 2 databases were released:
  - 'Snapshot'
  - 'Outcome' (subset of 'snapshot – includes children in care for a year or longer)

The Table provides an overview of numbers of cases in 'snapshot' and 'outcome' datasets by year (all ages)

	2007	2008	2009	2010	2011	2012
Snapshot	66773	65874	67541	70766	71215	71169
Outcome			43364	44194	46145	46608

Quantitative data cont'd

- Looked at associations between outcome data with all cases; the SDQ sample and then the sample which showed 'caseness'
- This gives you an idea of overall numbers of cases I examined.

	2009	2010	2011	2012
TOTAL 'outcome' aged 5-17	37620	37936	38723	38882
TOTAL SDQ sample age 5-17	22092 58.7%	23508 62.0%	24672 63.7%	24829 63.9%
SDQ Caseness aged 5-17	11110 50.3%	12000 51.0%	12112 49.1%	12147 48.9%

In summary:

Raised 'likely caseness'	Lowered 'likely caseness'
If convicted	If an unaccompanied asylum seeker
If have substance misuse problem	If parental absence was reason for entering care
If in residential care	If live with parents
If placed out of borough	If female
If had 3 or more placements during time in care	If non white
If disability was reason for entering care	If disability wasn't the reason for being in care
If white	If a teenage mum
If male	
If aged between 5-15	

Variables that did not affect ‘likely caseness’

- Legal status of child (s20 or s31). Equal numbers of both groups showed ‘likely caseness’
- Whether child has annual medical
- Whether child is present at their looked after review or has an advocate represent them.

Proxy indicators as indicators of potential change in children's mental health following introduction of the SDQ in 2009 – the 'Snapshot' data

- I selected variables which might act as 'proxy' MH indicators from the 'Snapshot database across 6 years of data:
  - Reason for entry into care
  - Placement type
  - Legal status
  - Length of placement
  - Teenage mother
  - UASC
- Difficult to draw conclusions. These data showed a continuation of patterns I had observed in the 'outcome' data
- BUT not possible to show any effect on these data from the introduction of the SDQ in 2009 as there is NO evidence of reducing difficulties over the 2009-2012 period.

- *However, this information gives half of the answer to my research questions, as although it may indicate the relationship between some factors, it does not tell me how social workers use the SDQ data in their work with children and young people, and how this influences service provision for children. This is addressed in the qualitative part of the study*

Qualitative study

- Focus groups with 58 social workers and focus groups and semi-structured interviews with 24 CAMHS workers. Focus groups for social workers were separate from those with CAMHS professionals.
- Analysis was thematic
- Broad themes have emerged from the findings relating to:
    1. Organisational structures and processes
    2. Professional roles
    3. Practice issues
- Normalisation Process Theory (May et al, 2009; May and Finch, 2009) - this theory proposes a working model of implementation, embedding and integration of an intervention in conditions marked by complexity and emergence. It helps in understanding why some processes seem to lead to a practice becoming normalised while others do not.

Qualitative results: Structures

- The structure of CAMHS Services across local authorities varies but most now have a dedicated service for looked after children. I have identified 3 models:
  - A – highly integrated services - clinicians were based in the same team or building as the SWs
  - B – moderately integrated - specialist services based in LA but not in the same building
  - C- no integration - specialist service based in NHS building
- Gathering of SDQ data in LAs – different processes (ranging from approaches being a bit of a mess (I'm being polite) to highly organised and integrated into the social work team (2 out of 9 of the local authorities included in the study).
- It is largely an administrative exercise which does not appear to have any link to improved services; indeed there is some interesting practice noted in terms of comparing neighbouring LA's in order to guage the mental ill health in the looked after population, without recourse to the way in which the data is gathered or the missing data
- CAMHS also gather SDQ data routinely on children they see, but it is a completely separate data gathering process to the LA and is sent to a different external body (CORC)

Qualitative results: Professional roles - Social Workers

- The SDQ is not routinely used by social workers. They do not have anything to do with the annual data collection process and often will not receive the results of the SDQ scores. Some question its robustness
- Mental health issues are, on the whole, viewed by social workers as the responsibility of CAMHS
- Consultation support offered by all CAMHS is viewed positively by SWs I interviewed
- Some fairly typical relationship issues still exist between CAMHS and SWs. i.e. CAMHS won't work individually with children who aren't in a stable and secure placement.
- Some of the waiting times for children to be seen are still very long indeed (CAMHS do not breach statutory protocols until after 13 weeks)
- With regard to mental health, social workers see their role as **monitoring**, **signposting, liaising** and **predicting** rather than working directly with the child or young person

Social workers (continued)

- The analysis identified three social work typologies:

  1. Social workers who are most likely to refer children to CAMHS

  2. Social workers who are least likely to refer children to CAMHS

  3. Social workers who refer less often but generally appropriately refer children to CAMHS

Professional roles: CAMHS

- High thresholds for CAMHS services. Consultation with social workers is used effectively in all services included in this study
- Use of SDQ score of 17+ as a requirement for CAMHS referral in some areas
- CAMHS have mixed views about the efficacy of the SDQ for work with looked after children. Also judgemental about SWs knowledge of tools with psychometric properties
- Many CAMHS oversee the annual collection of SDQ data and report good triangulation between children who have high SDQ scores and those known to specialist CAMHS/Looked after children services. Their use of SDQs is for a different purpose.

Practice issues:

- Social work
  - Children not seen by CAMHS before they are in some kind of permanency
  - Children placed out of borough and requiring CAMHS intervention
  - Young people ‘aging out’ of care. Adult mental health services have very different eligibility criteria

- CAMHS
  - Social workers knowledge about mental health issues in children is not good enough
  - SWs most likely to refer behavioural issues
  - CAMHS are sympathetic to the organisational issues affecting social workers – high workloads and high staff turnover
  - SWs have unrealistic expectations about what CAMHS intervention can achieve
  - CAMHS respond to the social worker as they would a ‘well attuned parent’ – patronising!

Conclusions

- As a public health intervention (which I would argue this is), are there benefits to regularly overseeing the MH of a group that we know is highly vulnerable? Yes….

BUT

- Not if we do nothing with these data at a national, local or individual level – that is unethical, isn't it?
- Or is the DFE annual aggregated reporting enough?

I don't think it is

Quantitative Recommendations

1. there are 3 options: continue as is; stop collecting data or use slightly more data, not just ‘total difficulties score’. BUT if nothing is done with data then there is no point upscaling

2. Only ‘total difficulties’ score is available currently, which doesn’t give a rounded view of children’s mental health and particular service need. Might be some issues here re how data are used at a strategic level.

3. SDQ screen should be done at entry into care (1st medical) in order to create a baseline.

4. LAs need to use the SDQ data more in practice via IRO, and at a strategic level

5. There are issues about what is done with the SDQ data. E.g. what are the implications for a looked after child of achieving a high score. Currently there is no compulsory action and no guarantee of services, with some services not being offered to children unless they score 17 or more on the SDQ.

Qualitative Recommendations

1. The skills and knowledge of social workers working with looked after children should also include knowledge about child and adolescent mental health, rather then it be seen as specialist.

2. There are two crunch points identified in the qualitative research which need to get sorted. The statutory guidance acknowledges both, but these two issues still remain problematic across the board.

   – looked after children placed out of borough and requiring CAMHS intervention

   - young people leaving care who have mental health problems. The interface with adult mental health is difficult as there are different criteria for adult mental health services, and many young people are not eligible for support

3. CAMHS must develop better responses to seeing children where help and support is needed early on in a placement.

4. The evidence base about what works with looked after children is thin – more resources for research in this area are needed.

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