



Department
for Education

Evaluation of the Adoption Support Fund: baseline survey of families

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Key messages

Headline messages from a 'baseline' questionnaire of adoptive parents and Special Guardianship Order carers whose children and families were about to receive support via the Adoption Support Fund between November 2018 and February 2020 include that:

- There were good and mostly improving levels of satisfaction with aspects of seeking help through the Fund including with the assessment process, family views being taken into account, choice of provider, also location of support.
- Findings from the Strengths and Difficulties Questionnaire (SDQ) completed by adoptive parents and SGO carers suggested that the needs of these children prior to the ASF funded support were statistically significantly greater than those in the overall British child and young person population. At baseline, the mean SDQ total difficulties score for the children in the sample was 19.28, compared to a mean score of 8.40 for all children in the British population. The majority (95%) of parents and carers reported that these difficulties had been present for over a year. These findings were corroborated by Child Behaviour Checklist (CBCL) parent report scores for the same children, indicating that a high proportion had needs in the clinical or borderline clinical range.
- However, the baseline SDQ scores also suggested that the emotional health and wellbeing difficulties of this sample of children were statistically significantly lower overall than those reported by parents in the earlier (Tavistock Institute, 2017) study of children who began accessing ASF funded support between May 2015 and May 2016.
- Approximately one half of all the children and young people in the sample had a form of (specialist) education plan and 31% of those aged 11 plus had a multi-disciplinary Education, Health and Care Plan (EHCP). This is about 10 times the rate of children with an EHCP in the overall population of English school children (UK Government Statistics Service, 2020).
- A proportion of children and young people in the baseline sample were described by their parents or carers as having a formal diagnosis of Attention Deficit Hyperactivity Disorder (13%), Autistic Spectrum Disorder (9%) or Foetal Alcohol Syndrome (6%) and a further 16% of parents and carers thought that a specific or additional diagnoses were currently being explored.
- Parent reported measures of their own emotional health and wellbeing were statistically significantly worse in this study's baseline sample compared with British norms, but similar to those reported in the earlier ASF study.

Executive summary

This report is the second in a planned sequence to present findings from an independent evaluation of the Adoption Support Fund (ASF) 2018-2021 undertaken by the Institute of Public Care at Oxford Brookes University.

The findings in this report relate to the first of three waves of an online questionnaire completed by over a thousand (1,008) adoptive parents and carers of children with a Special Guardianship Order (SGO)¹ between November 2018 and February 2020, immediately before a package of Adoption Support Fund (ASF) funded support commenced. Parents and carers will subsequently be asked to complete a further 2 waves of the questionnaire – when the funded support finishes and 6 months thereafter.

Comparisons will be made throughout the report with a study relating to families accessing the ASF in an early stage of its implementation between May 2015 and May 2016 (Tavistock Institute, 2017) hereafter referenced as ‘the earlier ASF study’.

Key findings relating to the experiences of families accessing support include that:

- Most parents and carers (67%) had heard about the Adoption Support Fund from their local authority or regional adoption agency social worker. An even greater proportion of SGO carers (74%) had heard about the Fund from their social worker. Others had heard about the Fund from a range of sources including the Adoption UK website or magazine, other parents or carers (word of mouth, voluntary adoption agencies or social media).
- Most (76%) parents and carers agreed or strongly agreed that the assessment had accurately identified the needs of their child. On a range of measures relating to the assessment, improvements were noted in comparison with the earlier ASF study, in particular the extent to which parent or carer views had been taken into account where the improvement was statistically significant. Some parents or carers with prior experience of applying to the Fund also commented that the assessment process had improved since the Fund’s inception. Positive experiences were often attributed to a good connection with an individual post-adoption support (social) worker. Less positive experiences were associated with delays in getting started with and completing an assessment, and a perception that the child’s difficulties were worsening during this waiting period.
- A relatively large proportion of parents and carers did not feel able to answer more detailed questions about the assessment process (between 12% and 27% per

¹ The baseline sample includes 109 SGO families, equivalent to 11% of the total sample. This proportion is similar to that relating to all families receiving funded support during the same period.

question) as they were not aware that there had been an assessment or thought that assessment documentation had not been shared with them.

- Most parents and carers expressed satisfaction with other aspects of seeking and getting help through the ASF, for example the choice of provider available to them (85%), the location of support (82%) or the number of sessions offered (80%). Satisfaction rates in relation to these areas also represented an improvement on those noted in the earlier ASF study.

Key findings relating to the characteristics of children and families accessing support include that:

- The largest proportion of children and young people subject of ASF funding and whose parents participated in the baseline evaluation were aged 5 -10 years (49%) and 52% were male. 84% were living with parents after an Adoption Order had been made, 11% were subject of a SGO and 5% were living with an adoptive parent without an Adoption Order having yet been made.
- Some of the children had a diagnosis of or recent treatment specifically in relation to Attention Deficit Hyperactivity Disorder (ADHD) 13%; Autistic Spectrum Disorder (ASD) 9%; or Foetal Alcohol Spectrum (Disorder) (FAS(D)) 6%. 16% parents and carers thought that a specific diagnosis or additional diagnoses were being explored. 68% parents and carers thought that their child did not have a diagnosis. The proportions of children with a reported diagnosis increased slightly with age, for example 18% of children aged 11+ were reported to have a diagnosis of ADHD and 14% a diagnosis of ASD.
- Approximately one half (48%) of the children were reported by their parents and carers to have a form of (specialist) education plan. 31% of children aged 11+ were reported to have a multi-disciplinary Education Health and Care Plan (EHCP) or Statement of Special Educational Needs (SEN). This is almost 10 times the rate of children in the overall population of English school children with such a plan (3.3%) in the year 2019 to 2020 (UK Government Statistics Service, 2020).
- With reference to the Strengths and Difficulties Questionnaire (SDQ), the emotional health and wellbeing needs of children in the sample, as reported by their parents or carers, were statistically significantly greater than those in the overall British child and young person population. These findings are corroborated by Child Behaviour Checklist (CBCL) parent report scores for these same children, indicating also that a high proportion (80% of those aged 1 ½ to 5 years and 90% of those 6 to 18 years) had needs in the clinical or borderline clinical range. Difficulties and problems increased with age to a peak at around 11-15 years after which they became less severe.

- However, the parent/carer rated SDQ scores for the baseline sample of adoptive and SGO children indicate that they also had statistically significantly lower levels of difficulty on average compared with those in the earlier ASF study. This finding may suggest that adopted children with priority including early access to the Fund were amongst those with the highest levels of need. The hypothesis is supported by other findings from the current study, including that children in the sample who were accessing the Fund for the first time had lower reported problems and difficulties compared with those who had already received at least one earlier package of support. Another linked hypothesis is that adoptive parents and SGO carers may now be seeking ASF help more pro-actively, including before reaching a crisis point.
- When asked how they thought the family was faring, half (50%) of parents expressed a view that they were 'managing', and 9% felt it was 'going really well'. However, their emotional health and wellbeing (as measured by the Short Warwick-Edinburgh Mental Well-being Scale) was statistically significantly worse compared with whole population norms, although about the same as in the earlier ASF study. 53% of parents and carers with a spouse or partner believed that having their child had caused problems in that relationship, more so than they would have expected.

Key findings relating to what families anticipated receiving by way of funded support to meet key aims include that:

- Parents and carers surveyed in this study so far were anticipating receiving a range of ASF-funded supports including: a creative or physical therapy for their child (35%); psychotherapy or another talking therapy for the child (32%); a form of family therapy (30%); one of a range of parent training courses specific to adoptive or SGO families (23%); therapeutic life story work for the child (13%) and / or a therapeutic short break for the child (5%).
- The most frequently reported main aim of the funded support for adoptive parents and SGO carers was to improve the child's emotional health and wellbeing (in 60% of cases) but also sometimes to help the child to develop more positive behaviours (11%); to improve family life and relationships (13%); for the parents and carers to develop skills in therapeutic parenting (7%); to help the family bond together (3%); to help the child's engagement with learning (3%); and to address child to parent violence (2%).

The subsequent two 'waves' of this longitudinal study with parents and carers will explore their experiences and their perceived impact of the funded support both in the short term (at the end of the funded support) and in the medium term (6 months afterwards).

1. Introduction

This report from the Institute of Public Care at Oxford Brookes University is the second in a sequence relating to an independent evaluation of the Adoption Support Fund (2018 - 2021) funded by the Department for Education².

The Adoption Support Fund (ASF) provides funds to local authorities (LAs) and regional adoption agencies (RAAs) to pay for essential therapeutic services for children who have left the care system either through adoption or as a result of a Special Guardianship Order (SGO). The ASF model is based on the existing statutory framework for the assessment of adoption support or SGO needs. The Fund aims to ensure that families with assessed needs receive timely, effective support to improve outcomes. More information on the Fund is available here: <https://www.gov.uk/guidance/adoption-support-fund-asf>.

This report explores early findings from the first of three ‘waves’ of a longitudinal survey of adoptive parents and carers of children with a Special Guardianship Order (SGO) who are eligible for ASF funded support. In this first wave, the findings relate to 899 adoptive parents and 109 SGO carer (total 1,008 parent carer) experiences of seeking and getting help through the Fund and aspects of their child and family needs before the period of funded support commenced.

Other aspects of the ASF evaluation in relation to which findings have been or will also be published include:

- Qualitative (in-depth) interviews with parents, carers and children who have received funded support – after the support has ended and 6 months later.
- Surveys and interviews with providers of therapeutic support for children and families – at two points in time during the evaluation project.
- Interviews with local authority and regional adoption agency staff working with or commissioning services for adopted children or children with a Special Guardianship Order – at two points in time during the evaluation period.
- Secondary analysis of anonymised data relating to the operation of the Fund and its beneficiaries – at several points in time through the evaluation period.

² All reports from this and previous evaluations of the Adoption Support Fund can be accessed here: <https://www.gov.uk/government/collections/evaluations-of-the-adoption-support-fund-asf>

One earlier report relating to a first wave of local authority / regional adoption agency and provider interviews and survey has already been published (The Institute of Public Care, 2020) and can be found [here](#).

Further reports are planned in 2021 including findings from the follow up questionnaires and interviews with parents and carers (relating to the impact of funded support) and the second-round interviews with or surveys of local authorities and providers (relating to their perceived changes in the landscape for adoption support in England since the time of the earlier report above).

Finally, as mentioned in the key findings and executive summary sections, comparisons will be made throughout the report with a study relating to an early implementation phase of the ASF from May 2015 to May 2016 (Tavistock Institute, 2017) hereafter known as 'the earlier ASF study'.

Family Survey Methodology

The baseline family questionnaire was operational (open to respondents) between **November 2018 and February 2020**, during which time adoptive parents and SGO carers³ were encouraged and supported⁴ to participate in the longitudinal online survey comprising 3 'waves' of participation:

- An initial baseline questionnaire completed as soon as possible after their application for funding from the ASF had been approved, and ideally before the funded support commenced. This questionnaire explored a range of areas including the needs of their children and experiences of applying to the ASF.
- A second questionnaire to be completed as soon as possible after the funded support ends focusing on the experiences of families in receiving funded support and its short-term impact.
- A further third questionnaire to be completed 6 months after the second survey exploring the medium-term impacts of funded support on the child and parent(s) or carer(s).

Evaluators will be able to compare responses from individual participants about themselves and a child of the family receiving ASF funded support (the eldest child where more than one is receiving funded support) across these three waves of survey. The responses include key measures of child and family wellbeing such as the Child

³ These parents and carers are those who gave their informed consent to participate in the evaluation via a local authority or regional adoption agency social worker or support worker

⁴ Including through a helpdesk facilitated by staff at IPC

Behaviour Checklist (CBCL) (Achenbach, 2000), the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 2001), the Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) (Collins et al, 2012)⁵ and the Brief Parental Self-Efficacy Scale (BPSES) (Woolgar et al, 2013). More detail about these measures can be found in Appendix 1 to this report.

At the time of wave one survey closure in February 2020, 1,008 parents and carers had completed an initial baseline questionnaire in relation to a child of the family with ASF funded support. This number of parents and carers completing and returning a questionnaire represents 49% of all those who had been sent a survey successfully and had not informed the evaluators they wished to withdraw. A relatively large proportion (28%) of parents and carers who initially gave their consent to participate were in fact already involved in the evaluation survey, usually where at least 2 'lots' of funding had been approved across 2 financial years, and so had to be excluded from participating again⁶. The overall sample represents 7% of the total of 15,320 'unique children' with an approved application for ASF support during the same timeframe⁷.

Table 1: Sampling frame for the ASF Baseline Survey

Cohort	Number
Parents / carers who gave their consent to participate and whose application details were sent to evaluators from The Fund Manager	4,227
Parents / carers who could participate (they were not already participating in the survey)	3,061
Parents / carers who could be sent a survey successfully (their email contact details and/or telephone number 'worked' ⁸ and they did not inform evaluators that they wished to withdraw their earlier consent)	2,062
Parents / carers completing a baseline ASF survey	1,008

Data Source: Baseline survey response monitoring data

The strengths of the reported findings from this baseline survey include:

⁵ The SDQ and SWEMWBS can be compared with an earlier study by the Tavistock Institute of the early implementation of the Fund but the CBCL can not

⁶ A proportion of other parents also could not be surveyed, for example because had no contact details or actively withdrew their consent

⁷ Source of this information is the Fund Manager

⁸ Although it is not possible to be certain about the number of parents who received the email

- The large number of respondents (over 1,000).
- That the online survey format includes many required fields, which has made it much more difficult to skip questions, resulting in a very complete set of data.
- That the survey questions (and responses) cover a large range of topics including, for this baseline questionnaire, considerable detail relating to child and family characteristics and needs; their experience of accessing the Fund previously; and their experience of seeking and getting help including through the ASF.

Study limitations include that:

- Evaluators had to exclude some families from participating, in particular where they were already taking part in the study but went on to receive further funding in a new financial year and to consent again to participating.
- The findings from the baseline questionnaire related to parents' and carers' experiences at the start of a journey in and through ASF support. Therefore, they were understandably tentative and may change as families progress further into and through support.
- Whilst findings relating to some standardised measures of child and parent or carer wellbeing can be compared across this and the earlier ASF study, the Child Behaviour Checklist (CBCL) cannot because this measure was selected and introduced for the first time for this evaluation, with the assistance of a Research Advisory Group for the project.
- Although key characteristics of children comprising the sample are on the face of it very similar to those of all children receiving funded support during the same period (see further sections on findings), logistic regression and chi squared analyses suggest that the sample is not fully representative of that larger group, in particular in relation to child age categories and placement status (rather than child gender or ethnicity), although the differences represent a small effect size. This means that we should be careful not to generalise about all children receiving funded support on the basis of the sample findings. This is a common issue with large survey samples in the absence of stratified random sampling techniques.
- A relatively small number and proportion (109,11%) of baseline responses related to SGO families which, although this proportion is very similar to that relating to all families receiving funded support during the same period, brings some limitations to the sub-group analyses.

Nonetheless, the findings offer an important and detailed analysis of the characteristics and needs of families accessing the Fund between November 2018 and February 2020 and their early experiences of seeking and getting help through the Fund.

2. Findings from the baseline survey

These findings are organised into 4 parts:

- What were the characteristics and needs of children in the sample about to access ASF-funded support?
- What were the characteristics and needs of parents and carers in the sample whose children were about to access ASF-funded support?
- What were the early experiences of these parents and carers seeking help from the Adoption Support Fund?
- What did families anticipate receiving by way of funded support to meet key aims?

What were the characteristics and needs of the children in the sample about to access ASF-funded support?

Child and family composition

The baseline children

The biggest proportion (49%) of children in the baseline cohort were in the age band 5 to 10 years. The smallest proportion (8%) were in the age band 0-4 years. The spread of child ages across age bands is relatively similar to that of the full cohort of children with ASF applications approved during the same period, as illustrated in Table 2 below:

Table 2: Baseline survey by age band compared with the whole cohort with approved ASF applications in the same timeframe: November 2019 to February 2020

Age Band	% and no. children in the baseline cohort	% children in the whole cohort with approved ASF applications ⁹
0 – 4 years	8%	7%
5 – 10 years	49%	47%
11 – 14 years	28%	27%
15 years plus	15%	19%

Data source: Baseline survey and application data

⁹ Source: Fund Manager

The age breakdown of SGO children was slightly different compared with the overall baseline cohort, including a greater proportion of children aged 5-10 years (59%) and fewer children aged 0-4 (5%), 11-14 (24%) or 15 plus (12%). Similarly, and as one might expect, the children living with parents before an Adoption Order is made were much younger overall, with 49% aged 0-4 years, 47% aged 5-10 years and only 4% aged 11-14 years (none were aged 15 plus).

There were slightly more male (52%) than female (48%) children in the baseline sample. The proportions are the same as in the overall cohort of children with ASF applications approved during the same period¹⁰.

Slightly more children of mixed ethnicity (12%) made up the baseline compared with all children with approved applications (9%). There were also slightly fewer children of White British / Irish / other ethnicity (83%) compared to all children with approved applications (86%) although 85% of the SGO children were noted to be White British / Irish / Other ethnicity. Other child ethnicities were as well represented in the survey as within the whole cohort.

The proportions of child placement types were also relatively similar in the baseline sample compared with all children with an approved application, as illustrated in Table 3 below. The largest group in the baseline sample (84%) were children living with adoptive parents after an Adoption Order had been made followed by children with a SGO (11%) and then children living with adoptive parents but not yet with an Adoption Order (5%).

¹⁰ SGO children were more evenly split between male (50%) and female (50%)

Table 3: Child placement types in the baseline sample and within the overall cohort of children with approved applications for funded support November 2018 - February 2020

Placement Status Type	No. children in the baseline sample	% children in the baseline sample	% all children with approved applications ¹¹
Living with adoptive parent(s) but not yet with an Adoption Order	49	5%	7%
Living with adoptive parents after an Adoption Order made	850	84%	80%
Living with carer(s) after a Special Guardianship Order made	109	11%	12%

Data Source: Baseline survey and application data

The survey also asked parents and carers questions about the child's status including whether the adoption was an inter-country adoption i.e., from outside the UK. This was the case in only 3% cases within the baseline sample and this compares with 2% of all children with an approved application overall. Most of these children had been adopted from Russia or China, but also from a range of more than 10 other countries.

A large proportion of children in the baseline sample had been living with adoptive parents or SGO carers for at least 3 years by the time of completing the survey. The time for which children had been living with parents or carers ranged from less than 6 months to over 17 years and the mode (most common) time range was 5 to 6 years, as illustrated in Table 4 below.

¹¹ This whole cohort breakdown does not quite add up to 100%. This is because there are a small number of children reported by the Fund Manager to have received funded support before the Special Guardianship Order was made (approximately 1%).

Table 4: Percentage (%) of children referenced in the baseline survey sample by length of time for which they have been living with adoptive parent(s) or SGO carer(s)

Time range child living with adoptive parent(s) or SGO carer(s)	% children in the baseline survey cohort
Less than 1 year	5%
1 - 2 years	9%
3 – 4 years	16%
5 - 6 years	20%
7 – 8 years	14%
9 – 10 years	13%
11 – 12 years	10%
13 – 14 years	8%
15 years and over	5%

Data source: Baseline survey.

The baseline parents and carers

Parents and carers completing the baseline questionnaire described themselves as being in a range of age categories from 25 to 84 years, but the largest group (49%) were aged 45 – 54 years. The age demographic was different between adoptive parents and SGO carers with SGO carers more likely to be in the older age categories, aged 55-74 years, and adoptive parents more likely to be aged 45-54 years or younger.

Table 5: Parents and carers completing baseline ASF Survey by age and type of placement

Age category	% parents and carers overall	No. and % SGO carers	No. and % adoptive parents
25 – 34 years	4%	10%	3%
35 – 44 years	24%	12%	26%
45 – 54 years	49%	25%	52%
55 – 64 years	20%	38%	18%
65 – 74 years	2%	15%	1%
75 – 84 years	Less than 1%	Less than 1%	None

Data source: Baseline survey. Note: 4/1,008 preferred not to give their age and they are not included in the percentages here

16% of parents and carers completing the baseline questionnaire described themselves as a single parent or carer, and 82% as a co-parent or carer. A small proportion (1%) reported another arrangement, mostly ‘co-parenting but living apart’. More SGO carers (39%) than adoptive parents (14%) described themselves as a single parent or carer.

Most parents and carers completing the baseline survey had at least a degree level qualification (65% overall including 70% of adoptive parents and 22% of SGO carers). A majority (66%) of all parents and carers described working, including full time (25%) or part time (41%) work. In many cases where there was a co-parent, they were described as being in full time (69%) or part time (14%) work.

63% of parents and carers completing a baseline survey reported that there was at least one other child of the family living with them. In most (75%) of these cases, this was just one other child and they were often a biological sibling of the adopted or SGO child subject of the study. However, in other instances, the other child(ren) were the parent’s or their partner’s birth child, a child adopted from another family, a fostered child, or a child with a Special Guardianship Order.

Whether children and families had received earlier ASF funded support

Parents and carers reported that the child who was the focus for the baseline questionnaire had received at least one earlier package of funded support in 37% of cases (39% of adoptive children and 17% of SGO children). This can be compared with a

slightly lower reported rate¹² of 30% for all children with an approved application during the same period. Additionally, 17% of parents and carers reported that another child of the family had received earlier ASF-funded support. 54% parents and carers thought that they had not received any earlier funded support (for any child of the family).

Many parents and carers reporting that their child had received at least one previous package(s) of ASF support went on to describe how their child's needs were so profound that more support had been required:

“Our son's trauma was buried very deep and therapy has very gradually started the process of dealing with what has happened to him. He was initially quietly resistant to any attempts to help him, but he is now much more relaxed and trusting” (adoptive parent)

“Long term support needed not a quick fix” (adoptive parent)

These parental observations were reinforced by findings from the standardised measures suggesting that the needs of these 'repeat application' children were greater (see section 'Combined SDQ and CBCL Findings' below).

Previously ASF-funded support was reported to have finished less than 6 months ago in 44% cases, more than 6 months but less than 1 year ago in 22% cases, more than 1 year but less than 2 years ago in 18% cases, more than 2 years but less than 3 years ago in 10% cases, and more than 3 years ago in 6% cases.

Child development, wellbeing, behaviour and diagnoses or difficulties prior to receiving ASF funded support packages

In the longitudinal survey, child behaviour, development and wellbeing have been measured in several ways:

- Using 2 validated scales selected with the support of a Research Advisory Group for the project: the parent-report versions of the Child Behaviour Checklist (CBCL)¹³ and the Strengths and Difficulties Questionnaire^{14 15}.

¹² Data source: The Fund Manager

¹³ For children aged 18 months to 18 years.

¹⁴ The earlier ASF study measured child behaviour, development and wellbeing using the SDQ and BAC-C/A

¹⁵ The SDQ parent report questionnaires were used for children aged 5 to 17 years. There is also another SDQ scale for children aged 2-4 years but, with Research Advisory Group support, the evaluation team opted not to use this scale as it is thought to be less valid and reliable than the scales for older children. Its main usefulness for this study was to compare scores with the (Tavistock Institute, 2017) study of children with earlier packages of ASF-funded support

- Direct questions of parents and carers about the existence of:
 - formal diagnoses of developmental conditions; and
 - formal plans of specialist support in school.

Key Findings from the Baseline Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a screening questionnaire for child behavioural difficulties and strengths, available in a parent-report version for children and adolescents between 4 and 17 years. The first part consists of 25 items, which are divided into 5 sub-scales each containing 5 items. The subscales assess: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and pro-social behaviours. Items are rated on a scale from 0 to 2, so that sum-scores per sub-scale range from 0 to 10. A total difficulties score is calculated based on 4 sub-scales excluding the pro-social sub-scale. The total scores range from 0 to 40, where higher scores indicate greater levels of difficulty for the child.

In addition, the SDQ impact supplement was used for this study. This comprises 5 questions about the impact of the child's difficulties on different domains of their life, chronicity of difficulties, distress, and the overall burden that these difficulties place on others. SDQ norms are available in relation to British children and relate to samples of children aged 5 to 15 years. It is for this reason that evaluators have undertaken most analyses of the baseline data in relation to children in this age range, also to enable comparisons with the earlier (Tavistock Institute, 2017) sample of the same age range. Some additional analyses have been undertaken in relation to the whole sample aged 5 years plus.

The findings and table below outline the average (mean) scores and their spread (standard deviation) for the SDQ scales of the baseline sample of 5–15-year-olds compared with British norms, and the SDQ scales scores from similarly aged children in the earlier ASF study.

- At baseline, the current study's sample average (mean) SDQ total difficulties scores (n=963, **Mean=19.28**, SD=6.56) were significantly greater than British total difficulties scores (norms) for 5 -15-year-olds (n=609, **Mean=8.40**, SD=5.80), $t(1570) = 33.48$, $p < .001$; $d=1.75^*$).
- However, compared to the earlier ASF study SDQ total difficulties score (n=792, Mean=23.37, SD=6.42), this survey's baseline sample average (mean) SDQ total difficulties score (n=963, **Mean=19.28**, SD=6.56) was statistically significantly less $t(1763)=13.12$, $p < .001$; $d = .6^*$.

The effect sizes for the two comparisons indicate that both are substantial findings¹⁶.

Table 6: SDQ mean scores and standard deviations (SD) by scale type for survey children compared with British norms and the earlier Tavistock (2017) cohort at baseline

SDQ scale	Baseline survey mean scores (SD) for 5–15-year olds	British mean scores (SD) for 5–15-year-olds	Tavistock (2017) comparison mean scores (SD) for 5–15-year olds
	Mean scores (SD)	Mean scores (SD)	Mean scores (SD)
Emotional Problems (5 items)	4.4 (2.8)	1.9 (2.0)	5.5 (2.6)
Conduct Problems (5items)	4.6 (2.5)	1.6 (1.7)	5.6 (2.3)
Hyperactivity (5 items)	6.2 (2.5)	3.5 (2.6)	7.7 (2.3)
Peer Problems (5 items)	4.2 (1.8)	1.5 (1.7)	4.6 (2.4)
Prosocial (5 items)	6.0 (2.4)	8.6 (1.6)	5.5 (2.2)
Total Difficulties (5 items) *	19.3 (6.6)	8.4 (5.8)	23.4 (6.4)
Impact score**	5.08 (2.8)	0.4 (1.1)	5.8 (2.6)

Data source: SDQ scores within the baseline sample

*This is generated by summing scores from all the scales except the prosocial scale. The resultant score ranges from 0 to 40 and is counted as missing if one of the 4 component scores is missing.

**The items on overall distress and impairment can be summed to generate an Impact score that ranges from 0 to 10 for parent report. Responses to the questions on chronicity and burden to others are not included in the impact score.

Chronicity of child difficulties as measured by the SDQ

Another key finding from the SDQ scores is that a large proportion (95%) of parents or carers in this baseline sample reported that these difficulties had been present for over a year.

¹⁶ Effect size is a way of quantifying the difference between two groups. An effect size of .6 can be interpreted as large (Cohen 1988).

Table 7: Frequency of parent/carer reported SDQ child difficulties by length of time these difficulties have been presented (for the core cohort of children aged 5-15 years)

How long have these difficulties been present?	Absolute Frequency	Relative Frequency (%)
1-5 months	11	1.2
6-12 months	34	3.6
Less than a month	2	0.2
Over a year	900	95
Total	947	100.0

Data source: SDQ scores within the baseline sample

Key findings from the Child Behaviour Checklist (CBCL)

The CBCL questionnaire for children aged 1 ½ to 5 years and for those aged 6 to 18 years obtained caregiver ratings of the child in relation to a series of “problem items” (99 for the lower and 118 for the higher age category). Parents completing the questionnaire were asked to rate their child's behaviour on a 3-point scale (*not true, somewhat or sometimes true, and very true or often true*).

- Items were scored in relation to ‘syndrome scales’ for example for the younger age group: Emotionally Reactive, Anxious/Depressed, Somatic Complaints (physiological symptoms frequently associated with internalising behaviours like anxiety and depression), Withdrawn, Attention Problems, Aggressive Behaviour, and Sleep Problems. Items were also scored in relation to DSM-Oriented scales made of items that a panel of experts have selected as matching parts of the diagnostic criteria for DSM-IV (Achenbach & Rescorla 2001) for example, also for the younger age group: Depressive Problems, Anxiety Problems, Attention Deficit/Hyperactivity (ADH) Problems, Autism Spectrum (AS) Problems, and Oppositional Defiant Problems.
- There are two "broad band" scales that combine several of the syndrome scales into *Internalizing problems* (problems that are mainly within the self, for example anxiety) and *Externalizing problems* (conflicts with other people and their expectations for children’s behaviour). There is also a *Total Problems* score, which is the sum of the scores of all the problem items.
- Each of the Syndrome, Internalizing and Externalizing, and Total Scores can be interpreted as falling in the *normal, borderline, or clinical* ranges. Scores in the borderline and clinical ranges differentiate between children who are typically

referred to mental health or special education services for behavioural/emotional problems and demographically similar children who are not typically referred.

A headline finding from the Child Behaviour Checklist (CBCL) scores for ASF-funded children in the sample prior to funded support commencing is that, according to parent and carer ratings, they were experiencing a very high level of clinical or borderline clinical problems with reference to US norms¹⁷.

The average (mean) total CBCL score for children aged 1.5 to 5 years and those aged 6-18 years in the baseline sample was statistically significantly higher compared with the equivalent scores in US normative samples i.e., the children in the baseline sample had significantly more problems overall compared with US norms.

80% of children aged 1 ½ to 5 years and 90% of children aged 6 to 18 years in the sample had total problems within the clinical or borderline clinical range, that is to say that their problems were outside of the normal range for children of the same age.

Table 8: Percentage (%) baseline children's Total Problem scores as defined by CBCL baseline parent of carer responses by age group

Type of problem / difficulty as defined by the CBCL	% children aged 1.5 to 5 years with clinical or borderline clinical problems	% children aged 6 to 18 years with clinical or borderline clinical problems
Total Problems	80%*	90%*

Data source: Baseline survey.

*Using cut offs for US normative samples. See Appendix 1 for an explanation of scoring and cut offs for these classifications.

Most of these children had total problems in the clinical rather than borderline clinical range.

- For children aged 1 ½ to 5 years, 6% were in the borderline clinical and 74% were in the clinical range.
- For children aged 6 to 18 years, 6% were in the borderline clinical and 84% were in the clinical range.

The average (mean) CBCL Internalising Problems (problems that are mainly within the self, for example anxiety) and Externalising Problems (conflicts with other people and

¹⁷ Unfortunately, no British or UK whole population norms are available for the purposes of comparison

aggressive behaviour) scores for children aged 1 ½ to 5 years and 6-18 years in the baseline sample were statistically significantly different to the equivalent scores in US normative samples. In relation to different types of child problems and difficulties, parent / carer reports suggest that over half (58%) of the children aged 1.5 to 5 years could be classified as having Internalising Problems and 85% Externalising Problems. Over 80% of children aged 6-18 years had both Internalising and Externalising Problems, as illustrated in Table 9 below:

Table 9: Percentage (%) children with different types of problems or difficulties as defined by CBCL baseline parent or carer responses by age group

Type of problem / difficulty as defined by the CBCL	% children aged 1.5 to 5 years with clinical or borderline clinical problems	% children aged 6 to 18 years with clinical or borderline clinical problems
Externalising	85%	81%
Internalising	58%	86%

Data source: Baseline survey CBCL scores

More detailed CBCL findings relating to the children aged 1 ½ to 5 years

In relation to the CBCL Syndrome scales, the baseline cohort of children aged 1 ½ to 5 years' values were highly statistically different to US normative sample values. In addition, the effect sizes for the differences were large. Apart from Anxious/Depressed Problems, Somatic Complaints and Sleep Problems, all CBCL 1 ½ - 5 Syndrome scales were more than one standard deviation (SD) from the mean of the US normative population. Emotionally reactive problems were more than two standard deviations and Attention Problems were three standard deviations from the mean of the US normative population. These differences are illustrated in Table 10 below:

Table 10: Summary statistics for CBCL scales for children aged 1 1/2 to 5 years in baseline ASF survey by syndrome scale compared with a US normative sample and including standard deviation (SD)

CBCL 1 ½-5 Syndrome Scale	Baseline Survey CBCL sample (1 ½ -5 years) N=127		CBCL (1 ½-5 years) US Normative Sample. N=700		Difference (SD units)
	Mean	SD	Mean	SD	
Emotionally Reactive	7.1	4.3	2.4	2.2	2.1
Anxious / Depressed	4.2	3.3	2.9	2.3	.6
Somatic Complaints	2.7	2.8	1.8	1.9	.5
Withdrawn	4.0	3.4	1.5	1.7	1.5
Sleep Problems	4.4	3.7	2.8	2.4	.7
Attention Problems	5.2	2.8	2.5	1.9	3.0
Aggressive Behaviour	19.4	8.7	10.4	6.4	1.4

Data source: Baseline survey CBCL scores

All CBCL DSM Oriented scale values were highly statistically different to US normative sample values and were all over one standard deviation from the mean of the US normative population, as illustrated in table 11 below. The difference was particularly strong in relation to Autistic Spectrum Problems, but also Oppositional Defiant problems.

Table 11: Mean scores and standard deviation (SD) for the baseline CBCL syndrome scales or children aged 1 1/2 to 5 years - by diagnosis type compared with a US normative sample and including standard deviation (SD)

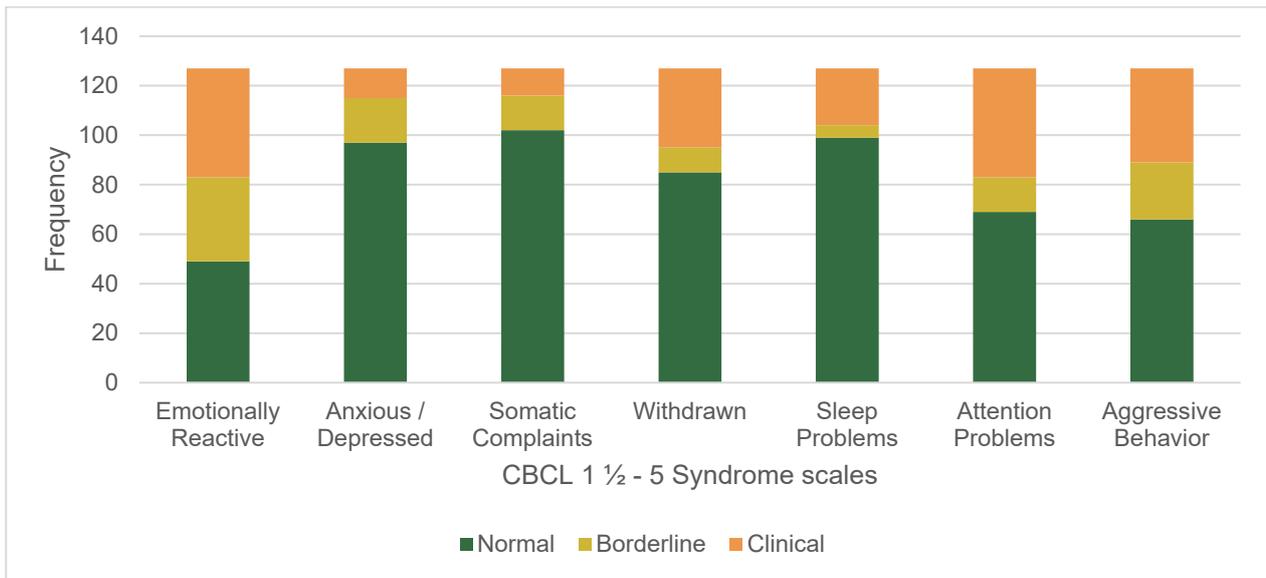
CBCL 1 ½-5 DSM Oriented Scale	CBCL Survey Sample (children aged 1 ½ to 5 years) N=127		CBCL US normative sample (children aged 1.5 to 7 years) N=700		Difference (SD units)
	Mean	SD	Mean	SD	
Depressive Problems	4.5	3.5	2.1	2.0	1.2
Anxiety Problems	6.3	4.7	3.4	2.5	1.2
Autistic Spectrum Problems	7.0	5.0	2.8	2.4	1.8
ADH problems	7.8	3.2	5.0	2.8	1.0
Oppositional Defiant Problems	7.1	3.4	3.6	2.5	1.4

Data source: Baseline survey CBCL scores

On the CBCL 1 ½ - 5 years syndrome scales, about a quarter of the children in the sample were reported to be in the Borderline Clinical and Clinical categories for Anxious/Depressed problems (24%), Somatic Complaints (20%) and Sleep Problems (22%). One third of the children were reported to be in the Borderline and Clinical categories for Withdrawn Behaviour (33%). Almost a half of the sample were reported to be in the Borderline and Clinical categories for Aggressive Behaviour (48%). However, the highest proportion of children in the sample reported to be in the Borderline Clinical and Clinical categories was for Emotionally Reactive problems (62%).

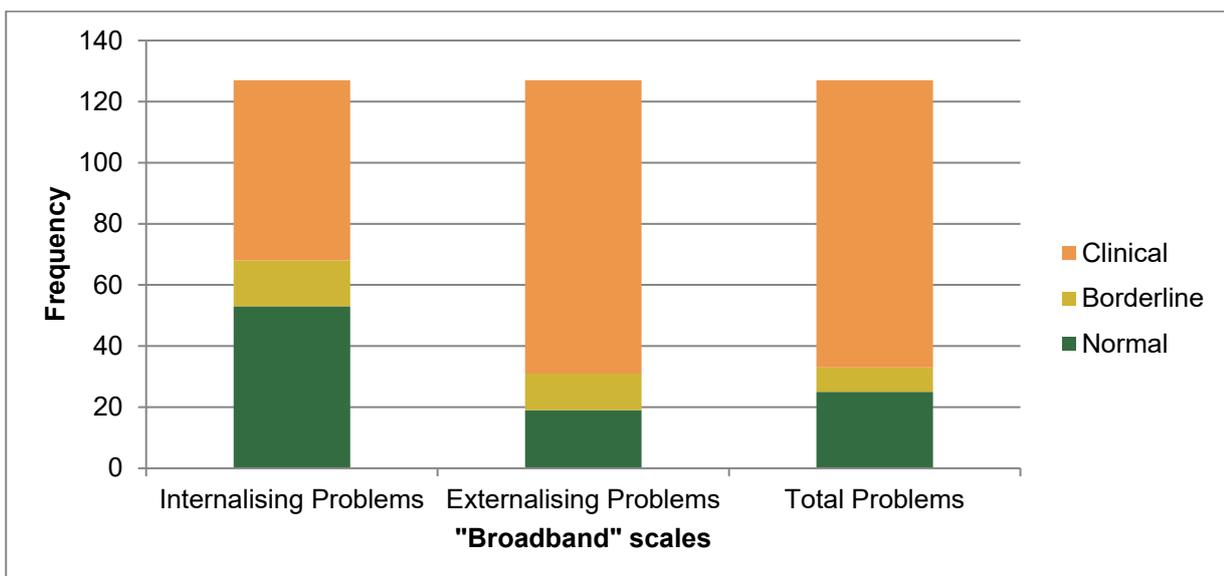
These findings are illustrated in Figure 1 below:

Figure 1: Bar chart showing frequency of CBCL T scores for children aged 1 1/2 to 5 years by syndrome scale category and range (normal, borderline and clinical)



When the syndrome scales are grouped into Internalising Problems, 58% of children in the sample could be placed in the Borderline and Clinical categories. 85% of children in the sample could be placed in the Borderline and Clinical categories for Externalising Problems. 80% of children in the sample were in the Borderline and Clinical categories for Total Problems.

Figure 2: Bar chart showing baseline CBCL T scores for children aged 1 1/2 to 5 years by internalising, externalising and total problems and range (normal, borderline or clinical)

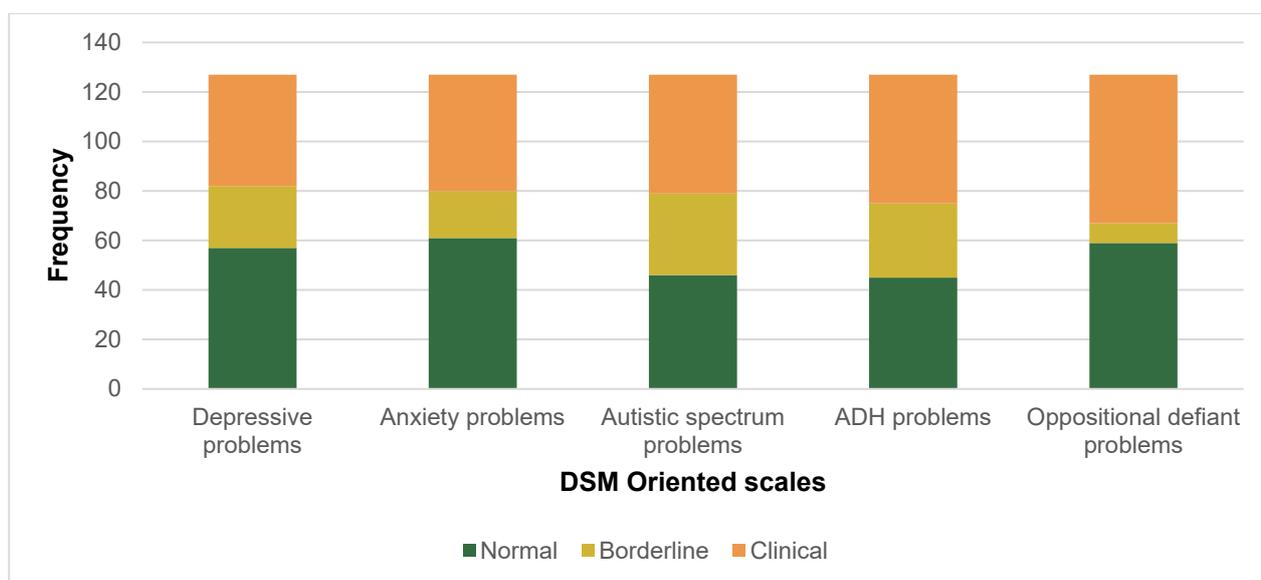


On the CBCL 1 1/2-5 years DSM-Oriented Scales, just over one half of children in the sample were in the Borderline and Clinical categories for Depressive Problems (55%),

Anxiety Problems (52%) and Oppositional Defiant Problems (53%). About two thirds of children in the sample were in the Borderline and Clinical categories for Autistic Spectrum (64%) and Attention Deficit Hyperactivity Problems (65%).

It is important to note that a particular score on a DSM Oriented scale is not directly equivalent to a clinical diagnosis which would normally involve a range of other information (for example about age of onset or duration of problems) and / or observations. Additionally, the items on the DSM Oriented scales do not correspond precisely to DSM criteria for a diagnosis.

Figure 3: Bar chart showing CBCL baseline T scores for children aged 1 1/2 to 5 years by DSM Orientated scales and range (normal, borderline or clinical)



More detailed CBCL findings relating to the children aged 6 to 18 years

CBCL 6 to 18 years: Syndrome scales

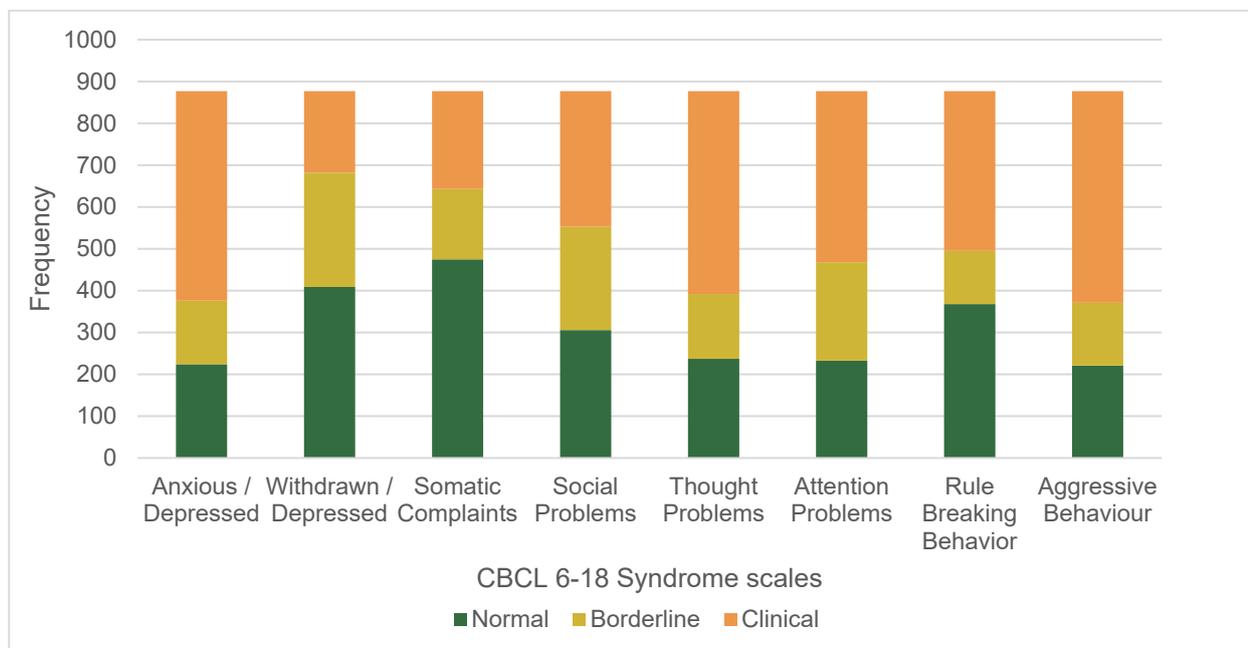
All survey CBCL 6-18 syndrome scale, broadband scale and DSM oriented scale values were highly statistically different to US normative sample values. In addition, the effect sizes for the differences were large. Apart from Somatic Complaints, all syndrome scales were about two standard deviations from the mean of the US normative population across genders and age ranges. Thought problems were about three standard deviations from the mean of the US normative population across genders and age ranges. More detail relating to these findings can be found in Appendix 1 to this document, including a breakdown by age 'group' and gender.

Internalising and Externalising Problems for children in the sample were all over two standard deviation from the mean of the US normative population across genders and age ranges. Total Problems were about three standard deviation from the mean of the US normative population across genders and age ranges.

Apart from Somatic Complaints (one standard deviation) all DSM Orientated scales were either 2 (Attention Deficit Hyperactivity Problems and Oppositional Defiant Problems), 3 (Depressive Problems and Conduct Problems) or 4 standard deviations (Anxiety Problems) from the mean of the US normative population.

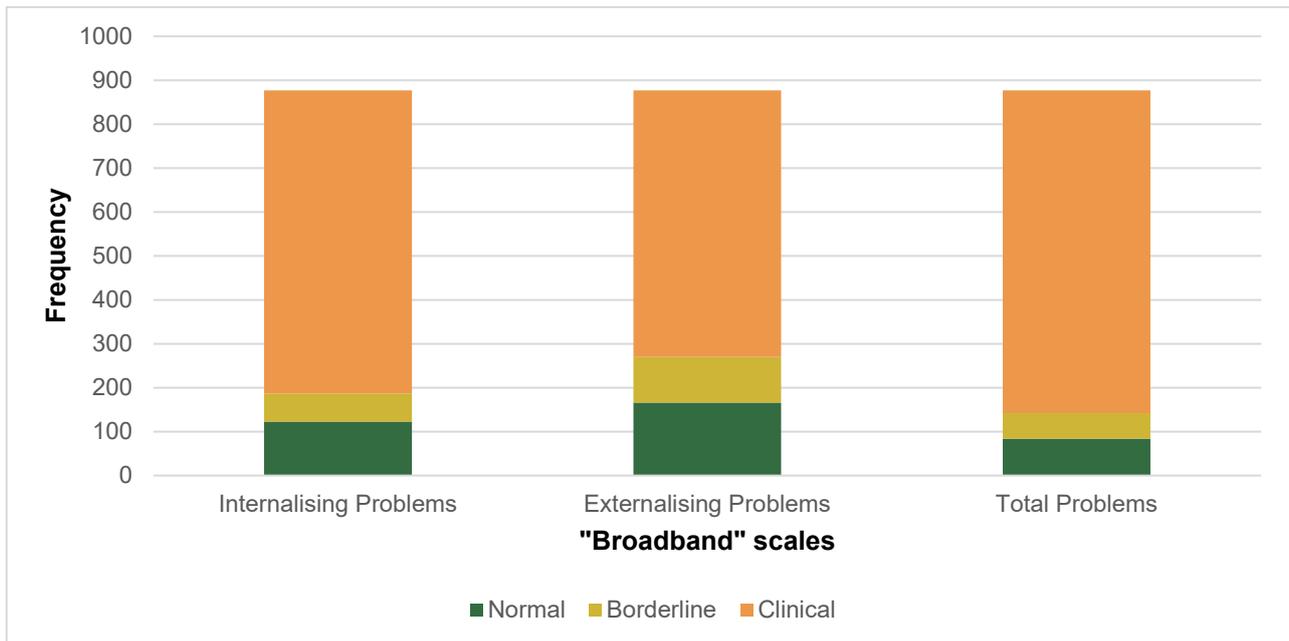
For the CBCL 6-18 Syndrome scales, about three quarters of the children were reported to have borderline or clinical Aggressive Behavioural Problems and Anxious/Depressed problems (74%), Thought Problems (73%) and Attention Problems (73%) in the borderline or clinical range. About two thirds of the sample was reported to have Social Problems (65%) in the borderline or clinical range. Over half the sample was reported to have Withdrawn/Depressed problems (53%) and Rule Breaking Behaviour Problems (58%) in the borderline or clinical range. Just under a half (46%) of the children were reported to have Somatic Complaints in the borderline or clinical range.

Figure 4: Bar chart showing the frequency of CBCL 6-18 symptom scales T scores in the normal, borderline and clinical range for children aged 6 to 18 years*



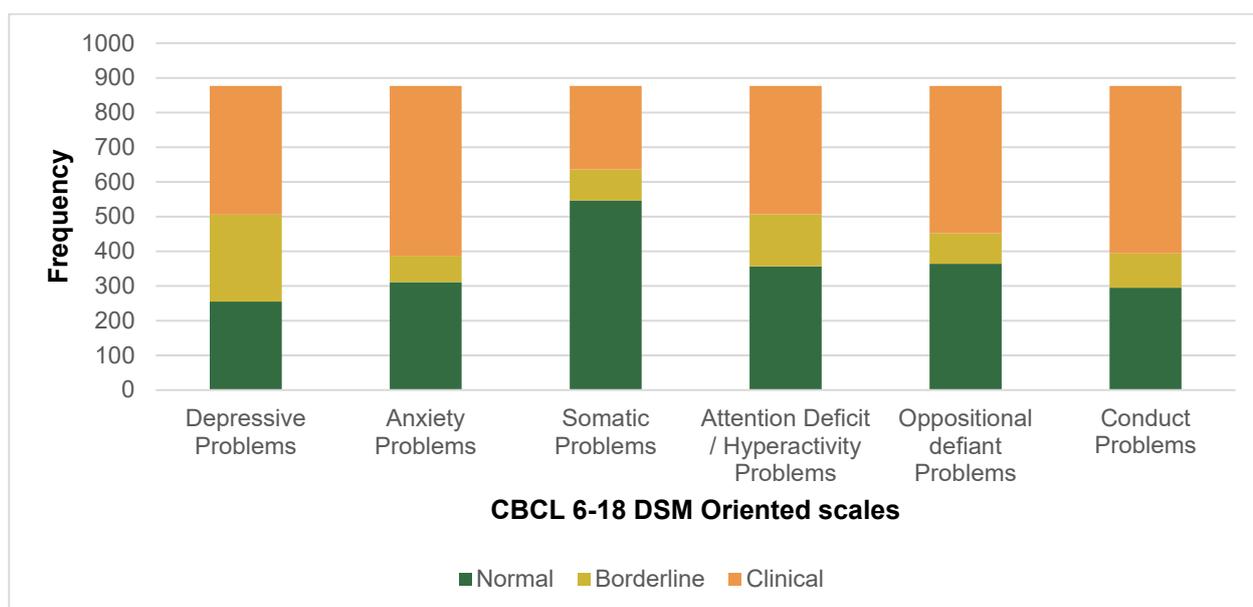
On the broadband scales, 86% of the sample were reported to have Internalising problems and 81% Externalising problems in the borderline or clinical range. 90% of the sample had Total Problems in the in the borderline or clinical range (most of these i.e., 84% were in the clinical range).

Figure 5: Bar chart showing the frequency of Internalising, Externalising and Total Problems CBCL baseline T scores for children aged 6 to 18 years by normal, borderline and clinical range



On the CBCL 6-18 DSM-Oriented scales, about three quarters (71%) of the children in the sample were reported to have Depressive Problems in the borderline or clinical range. About two thirds of the sample was reported to have Anxiety Problems (65%) and Conduct Problems (66%) in the borderline or clinical range. More than half of the sample were reported to have Attention Deficit Hyperactivity Problems (59%) and Oppositional Defiant Problems (58%) in the borderline or clinical range. About a third of the sample was reported to have Somatic Complaints (38%) in the borderline or clinical range.

Figure 6: Bar chart showing CBCL DSM Orientated Scales T scores for children aged 6 to 18 years by normal, borderline or clinical range



One third (33%) of the sample of 6–18 year-olds were reported by their parents or carers to have sometimes or often deliberately self-harmed or attempted suicide, including a slightly greater proportion of girls (37%) than boys (30%).

Combined SDQ and CBCL findings

Combined SDQ and CBCL findings suggest that:

- This sample of children were experiencing difficulties and problems that were significantly greater than overall ‘normative’ populations of children in Britain (SDQ) and the USA (CBCL). The difference is statistically significant and very large.
- Problems and difficulties increased with age to a ‘peak’ at between 11-15 years, becoming less severe thereafter.
- Children in the sample who were receiving ASF funding for the first time had lower-level difficulties overall compared with those who had accessed the Fund at least once previously. The difference is statistically significant for children of school age. One hypothesis to explain these findings across both standardised measures and all age categories is that families who sought support in an earlier wave of ASF funding arguably had the greatest needs – that they were prioritised in these early waves of funded support. Another hypothesis is that children requiring more than one package of funded support have greater levels of need overall compared with all those starting a funded package of support (incorporating those who may only need one funded package).

- The level of difficulties and problems were similar for children in the sample with an Adoption Order and those with an SGO. The level of difficulties and problems were lower for those children in the sample who were awaiting an Adoption Order although it should be noted that these children were often also younger in age.

Formal Diagnoses

The majority of parents and carers (68%) thought that their child did not have any diagnosed disorder or developmental condition. However, about one third parents or carers (32%) reported that their child did have one or more formal diagnoses of or had received treatment for a developmental condition such as Attention Deficit Hyperactivity Disorder (ADHD), Autistic Spectrum Disorder (ASD) or Foetal Alcohol Spectrum (Disorder) (FAS(D))¹⁸.

The proportion of parents and carers reporting that their child had a formal diagnosis or treatment for a condition increased in relation to the child's age, as explored in Table 12 below:

Table 12: Child formal diagnoses and treatment for developmental conditions reported by parents and carers in the baseline ASF Survey (numbers and percentages (%))

Diagnosis or Treatment for	No. children	% children	% children aged 11 plus
ADHD	127	13%	18%
ASD	88	9%	14%
FAS(D)	59	6%	7%

Data source: Baseline survey

These rates are much higher than in the overall child population, at least for ASD and ADHD. For example, current NICE Guidelines suggest that prevalence rates of ADHD are 1-2% and Autistic Spectrum Disorder 'at least 1%' within childhood populations (NICE Guidelines, 2018 updated 2019 and NICE Guidelines, 2011 updated 2017). NICE Guidelines for Foetal Alcohol Syndrome are not yet published. However, a recent large-scale UK study of children (McQuire et al, 2018) found that at least 6% screened positive for FAS(D)¹⁹.

¹⁸ The full question read 'Has your child ever had a diagnosis or treatment for a developmental problem, for example ADHD, Autistic Spectrum Disorder or Foetal Alcohol Syndrome?'

¹⁹ Although the researchers in this study emphasised that screening for prevalence is not equivalent to a formal diagnosis.

Some of the children already had multiple diagnoses, most commonly ADHD and ASD combined (4% of all children in the baseline sample) but also ADHD and FASD (2%), ASD and FASD (1%) and all 3 diagnoses (1%).

The rates of reported diagnoses were slightly different for the SGO and adopted children in the baseline sample, with a greater proportion of adopted children diagnosed or being treated for ADHD and slightly lower proportion diagnosed or being treated for FAS(D) compared with SGO children, as illustrated in Table 13 below:

Table 13: Number and percentage (%) children with a formal diagnosis or treatment for developmental conditions by type of placement (adoption or SGO)

Diagnosis or Treatment for	% all adopted children	% all SGO children
ADHD	13%	10%
ASD	9%	10%
FAS(D)	6%	8%

Data source: N=1,008. Baseline survey

A further 18% of parents and carers thought that their child had ‘another or other’ diagnoses and described these in a variety of ways including: attachment disorders or difficulties; sensory processing disorders or difficulties; chromosome disorders; post-traumatic stress disorder; developmental delay; global developmental delay; dyslexia or dyspraxia; speech and language delay; or a learning disability.

160/1,008 (16%) parents and carers including a small number (8) of those already with a diagnosis thought that a specific diagnosis was currently being explored in relation to their child, mostly ADHD, ASD or FAS(D).

Formal plans of support in school

The baseline survey also asked parents and carers to state whether their child had an educational support plan, including a more specialist or multi-disciplinary Education, Health and Care Plan (EHCP) or Special Educational Need (SEN) Plan or another type of school or educational support plan.

A quarter of parents or carers reported that their child had an EHCP or an SEN Plan and a further 23% reported that their child had another form of plan or additional school-based support. 40% did not think that their child had such a plan or support, 9% were unsure. A further 3% did not answer this question.

Table 14 below explores the number and proportion of parents and carers who thought that their child had different forms of plan. As with other identified difficulties, the number

and proportion of children with such a specialist support plan increased slightly with their age.

Table 14: Number and percentage (%) baseline survey children reported by parents or carers to have different types of educational (support) and broader multi-disciplinary support plans

Type of Plan	No. children	% children	% children aged 11 plus
EHCP or SEN Plan	252	25%	31%
Additional support planned by school but not EHCP or SEN	157	16%	16%
Another type of educational plan	75	7%	10%

Data source: N=1,008. Baseline survey

A slightly lower proportion of the SGO children aged 11 plus had such plans compared with adopted children of a similar age in the cohort. For example, 28% of SGO children were reported to have an EHCP Plan compared with 32% of the adopted children. 15% of the SGO children had additional support planned compared with 16% of the adopted children.

These rates of EHCP or similar plan can be compared with recent all-England figures suggesting that currently 3.3% of all pupils have an EHCP (UK Government Statistics Service, 2020).

What were the characteristics and needs of parents and carers whose children were about to access ASF-funded support?

Parent / carer perceptions of how the family was faring

Parents and carers completing a baseline questionnaire before the funded programme of ASF support commenced were asked how they thought the family was faring with reference to a series of specified options plus 'other'. The findings suggested that:

- 50% of families applying for ASF funded support were experiencing challenges and rewards but thought that they were managing overall.
- However, 36% reported they were struggling to manage but were committed to keeping the child in the family.

- A small proportion (3%) considered that it was possible the child might not remain in the family.

More about the numbers and proportions of parent / carer responses by option can be found in Table 15 below:

Table 15: Parent responses in relation to a baseline survey question about how they are faring as a family by response type (number and percentage (%))

Response	No. parent / carer responses	% of parent / carer responses
It's going really well	94	9%
There are challenges, but also rewards and overall, we are managing	500	50%
Ongoing challenges and we are struggling to manage but we are totally committed to keeping our child in this family	361	36%
Many challenges – it is possible that our child will not remain in this family	34	3%
The adoption or special guardianship has broken down	2	0.2%
Other (please specify)	17	2%

Data source: N=1,008. Baseline survey

The rates are approximately the same for SGO and adoptive families.

Parents and carers completing the baseline questionnaire for this evaluation mostly reported never thinking of having their child removed (67%), although others reported thinking about this rarely (16%), sometimes (13%) or often (4%). The rates for SGO carers and adoptive parents were very similar.

Parental Self-Efficacy

In the baseline questionnaire, parents and carers were asked to score themselves against the Brief Parental Self-Efficacy Scale (BPSES) (Woolgar et al, 2013). This is a five-item scale measure of parental confidence in their ability to parent a child. There are no known national norms against which to compare the findings.

As illustrated in the table below, at baseline, parents and carers reported greater levels of confidence in relation to knowing that they can make an important difference to their child's life and lower levels of confidence in relation to being in fact able to do the things

to improve their child’s behaviour or knowing what to do in most situations to ensure their child behaves.

Table 16: Percentage (%) of parent responses to questions about their parenting in the Brief Parental Self Efficacy Scale by type of response

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Even though I may not always manage it, I know what I need to do with my child	1%	8%	13%	59%	19%
I am able to do the things that will improve my child's behaviour	1%	9%	26%	53%	11%
I can make an important difference to my child	1%	1%	8%	51%	39%
In most situations I know what I should do to ensure my child behaves	2%	10%	23%	53%	12%
The things I do make a difference to my child's behaviour	1%	6%	22%	53%	18%

Data source: N=1,008. Baseline survey

However, overall, the average (mean) total score (20.00 (SIQR=2) suggests that these parents and carers had a relatively high degree of confidence in their ability to parent their child (where the minimum total score is 5 and the maximum is 25).

Parent / carer emotional health and wellbeing and inter-couple relationships

Parents and carers completing the baseline questionnaire in relation to their experiences before ASF funded support commences had statistically significantly worse emotional health and wellbeing as measured by the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) compared with the whole (adult) population norms for England.

However, they had very similar levels of emotional health and wellbeing compared with parents and carers participating in the earlier ASF study, as illustrated in Table 17 below.

Table 17: Mean (average) SWEMWBS scores exploring adult emotional health and wellbeing across the current and earlier ASF study baseline cohorts and compared with adult population norms

	Parents and carers in the current baseline	Parents and carers in the earlier ASF study	Adult population norms for England
Mean (average) scores. Lower scores indicate lower wellbeing	20.94	21.06	23.60

Data sources: Baseline survey; earlier ASF (Tavistock Institute, 2017) study, and adult population norms for England (SWEMWBS, 2011). Note that lower scores indicate lower wellbeing.

The average (mean) scores for carers with a Special Guardianship Order (Mean=21.36, SD=3.17) and parents with an Adoption Order (Mean=20.91, SD=3.52) were very similar, as were those for parents and carers whose family had received an earlier package of support (Mean=20.94, SD=3.50) compared with those for whom this was a first package of ASF-funded support (Mean=20.93, SD=3.47).

In a stand-alone question about their primary adult relationship, 55% of adoptive parents and 44% of SGO carers agreed that having a child had caused more problems than they would have expected with a spouse or partner (where they had a spouse or partner). There are no known national norms against which to compare the responses to this question.

Table 18: Percentage (%) adoptive parents and SGO carers agreeing or disagreeing with the statement: 'Having a child has caused more problems than I would have expected in my relationship with my spouse or partner' in the baseline ASF survey

Extent of agreement with the statement	% adoptive parents	% SGO parents	% parents and carers overall
Strongly agreed	23%	9%	21%
Agreed	32%	35%	32%
Not sure	13%	7%	12%
Disagreed	22%	21%	22%
Strongly disagreed	11%	28%	12%

Data source: N=867. Baseline survey (parents with a spouse or partner)

What were the early experiences of parents and carers seeking help from the Adoption Support Fund?

How were families directed or signposted to the ASF?

Most parents and carers completing a baseline questionnaire during November 2018 to February 2020 (67%) had heard about the Adoption Support Fund from their local authority or regional adoption agency social worker. An even greater proportion of SGO carers had heard about the Fund from their social worker (74%). Others had heard about the Fund from a range of sources as outlined in Table 19 below:

Table 19: Source of parent or carer hearing about the ASF by proportion (%)

Source	% in the baseline cohort
Local Authority or Regional Adoption Agency social worker	67%
Adoption UK website or magazine	6%
Word of mouth e.g., from another parent or carer	6%
Voluntary Adoption Agency (VAA) social worker	5%
Social media	4%
Child's school	2%
Meeting arranged by the local authority or VAA	2%
School based worker	2%
CAMHS or other therapist	1%
From own work (it's in the nature of the work I do)	1%
Own research	1%
Other e.g., other websites, poster or leaflet, VAA newsletter	3%

Data source: N=1,007. Baseline survey

The Assessment of Child and Family Need(s)

Local authorities are required to undertake assessments of the need for and nature of adoption support at the request of a range of people including the (prospective) adopted child and their (prospective) adoptive parents²⁰. Any application to the Adoption Support

²⁰ Adoption Statutory Guidance that can be found here:
<https://www.gov.uk/government/publications/adoption-statutory-guidance-2013>

Fund must be supported by a recent assessment of support needs for the child and family in question. The baseline questionnaire asked parents and carers to 'rate' a series of statements about seeking and getting help including through an assessment of their needs.

A headline finding was that 76% agreed (50%) or strongly agreed (26%) that they were overall happy with the assessment. Only 7% disagreed or strongly disagreed with this statement.

However, in relation to this and other more detailed statements about assessments, a relatively large proportion of parents 'neither agreed nor disagreed' (between 12% and 27% per question). The comments made by parents and carers in the 'free text boxes' relating to these questions suggest that the reason for parents not having an opinion about this area of seeking help is that they did not know whether there had been an assessment or had not seen an assessment.

"I didn't see a copy of the needs assessment for the application so I can't answer many of the questions above, hence putting neither agree nor disagree" (adoptive parent)

Other mostly positive findings included that:

- 84% agreed or strongly agreed that their views and preferences had been taken into account in the assessment process.
- 76% agreed or strongly agreed that the assessment had accurately identified the needs of their child.
- 66% agreed or strongly agreed that the assessment had accurately identified the needs of the whole family.
- 61% agreed or strongly agreed that it had been easy to arrange an assessment.

"Having the assessment for the support fund changed our lives – we went from feeling like our family was falling apart and that we couldn't cope and we had to seriously consider putting our own children safety and needs first ... to feeling that we weren't on our own, we were going to get support for our SGO, that there was hope" (SGO carer)

Where parents or carers reported a positive or very positive experience of the assessment process, this was attributed mostly to a good connection or contact with an individual Post-Adoption Support (Social) Worker.

"We have had a very professional and supportive social worker who just 'gets' it with regard to our son and the challenges we face" (adoptive parent)

These findings represent an overall improvement compared with the same questions asked of adoptive parents seeking ASF help for the earlier ASF study, at which point only 74% were happy with the overall assessment, 73% thought it accurately identified the needs of their child, and 72% thought that their views and preferences had been taken into account. The difference in relation to family views and preferences being taken into account is statistically significant ($\chi^2(1) = .94, p < .001$).

Several parents or carers participating in this evaluation had experience of the Fund dating back to near or at its inception. Where they offered a perspective about the period since, most thought the assessment process had improved.

“I had previously tried to get an assessment several years ago and was told it would not be possible and that we wouldn’t qualify. I was very frustrated and therefore had to pursue a number of other avenues myself to try to get support for (X). I approached the local authority again last year after they had made some organisational changes and found them much more helpful” (adoptive parent)

However, 39% parents or carers participating in the current baseline survey thought that they had had to wait a long time for an assessment (agreed or strongly agreed with the statement ‘I had to wait a long time for the assessment’).

“It takes far too long. Our child has been extremely violent, to the point where I have feared for my safety. It is unacceptable to have to wait for months for support. Even if a full assessment has to take that long, there should be a facility to provide families with emergency help, with a much less detailed assessment, in cases such as ours” (adoptive parent)

“It was a struggle to get the SGO support worker to get appropriate costings to enable them to put forward to the ASF. This was a game of ping-pong... it should have taken place in one meeting all together... we could have saved months of time!” (SGO carer)

The earlier ASF study baseline questionnaire also asked adoptive parents questions about the timing between requesting and getting an assessment but not in exactly the same way. 41% respondents to the earlier study baseline questionnaire agreed with the statement ‘waiting for an assessment took too long’ compared with a slightly lower proportion (39%) of respondents to the current baseline survey agreeing with the statement ‘I had to wait a long time for the assessment’.

A less positive experience of the assessment process was associated with these delays in the process and with child or family problems getting worse during the waiting period. Some parents and carers attributed these delays to a lack of social workers being available in the organisations providing assessments and/or being ‘stuck between

organisations' where their child had been placed in a different local authority to the one from which they were adopted.

"We had to wait a long time and chase up. There were significant delays in allocating a post adoption support worker due to capacity issues within the local authority. We had to wait about a year and a half from initially requesting help to being allocated a social worker. Once we had a social worker, things moved quickly for which we are grateful" (adoptive parent)

"...as we adopted out of county, I was passed back and forth between the placing authority and my local authority as to who was responsible for completing the assessment for us, or even allocating a social worker" (adoptive parent)

Faced with delays or other perceived barriers to getting an assessment and getting support, some parents stated that they had paid themselves for an assessment (privately) or wished that they had done so.

Only just over a half (56%) of parents or carers completing the baseline questionnaire considered that the assessment had involved all the services and people who could contribute to an understanding of their needs²¹. Parents and carers who expressed a more negative response to this question often thought that the assessment had been 'too basic' or 'insufficiently holistic or specialist'.

Other aspects of seeking help through the Adoption Support Fund

Adoptive parents and carers of children with an SGO were mostly satisfied or very satisfied with other aspects of seeking and getting help through the ASF such as the choice or location of provider.

In relation to most aspects, the proportion of satisfied or very satisfied parents and carers was an improvement on that expressed by other parents and carers participating in the earlier ASF study. This was particularly so in relation to the choice and location of the provider and the number of sessions being offered to the family. However, satisfaction levels declined in relation to the time between assessment and receiving support.

Parent and carer satisfaction rates with these and other aspects of seeking and getting help through the ASF, for example the choice of provider and type of support offered to them, are explored in Table 19 below.

²¹ This question was not asked in the earlier Tavistock (2017) baseline questionnaire

It should be noted that this and the earlier ASF study baseline questionnaires were seeking the views of parents and carers before the funded support started, so their expressed views were in relation for example to the type of support in advance of it actually being experienced. A proportion of parents and carers said that they 'did not know yet' in relation to each question, reducing the overall number of responses in each case²².

Table 20: Percentage (%) of parents and carers expressing satisfaction with aspects of seeking and getting ASF support compared with those involved with the earlier (Tavistock, 2017) evaluation of earlier experiences of the Fund

Aspect of seeking and getting help through the ASF	% (and no.) satisfied or very satisfied in the baseline survey 2018-2020 ²³	% satisfied or very satisfied in the earlier ASF study baseline survey
Choice of provider	85%	79%
Type of support offered	84%	88%
Location of support offered	82%	77%
Number of sessions offered	80%	73%
Time between assessment and receiving support	60% ²⁴	72%

Data sources: Baseline survey from this study (N=574 to 766 depending on the item. Other survey participants did not have a view) and the earlier (Tavistock, 2017) study

SGO carer satisfaction rates for aspects of seeking and getting ASF support were mostly slightly lower, where they expressed a view. For example, SGO carers were satisfied or very satisfied with the choice of provider in 82% cases; as with the type of support offered (80%); location of support (78%) and number of sessions offered (72%). Slightly more SGO carers were satisfied or very satisfied with the time between assessment and receiving support (70%). These differences do not greatly affect the overall scores as

²² The proportion saying that they 'did not know yet' was between 6% (length of time between assessment and receiving the support), 7% (location of support), 11% (choice of provider), 12% (type of support) and 19% (overall number of sessions offered)

²³ These percentages excluding in each case a small proportion of parents or carers who 'did not know yet' (between 6% and 19% per question) with the largest (19%) in relation to the question about number of sessions

²⁴ It is important to note that the further comments of at least some of the parents reporting dissatisfaction with the time between assessment and receiving support suggests that they were referring in fact to the timescales for the whole process of seeking and getting help. This may also be the case in the earlier (Tavistock Institute, 2017) sample.

scores for adoptive parents (in the majority) are almost exactly the same as the overall ones.

Overall dissatisfaction with these key aspects of seeking and getting help was expressed by a very low proportion of parents or carers overall (between 3% and 6% per question). Most of the rest expressed an opinion that they were 'neither satisfied nor dissatisfied' (between 11% and 15% per question).

However, many parents who expressed satisfaction with these elements of getting help 'so far' also expressed a degree of relief that support was being put in place, sometimes that it was 'worth the wait'.

"The social worker took a while to find a compatible provider for our daughter, but it was worth the wait" (adoptive parent)

"It has been FABULOUS. Very supportive social worker and a therapist who is able to articulate our needs" (adoptive parent)

Some considered themselves lucky to have had a good choice of provider relatively local to them (mostly parents and carers living in more urban areas).

".. we are lucky to live in London where so many great providers are located. Also, our social worker is very helpful and proactive" (SGO carer)

Others described being willing to travel relatively long distances to obtain good quality support, although they acknowledged that this could take its toll on both children and parents / carers over time.

"I applied for a provider who was based in (place in the North East), I am based in London. It was my choice so that my little one received a comprehensive therapeutic assessment, which would provide the best course of therapy for him" (parent)

The main exception to this generally improving view of access to ASF-funded support was the length of time between assessment and receiving support.

"After many months, we have only just received confirmation of funding (in November) and have yet to start the therapy... We will struggle to complete it by the end of the financial year and risk the money being returned rather than being able to continue into the new financial year. This is very stressful for us!" (adoptive parent)

Other concerns mentioned by some parents or carers included:

- That the support they needed was located too far away and that this made it less sustainable than more locally accessed help (more likely for families in rural locations).
 - “It’s an hour and twenty minutes away and will mean my daughter after will miss a full day of school each week” (adoptive parent)
 - “I have a 90-mile round trip and it takes 3 hours off my daughter’s school day to go to therapy” (adoptive parent)
- That there would not be sufficient sessions to meet their child’s needs, in recognition of the need for the child to first establish a trusting relationship with the therapist.
 - “It’s very difficult when the sessions run out and your child is just starting to make progress” (adoptive parent)
- That the advice they had received (about which provider to select) had not been sufficiently robust.
 - “It was extremely disconcerting to be given a very long list of possible providers that we then had to research online and make a decision on who to select when we have very little knowledge or experience of support” (adoptive parent)
- That the therapy had to or might have to stop at short notice (because of a need to re-apply again in a new financial year).
 - “Our child had to wait a very long, uncertain period of time between one block of therapy and the next. This caused a huge set back in his confidence and security” (parent)
- Difficulties in accessing appropriate time ‘slots’ for their child(ren)’s therapy, particularly where more than one child was involved.

What did families anticipate receiving by way of funded support to meet key aims?

Parents and carers were asked in the baseline survey what they thought they were getting by way of ASF funded support (and its main aim) in order to commence an exploration of the impact of specific interventions on outcomes for children and young people.

Most parents and carers thought the main aim of the ASF funded support was to improve the child’s emotional health and wellbeing (60%) or family life and relationships (13%), or to help their child to develop more positive behaviours (11%). All parent and carer responses to a question about the main aim are set out in Table 21 below:

Table 21: Percentage (%) parents and carers by their stated main aim of ²⁵ ASF support

Main aim of the ASF support	% parents / carers selecting this as the main aim
To improve my child's emotional health and wellbeing	60%
To improve our family life and relationships	13%
To help my child to develop more positive behaviours	11%
To help me / us to develop skills in therapeutic parenting	7%
To improve my child's engagement with learning	3%
To help our family bond together	3%
To address child to parent violence	2%
To help my child to understand sexual boundaries and behaviours	0.5%

Data source: N=1,008. Baseline survey

SGO parents responded in a slightly different way to adoptive parents with a greater proportion suggesting that the main aim of the ASF support was to improve their child's emotional health and wellbeing (64%) and no parents suggesting that it was to help them to develop skills in therapeutic parenting or to address child to parent violence²⁶.

Evaluators anticipated that parents and carers completing the baseline questionnaire might not know exactly the nature of the funded support they or their child would be receiving around the time funding approvals have been made. However, in fact, for the purposes of the baseline questionnaire, parents and carers were prepared to suggest categories of funded support that they thought they were going to receive. Some parents and carers thought that they would be receiving more than one type of funded support.

The most commonly selected categories were: a creative or physical therapy involving the child only (35%); psychotherapy or another talking therapy for the child (32%); a

²⁵ It is possible that, for some parents / carers and families, there were more than one aim, but they were asked to identify only a single main aim.

²⁶ Other scores were very similar to the overall cohort

family therapy (30%); a creative therapy involving the child and parent (27%) or parent training courses (23%)²⁷.

Table 22: Percentage (%) parents and carers who anticipate receiving different types (categories) of ASF funded support

Category of funded ASF support	% (and no.) of parents / carers who anticipate receiving this support
A creative or physical therapy involving the child only , for example: Play, Art, Music or Drama Therapy	35%
Psychotherapy or another talking therapy for the child only , for example: Cognitive Behavioural Therapy, Eye Movement Desensitisation and Reprocessing, or Sensory Integration Processing Therapy	32%
A family therapy , for example: Dyadic Developmental Practice, Systemic Family Therapy or Multi-Systemic Therapy	30%
A creative therapy involving the child and a parent / carer , for example: Theraplay, Play Therapy, or Parent/Child Attachment Play	27%
A parent training course , for example: 'Building Attachments', 'Nurturing Attachments', 'Non-Violent Resistance' or 'Enhancing Adoptive Parenting'	23%
Therapeutic life story work	13%
A therapeutic short break	5%

²⁷ The range and proportion of supports anticipated by SGO carers were very similar to the overall cohort.

3. Conclusion and Next Steps for the Survey

This analysis of baseline family survey responses provides a rich source of information about the nature of children and families receiving ASF-funded support between November 2018 and February 2020 and their presenting needs. There are also some very interesting findings relating to a comparison of reported and 'scored' child strengths and difficulties in this current cohort compared with another of children and families accessing the Fund in the earliest stages of its development (in 2015-2016).

Evaluators anticipate, for a sizeable proportion of this current cohort recruited into the study in November 2018 to February 2020, being able to compare the difficulty levels experienced by children and families before receiving funded support with those that they are experiencing at the end of funded support and 6 months thereafter. These findings will form the content of the two planned subsequent reports.

Appendix 1: Standardised Measures Analysis: Technical Document

Introduction

The following standardised measures were included in the baseline ASF family survey:

- Relating to child behaviour and emotional health and wellbeing: The Child Behaviour Checklist (CBCL) (Achenbach, 2000) and the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 2001) – both parent / carer reports.
- Relating to the emotional health and wellbeing of parents and carers, the parent / carer-report Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS) (Collins et al, 2012).
- For parent-reported efficacy in relation to parenting: The Brief Parental Self Efficacy Scale (Woolgar et al, 2013).

Data from each of the 1,008 completed baseline questionnaires was analysed using IBM SPSS v26 and Microsoft Excel was used to produce figures and tables.

After the preparation and cleaning of the data, the five validated scales (CBCL for children aged 1 ½ to 5 years, CBCL for children aged 6 to 18 years, SDQ, BPES, SWEMWBS) were computed in line with the requirements made by the scale developers. Where there were missing values (in only 4/1008 cases), these were excluded from the calculation of total scores of the scale.

Significance tests were used to identify differences between variables. Assumptions for significance tests were met and, for cases that did not meet the assumptions for parametric tests, non-parametric alternatives were used. Only where the sample size per group was large enough to justify parametric tests were parametric results reported. A significance level of 5% was used and tested two-sided if not stated otherwise. Effect sizes are reported in addition to significance test results to make judgements about the magnitude of an effect.

Identifying norms against which the population of children in our survey may be compared

British means and standard deviations for the SDQ were obtained from a large national survey of child and adolescent mental health carried out by the Office for National Statistics and funded by the Department of Health (Melzer et al 2000). This representative British sample included 10,438 individuals aged between five and fifteen. Complete SDQ information was obtained from 10,298 parents (99% of sample and 4,228 eleven to fifteen-year-olds (93% of this age band)).

CBCL 1 ½-5 years and CBCL 6-18 years norms were obtained from representative samples drawn from the 1999 US National survey of children. 700 non-referred children provided norms for the CBCL 1 ½ - 5 years sample and 4994 children, including some with relatively high problem scores and referred or not referred to mental health or other specialist services, provided norms for the CBCL 6-18 years sample.

Norms for the CBCLs are not available for the UK population and it is not clear whether societal differences would affect CBCL scores. There is some evidence from the published literature that culture differences may influence CBCL scores. Crijnen et al (1999) compared CBCL syndromes for 11,887 children from Australia, Belgium, China, Germany, Greece, Israel, Jamaica, the Netherlands, Puerto Rico, Sweden, Thailand and the United States. Medium effects for culture were found for two syndromes, while small effects were found for the other six syndromes. Across cultures, girls had higher scores for Somatic Complaints and Anxious/Depressed, while boys had higher scores for Attention Problems and Aggressive Behaviour. Crijnen et al (1997) also compared CBCL Internalising, Externalising and Total Problems scores in general child and young person population samples across 12 cultures. The lowest problem scores were reported for Sweden and the highest scores were reported for Puerto Rico²⁸. Different cutpoints on the CBCL problem scales can also make a difference. For example, Biederman (2001) found that T scores >65 on CBCL Aggressive Behaviour were better than other cutpoints for predicting persisting versus remitting conduct disorders in boys with ADHD.

It is also possible that there may have been changes in average problem scores in the US over time (since the National Survey in 1999). Achenbach and Howell (1993) had already found that CBCL problem scores were higher in 1989 general population sample compared with an earlier 1976 general population sample. However, by contrast, Verhulst et al (1997) did not find as many significant changes in CBCL scores in general population samples of Dutch children from 1983 to 1993.

While CBCL norms are not available for the UK population, SDQ norms are available for the USA population. From the literature, it is known that some aspects of CBCL DSM Oriented scales are strongly correlated with US SDQ scales (Goodman 2001; Kovacs 2014). When compared, UK SDQ norms are similar to US SDQ norms and this suggests that any disparity between US CBCL norms and UK norms may not be substantial.

²⁸ However, the difference in scores might have reflected differences in sampling methods. In Puerto Rico, an Island-wide sample was assessed with completion rate of 96%. In Sweden, a school-based sample was assessed in two relatively affluent areas with a response rate of 83%.

Key findings about child problems from the Child Behaviour Checklist (CBCL)

CBCL key findings in the child age category 1 ½ to 5 years

The CBCL questionnaire for children aged 1 ½ to 5 years used in this evaluation obtained caregiver ratings of the child in relation to 99 “problem items”. Items were scored on the following syndrome scales: Emotionally Reactive, Anxious/Depressed, Somatic Complaints (physiological symptoms frequently associated with internalising behaviours like anxiety and depression), Withdrawn, Attention Problems, Aggressive Behaviour, and Sleep Problems. Items were also scored on the following DSM-Oriented scales made of items that a panel of experts picked as matching parts of the diagnostic criteria for DSM-IV (Achenbach & Rescorla 2001). Depressive Problems, Anxiety Problems, Attention Deficit/Hyperactivity (ADH) Problems, Autism Spectrum (AS) Problems, and Oppositional Defiant Problems. Parents/carers completing the questionnaire rated their child's behaviour on a 3-point scale (*not true, somewhat or sometimes true, and very true or often true*), and were instructed to rate the behaviour ‘as it occurs now or within the previous two months’.

The main scoring for the CBCL 1 ½-5 is based on statistical groupings of sets of behaviours that typically occur together. There are two "broad band" scales that combine several of the syndrome scales: *Internalizing problems* (problems that are mainly within the self, for example anxiety) sums the Anxious/depressed, Withdrawn-depressed, and Somatic complaints scores; *Externalizing problems* (conflicts with other people and their expectations for children's behaviour) combines Rule-breaking and Aggressive Behaviour scores. There also is a *Total Problems* score, which is the sum of the scores of all the problem items (the CBCL has a few items that only contribute to the *Total Problems score*: these were considered clinically important even though too rare to include in the individual syndrome scales).

The CBCL 1 ½ -5 also uses a normative sample to create standard scores. These compare the raw scores with what would be typical compared to responses for US children of the same gender and similar age. The standard scores are scaled so that 50 is average for the child's age and gender, with a standard deviation of 10 points. Higher scores indicate greater problems.

Each of the Syndrome, Internalizing and Externalizing, and Total Scores can be interpreted as falling in the *normal, borderline, or clinical* ranges. T scores from 65 (93rd percentile) to 69 (97th percentile) are considered to be in the borderline clinical range because they are high enough to cause concern whereas those of 70 and above are considered to be in the clinical range (98th percentile). Scores in the borderline and clinical ranges clearly delineate between children who are typically referred to mental

health or special education services for behavioural/emotional problems and demographically similar children who are not typically referred.

The most accurate cut points for Internalising, Externalising and Total Problems to discriminate between referred and non-referred children are at about the 80th and 84th percentiles of normative samples i.e., borderline clinical range T scores of 60 through 63; T≥64 for the clinical range. The reason for the measure developers choosing the lower cut points for these scales is that they encompass more numerous and diverse problems than on the syndrome scales.

CBCL1 ½ - 5 “Broad band” and Total Problems Scales

All CBCL 1 ½ - 5 “broadband scale” values were highly statistically different to US normative sample values. In addition, the effect sizes for the differences were large. Internalising, Externalising and Total Problems scores were all over one standard deviation from the mean of the US normative population.

The following table summarises the average (mean) scores and their spread (standard deviation) for the CBCL 1 ½ - 5 “broadband and total problem scales”.

Table 23: Summary statistics for the baseline CBCL scales of children aged 1 1/2 to 5 year by Internalising, Externalising and Total Problems and compared with a US normative sample

CBCL1 ½ - 5 Internalising, Externalising and Total Problems Scales	CBCL Survey Sample (children aged 1 ½ to 5 years) N=127		CBCL US normative sample (children aged 1.5 to 7 years) N=700		Difference (SD units)
	Mean	SD	Mean	SD	
Internalising Problems	18.0	11.7	8.6	6.2	1.5
Externalising Problems	24.6	10.5	12.9	7.7	1.5
Total Problems	65.1	32.6	33.3	18.7	1.7

The following three tables and stacked bar charts summarise the T score categories for each syndrome, “broad band” scales and DSM Oriented scales interpreted as falling in the *normal*, *borderline*, or *clinical* behaviour ranges.

CBCL 1 ½ - 5 Syndrome scales: T score categories

On the CBCL 1 ½ - 5 years syndrome scales, about a quarter of the children in the sample were reported to be in the Borderline Clinical and Clinical categories for Anxious/Depressed problems (24%), Somatic Complaints (20%) and Sleep Problems (22%). One third of the children were reported to be in the Borderline and Clinical categories for Withdrawn Behaviour (33%). Almost a half of the sample were reported to be in the Borderline and Clinical categories for Aggressive Behaviour (48%). The highest proportion of children in the sample reported to be in the Borderline Clinical and Clinical categories was for Emotionally Reactive problems (62%).

Table 24: CBCL baseline T score categories for children aged 1 1/2 to 5 years by syndrome scale and range (normal, borderline clinical and clinical)

CBCL 1 ½ – 5 Syndrome scale	n	Normal (0≤T≤64) n (%)	Borderline (65≤T≤69) n (%)	Clinical (70≤T≤100) n (%)
Emotionally Reactive	127	49 (38)	34 (26)	44 (36)
Anxious / Depressed	127	97 (76)	18 (14)	12 (10)
Somatic Complaints	127	102 (80)	14 (11)	11 (9)
Withdrawn	127	85 (67)	10 (8)	32 (25)
Sleep Problems	127	99 (78)	5 (4)	23 (18)
Attention Problems	127	69 (54)	14 (11)	44 (35)
Aggressive Behaviour	127	66 (52)	23 (18)	38 (30)

Table 25: CBCL baseline T scores for children aged 1 1/2 to 5 years by internalising, externalising and total problems and range (normal, borderline or clinical)

CBCL 1 ½ - 5 Internalising, Externalising and Total Problems	n	Normal (0≤T≤59) n (%)	Borderline (60≤T≤63) n (%)	Clinical (64≤T≤100) n (%)
Internalising Problems	127	53 (42)	15 (12)	59 (46)
Externalising Problems	127	19 (15)	12 (9)	96 (76)
Total Problems	127	25 (20)	8 (6)	94 (74)

CBCL (1 ½-5 years) DSM-Oriented Scales T score categories

On the CBCL 1 ½-5 years DSM-Oriented Scales, just over one half of children in the sample were in the Borderline and Clinical categories for Depressive Problems (55%), Anxiety Problems (52%) and Oppositional Defiant Problems (53%). About two thirds of children in the sample were in the Borderline and Clinical categories for Autistic Spectrum (64%) and Attention Deficit Hyperactivity Problems (65%).

It is important to note that a particular score on a DSM Oriented scale is not directly equivalent to a clinical diagnosis which would normally involve a range of other information (for example about age of onset or duration of problems) and / or observations. Additionally, the items on the DSM Oriented scales do not correspond precisely to DSM criteria for a diagnosis.

Table 26: CBCL baseline T scores for children aged 1 1/2 to 5 years by DSM Oriented Scales and range (normal, borderline or clinical)

CBCL 1 ½-5 DSM Oriented Scales	n	Normal (0≤T≤64) n (%)	Borderline (65≤T≤69) n (%)	Clinical (70≤T≤100) n (%)
Depressive problems	127	57 (45)	25 (20)	45 (35)
Anxiety problems	127	61 (48)	19 (15)	47 (37)
Autistic spectrum problems	127	46 (36)	33 (26)	48 (38)
ADH problems	127	45 (35)	30 (24)	52 (41)
Oppositional defiant problems	127	59 (47)	8 (6)	60 (47)

CBCL findings in the child age category 6 to 18 years

The CBCL 6–18 is a 118-item parent report measure designed to assess behavioural and emotional problems in children and young people aged 6–18 years. This measure includes items and subscales aimed at assessing symptoms of anxiety, depression, somatic complaints, social problems, thought problems, attention problems, rule-breaking behaviour and aggressive behaviour. These subscales can be grouped into two higher-order factors (“Broadband” scales) *Internalising* and *Externalising* behaviours. By summing up all the problem items, a *Total Problems* score can also be computed.

The norm referenced CBCL 6-18 is completed by parents and caregivers, and it describes a child's functioning during the previous six months. The items measure specific emotional and behavioural problems on a three-point Likert scale (0= "Not True," 1= "Somewhat or Sometimes True," or 2= "Very True or Often True").

Raw scores for each scale are converted to norm-referenced *T*-scores (Mean = 50, SD = 10). ASEBA assigned normalised *T* scores to the raw scores of a CBCL scale according to the percentiles found for the raw scores in the normative sample, separately for each gender at ages 6-11 and 12-18. *T* scores from 65 (93rd percentile) to 69 (97th percentile) are considered to be in the borderline clinical range because they are high enough to cause concern but not high enough to place the children in the clinical range ($T \leq 70$ 98th percentile). Scores in the borderline and clinical ranges clearly delineate between children who are referred to mental health or special education services for behavioural/emotional problems and demographically similar children who have not been referred.

The most accurate cut points for Internalising, Externalising and Total Problems to discriminate between referred and non-referred children are at about the 80th and 84th percentiles of normative samples i.e., borderline clinical range *T* scores of 60 through 63; $T \geq 64$ for the clinical range. The reason for developers choosing the lower cut points for these scales is that they encompass more numerous and diverse problems than on the syndrome scales.

The following sections and 12 tables summarise the average (mean) scores and their spread (standard deviation) for the CBCL 6 to 18 years' syndrome scales, "broadband" scales and DSM Oriented scales calculated in relation to children aged 6 to 18 years whose parents or carers completed a baseline questionnaire for this evaluation. In each case, these are compared with a US normative sample. They are broken down in each case by sub-age categories i.e., 6-11 years and 12-18 years, and by gender.

CBCL 6 to 18 years: Syndrome scales

All survey CBCL 6-18 syndrome scale, broadband scale and DSM oriented scale values are highly statistically different to US normative sample values. In addition, the effect sizes for the differences were large. Apart from Somatic Complaints, all syndrome scales are about two standard deviations from the mean of the US normative population across genders and age ranges. Thought problems are about three standard deviations from the mean of the US normative population across genders and age ranges.

Table 27: Summary statistics for the baseline survey CBCL scales for boys aged 6 to 11 years - by syndrome scale and compared with a US normative sample

Syndrome Scale	CBCL (6-18) survey sample: boys aged 6-11 years (n=279)		CBCL (6-18) US normative sample for boys aged 6-11 years (n=1651)		Difference (SD units)
	Mean	SD	Mean	SD	
Anxious / Depressed	9.9	5.7	2.8	2.7	2.6
Withdrawn / Depressed	4.3	2.5	1.1	1.6	2.0
Somatic Complaints	3.3	3.3	1.1	1.7	1.3
Social Problems	7.2	3.8	2.4	2.6	1.9
Thought Problems	7.4	5.0	1.8	2.0	2.8
Attention Problems	11.1	4.3	3.8	3.4	2.2
Rule Breaking Behaviour	5.8	4.0	1.9	2.1	1.9
Aggressive Behaviour	17.0	8.2	4.7	4.3	2.9

Table 28: Summary statistics for the baseline survey CBCL scales for boys aged 12-18 years - by syndrome scale and compared with a US normative sample

	CBCL 6-18 survey sample: Boys 12-18 years (n=163)		CBCL6-18 US normative sample: Boys 12-18 years (n=1447)		
Syndrome Scale	Mean	SD	Mean	SD	Difference (SD units)
Anxious / Depressed	9.5	5.6	2.6	2.7	2.6
Withdrawn / Depressed	6.1	3.4	1.9	2.2	1.9
Somatic Complaints	3.6	3.7	1.1	1.8	1.4
Social Problems	7.6	4.1	1.8	2.3	2.5
Thought Problems	6.9	5.0	1.6	1.9	2.8
Attention Problems	11.3	4.2	4.0	3.7	2.0
Rule Breaking Behaviour	8.8	5.7	2.8	3.4	1.8
Aggressive Behaviour	16.6	8.5	4.7	4.8	2.5

**Table 29: Summary statistics for the baseline CBCL scale for girls aged 6-11 years
- by syndrome scale and compared with a US normative sample**

Syndrome Scale	CBCL 6-18 survey sample: Girls 6-11 years (n=233)		CBCL6-18 US normative sample: Girls 6-11 years (n=870)		Difference (SD units)
	Mean	SD	Mean	SD	
Anxious / Depressed	9.8	5.9	3.2	2.9	2.3
Withdrawn / Depressed	4.3	2.8	1.4	1.7	1.7
Somatic Complaints	4.1	3.5	1.3	1.7	1.7
Social Problems	7.5	4.1	2.6	2.6	1.9
Thought Problems	6.5	4.8	1.7	1.8	2.7
Attention Problems	10.3	4.8	3.2	3.1	2.3
Rule Breaking Behaviour	4.9	3.5	1.6	1.8	1.8
Aggressive Behaviour	15.1	7.8	4.5	4.3	2.5

Table 30: Summary statistics for the baseline CBCL scales for girls aged 12-18 years - by syndrome scale and compared with a US normative sample

Syndrome Scale	CBCL 6-18 survey sample: Girls 12-18 years (n=231)		CBCL6-18 US normative sample: Girls 12-18 years (n=1026)		Difference (SD units)
	Mean	SD	Mean	SD	
Anxious / Depressed	10.7	5.9	3.2	3.1	2.4
Withdrawn / Depressed	6.1	3.4	1.9	2.1	2.0
Somatic Complaints	4.8	3.9	1.4	1.9	1.8
Social Problems	7.3	4.3	1.8	2.3	2.4
Thought Problems	6.7	4.6	1.4	1.7	3.1
Attention Problems	9.5	4.6	2.7	3.1	2.2
Rule Breaking Behaviour	7.2	5.8	2.2	3.0	1.7
Aggressive Behaviour	14.5	8.6	4.4	4.7	2.2

CBCL 6-18 “Broadband” scales

Internalising and Externalising Problems for children in the sample were all over two standard deviation from the mean of the US normative population across genders and age ranges. Total Problems were about three standard deviation from the mean of the US normative population across genders and age ranges.

Table 31: Summary statistics for the baseline CBCL scales for boys aged 6 to 11 years - by Internalising, Externalising and Total Problem scores and compared with a US normative sample

	CBCL 6-18 survey sample: Boys 6-11 years (n=279)		CBCL6-18 US normative sample: Boys 6-11 years (n=1651)		
CBCL 6-18 Internalising, Externalising and Total Problems Scales	Mean	SD	Mean	SD	Difference (SD units)
Internalising Problems	17.6	9.7	5.1	4.8	2.6
Externalising Problems	22.9	11.5	6.6	6.0	2.7
Total Problems score	74.0	31.0	23.4	16.9	3.0

Table 32: Summary statistics for the baseline CBCL scales for boys aged 12 to 18 years - by internalising, externalising and total problem scores and compared with a US normative sample

	CBCL 6-18 survey sample: Boys 12-18 years (n=279)		CBCL6-18 US normative sample: Boys 12-18 years (n=1447)		
CBCL 6-18 Internalising, Externalising and Total Problems Scales	Mean	SD	Mean	SD	Difference (SD units)
Internalising Problems	19.16	10.8	5.6	5.3	2.6
Externalising Problems	25.4	13.0	7.5	7.5	2.4
Total Problems score	77.9	32.7	23.7	19.0	2.9

Table 33: Summary statistics for the baseline CBCL scales for girls aged 6 to 11 years - by internalising, externalising and total problem scores and compared with a US normative sample

CBCL 6-18 Internalising, Externalising and Total Problems Scales	CBCL 6-18 survey sample: Girls 6-11 years (n=233)		CBCL6-18 US normative sample: Girls 6-11 years (n=870)		Difference (SD units)
	Mean	SD	Mean	SD	
Internalising Problems	18.2	10.3	6.0	5.0	2.4
Externalising Problems	20.0	10.6	6.1	5.6	2.5
Total Problems score	70.2	31.7	22.9	16.6	2.9

Table 34: Summary statistics for the baseline CBCL scales for girls aged 12 to 18 years - by internalising, externalising and total problem scores and compared with a US normative sample

CBCL 6-18 Internalising, Externalising and Total Problems Scales	CBCL 6-18 survey sample: Girls 12-18 years (n=194)		CBCL6-18 US normative sample: Girls 12-18` years (n=1026)		Difference (SD units)
	Mean	SD	Mean	SD	
Internalising Problems	22.2	10.7	6.5	5.7	2.8
Externalising Problems	22.1	13.8	6.6	7.0	2.2
Total Problems score	74.6	34.4	22.0	18.2	2.9

CBCL 6-18 DSM Oriented Scales

Apart from Somatic Complaints (one standard deviation) all DSM Orientated scales are two (Attention Deficit Hyperactivity Problems and Oppositional Defiant Problems), three standard deviations (Depressive Problems and Conduct Problems) and four standard deviations (Anxiety Problems) from the mean of the US normative population.

Table 35: Summary statistics for the baseline DSM Orientated Scales for boys aged 6 to 11 years and compared with a US normative sample

CBCL6-18 DSM Oriented Scale	CBCL 6-18 survey sample: Boys 6-11 years (n=279)		CBCL6-18 US normative sample: Boys 6-11 years (n=1651)		Difference (SD units)
	Mean	SD	Mean	SD	
Depressive problems	6.3	4.2	1.4	1.9	2.6
Anxiety problems	7.9	4.4	1.4	1.5	4.3
Somatic Problems	1.9	2.3	.7	1.3	.9
ADH problems	9.1	3.6	3.7	2.9	1.9
Oppositional defiant problems	6.3	2.5	2.4	2.0	2.0
Conduct Problems	9.7	6.2	1.9	2.5	3.1

Table 36: Summary statistics for the baseline DSM Orientated Scales for boys aged 12 to 18 years and compared with a US normative sample

CBCL6-18 DSM Oriented Scale	CBCL 6-18 survey sample: Boys 12-18 years (n=163)		CBCL6-18 US normative sample: Boys 12-18 years (n=1651)		Difference (SD units)
	Mean	SD	Mean	SD	
Depressive problems	7.7	4.4	1.6	1.2	5.1
Anxiety problems	7.0	4.6	1.2	1.5	3.9
Somatic Problems	2.1	2.6	.8	1.4	.9
ADH problems	8.7	12.2	3.2	2.9	1.9
Oppositional defiant problems	6.3	2.6	2.4	2.2	1.8
Conduct Problems	11.8	7.0	2.4	3.4	2.8

Table 37: Baseline CBCL syndrome scales for girls aged 6 to 11 years - by diagnosis type and compared with a US normative sample

CBCL6-18 DSM Oriented Scale	CBCL 6-18 survey sample: Girls 6-11 years (n=194)		CBCL6-18 US normative sample: Girls 6-11 years (n=1651)		Difference (SD units)
	Mean	SD	Mean	SD	
Depressive problems	6.5	4.3	1.4	1.9	2.7
Anxiety problems	7.7	4.3	1.7	1.6	3.8
Somatic Problems	2.6	2.6	.8	1.3	1.4
ADH problems	8.2	2.6	3.0	2.7	1.9
Oppositional defiant problems	5.8	2.6	2.2	1.9	1.9
Conduct Problems	7.6	5.6	1.4	1.9	3.3

Table 38: Summary statistics for the baseline DSM Orientated Scales for girls aged 12 to 18 years and compared with a US normative sample

CBCL6-18 DSM Oriented Scale	CBCL 6-18 survey sample: Girls 12-18 years (n=194)		CBCL6-18 US normative sample: Girls 12-18 years (n=1651)		Difference (SD units)
	Mean	SD	Mean	SD	
Depressive problems	8.9	4.9	1.9	2.4	2.9
Anxiety problems	7.9	4.5	1.4	1.6	4.1
Somatic Problems	2.9	2.8	1.0	1.4	1.4
ADH problems	7.0	4.0	2.3	2.5	1.9
Oppositional defiant problems	5.6	3.0	2.2	2.0	1.7
Conduct Problems	9.6	7.2	1.8	2.9	2.7

The following three tables and stacked bar charts summarise the T scores for each syndrome, “Broadband” scales and DSM oriented scales interpreted as falling in the *normal*, *borderline*, or *clinical* behaviour in relation to children in the baseline cohort aged 6 to 18 years. Overall, on the CBCL 6-18 scales, the survey sample had a high proportion of children considered to be in the borderline or clinical categories.

CBCL 6-18 Syndrome Scales T scores

For the CBCL 6-18 Syndrome scales, about three quarters of the children were reported to have borderline or clinical Aggressive Behavioural Problems and Anxious/Depressed problems (74%), Thought Problems (73%) and Attention Problems (73%) in the borderline or clinical range. About two thirds of the sample was reported to have social problems (65%) in the borderline or clinical range. Over half the sample was reported to have Withdrawn/Depressed problems (53%) and Rule Breaking Behaviour Problems (58%) in the borderline or clinical range. Just under a half (46%) of the children were reported to have Somatic Complaints in the borderline or clinical range.

Table 39: CBCL 6-18 baseline T scores categories for children aged 6-18 years by normal, borderline clinical and clinical range and syndrome scale

CBCL 6-18 Syndrome scales	n	Normal (0≤T≤64) n (%)	Borderline (65≤T≤69) n (%)	Clinical (70≤T≤100) n (%)
Anxious / Depressed	877	224 (26)	152 (17)	501 (57)
Withdrawn / Depressed	877	409 (47)	273 (31)	195 (22)
Somatic Complaints	877	475 (54)	168 (19)	234 (27)
Social Problems	877	306 (35)	247 (28)	324 (37)
Thought Problems	877	237 (27)	155 (18)	485 (55)
Attention Problems	877	233 (27)	235 (27)	409 (46)
Rule Breaking Behaviour	877	368 (42)	127 (14)	382 (44)
Aggressive Behaviour	877	221 (25)	150 (17)	506 (58)

CBCL 6-18 “Broadband” scales T scores

On the broadband scales, 86% of the sample was reported to have Internalising problems and 81% Externalising problems in the borderline or clinical range. 90% of the sample had Total Problems in the in the borderline or clinical range (most of these i.e., 84% were in the clinical range).

Table 40: CBCL baseline T scores categories for children aged 6 to 18 years by Internalising, Externalising and Total Problems and by range (normal, borderline, clinical)

CBCL 6-18 Internalising, Externalising and Total Problems scale	n	Normal (0≤T≤59) n (%)	Borderline (60≤T≤63) n (%)	Clinical (64≤T≤100) n (%)
Internalising Problems	877	123 (14)	64 (7)	690 (79)
Externalising Problems	877	166 (19)	104 (12)	607 (69)
Total Problems	877	84 (10)	58 (6)	735 (84)

CBCL 6-18 DSM-Oriented Scales T scores

On the CBCL 6-18 DSM-Oriented scales, about three quarters (71%) of the children in the sample were reported to have Depressive Problems in the borderline or clinical range. About two thirds of the sample was reported to have Anxiety Problems (65%) and Conduct Problems (66%) in the borderline or clinical range. More than half of the sample were reported to have Attention Deficit Hyperactivity Problems (59%) and Oppositional Defiant Problems (58%) in the borderline or clinical range. About a third of the sample was reported to have Somatic Complaints (38%) in the borderline or clinical range.

Table 41: CBCL baseline T scores categories for children aged 6 to 18 years by DSM Oriented Scale and range (normal, borderline, clinical)

CBCL 6-18 DSM Oriented scale	n	Normal (0≤T≤64) n (%)	Borderline (65≤T≤69) n (%)	Clinical (70≤T≤100) n (%)
Depressive Problems	877	255 (29)	251 (29)	371 (42)
Anxiety Problems	877	311 (35)	76 (9)	490 (56)
Somatic Problems	877	547 (62)	89 (10)	241 (28)
Attention Deficit / Hyperactivity Problems	877	357 (41)	150 (17)	370 (42)
Oppositional defiant Problems	877	364 (42)	88 (10)	425 (48)
Conduct Problems	877	295 (34)	99 (11)	483 (55)

Reported self-harm

One third (33%) of the sample of 6–18-year-olds were reported by their parents or carers to have sometimes or often deliberately self-harmed or attempted suicide.

Table 42: CBCL 6-18 years Parent Reported Frequency of child deliberately self-harming or attempting suicide (Question 18)

Child deliberately harms self or attempts suicide	Absolute Frequency	Relative Frequency (%)
Not True (as far as you know)	587	67
Somewhat or Sometimes True	222	25
Very True or Often True	68	8
Total	877	100

The rate was slightly higher for girls (37%) compared with boys (30%), as outlined in Table 43 below.

Table 43: CBCL 6-18 years number and % of parent or carer reports of their child deliberately harming themselves or attempting suicide by gender (Question 18)

	Not True (as far as you know)	Somewhat or Sometimes True	Very True or Often True	Total
Female	274 (63%)	116 (27%)	42 (10%)	432 (100%)
Male	313 (70%)	106 (24%)	26 (6%)	445 (100%)

Combined Core SDQ and CBCL findings

As the subscales of each instrument differ in number, content and how they are measured, direct comparisons of subscale scores are difficult. However, Kovacs and Sharp (2014) identified similar problems measured by the SDQ and CBCL (both map to DSM criteria). The most similar subscales of the SDQ and CBCL are those that measure the sum of scores for each instrument: Total Problems and Total Difficulties. It is possible to group together the SDQ Emotional Problems scale and the CBCL 11-18 DSM Oriented scales Affective Problems and Anxiety Problems. Furthermore, the SDQ Conduct Problems are like the CBCL 6-18's Conduct Problems and Oppositional Defiant Problems. Finally, the SDQ Hyperactivity scale is comparable to the CBCL's Attention Hyperactivity Deficit Problems scale.

The following table lists the summary statistics for similar items of the SDQ for children aged 5-15 years and CBCL for children aged 6-18 years compared with related normative samples. What is clear from this data is that the school-aged children in the baseline survey sample had elevated levels of emotional distress, conduct problems and hyperactivity/ADH problems and total problems/difficulties as measured by the SDQ and CBCL, compared with both British and US normative samples. Not only were these differences statistically significant they were also very large. Apart from Hyperactivity, all SDQ mean scores were more than one standard deviation from the mean of the British normative population. The differences between survey sample scores and US normative sample are even more marked for the CBCL 6-18. ADH and Oppositional Defiant Disorder Problems are about two standard deviations from the US normative population mean. Conduct Problems, Emotional Problems and Total Problems are about three standard deviations from the US normative population mean. Anxiety Problems are about an extremely large four standard deviations from the US normative population mean.

Table 44: Summary statistics for the SDQ and CBCL 6-18 compared with values from the British and US normative samples

SDQ subscale 5 - 15-year-olds	Survey Mean (SD)	SDQ Problem scale scores for British normative sample Mean (SD)	SDQ Difference (SD units)	CBCL 6 - 18 subscale	Survey Mean (SD)	Problem scale scores for US normative sample pooled Mean (SD)	CBCL 6-18 Difference (SD units)
Total Difficulties*	19.4 (6.6)	9.3 (6.0)	1.7	Total Problems*	73.8 (32.3)	23.1 (17.8)	2.9
Emotional problems*	4.4 (2.8)	1.8 (2.0)	1.3	Affective Problems*	7.2 (4.5)	1.6 (2.1)	2.7
				Anxiety Problems*	7.7 (4.5)	1.4 (1.6)	3.9
Conduct Problems*	4.6 (2.5)	1.8 (1.8)	1.6	Conduct Problems*	9.5 (6.6)	1.9 (2.8)	2.7
				ODD Problems*	6.6 (3.0)	2.3 (2.3)	1.9
Hyperactivity*	6.2 (2.5)	4.1 (2.8)	.8	ADH Problems*	8.3 (3.8)	3.2 (2.8)	1.8

*similar problem area

Differences in child SDQ Total Difficulties and CBCL Total Problems by whether they had received earlier ASF support

The average (mean) SDQ Total Difficulties scores and CBCL Total Problems scores for the four groups (1) Previously received ASF support for this child*, (2) Previously received ASF support for another child of the family, (3) Previously received ASF support for this child and for another child of the family, and (4) No previous ASF support, were compared. 'This child' refers to the child who is the subject of the present ASF application.

On average, children aged 1 ½ - 5 years with no previous ASF funded support had lower CBCL Total Problems scores than children who had received previous ASF funded support for this child. However, the difference was not statistically significant.

For children aged 6-18 years, the SDQ and CBCL data indicated that, on average, the Total Difficulties and Total Problems scores for the No previous ASF funded support group were lower than for children who had received Previous ASF funded support for this child. The differences between the groups were highly statistically significant with medium effect sizes. Additionally, the SDQ and CBCL data indicated that, on average, the Total Difficulties and Total Problems scores for the No previous ASF funded support group were lower than for children who had received Previous ASF funded support for this child and another child in the family group. The difference between the groups was statistically significant with medium effect sizes.

One hypothesis to explain these findings across both standardised measures and all age categories is that families who sought support in an earlier wave of ASF funding arguably had the greatest needs – that they were prioritised in these early waves of funded support. Another hypothesis is that children requiring more than one package of funded support have greater levels of need overall compared with all those starting a funded package of support (incorporating those who may only need one funded package).

A further statistically significant result was revealed for the SDQ (6-18 years) data only. This was that the No previous support group's mean Total Difficulties score was statistically significantly lower compared to the Previously received ASF support for another child of the family group with a small effect size. The detailed findings are broken down in the following 3 subsections.

SDQ Total Difficulties and CBCL 1 ½ -5 years Total Problems

No SDQ data was collected for this age group. For the CBCL 1 ½ - 5 years data, numbers were only sufficiently large to enable a statistical comparison between the Previously received ASF support for this child group and the No previous ASF support group. While the mean Total Problems score was lower for the No previous ASF support group (M=61.45; SD=32.26) compared to the Previously received ASF support for this child group (M=76.05; SD=35.59), there was no statistically significant difference between the groups.

SDQ Total Difficulties scores (6-18 years)

There was a highly statistically significant difference between the Total Difficulties scores for previous ASF support groups as determined by a one- way ANOVA $F(3, 1031) = 15.32, p < .001$. A Tukey post hoc test revealed that the SDQ Total Difficulties scores were statistically significantly lower for:

- The No previous support group (18.25; SD=6.51) compared to the Previously received ASF support for this child group (M=21.18; SD=6.24), $p < .001$; $d = .5$

- The No previous support group (18.25; SD=6.51) compared to Previously received ASF support for another child of the family group (M=19.73; SD=6.90), $p < .05$; $d = .2$
- The No previous support group (18.25; SD=6.51) compared to the Previous support for this child and for another child of the family group (M=21.11; SD=6.47), $p < .01$; $d = .4$

There was no significant difference between the: Previously received ASF support for this child group compared with Previously received ASF support for another child of the family group; the Previously received ASF support for this child group compared with Previously received ASF support for this child and for another child of the family group; the Previously received ASF support for another child of the family group compared with Previously received ASF support for this child and for another child of the family group.

CBCL 6-18 Total Problems scores

There was a statistically significant difference between the Total Problems scores and previous ASF support groups as determined by a one- way ANOVA $F(3, 1039) = 14.00$, $p < .001$. A Tukey post hoc test revealed that the CBCL 6-18 Total Difficulties score was statistically significantly lower for

- The No previous ASF support group (68.56; SD=32.56) compared to the Previously received ASF support for this child group (M=82.45; SD=34.40), $p < .001$; $d = .4$
- The No previous ASF support group (68.56; SD=32.56) compared to the Previously received ASF support for this child and for another child of the family (M=84.89; SD=30.69), $p < .001$; $d = .5$

There was no significant difference between the: Previously received ASF support for this child group compared with Previously received ASF support for another child of the family group; the Previously received ASF support for this child group compared with Previously received ASF support for this child and for another child of the family group; the Previously received ASF support for another child of the family group compared with No previous ASF support.

Table 45: CBCL scores for children aged 1 1/2 to 5 years and 6-18 years by whether they have previously received ASF support

Whether previously received ASF support	CBCL 1 ½ - 5 Total Difficulties			CBCL 6-18 Total Difficulties			SDQ (6-18 years) Total Problems		
	n	Mean	SD	n	Mean	SD	n	Mean	SD
Yes, for this child	22	76.05	35.59	348	82.45	34.40	344	21.18	6.24
Yes, for another child of the family	6	77.33	29.60	159	75.77	32.77	158	19.73	6.90
Yes, for this child and for another child of the family	4	72.75	9.74	83	84.89	30.69	83	21.11	6.47
No previous support	95	61.45	32.26	453	68.56	32.56	450	18.25	6.51

Differences in total difficulties or problems scores by placement type

SDQ (6-18 years) scores by placement type

There was a statistically significant difference between the SDQ Total Problems scores and placement type as determined by a one- way ANOVA $F(2, 960) = 4.08, p < .05$. A Tukey post hoc test revealed that the SDQ Total Problems scores was statistically significantly lower for

- Living with you but not yet with an Adoption Order (M=16.15, SD=6.21) and Living with you after an Adoption Order (M=19.42, SD=6.46), $p < .05$; $d = .5$
- Living with you but not yet with an Adoption Order (M=16.15, SD=6.21) and Group 3 Living with you after a Special Guardianship Order has been made (M=19.24; SD=7.24), $p < .05$; $d = .4$

There was no significant difference between the SDQ Total Problems scores between the Living with you after an Adoption Order has been made and Living with you after a Special Guardianship Order has been made.

CBCL scores (6-18 years) by placement type

It was not possible to calculate summary CBCL 1 ½ - 5 statistics for the Living with you but not yet with an Adoption Order subgroup (n=3). There was a small and not statistically significant difference between the CBCL 1 ½ - 5 scores for the Living with you after an Adoption Order has been made subgroup (M=66.88, SD=32.97) and the Living with you after a Special Guardianship Order has been made subgroup (M=67.82, SD=26.39).

As regards the CBCL6-18 data, on average, there was a weakly statistically significant difference between the Total Problems scores and placement groups as determined by a one-way ANOVA $F(2, 874) = 3.26, p < .05$. A Tukey post hoc test revealed that there was no significant difference between CBCL 6-18 Total Difficulties scores for the placement groups. There are several reasons why post-hoc tests may appear non-significant while the global effect is significant. In this case, the weakly significant global effect (ANOVA p-value is equal or close to the significant level) may account for the result. In addition, the Tukey HSD Post Hoc Test is a conservative multiple comparison test and is more likely to reject significant differences between means that are, in reality, important.

These are interesting findings in relation to older children and young people (aged 6 years plus) where there is some evidence of important differences in problems depending on placement type. SDQ Total Difficulties and CBCL 6-18 Total Problems scores were lowest for children and young people who have not yet received an Adoption Order and highest in the Adoption Order has been made group. This seems to suggest that behavioural and emotional problems as measured by the CBCL6-18 tend to manifest themselves later in the adoption journey rather than immediately when a child or young person is placed with a family.

Table 46: SDQ Total Difficulties and CBCL Total Problems scores by placement type for children aged 1 1/2 to 5 years and 6-18 years by child status

Placement type	CBCL 1 ½-5 Total Problems			CBCL 6-18 Total Problems			SDQ (6-18 years) Total Difficulties		
	n	Mean	SD	n	Mean	SD	n	Mean	SD
Living with you but not yet with an Adoption Order	3	N/A	N/A	22	59.27	32.27	34	16.15	6.21
Living with you after an Adoption Order has been made	109	66.88	32.97	760	74.81	32.14	823	19.42	6.46
Living with you after a Special Guardianship Order has been made	11	67.82	26.39	95	69.40	33.93	106	19.24	7.24

Differences in child difficulties and problems by age

The table below demonstrates how, at baseline, there is a trend of increasing CBCL and SDQ Total problem scores with increasing child age up to about 15 years. CBCL and SDQ total problems scores were lowest for the under 5 years of age group and highest in the 11-15 age group. The over 15 age group showed a decrease in CBCL and SDQ total problems scores.

Table 47: CBCL and SDQ scores by age group

Age	n	CBCL 1 ½ - 5 Total Problems Mean (SD)	CBCL 6-18 Total Problems Mean (SD)	n	SDQ (6-18) Total Difficulties Mean (SD)
Under 5	69	58.28 (31.64)	n/a	86	18.22 (5.99)
5-10	494	n/a	72.54 (31.20)	494	19.52 (6.46)
11-15	336	n/a	76.82 (32.94)	336	19.72 (6.74)
Over 15	100	n/a	71.50 (34.86)	100	17.80 (6.84)

A one-way ANOVA was conducted to compare the effect of age group on SDQ Total Difficulties scores. There was a significant effect of age group on SDQ scores for the four age groups ($F(3, 1012) = 3.03, p < .05$). Post hoc comparisons showed no significant differences between the age groups except for between the 11-15 and over 15 age groups.

A one-way ANOVA was conducted to compare the effect of age group on CBCL Total Problem scores. There was a significant effect of age group on SDQ scores at the $p < .05$ level for the four age groups ($F(3, 995) = 6.48, p < .001$). Post hoc comparisons using the Tukey HSD test indicated that the mean Total Problems score for the under 5 age group ($M = 58.28, SD = 31.64$) differed significantly compared to the 5-10 age group ($M = 72.54, SD = 31.20$), $p < .001$, the 11-15 age group ($M = 76.82; SD = 32.94$), $p < .001$ and over 15 age group ($M = 71.50; SD = 34.86$), $p < .01$. There was also a significant difference between the 5-10 ($M = 72.54, SD = 31.20$), age group and the 11-15 ($M = 76.82; SD = 32.94$), $p < .05$, age group.

There was no significant difference between the under 5 age group and the over 15 age group and the 11-15 age group and the over 15 age group.

Findings relating to the Brief Parental Self Efficacy Scale

The Brief Parental Self Efficacy Scale (BPSES) is a five-item scale measure of the confidence that parents hold in their ability to parent their child. The scale was developed by Woolgar et al (2013).

The minimum score is 5 and the maximum is 25.

Table 48 below summarises the frequency and, in brackets, the percentage of respondents in each category of the BPSES.

Table 48: Parent/carer response to questions about their parenting in the Brief Parental Self Efficacy Scale by type of response

	Strongly disagree (%)	Disagree (%)	Neutral (%)	Agree (%)	Strongly agree (%)
Even though I may not always manage it, I know what I need to do with my child	13 (1)	79 (8)	131 (13)	590 (59)	195 (19)
I am able to do the things that will improve my child's behaviour	14 (1)	87 (9)	259 (26)	538 (53)	110 (11)
I can make an important difference to my child	8 (1)	14 (1)	84 (8)	510 (51)	392 (39)
In most situations I know what I should do to ensure my child behaves	19 (2)	101 (10)	229 (23)	536 (53)	123 (12)
The things I do make a difference to my child's behaviour	15 (1)	58 (6)	219 (22)	534 (53)	182 (18)

Data source: Baseline survey, responses to Brief Parental Self Efficacy Scale

90% of parents and carers agreed or strongly agreed that they could make an important difference to their child. About three quarters of parents and carers agreed or strongly agreed that they knew what to do with their child (78%) and that the things they do make a difference to their child's behaviour (71%). About two thirds of parents and carers agreed or strongly agreed that they were able to improve their child's behaviour (64%) and that they knew what to do to ensure their child behaves (65%).

The median BPES total difficulties score was 20.00 (SIQR=2) and suggests that the parents, on average, had a relatively high degree of confidence in their ability to parent their child. However, overall, the mean total score (20.00 (SIQR=2) suggests that, on average, these parents and carers had a relatively high degree of confidence in their ability to parent their child (where the minimum total score is 5 and the maximum is 25).

Findings relating to the Short Warwick Edinburgh Mental Well-being Scale

The Short Warwick and Edinburgh Mental Well-being Scale (SWEMWBS) is used to measure parental wellbeing. SWEMWBS consists of 7 items each to be rated on a 5-point Likert-scale. Scoring involves summing up the scores of each item to a sum score ranging from 7 to 35, and then transforming the raw score to a metric score. Only for cases with no missing values are sum scores computed. In general, lower scores represent lower levels of mental well-being. In contrast to the full WEMWBS, the shorter scale relates more to functioning rather than feeling.

Table 49 below summarises the frequency and, in brackets, the percentage of responses in each category of the SWEMWBS.

Table 49: Parent/carer responses to SWEMWBS statements by response type

SWEMWBS statement (n=1008)	None of the time (%)	Rarely (%)	Some of the time (%)	Often (%)	All of the time (%)	Average Frequency
I've been feeling optimistic about the future	41 (4)	157 (16)	469 (46)	287 (29)	54 (5)	3.5
I've been feeling useful	21 (2)	99 (10)	440 (44)	371 (37)	77 (7)	3.4
I've been feeling relaxed	97 (9)	371 (37)	405 (40)	128 (13)	7 (1)	2.6
I've been dealing with problems well	17 (1)	93 (9)	549 (55)	315 (31)	34 (3)	3.2
I've been thinking clearly	13 (1)	79 (8)	462 (46)	387 (38)	67 (7)	3.4
I've been feeling close to other people	32 (3)	165 (17)	381 (39)	327 (32)	93 (9)	3.5
I've been able to make up my own mind about things	7 (1)	42 (4)	309 (30)	482 (48)	168 (17)	3.8

The mean SWEMWBS score for parents and carers participating in the baseline survey was 20.94 (SD=3.48). Table 42 below compares the mean, standard deviation and minimum / maximum scores for parents in the baseline survey with population norms for England and with the earlier Tavistock Institute (2017) baseline survey results.

Table 50: SWEMWBS parent/carer scores by current baseline survey compared with Tavistock Institute (2017) baseline survey and population norms for England

Comparison Group	n	Mean	(SD)
Current baseline survey	1008	20.94	3.48
Tavistock (2017) baseline survey	299	21.06	3.86
SWEMWBS Population Norms in Health Survey for England data 2011	7196	23.61	3.90

On average, parent carer respondents to the IPC survey had lower mental well-being measured by the SWEMWBS (M=20.94, SE=0.11) than respondents in Health Survey for England data (2011) (M = 23.61, SE = 0.05). This difference was significant $t(8202) = 20.62, p < .001$) and represented a small-sized effect $r = .25$. There was no statistical difference between the IPC sample and the Tavistock sample (2017).

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