Public Health Research

Synopsis

Well-being package for foster carers and teachers of looked-after children aged 8 to 11 years: the STrAWB feasibility RCT

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Abstract

Background: Children in care are at elevated risk of mental health issues and poorer well-being, and social care and health services are under pressure to meet their needs. The Shared Training and Assessment for Well-Being programme is a recent approach to training and assessment designed to bring together foster carers and designated teachers to identify and meet the well-being needs of primary school-aged children in care, across the home and school contexts.

Objectives: This feasibility randomised controlled trial addressed key questions concerning the acceptability of the Shared Training and Assessment for Well-Being intervention (including training, assessments, clinical review and feedback) and the feasibility of the research design for a larger randomised controlled trial (including recruitment, randomisation and outcome measures).

Design: This was a two-arm randomised controlled trial (Shared Training and Assessment for Well-Being intervention vs. control group), with two points of data collection (baseline and 12-month follow-up) for our primary and secondary outcomes.

Setting: The study focused on looked-after children from four local authorities in southern England. In the context of the COVID-19 pandemic, both the research and intervention activities were undertaken online with participants.

Participants: Looked-after children aged 8–11 years were recruited from the participating local authorities, along with their foster/kinship carers and designated teachers. Carers for all children in the authorities meeting inclusion criteria were initially invited to participate. The original target sample size was 70 children, with 35 receiving the Shared Training and Assessment for Well-Being intervention and 35 in the control group. However, only 21 looked-after children were successfully recruited and randomised.

Interventions: Shared Training and Assessment for Well-Being is an integrated approach that combines training on mental health, well-being and resilience for foster carers and designated teachers; a multi-informant assessment package; review of assessments by mental health experts; and feedback to enable key adults to respond to identified needs and strengths. COVID-19 adaptations enabled all key elements to be delivered remotely.

Main outcome measures: Two multi-informant primary outcome measures were included as possible candidates for a larger randomised controlled trial: the Strengths and Difficulties Questionnaire and the Paediatric Quality of Life Scale. A further multi-informant secondary outcome measure was also included: the Behavioural and Emotional Rating Scale.

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Results: Feasibility was not demonstrated, as recruitment was heavily impacted by the COVID-19 pandemic and further attrition occurred over the extended project duration. For the small number who completed the Shared Training and Assessment for Well-Being package, key elements of the intervention were acceptable to participants. In addition, beyond issues with recruitment and retention, key aspects of the randomised controlled trial design, including randomisation, were acceptable.

Limitations: It is impossible to distinguish precisely between impacts of COVID-19 and broader challenges with securing the capacity and stability needed to deliver and evaluate the Shared Training and Assessment for Well-Being intervention.

Conclusions: Key elements of the Shared Training and Assessment for Well-Being intervention and randomised controlled trial process were acceptable, but the overall randomised controlled trial research design was not feasible in this study. The project was heavily compromised by the impact of the COVID-19 pandemic on foster carers, schools, local services and children.

Future work: Potential strategies are suggested to address challenges with evaluating integrated training and assessment approaches aimed at key adults supporting looked-after children.

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Introduction

Mental health and well-being of looked-after children

The most recent statistics from the Department for Education[1] show that there were 82,170 children looked after in England on 31 March 2022, of whom 18% were aged 5–9 and 39% aged 10–15 years. Risk of abuse or neglect remained the most common reason for being looked after (66% of children), and the majority of children were in foster care with unrelated (55% of all placements) or kinship (15%) carers.

The increased risk of mental health difficulties following childhood abuse or neglect is well documented.[2] Given that the majority of looked-after children entered care due to maltreatment, it is unsurprising that evidence indicates children in care are at a higher than average risk of mental health issues[3–5] and have higher levels of mental, emotional or behavioural disorders or symptoms than other children.[6] Although adolescence sees the emergence of many mental health disorders in the general population, studies show that the gap between looked-after children and their peers in the prevalence of diagnosable disorders is even greater for those aged between 5 and 10 years than for older children.[7] There is evidence that young people are leaving care with mental health problems likely to compromise their ability to cope in the adult world.[8] In the shorter term, poorer mental health has been linked to educational difficulties for all children[9,10] and for looked-after children in particular,[11] who continue to lag behind their peers in terms of academic outcomes.[12]

Looked-after children are also over-represented as users of Child and Adolescent Mental Health Services (CAMHS).[7] However, services struggle to effectively meet this need, as documented in a report from the House of Commons Education Committee.[13] A survey of its members by the Association of Directors of Children's Services[14] indicated that although given priority over other children, looked-after children still experience delays in accessing CAMHS; this is exacerbated when children move placement or are placed outside of their home local authority, often requiring new referrals. A meta-analysis[6] showed that placement stability (in terms of placement length and fewer moves) acted as a protective factor against increased mental health issues. In some cases, mental health services refuse to provide a service until the child is in a 'stable' placement; given that mental ill health is a risk factor for care placement breakdowns,[15] this can create a vicious cycle whereby the mental health treatment that might improve placement stability is not accessible until the placement is stable.[16] A report by the National Society for the Prevention of Cruelty to Children[17] estimated that £6.4M could be saved in the UK annually by meeting looked-after children's mental health needs and, as a result, maintaining stable placements.

Looked-after children can also exhibit a range of subclinical psychological characteristics that do not individually reach the threshold for clinical diagnoses but which can, nonetheless, impact significantly on their daily lives.[18] The outcome of this can be diverse and personalised.[2,3,19] In his evidence to the Commission on Young Lives,[20] Professor Peter Fonagy of the Anna Freud Centre noted that a 'general vulnerability' can manifest itself in multiple needs across a range of areas, but if none of these reach a clinical threshold then treatment will not be forthcoming. In any case, specialist clinical interventions might not be appropriate for children displaying multiple needs, and a focus solely on mental ill health ‘can be a distraction’.[14]

Viewing mental health as part of the broader picture of a child’s well-being could be particularly useful in work with looked-after children. The Bright Spots Programme[21] adopts a definition of well-being as: ‘feeling good and functioning well at an individual and interpersonal level’. This is in line with Public Health England’s[22] definition:

> *Mental wellbeing is described as more than the absence of mental illness and is inextricably linked with an individual’s emotional, physical and social wellbeing. It is influenced by their resilience and physical health, relationships and the wider social, economic, cultural and environmental conditions in which they live.*

This multifaceted, context-dependent conceptualisation of well-being underlies the Shared Training and Assessment for Well-Being (STrAWB) programme that is the subject of the present study. STrAWB offers an opportunity for the early identification of children’s needs across the home and school contexts, enabling the appropriate support to be put in place in order to produce resilient outcomes. Overall, the programme’s approach moves away from viewing resilience as an ‘intrinsic’ attribute of the individual,[23] and towards a definition that captures the role of external processes and supportive social networks[24] in fostering the psychological underpinnings of well-being. In so doing, it acknowledges the range of risk and protective factors for children’s mental health, at the level of the individual child, the family, the school and the community.[25]

Well-being in different contexts

In her evidence to the Commission on Young Lives,[20] Professor Mina Fazel criticised a ‘siloed’ system of health, social care and education: ‘In a child’s mind these things are not siloed’. The Commission’s report argues that early interventions need to be embedded within the care and education systems, among others, offering a broader and more holistic approach in which organisations are ‘working from the same page’.

Schools have a statutory duty to promote the mental health and well-being of all pupils, through prevention, early identification of need, early support and access to specialist support where necessary.[25] The joint Department of Health/Department for Education Green Paper *Transforming Children and Young People’s Mental Health*[26] placed schools and colleges at the centre of their strategies for early intervention. The approach included the introduction of designated senior leads for mental health in schools, the creation of mental health support teams responsible for the delivery of mental health and well-being support in schools and colleges, and a trial to reduce waiting times for NHS specialist services. The aim was to start with a small number of ‘trailblazer’ areas, with the target of rolling out these schemes to at least one-fifth of the country by the end of 2022–3.

For looked-after children, there is also the provision of at least one person employed by the local authority to promote the educational achievement of that authority’s looked-after children [the virtual school head (VSH)], and the use of personal education plans (PEPs) as a distinct part of the child’s care plan, which summarises the child’s current attainment and progress and documents what needs to happen for the child to fulfil their educational potential. Individual schools are also required to have a designated teacher (DT) for looked-after children, responsible for supporting all children in care in that school. Statutory guidance on promoting the health and well-being of looked-after children[27] states that the VSH and DT should both be aware of any health-related information (physical or mental) that might impact on their learning. The final report of the Expert Working Group on looked-after children’s mental health[28] also recommends that every DT should have the training and competence in identifying and understanding the mental health needs of all their looked-after pupils.

Children’s social networks and peer relationships, and participation in extracurricular activities, are factors associated with improved resilience in primary-aged children.[29] Previous research has shown that relationships at school predict differences in mental health and well-being outcomes, via a variety of psychological dimensions relating to self-perception and empathy.[20] Evidence that looked-after children’s mental health and well-being is linked to positive experiences and peer relationships in school, as well as with carers,[5,30] suggests there is a need for assessments that can identify children’s social and emotional well-being in both the home and school contexts. Yet at present, assessments of mental health in looked-after children are restricted to the annual completion of the Strengths and Difficulties Questionnaire (SDQ)[31] by foster carers (FCs) or residential staff, despite evidence that ratings of looked-after children’s behaviour often differ across the home and school contexts.[32] A combination of assessments at home and at school can pick up on any differences in well-being across contexts.[33,34] The combination of different perspectives is also likely to more accurately predict mental health issues.[35,36] Statutory guidance for local authorities[37] therefore notes that looked-after children might benefit from the triangulation

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of SDQ scores from all three possible informants, though this is not currently standard practice.

Mental health and well-being in the context of COVID-19

It is important to ground the present study – a feasibility randomised controlled trial (RCT) of the STrAWB intervention – in the context of the COVID-19 pandemic. The study began on 1 April 2020, just 1 week after the first lockdown was implemented in the UK. This required a major adaptation to the intervention, which is described in the *Methods* section. In the *Results* section, we also discuss the impact of subsequent lockdowns, school closures and restrictions on in-person gatherings on this study.

The pandemic has also had a significant effect on children's mental health and well-being. NHS Digital's mental health survey[38] showed that the prevalence of probable mental health disorders for children aged 7–10 years had risen from 10.6% in 2017 to 15.3% in 2020, and peaked at 18.1% in 2021; by 2022, the rate had fallen again to 15.2% of children in this age group, but it remains to be seen whether and when this will return to pre-pandemic levels. A report by the Department for Education[39] showed that young people's well-being had also taken a turn for the worse during the pandemic – particularly during periods of lockdown – but that this had returned to pre-pandemic levels by June 2021.

Prior to the pandemic, only 40% of children with a diagnosable condition were able to access the treatment they needed; this, in combination with the increased need created by the pandemic, means there is a backlog of children with unmet needs and an overstretched system.[40] The committee in the House of Commons report[40] noted that given these issues, the scale and speed of the government's planned improvements to mental health services were not sufficient.

The Adoption and Children (Coronavirus) (Amendment) Regulations 2020 came into effect on 24 April 2020 and included optional amendments to usual procedures regarding children's placements, the assessment of FCs and statutory visits by social workers (SWs). They were seen as controversial in their potential to place children at further risk, but few of the local authorities in a study that year[41] had adopted the amendments. Local authorities reported difficulties in finding placements for children, and options were reduced as carers aged over 70 years or who were shielding for health reasons could not take on new placements. In response, the capacity of existing carers was expanded and more use was made of kinship care. Respondents praised the efforts of FCs to minimise disruptions.

A survey of FCs by The Fostering Network[42] covered the topic of education during lockdown, and feelings about returning to school: 78% of children were not physically attending school when schools were open to vulnerable children, due largely to decisions not to send them to school or (less frequently) schools being closed or being unable to provide for special educational needs. Decisions to keep children at home were made in the child's best interests by the team around them, and included considerations of potential stigmatisation if children in care were seen to be 'different' from their peers. The need for routine was cited both as a reason for sending children to school and – where the regular routine was disrupted – as a reason for keeping them at home.

Surveys by Research in Practice[43] showed that some young people in care valued the additional one-to-one time with carers afforded by the lockdown, and over one-third said their relationship with carers had improved since the start of lockdown. Similarly, some carers surveyed by The Fostering Network[42] mentioned a positive impact on children's well-being and on their relationship with the family, arising from increased one-to-one support and the removal of some external pressures. Other children, however, were said to have experienced increased mental health difficulties. The majority (64%) of kinship carers surveyed by the organisation Kinship felt that the COVID-19 lockdowns had had a negative impact on their children's physical and mental well-being.[44]

Research in Practice[43] noted that some children missed the routine of attending school and the social contact. Although guidance at the time was that schools remained open for looked-after children, 73% of those surveyed had not attended in person during lockdown. Some FCs noted that home-schooling meant a substantial time commitment and increased responsibility. Many carers also had to manage the arrangement and supervision of virtual contact with children's birth families, which was a new responsibility. Although some carers felt that lockdown had been a positive time and offered a chance to strengthen relationships with children, more felt that it had been hard work and carried a financial burden.

Identification of need

Given the increased risk of mental health difficulties and poorer well-being for looked-after children – and the complicating factors arising from the COVID-19 pandemic – the early identification of need in this group is crucial. More broadly, the Health and Social Care Committee's inquiry into children and young people's mental health recommended that government 'must take radical steps to shift the focus in mental health provision towards early intervention and prevention'.[40] The Children and Young People's Mental Health and Wellbeing Taskforce report[45] notes that the prevention of escalating need through early identification is not only effective but also cost-effective. It recommends the provision of comprehensive assessments to enable early identification of problems and to avoid escalation and long-term impairment. Guidance from the National Institute for Health and Care Excellence[4] also applies this recommendation of early identification and intervention for mental health issues specifically to looked-after children.

The final report from the Expert Working Group on the mental health of looked-after children[28] recommended that the SDQ should be supported by a broader set of measures which can trigger a comprehensive mental health assessment where this is appropriate, and that these measures should represent the perspectives of the young person, their caregivers and professionals. There is a general agreement that objective and subjective approaches are needed in measuring well-being.[46] However, the National Children's Bureau[47] notes the lack of any consistent method for measuring looked-after children's well-being, beyond the SDQ; such consistency could provide not only information to plan services but also an indicator of the effectiveness of the care system.

The 'Your Life, Your Care' survey, specifically developed for and with looked-after children by Coram Voice and the University of Bristol in the Bright Spots Programme,[48] is a measure of looked-after children's subjective well-being and their experiences in care; however, to date, this tool has been used primarily to provide a picture of children's experiences at the level of the local authority, in order to inform improvements to services, and has not been used to inform individual support plans.

The government-funded Mental Health Assessment Pilots for looked-after children operated across nine local authorities and aimed to test changes to the assessment system when children first entered care. This new approach to assessment included a suite of measures to supplement the SDQ, the addition of a written output from the child's perspective and the introduction of a virtual mental health lead (VMHL) to support front-line assessors. The evaluation of the pilots[49] showed that the VMHL was popular across sites, though the quality of the written output was variable and its production was resource-intensive. The interpretation of responses on some of the assessment measures was also felt to be intimidating for practitioners without a clinical background. It is unclear at this point whether the pilot scheme will be taken forward; in any case, its use is restricted to the period shortly after a child enters care.

The role of training

The Independent Review of Children's Social Care[50] recommended that FCs and kinship carers need to be given the training that will help them provide the best care for children. FCs value training, seeing it as important in improving the care they offer,[51] and several recent policy and practice publications have recommended that FCs should be trained to identify children's mental health difficulties at an early stage.[13,17,52] Yet, there is little coverage of mental health content in pre-service training or in training for approved FCs, and in a survey by The Fostering Network,[16] FCs reported that the provision of training on this topic 'is falling short of what is required'.

The House of Commons Education Committee report[13] also calls for the inclusion of mental health training in initial teacher education, and for teachers and schools to be better equipped to identify, assess and support children and young people with mental health difficulties. Previous research shows that FCs value training in which they are given the opportunity to work together with other professionals;[53] for this reason, the STrAWB training programme includes joint sessions for FCs and DTs to learn together.

Study aims and objectives

This was a feasibility study of an innovative training and assessment package for FCs and schools. The aim of the study was to determine the feasibility, and to inform the design, of a RCT evaluating the STrAWB intervention for children in foster and kinship care. It aimed to test the components of any larger RCT with a smaller sample, and address uncertainties around key parts of the process.

The research questions for the study were:

1. Is the STrAWB intervention acceptable to participants?
    - This question covers the acceptability of the training, assessments, child profiles and feedback meetings, and intervention costs.

2. Is the research design feasible for a larger RCT?
    - This question covers feasibility of the key research processes in terms of recruitment and retention, randomisation, primary and secondary outcome measures, and an economic measure of service use.

The report presents our findings on these research questions in the context of the COVID-19 pandemic.

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Methods

Here we outline the methods specified in the original study protocol, as well as those that were added following issues with recruitment.

Design

The design was a randomised feasibility trial. The project primarily aimed to test whether the STrAWB package of training, assessment and clinical review for looked-after children could feasibly be delivered and evaluated in a RCT. The pilot intervention employed the same design that would be used in a full trial, should this be judged to be feasible: namely, a two-arm RCT, with two points of data collection (baseline and 12-month follow-up) for our primary and secondary outcomes.

Intervention

The STrAWB intervention for looked-after children is an innovative training and assessment package for FCs and schools. It provides a unique opportunity to bring together carers and teachers to discuss children's well-being in both the home and school contexts. STrAWB's unique cross-context approach can help with early identification of mental health difficulties and support for children's well-being, and it has the potential to reduce the risk of developing or escalating mental health problems and to improve resilience following maltreatment.

The STrAWB package consists of four key elements, each of which was experienced only by those in the STrAWB intervention arm:

1. integrated training on mental health, well-being and resilience for FCs and DTs
2. home-based assessment completed by trained FCs, based on observations of key signs and indicators of potential mental health difficulties, children's strengths and an outline of activities, including online and screen time; and by the children themselves, involving measures of social and emotional functioning in the home and school contexts
3. school-based assessment by school staff
4. review of the combined baseline measures and STrAWB assessments by a mental health expert, to create individual child profiles of strengths and needs, with recommendations for support strategies, allowing key adults to identify and respond to the needs of looked-after children within the home and school settings.

In 2017–8, STrAWB was trialled in a small pilot study with 18 children. FCs and DTs gave positive feedback; they particularly valued the opportunities for improved communication and integrated working. Resulting changes to practice included securing counselling sessions on the basis of the evidence provided in one child's profile, and relocating teaching assistant work within the classroom to maintain peer relationships for another child.

As originally designed and piloted, for element (1), FCs and DTs of children in the STrAWB pilot study attend a 2-day face-to-face training course (FCs attending both days, DTs 1 day), in venues provided by the local authority (e.g. schools and family centres). Training sessions are delivered in small groups (a maximum of 12 people) and include information-sharing from the trainers [using PowerPoint® (Microsoft Corporation, Redmond, WA, USA) slides], as well as video, exercises and guided discussion. Necessary adaptations in the context of COVID-19 are described below.

Trainees are provided with an accompanying handbook in hard copy and as a portable document format (PDF) file (around 80 pages), the sections of which mirror the content of the training but explore topics in more depth: background and context; well-being, resilience and strengths; social factors; mental health factors; mental health problems, including the importance of impact on daily life and discussion of the diagnostic approach; the STrAWB assessments; talking and listening; resources; and references. Both the handbook and the training are 'theory-neutral' and are not framed in terms of any particular theoretical orientation. For example, they do not make any assumptions that mental health and well-being difficulties among looked-after children are purely issues of developmental trauma or attachment. This helps to avoid narrowing the scope of the work, and makes the STrAWB package more accessible, inclusive and shareable.

For elements (2) and (3) of the intervention, in the month directly following the training, information is collected from FCs, DTs and children, with online and hard copy (via registered post) options. This information feeds into individual child profiles compiled by a mental health expert who reviews the completed assessments (element 4). The information collected at this stage (with information on the informants) is as follows:

- Foster carers complete the STrAWB 'well-being profile' (WBP), a diary method which involves recording core signs/symptoms in the participating children, with attention to impact and context, over a 2-week observation period. Six signs/symptoms which occur across the spectrum of disorders were selected based on their utility as possible markers for

clinical difficulties and ease of observation: mood, anxiety, focus, sleep, fearfulness and impact. The WBP also includes a review of the child's strengths, and an overview covers children's personal care, practical skills, speech and language, psychotic symptoms, eating, head injury and leisure activities (including online). The profile elicits free-text answers with daily context.
- Children are supported by their carers to complete brief self-report measures at home, to provide a broader assessment of interpersonal activities, perceived relationship quality, and self-perceptions across the home and school contexts. Qualities of relationships within the peer context, both in terms of general peer acceptance and dyadic friendships, are assessed using a shortened version of the Loneliness Questionnaire[54,55] and the Best Friend Index.[56] We also assess some of the factors that are established antecedents to mental health difficulties, such as perceived self-efficacy and self-esteem, using items from the Student Resilience Survey,[57] the EU Kids Online Survey,[58] a shortened version of the Self-Perception Profile for Adolescents,[59,60] and the Stirling Children's Well-being Scale[61] (a positively worded measure of children's emotional and psychological well-being).
- Teachers complete the Mulberry Bush Social and Emotional Development Scale, which was co-created and successfully piloted by members of the research team with expert practitioners at the Mulberry Bush residential school for traumatised children.[62] The scale provides measures of children's social regulation of behaviour and emotions in ways that specifically capture the needs of this particular group.

The baseline responses on our primary and secondary outcome measures (see further details below) also feed into the child profile. The respondents completing each measure are given in parentheses:

- Primary outcome measure 1: the SDQ,[31] a brief behavioural measure, which is currently routinely completed on an annual basis by FCs in England regarding children in their care (child self-report; FC; teacher).
- Primary outcome measure 2: the Paediatric Quality of Life Scale (PedsQL),[63] which includes some items that overlap substantially with the SDQ, but also includes physical health and activities (child self-report; FC).
- Secondary outcome measure: the Behavioural and Emotional Rating Scale (BERS),[64] which assesses areas of personal strength (FC; teacher).

Written guides on how to complete each measure, including tips on any 'difficult' or ambiguous wording (as identified by our Project Advisory Group and members of the Young People's Advisory Group for Kent, Surrey and Sussex), are available on the project's web pages (https://www.sussex.ac.uk/research/projects/strawb/; accessed 30 January 2025). There is also a short video guide on how to access and complete the forms online.

Using templates already created and implemented successfully in our initial pilot, these school, home and self-report assessments are combined for children in the intervention arm to form individual profiles of each child's strengths and needs. The research team collates each child's assessment measures and sends them to a mental health expert. Individual child profiles are created to identify concerns and signpost appropriate onwards referrals. In the present study, the mental health experts were a child and adolescent psychiatrist and a clinical psychologist.

The child profile is then returned to the child's carer, teacher and SW, and they are asked to hold a feedback meeting to discuss the child profile and decide on next steps. Ahead of the meeting, carers are asked to go through an 'All About Me' form with the child, which summarises the information from the child profile in a child-friendly manner and gives them the opportunity to add their own thoughts that can be brought to the adults' feedback meeting. We provide a set of guidelines for feedback sessions, which aim to help attendees to understand the information contained in the child profile and to take appropriate steps where needed, including logging any resulting actions on a 6-monthly basis. Not all feedback sessions might be attended by children's SWs if their schedules do not allow for this, although we do encourage their attendance.

Adaptations to the intervention

The STrAWB training programme was initially developed as part of a pilot study and delivered in person by two trainers. Due to the COVID-19 pandemic, it was necessary to revise the content and delivery to accommodate online working. This was developed by the initial creator of the content, in collaboration with members of the research team. The Project Advisory Group was involved and consulted on development.

The adapted training consists of three self-study sessions, hosted on Padlet (a cloud-based collaboration platform used in many education settings that allows people to upload, share content and work on virtual bulletin boards called Padlets: https://padlet.com/; accessed 30 January 2025), which alternate with three facilitated online classes, hosted on Microsoft Teams® (Microsoft Corporation,

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Redmond, WA, USA). The Padlet sessions include a range of written content, discussion prompts and videos, covering the experiences of looked-after children and relevant mental health and well-being topics. Carers and teachers are able to complete these self-study sessions whenever convenient, and each one takes up to 1 hour to complete. Participants can self-assess their learning via a series of online quizzes at the end of each Padlet session. Facilitated online classes are led by a member of the research team and include some information-sharing from the trainer (using PowerPoint slides) but with maximum opportunity for focused discussion. Each facilitated online class lasts 90 minutes, and carers and teachers are instructed to book onto the same class for session 2 and (where possible) session 4; session 6 is for carers only.

The structure and broad content of the sessions was as follows:

- Session 1 (Padlet): the STrAWB approach – an outline of the STrAWB intervention's aims and approaches to understanding mental health and well-being. Participants are invited to watch a video co-produced with looked-after children about their experiences of coming into care (*My Name is Joe*: www.youtube.com/watch?v=j7hXsBi9jG8; accessed 30 January 2025).
    - Foster carers are also invited to complete an online instrument considering the assets and strengths of the index child that may support their health and well-being.
- Session 2 (Microsoft Teams): review of the content of session 1 and further detail on the STrAWB approach and key concepts: well-being, resilience, strengths, relationships and mental health.
- Session 3 (Padlet): introducing key concepts such as 'enabling' the child (as distinct from 'supporting') and reviewing the relationship between home and school to facilitate and strengthen joint working.
- Session 4 (Microsoft Teams): an introduction to key concepts relevant to mental health and well-being; common mental health difficulties experienced by children and young people; identifying problems and when to be concerned; and issues related to the diagnostic approach to mental health.
- Session 5 (Padlet): understanding key clinical mental health diagnoses via a series of videos covering depression, anxiety, post-traumatic stress disorder, conduct disorders and attention deficit hyperactivity disorder. Introducing the 'CLIPS' acronym (clustering, impairment, persistence and severity) as an aid to early identification and when to seek help.
- Session 6 (Microsoft Teams): a session for FCs to review the intervention assessment measures and how to complete them, and consolidating learning from the course.

Sample

We recruited looked-after children aged 8–11 years (in school years 4–6) from four local authorities in southern England, and their foster/kinship carers and DTs (a dedicated role in each school). All FCs and kinship carers in the four local authorities who were looking after children eligible for the study were initially invited to participate. Our inclusion criteria were for children who:

1. were in foster or kinship care at the time of recruitment, and had been with their current carers for at least 3 months
2. had experienced abuse and/or neglect while living with birth families (identified in their Child in Need records)
3. were under a care order (i.e. excluding those in care under Section 20 of the Children's Act)
4. were in year 4, year 5, or year 6 of primary school at the point of recruitment
5. had sufficient communication and literacy skills to complete self-report assessments.

The original sample size target for this study was 70 children, along with their carers and teachers. One group of 35 participants would receive the STrAWB intervention and the other group would receive treatment as usual, with children randomised in a 1 : 1 allocation ratio.

Participating local authorities approached the FCs and DTs of all eligible looked-after children for inclusion in the study. A letter or e-mail of support was sent from each local authority to all potential participating schools and FCs, along with a short leaflet outlining the key points about the study. Local authorities then provided the research team with contact information for the carers, teachers and SWs. Two of the participating local authorities used an opt-in procedure for providing contact information: having read the study leaflet, FCs and DTs had to provide written consent to having their information passed on to the research team for a further discussion about whether they might want to participate in the study. The remaining two local authorities used an opt-out procedure: all FCs and DTs of eligible children were notified that their contact details would be passed on to the research team, and were given an opportunity to say if they did not want this to happen.

On receiving contact details, the research team sent all FCs and DTs a full information sheet and consent form, written in clear and accessible language; the majority completed their consent using an online option, with only a small number opting for a postal consent form. FCs also received an information leaflet for the child and a children's assent form. Children's SWs received information about the study, to keep them informed. The purpose of the study was explicitly stated and contact details of the research team provided. Assent was also sought from children.

In practice, we were only able to recruit 21 children to the study, and there was a considerable level of attrition; the *Results* section of this report explores the key explanations for these issues.

Equality, diversity and inclusion

Besides the exclusion criteria outlined above, no criteria were imposed in terms of the ethnicity, gender or gender expression of children, carers or teachers. We were keen to ensure that kinship carers were represented in the study along with FCs, given that they are often under-represented in research and can feel unsupported by local authorities.[44] The research team consisted mainly of British university-based staff, with different genders and ethnicities represented. One of the researchers and two consultants had experience of living in care; one was also a FC; another researcher had experience as part of a fostering family. At least two of the team had chronic health conditions, and at least two had experienced mental ill health.

Randomisation

We set out to randomly allocate children whose key adults consented to their participation to either the STrAWB intervention or the control arm in a 1 : 1 ratio. Initially this was done using block randomisation, with a block size of two, and only randomising participants when there were two available within a local authority. At the end of the recruitment period, any single participants who remained in each local authority were allocated to an arm using simple randomisation. This led to an imbalance in the arms, as a greater number of these single participants were allocated to the STrAWB intervention condition than to the control condition. In a larger trial this effect would be diluted, and the imbalance would not be as large. Alternatively, the remaining single children could be grouped and randomised in blocks, also reducing imbalance.

Where there was more than one child per school, both children were allocated to the same condition (i.e. cluster randomised by school), because the same DT would be responsible for both; this was to avoid possible contamination between study arms. This was the case for two of the children with consent.

Of the 21 children who were recruited and randomised to conditions, a total of 13 children were allocated to receive the STrAWB intervention. The control group consisted of eight children who met the same inclusion criteria as the intervention group, and they and their FCs and DTs completed our primary and secondary outcome measures. Please note that, as described in the *Results* section below, there was further attrition over the duration of the project. The full training and assessment package was completed for only 6 of the original 13 children in the STrAWB condition.

Measures

The study included a range of measures to test the acceptability of the intervention (research question 1) and the feasibility of the research methods for a larger RCT (research question 2). Methods included surveys, interviews, a calculation of the cost of the intervention, primary and secondary outcome measures, and a measure of service use. *Table 1* shows which of the measures were used to collect data for the two research questions.

Post-training survey

All FCs (n = 5) and DTs (n = 5) attending the training sessions completed an online survey after the final session. The surveys included Likert scale ratings on the quality, usefulness and delivery of the training sessions, along with open-ended questions (e.g. 'What was the best thing about the STrAWB training?', 'In what area(s) does the STrAWB training most need to improve?').

Interview with mental health experts

A joint online interview was conducted with the two mental health experts to assess their experience of reviewing the assessments to produce individualised child profiles. This included questions on: how informative the measures were in helping them to assess children's strengths and support needs across the home and school contexts; the clarity and usefulness of the guidance provided; and the

TABLE 1 Study methods used for the two research questions

	Research question 1 (intervention)	Research question 2 (research)
Post-training survey	•	
Interview with mental health experts	•	
Calculation of intervention cost	•	
Interviews with study participants	•	•
Survey of non-trial participants		•
Primary and secondary outcome measures		•
Measure of service use		•

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most appropriately qualified mental health professionals to fulfil this role in any larger roll-out.

Calculation of intervention cost

To calculate a comprehensive unit cost for the intervention, information was collected from the research team on time spent delivering the intervention, staff salaries, training costs and materials. Further details are provided in the costing report in *Appendix 1*.

Interviews with study participants

Semistructured interviews were conducted online or by telephone with the different stakeholders involved in the project: FCs, DTs and SWs (we had also planned to interview children, but none of the children who remained in the study agreed to be interviewed). These were originally planned to fall 6 and 12 months after the provision of the child profiles; in practice, they took place between 2.9 and 23.1 months after the baseline measures had been submitted. A small number of individuals were not able to commit to an interview; instead, they responded to questions on the interview topics through an online survey. Interviewees were selected from both the intervention and the control arm, to enable the fullest possible information to be gathered on the trial process and the intervention. Originally, this was planned to be a selected subsample [FCs = 10, DTs = 10, SWs = 10, looked-after children = 10, and virtual school staff members (VSs) = 4], but given the general recruitment issues on the study, all participants were invited to take part in interviews. The final sample of interviewees included nine FCs (including two interview replacement surveys), five DTs, two SWs and three VSs.

The interviews were planned to explore the potential facilitators of and barriers to implementation in routine settings as part of a full trial, focusing on the following topics:

- Acceptability of the intervention (intervention arm only). Open questions were used to elicit stakeholders' thoughts on each element of the STrAWB package, including the experience of training (e.g. whether timing of live sessions was convenient), assessment (e.g. whether they preferred to complete measures online or in hard copy, whether surveys were of an appropriate length to retain engagement from start to end, and whether the phrasing of any questions was unclear or problematic) and feedback (e.g. the clarity of the child's individual profile and how useful it had been in informing subsequent support). Interviewees were prompted to share both positive and negative opinions, and were asked about potential changes to the content and delivery of the intervention for a full trial.
- Experience of recruitment (both arms). Questions for the virtual schools explored their motivation to participate in the study, and their experience of compiling the list of eligible children and negotiating the opt-in or opt-out process of consent to pass on contact details. Questions for all interviewees included whether the mode of initial contact from the research team via local authorities (e.g. mail, e-mail) was appropriate, whether recruitment materials (leaflets, full information sheets and consent forms) were easy to understand and useful in terms of helping them decide to participate, and the ease of contacting the research team with any questions.
- Acceptability of randomisation (both arms). Questions explored carers' and teachers' responses to the process of randomisation, and whether their allocation to the intervention or the control arm affected their attitudes to the study and to completing the outcome measures.
- Appropriateness of primary outcome measures (both arms). We asked interviewees to comment on the ease of use and clarity of individual items on the SDQ and the PedsQL, and to compare them as measures of looked-after children's well-being in terms of their comprehensiveness and whether the items are age-appropriate (both chronologically and developmentally).
- In light of the issues with recruitment, we also added questions to our interviews about facilitators of and barriers to participation, and asked for their ideas about how to facilitate participation in future iterations of the study.

Survey of non-trial participants

Also, in light of the issues with recruitment, a survey was sent out to all carers and teachers who had decided not to participate in the trial. We received responses from six carers and two DTs. The survey asked about general factors that might influence a carer's or teacher's decision about whether to take part. The survey also asked how we might make it easier for carers and teachers to take part in STrAWB in future, asking them to select from suggestions made by the Project Advisory Group, such as approaching eligible schools first and carers later in the process, as well as providing space for free-text answers.

Primary and secondary outcome measures

The study included the proposed primary and secondary outcome measures for a full RCT. The measures were collected from both arms at baseline (prior to randomisation) and at follow-up. The follow-up was originally planned to occur 12 months after baseline; in practice, due largely to delays in responding which had to be chased up by the research team, follow-up measures were completed on average 15 months after baseline by carers, 14 months after baseline by children, and 18 months after baseline by teachers. The primary and secondary outcome measures were collected for a total of 21 children at baseline and 7 children at follow-up. We tested two potential primary outcome measures of mental health and well-being, in the intervention and control arms, to assess which was more comprehensible, developmentally appropriate and useful. Online resources (a 'getting started' video and multimedia web guides for completing assessments) were provided to all participating FCs and teachers.

Primary outcome 1 was the SDQ,[31] a brief behavioural measure, which is currently routinely completed on an annual basis by FCs in England regarding children in their care. Use of the SDQ with looked-after children has been shown to provide a good estimate of the prevalence of mental health conditions.[65] There is evidence with looked-after children that using multi-informant SDQs to combine different perspectives is a reliable predictor of mental health difficulties,[35] so in this study it was completed by the carer, teacher and child. The inclusion of a second option for the primary outcome was due to the validation of the self-report version of the SDQ having occurred only with children aged 11 years and over, although other studies[62,66] have successfully used the SDQ self-report with children as young as 7 years, and report satisfactory levels of reliability.

Primary outcome 2 was therefore a second measure of mental health and well-being. The PedsQL[63] includes some items that overlap substantially with the SDQ, but the subscales also include physical health and activities. It has been validated for use with our age group, and was completed here by the carer and the child.

Our secondary outcome measure was the strength-based BERS.[64] The BERS assesses areas of personal strength not covered by the SDQ or the PedsQL, and thus the primary and secondary measures act to complement each other and provide a more rounded picture of children's mental health. Given that the wording and length of the child self-report version of the BERS are designed for children aged 11+ years, in this study it was completed only by the carer and teacher.

Participants chose to complete measures online or on paper (with prepaid return postage supplied) within 2 weeks of completion of the training. FCs were asked to support children to complete questionnaires at home and received guidance during the training. Children were asked to complete the questionnaires in one to three sittings within 1 week.

Measure of service use

The Client Service Receipt Inventory (CSRI)[67] is a tool used to collect information on the whole range of services and supports that study participants may use (see www.pssru.ac.uk/csri/what-is-the-csri/; accessed 30 January 2025). The data can be used for a wide range of purposes, including for estimating the costs of service receipt. It is therefore commonly used in economic evaluations. A short version was developed and refined with input from the Project Advisory Group for use with this study, building on several recent trials and pilot studies in school settings.[68] At baseline and follow-up, FCs and children in both study arms were asked to provide information from the last full school term about contacts with general and mental health services, social care and education support, as well as informal help received from voluntary organisations, carers and friends. The adapted CSRIs were completed for 21 children at baseline and 6 children at follow-up.

Data analysis

Quantitative data from surveys and on the primary and secondary outcome measures were subjected to descriptive analyses. All qualitative data from interviews and surveys were subjected to thematic analysis,[69] organising the themes around the framework of topics covered by our research questions, notably the acceptability of the STrAWB intervention and the feasibility of the research design for a larger RCT.

Patient and public involvement

All research instruments were presented to and discussed with our Project Advisory Group of FCs, education and local authority staff, care-experienced young people, and mental health experts, to obtain feedback and suggestions for any amendments or additions. Carers and a child volunteer worked through the baseline and post-training measures; their feedback informed our advice on the length of time they would take to complete, as well as a guide for FCs that covered definitions of certain terms, and suggestions on how to support the child in completing the measures. We are grateful to the Young People's Advisory Group for Kent, Surrey and Sussex for the invaluable feedback provided on the recruitment and assessment materials for children.

Results

Research question 1: is the STrAWB intervention acceptable to participants?

The findings presented here are drawn from the different methods used to assess the acceptability of the training, assessments, child profiles and feedback meetings, and intervention costs. The intervention package was delivered

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for only 6 children (in contrast to the original target of 35), and so our evaluation of the acceptability of the STrAWB intervention relates only to this small group of children and their FCs and DTs. A detailed account of the challenges with recruitment and retention is presented in relation to research question 2 later in this section.

Acceptability of the training

Five carer–teacher pairs (responsible for six children) completed the training. Trainers' records showed that the checklist of topics for each of the live sessions was fully covered for each pair, and that all participants were engaged and that they contributed and asked questions. Five participants completed an online evaluation form that gathered data about their experiences of joining and taking part, training content, facilitation and aspects that worked well, as well as areas for improvement. Five interviewees, including one replacement survey respondent, also shared their experience of training.

Scheduling

Co-ordinating the calendars of both the FC and DT to attend the training at the same time was reported to be 'very difficult' or 'hard' by two FCs. This was due to the busyness of the DTs' schedule. DTs reported in interviews that their ability to commit time to a programme like STrAWB had to be carefully considered among other demands on their time. One DT described having a role on the senior leadership team which meant that not all of their responsibilities could be covered by 'supply'.

Delivery and duration

Foster carers reported that the duration of the training was suitable. All survey respondents took around the suggested time or less to complete the Padlet exercises. Most felt that the pace of the facilitated classes was 'about right', with enough time for questions and discussion, though two of the five said it was 'too slow'. All respondents felt that the facilitator in the live sessions was 'friendly and approachable', 'helpful and engaging' and knowledgeable about the subject. The trainer's notes suggested that there was scope to increase the time allowed for discussion points, relative to the informative content.

One DT agreed that the current format of STrAWB training, with two short 1.5-hour live sessions, was easier to schedule than if they had to find a half-day to do the material all in one go:

> *[I]t's just hard to find time, so the least amount of time, you know, you'll get more success. The least amount of time that still makes the training work, I think. . . . So, two hour-and-a-half sessions would be better.*
>
> *DT*

However, one survey respondent noted that the gap between sessions could have been longer to allow more time for the Padlet sessions.

Online format

The online format of the training had worked well for most participants. All survey respondents said it was 'very easy' or 'easy' to access the Padlet sessions, and to navigate and use the platform. All respondents reported that joining and taking part in the online facilitated sessions was 'very easy'. A DT reflected that because of the online format, having just them and the carer involved was beneficial, indicating it might have been more difficult if there were multiple people trying to contribute to an online discussion:

> *So, because it was just the three of us an online meeting was really easy. I think if I'd have been on training where they'd been maybe 10 other participants, I think that's quite hard.*
>
> *DT*

One DT also talked about the benefits logistically of training online. Reducing travel time and costs facilitated the DT to attend the training sessions:

> *Having training online, it just seems so much more economical with the time and the money and the petrol.*
>
> *DT*

Few interviewees expressed a particular preference for training online or in person. However, one FC did say they 'prefer face-to-face' training, explaining that they are 'a bit of a technophobe'. This carer acknowledged that this project occurred at a time where in-person training 'wasn't possible for anybody', reflecting that the online sessions were 'doable' and reporting that they had enjoyed the training overall.

Usefulness and benefits

All survey respondents found the Padlet and live sessions either 'very useful' or 'somewhat useful', except for one respondent who reported that session 2 was 'not very useful'. The films used in the sessions were rated by most as 'very helpful' or 'quite helpful'. Three out of five reported that the content of both Padlet and live sessions was 'somewhat new', though two out of five reported that it was 'not at all new'. One wrote that:

> *The content is fairly obvious/basic for most carers. I would have liked a much more in-depth/detailed training.*
>
> FC

It is difficult to assess the extent to which this response was a result of having adapted the training from face-to-face to online sessions as necessitated by COVID, versus being a reflection of the knowledge and experience of this particular sample. Usefulness of the training was described in different ways. One benefit three interviewees reflected on was the way the training supported building positive relationships between FCs and DTs:

> *It meant [DT name] and I were building more of a relationship because you know, if you're talking about supporting the well-being of a young person, they [the child] need to see that professionals are working together.*
>
> FC

That the training was going to be school staff and FC training together was described by one carer as a reason for wanting to take part:

> *For us it was that there were sessions for us to meet with the trainer and school, so we were having those sessions together so we knew we were getting the same messages.*
>
> FC

Although the sessions were designed for larger groups, in practice all sessions were attended only by one carer–teacher pair. One FC referred to the benefit of this as meaning that the training was 'personalised' for their child.

One DT explained how having the time to hear from the carer in the training about how things were at home was useful, because they had a good idea of the circumstances at school, but having the dedicated time together through training helped build her understanding of how the children were at home:

> *But it just gave us the space to hear what life was like with the [siblings] at home, because we all know that children can sometimes play a different role at school and at home.*
>
> DT

Survey respondents noted that the best thing about the training was having the time to talk, work closely with each other (FCs and DTs) and focus on the child. This idea of having dedicated time to concentrate on the fostered child in the reflective way that STrAWB allowed was voiced by another FC:

> *The process for us was not that it necessarily told us anything new, but to actually sit down and focus on the child and to unpick the bits and say like what is it that's causing the problem. Things that we know, but perhaps were just overlooking because they weren't at the forefront.*
>
> FC

One DT talked about how the training 'refreshed' what they knew already. They explained that an additional benefit of the training had been around transferring the knowledge that was developed, or refreshed, in the training to use with other children, and sharing the application of this knowledge with other staff:

> *So, I know that the [siblings] were the named subjects, but actually the fact that a lot of the ideas we could pass through and use with other children as well. . . . Yeah, I've shared with the LSCs [Learning Support Caseworkers] and the ELSAs [Emotional Literacy Support Assistants] sort of some of the things that, went through and just reminding them. . . . and it's kind of looking back at why do they not develop good relationships? Why don't they, you know, value the relationships or why do they sabotage things? So, that was really useful just to kind of remind us that children can't always verbalise what's going on. They might show through their behaviour and then we have to kind of unpick it.*
>
> DT

Acceptability of the post-training assessments

All measures and all individual items on each measure were completed by carers and teachers. All five of the STrAWB participants, both DT and FCs, indicated that the number of forms to fill in was 'fine' or 'really manageable'. Unfortunately, when one FC opted to complete a hard copy of the diary for their two children, and their children completed a hard copy of the post-training child form, these were later lost in the post despite being tracked (the hard copies did not include any names, just anonymous ID codes). A summary was completed by the researcher (in consultation with the carer) for each of these two children to replace the diaries. The children did not feel able to complete the child forms again, so only three out of five children's measures were received. Two DTs said that if they needed support completing the online forms about the children, they could delegate the task to the most appropriate staff member at that point.

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Foster carers were asked to complete a daily diary in the 2 weeks after their last training session. All the carers who took part in follow-up data collection completed the diary. On the WBP diary measure, a number of carers' entries stated 'nothing significant' for specific indicators (mood, irritability, focus, sleep, fearfulness, impact, triggers) – but these varied both across individuals and within individual over the 2-week period, suggesting that the duration of reporting and the range of indicators are needed to capture the complexity of children's emotional and behavioural states.

There were slightly varying views about the task of completing the diaries. Overall, most of the carers found the task manageable. One FC described making use of the daily records that they routinely write for social care, so for this carer 'it wasn't anything that we're not already doing'. Another carer, completing the interview replacement survey, indicated that the completion of the diary was straightforward, but would have liked to include a longer time frame:

> *Easy, but doesn't necessarily show a true reflection, I feel over a month would be better.*
>
> *FC*

One carer decided to delay the diary in order to capture an event for the child that they felt would be beneficial to reflect on regarding the child's well-being, although they indicated in the diary that this had been a 'typical' week for the child:

> *Think I started and then realised, actually, there was, might have been a contact. Something had such an impact on him, I thought actually that's probably really useful to talk about and I think that's what I did.*
>
> *FC*

Future versions of STrAWB may need to consider the balance between offering carers the flexibility to choose a 2-week period that will capture the most useful information for the expert review, against the issues created by having a longer delay between training and review. For example, carers might be asked to select an appropriate 2-week period within the month following training.

Acceptability of the child profiles and feedback meetings

The two mental health experts had completed four child profiles between them by the time of closedown, and were asked in a joint interview to comment on the process. They both felt that the guidance provided around the purpose of the study and the measures used was useful and contained the right level of information. They also felt that the range of information provided by the multi-informant assessments was 'really helpful', and commented that they would not normally have access to such a broad mix of areas including loneliness and the child's best friendships when conducting assessments in a formal clinical setting. Compared to the referrals they generally received, they felt the assessments provided more information, were more structured and clearer:

> *I wish I got kids into my service like that, that I had all this information already. [It would make] my life so much easier. I mean, it was, it was really, really, really good.*

Both experts described the most helpful information as being the WBP, which made the information in the questionnaires 'come to life'. They praised the carers for the amount of effort that had gone into writing the diaries, and noted that one example contained so much rich information that 'I could make a diagnosis without doing the [clinical] interview'. One expert felt it would be useful to include the definitions of the six subheadings from the handbook in the diary itself, as they had noticed some duplication in the information recorded. They both suggested adding a heading on the quality of the child's relationship with the carer to provide further useful information for the profiles.

The experts valued having information from three sources, particularly the child's self-report, and commented on how revealing it was when the child's questionnaire scores indicated they felt something was not a problem, whereas the adults rated it as an issue. Such discrepancies were seen as an opportunity to ask further questions in the child profile.

As experienced CAMHS consultants (one a psychiatrist, the other a psychologist), both experts commented that although STrAWB was not designed to screen for particular issues, it was difficult not to approach reading the assessment information from a diagnostic standpoint:

> *[It gives] a picture of, you know, possibilities of diagnosis, which is really helpful to hang your understanding on a thing. But there's also so much more around the other aspects of their well-being as well. So that's why it's so much better . . . I mean, honestly, there's stuff to help you think diagnostically and the stuff to help you think about the sort of richer formulation as well.*

They felt that adding more mental health-related measures (such as on anxiety or depression) might begin to make the forms overwhelming to complete, and that the current mix of measures struck the right balance.

One of the experts had been involved in the previous pilot study and was able to complete each child profile in around an hour; the other was new to the study and took several hours for each one. They felt that a reasonable average time for completion was 2.5 hours, and that practitioners would get quicker the more child profiles they completed.

The experts discussed the language they used in writing the child profiles, as one had received feedback from the research team about the inclusion of technical terms. They felt it would be useful to include a short note in the experts' guidance about literacy levels and language. They commented that the use of 'inclusive and flexible language' would run the risk of some mental health services to whom children might subsequently be signposted rejecting the information, but also noted that services had a 'fragmented' approach to this and some would also reject information that was too technical. The most important thing, therefore – especially given that these were self-directed sessions with no researcher present – is to ensure that the language can be easily understood by carers and teachers.

In the present study, a member of the research team had produced the child-friendly 'All About Me' summary of the information written in the child profile, for FCs to talk through with the child and gather their views to feed into the feedback session. Asked whether this could be part of the mental health expert's role, they felt that this would require a very different style of writing and one which they were not used to producing, leading them to suggest that in a full trial, this role should continue to be filled by a different person with experience of writing for children. The experts cautioned, however, that the study could have no control over how carers talked about the information with children, and that there was likely to be substantial variation in this.

When asked to describe who might be best placed to produce child profiles in any larger trial of STrAWB, the experts said that the most important qualities were 'experience and open-mindedness and the combination of those two together', as well as 'consistency' and the ability to put all the information together. They felt this would most likely be found in a band 7 CAMHS practitioner nurse. The experts cautioned that it would be best to avoid specialist practitioners from 'the looked-after service', who they felt can sometimes show a narrow focus on the subject of their most recent training (such as viewing everything as an attachment issue) rather than bringing knowledge of a variety of children. However, in order to understand the context of the information in the assessments, a practitioner would need to have an understanding of the looked-after system, the challenges that young people who have been looked after experience, and how that may influence their emotional state. They felt this would best be delivered through a short training session, which would have implications for the cost of the intervention.

The FCs reported agreeing with the content of the child profiles, and none of the carers had any difficulty understanding the profile. In addition, no carer reported issues with the 'All About Me' profile that was written for the children, other than the child not wanting to engage in long discussions. Three carers talked about being confident to go through the 'All About Me' profile with their child. One specifically described going through the profile in sections, rather than doing it all in one go:

> *The thing is, with [child], you drip feed things. Because he can't take it all in at once.*
>
> *FC*

When the FCs reflected on the information provided by the child profiles, no carer reported finding out anything unexpected or new in terms of information about the child. However, one specifically described how despite this, it was still beneficial to see that a clinical professional could recognise similar issues:

> *I think in a way, is it awful to say, that I was a little bit disappointed. I thought I wanted some great revelation and then I realised actually 'no', I was being ridiculous. You know that unless they've got a crystal ball, it just wasn't possible. . . . But again, what was really nice it kind of felt like it was 'You're on the right path'.*
>
> *FC*

Feedback meeting

There were mixed reports about whether feedback meetings were held at the end of the STrAWB intervention period. For three of the children (represented by two FCs and one DT), feedback meetings were reported not to have happened. One of the omissions was due to delays in the data collection about the focus children – such that the child profile was unavailable during the data collection time frame. The other two described school transition processes (i.e. mid-year school transfer) and other school-related issues being the reason that the feedback meetings were not held:

> *At that stage they knew he was going, so he wasn't a priority and I thought 'you know what? It's not worth*

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> *kicking up the fuss and doing it'. Cause what's that going to achieve?*
>
> FC

Interestingly, one SW recalled attending a meeting, but the corresponding FC reported that no final feedback meeting had occurred. The SW spoke very positively about how meeting together to talk specifically about the child's progress and about the child profile was beneficial to their job role:

> *Within my role, it helped me to understand where [child] is in terms of his emotional well-being. So that is a helpful tool for me, you know. To know where he was and also to help me in the future if there's any intervention that I need to look at and put in to continue supporting him with his emotional well-being . . . With this tool I think it really gave us something to say 'ohh OK, all these years he's been getting therapy, emotional support, . . . we can actually trace the steps back from when he started to his current position'. So yeah, it was a really helpful tool.*
>
> SW

Another SW described attending the feedback meeting, and suggested that the content of the meeting was very similar to other meetings the same people would attend:

> *There was one meeting that we, that I had with the school and the foster carer where the designated teacher completed a form. . . . I have certainly the feeling that we were regurgitating stuff that we had already discussed because obviously we have review processes, we have professional network meetings, so there was nothing within that meeting that stood out.*
>
> SW

Only one carer completing the interview replacement survey indicated that they 'somewhat agreed' that the purpose of the meeting was clear and that the meeting was useful. However, they 'neither agreed nor disagreed' with the statements about developing an action plan during the meeting.

Cost of the intervention

An explanation of how the unit cost was calculated is provided in *Appendix 1*. Assuming that the DT held a senior leadership role in the school, the total cost per FC or child of the STrAWB programme was £1496. This included costs to the education sector of £704, costs to the social care sector of £410 and an additional £382 for costs that occurred for the training and intervention provider (e.g. mental health service provider). If a lower cost for the DT was taken, the total cost reduced to £1210.

Research question 2: is the research design feasible for a larger randomised controlled trial?

The findings presented here draw from the different methods used to assess the feasibility of the key research processes in terms of recruitment and retention, randomisation, primary and secondary outcome measures, and an economic measure of service use.

Feasibility of recruiting virtual schools to the research study

All of the VSs who were interviewed said that the reason their local authority had got involved in the STrAWB project was a keen interest in supporting children's mental health and emotional well-being. One VS also stressed their local authority's commitment to basing its practice on research evidence. Another key reason for involvement was the opportunity to 'upskill' professionals – particularly carers – through the training; this was felt to be an advantage over projects that only offered 'another survey'.

They pointed out that one key 'selling point' of STrAWB was the opportunity to strengthen working relationships between carers, SWs and DTs: something that 'all virtual schools are trying to get honed' for the PEP process. The ability to feed directly into an action plan should attract local authorities to take part in future studies:

> *But you're doing it from a knowledge base of the child, because the child's involved [in the project] as well, I think that's unique. I think that's your USP.*
>
> VS

Virtual school staff members also discussed the challenges that might face an individual local authority when deciding whether to take part. Two VSs discussed the impact on staff capacity of the expansion of the VSH's duties to cover all children with a SW; one was also involved in the pilot scheme to expand the Pupil Premium Plus to young people over the age of 16 years. Another mentioned the impact of an unfavourable Ofsted judgement, meaning there were 'an awful lot of other things going on for us'.

For the two local authorities that required their own research governance applications prior to sign-off, there was a time commitment from staff in obtaining this. Once signed up to the study, all of the VSs said that compiling the list of eligible children had been very easy because of their access to 'robust' data on looked-after children, though the pause in recruitment (detailed below) did mean they had had to go back later and revise the list because some children had moved placement. One VS noted that the project was focusing on 'what is, by their very nature, quite an unstable cohort of children'.

Feasibility of recruiting and retaining children, carers and teachers in the study

The COVID-19 pandemic, and in particular the uncertainty that existed in 2020–1 around school closures and learning from home, had a significant impact on our recruitment processes. We instigated a recruitment pause in February 2021, reopening in April 2021. We continued to recruit children to the study until March 2022.

Initial conversations with the VSHs suggested that there were around 300 children across the four local authorities who fitted the study's eligibility criteria. Information about the study was sent to the carers, teachers and SWs of all eligible children, and they were asked whether they were happy to have their contact details passed on to the research team. In two local authorities, this was done using an opt-out process; in the other two local authorities, an opt-in process was used. The use of the opt-in process in the largest local authority (with over 200 eligible children) had a significant effect, as the carers and teachers of only 11 children consented to have contact details passed on. In addition, consideration of children's circumstances beyond the exclusion criteria (e.g. where children were deemed not to be 'settled' or where court dates were imminent) across the local authorities further diminished the size of the recruitment list.

The VSs agreed that what had taken the most time was chasing up carers, SWs and teachers. In particular, the two VSs whose research governance agreements stipulated that individual children's SWs give consent for children's participation (rather than the blanket consent given for all eligible children in the other two local authorities) had spent a substantial amount of time contacting SWs:

> *It just took ages and half of them never responded . . . We could have done your 70 straight off if they had all done as they were asked and simply went, yeah or no. Honestly I thought when I sent it out to social workers at least 50 were going to come in and instead of which they just didn't answer. So I re-sent out everything three times. Twice . . . What I hadn't realised was the amount of repeat chasing. It was the chasing that wore me out. And it actually became soul-destroying . . . I had to watch the list dwindle even though the frustrating thing is that I knew the carers wanted to be involved, 'cause I'd met them in care in meetings and they were waiting. But their social workers just couldn't, I think that they just weren't like, didn't prioritise it. They didn't give it the time and the priority, the buy-in that I had expected.*
>
> *VS*

The VS felt this was due to a combination of a lack of understanding about how the project differed from others they were involved in (such as another research team's survey on the mental health of adolescents in care), alongside a lack of capacity to prioritise the research; this was compounded by a national issue of high levels of turnover and absence in social work staff.

Early meetings with the principal SW and the assistant director for corporate parenting to gain their buy-in to the project were suggested as a potential strategy for overcoming the barrier with SWs. Indeed, in another local authority, the initial conversation about taking part had been with the VSH and the principal SW, and the principal SW had then taken the lead on getting sign-off for the project; the VS felt this had worked well.

In total, 91 children's names were received from the local authorities, and each child's carer and teacher were e-mailed with a study information sheet and consent form (and/or a link to an online consent form). Chaser e-mails were sent for those who did not respond, and these were followed up with phone calls. For those who consented, consent was typically received within three calls for both FCs and DTs; however, an agreed number of e-mails (three for FCs; six for DTs) and calls (six for FCs; three for DTs) was tried before logging 'no further action' and excluding the child from the study. Substantial time and effort were therefore required to recruit the sample.

From the list of 91 names, 24 children were recruited into the study and consent was provided by the key adults; however, a further 3 were withdrawn before any baseline measures and before randomisation were completed, leading to a final sample of 21 children. From the original list of 91 potential participants, this represents a conversion rate of 23.1%. Our earlier pilot study had achieved a conversion rate of around 40%, but this was aided largely by the researchers attending in-person events for FCs to boost recruitment, which was not possible in the current study. A conversion rate of 23% means that we would have needed to receive the names of around 304 children to have achieved our target sample of 70. As we did not achieve our target sample, it was not possible to conduct the analyses needed to calculate the sample size needed for a full RCT.

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Figure 1 presents a flow diagram of recruitment and retention in the study. As the diagram shows, 15 of the 91 children on the initial list were excluded because they did not meet the study criteria: for 10 of these children, this was due to a significant change in living circumstances (most often a placement move) that had occurred in the short time since the VSH provided the list; a further 3 children had experienced a recent bereavement. For 11 children (including 4 with DT consent), we were unable to contact the child's carer despite repeated attempts. The FCs of 25 children (including 8 with DT consent) declined to take part: the most common reasons given were that (in 7 cases) the carer did not have the capacity to be involved due to other demands and (in 6 cases) that the carer did not think it was the right time for the child to participate (e.g. because of forthcoming moves in placement or school). The DTs of 13 children (including 6 with FC consent) declined to take part: the most common reason given (in 7 cases) was a lack of capacity, with 1 DT explicitly linking this to the pressures of being in a national lockdown.

Of the three children withdrawn from the study shortly after consent was received, two were siblings, and the carer's judgement on seeing the baseline measures was that the children could not understand the questions and would become too stressed by participating in the study. The third withdrawal was due to a placement move.

The largest attrition after this point was in the STrAWB group, where a further seven children were withdrawn: this was due to withdrawals by four FCs (due to a change in the carer's or child's circumstances), two DTs (where neither had the capacity to take part – and in one case the FC stopped engaging while the school were trying to find an alternative staff member to attend the training), and one SW (due to a forthcoming placement disruption).

The FCs and DTs of six children completed the STrAWB training. One FC withdrew from the study after the training, citing a significant change in the child's situation and behaviour. The carer was concerned that the information provided in the baseline surveys was no longer accurate and requested that all data be deleted for this child. The carer had also returned to work and had limited time.

Post-training measures were completed for five children. As mentioned in the *Methods* section, a hard copy of the diary for two children, and those children's self-report post-training child form, were later lost in the post. A summary was completed by the researcher (in consultation with the carer) for each of these two children to replace the diaries, but the children did not feel able to complete the child forms again. Due to the significant delay this caused, these two children's feedback meetings have not yet been held.

Two children in the control group were withdrawn when contacted about the follow-up surveys: in both cases, this was due to a change of placement. By the point when the study closed down, only a small number of follow-up surveys had been returned (all five FCs in the STrAWB group but only two out of six in the control group; no STrAWB DTs and only two control DTs; and just one child in each group). It is possible that further e-mail or telephone contacts would have increased these numbers had time allowed, but of note is that there had been changes since baseline in the key adults for children: two (one STrAWB, one control) having changed DT and a further four (three STrAWB, one control) having changed both DT and SW.

The level of contact with participants across the course of the study was high, and included contact about consent, baseline and follow-up measures, and (for those in the STrAWB condition) booking training, completing post-training measures and providing child profiles for the feedback session. Many of the calls and e-mails did not receive a response, leading to multiple attempts to contact being logged. In total, the carers of children in the STrAWB condition received 9–53 phone calls and 22–30 e-mails (most of the numbers at the higher end of this scale are because numerous attempts to contact went unanswered). Equivalent figures for carers in the control group were 9–21 calls and 3–18 e-mails. Overall, slightly fewer attempts were needed to contact DTs: 7–14 calls and 15–30 e-mails in the STrAWB condition, and 9–15 calls and 5–16 e-mails in the control group. Where higher numbers of contacts were logged for DTs, this was often due to a lack of a direct number for the DT meaning the researchers spoke to school receptionists several times before being able to catch the DT. Overall, this represents a significant amount of researcher time expended on recruitment and data collection.

How did individuals decide whether or not to participate?

A number of reasons for not participating were reported in a survey of FCs and DTs who had declined to participate in the main study. The most common reason was time constraints (two DTs, three FCs), often compounded by the pandemic's impact on education and children's social care. The context put pressure on resources, and specifically the availability of staff in schools due to staff illness or having to cover for colleagues who might be unwell – at unprecedented rates. This issue was echoed by one of the participating DTs who described the impact of the pandemic in school:

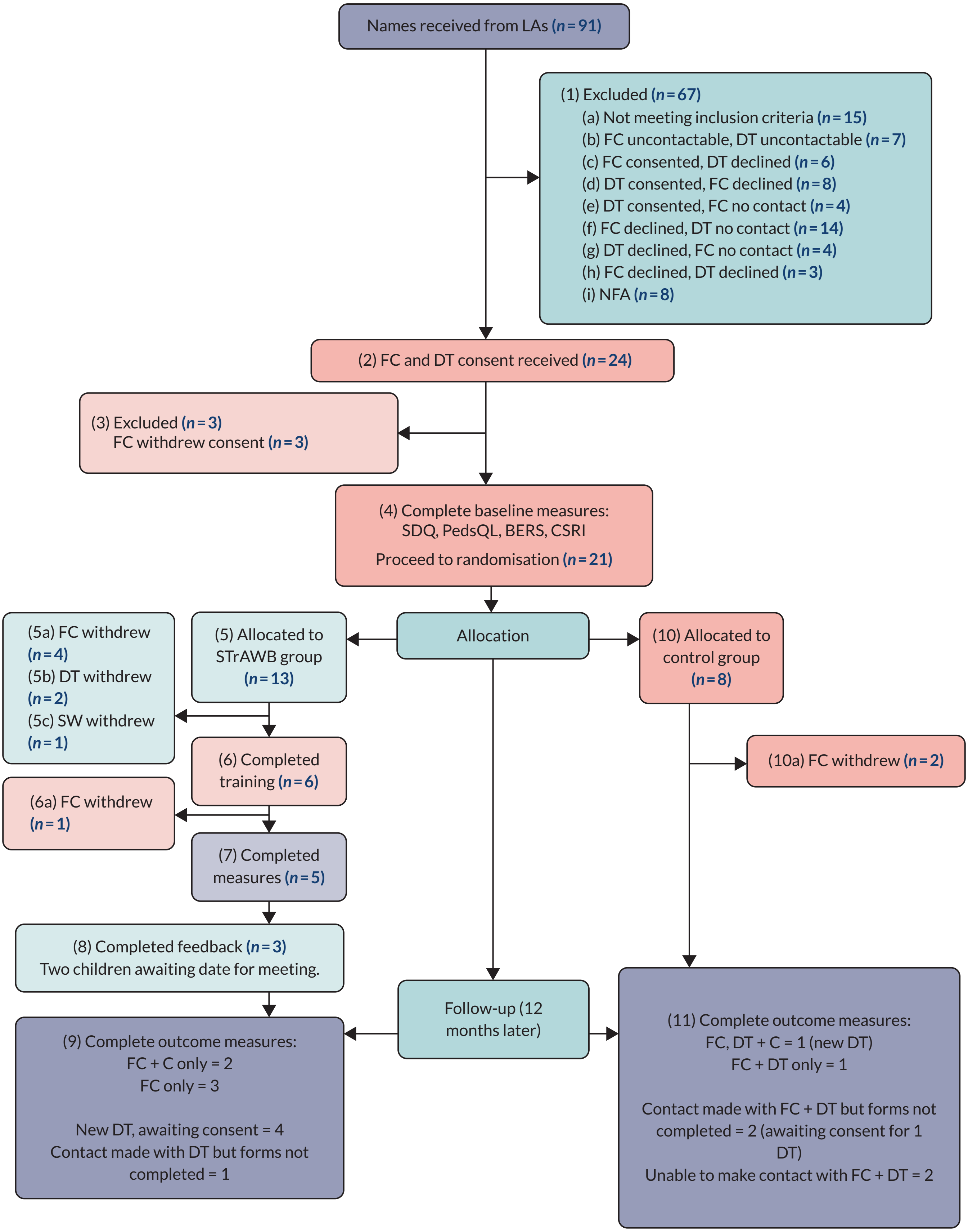

FIGURE 1 Consolidated Standards of Reporting Trials flow diagram for STrAWB project. C, child; LA, local authority.

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> *I think also it's been a bad time for you setting this up, unfortunately for you, only because during COVID, you know, we were having people left right and centre just disappearing. . . . it's been really hard to release people from class to do things because of sickness. . . . some days we had five people out with COVID. So, although we have a lot of internal cover teachers, we were having to pull people from all sorts of things to actually just have a body in front of the class for the day.*
>
> *DT, STrAWB*

The VS interviewees agreed that COVID had had a 'quite massive' impact on schools, in terms of being able to contact DTs but more importantly in their capacity to take on anything extra. They felt the same was true of carers, and that the implications for carers' capacity to participate was compounded where carers had three or four other children living with them (another response given by the non-trial participants' survey). One VS also felt the pandemic had had an effect on the stability of foster placements:

> *I think anecdotally I would say pressure on placements means there's been more movement. I would have to look back at the data and see if that was true for that age group. But I think it is possible. So, if you had quite a lot of stability during COVID because people couldn't move, but obviously once it finished, then I suppose people who had been struggling then were like, 'OK, well, we can't do this any more.' So, and I think a lot of people rethought their lives, didn't they during that time. You know, maybe and at that point foster caring wasn't what they wanted to do any more.*
>
> *VS*

Non-trial participants (five FCs, one DT) indicated that more experience as a carer was one of the main factors that would help them to participate in a project like STrAWB. It was also indicated that where the FC and DT knew each other well already, this would support the involvement and agreement of both people to participate. One participating DT reported that having a good relationship with the FC helped them to make the decision to get involved:

> *We'd see [FC] quite frequently and she was really keen to do it, so that was probably quite a driver as well.*
>
> *DT, STrAWB*

Motivations to take part in STrAWB varied across the interviewees. The most common reason to, shared by six interviewees, was to be helpful for children and services in the future:

> *There's not enough money and there's a lot of children coming through with mental health for it being COVID and stuff like that. So, I really think it's a good scheme and, so, I would do what you need me to do because hopefully this would take off, you know, like, and you'll get more funded and everything like that and it will help children especially looked-after children. . . . Because it's to do with children's mental health, and . . . basically there's not enough funding. There's not enough resources. There's not enough people out there. So, I think if it benefits children, I think it's brilliant if it takes off.*
>
> *FC, control*

A similar motivation expressed by five interviewees was the desire to support research activities that could lead to future benefits for the sector, services and looked-after children.

> *I'm very much a believer, if you don't help research, as much as you can with anything, there's no way on earth we can improve and move forward and hopefully we're being the recipient of the good, the focus that research does.*
>
> *FC, STrAWB*

> *If someone's doing research into children in care, which is children I work with, yeah if one of my children is involved then I'll follow it through.*
>
> *DT, control*

One carer indicated one of their motivations came from a desire to have well-being support for the child.

Two DTs reported getting a high volume of e-mails asking for their involvement in research or mental health programmes. In order to determine which to participate in, one DT described a process of skim-reading e-mails to determine whether it aligns with their 'development plan or at the top [of the] list of a child's needs'. That said, two DTs agreed that they were the right school contact for a programme like STrAWB, since their dedicated role gave them an oversight of looked-after children in school that class teachers might not have.

Moving forward, the VSs felt that carer recruitment might be improved by sending out information about the study through the local fostering network or Foster Care Association. One VS suggested that offering STrAWB as a slot in their existing programme of attachment and trauma aware training might improve recruitment, since DTs would be attending those anyway. However, another VS stated that their training was mainly for new DTs and that there were few group meetings outside of that for DTs. Even network meetings for special educational needs co-ordinators (SENCOs) and designated safeguarding leads (DSLs) – which are often joint roles for DTs – were ‘not necessarily brilliantly attended’.

How acceptable were the recruitment materials?

All interviewees expressed the view that the recruitment materials were clear and concise, and felt that they had the information they needed to be able to make a decision about whether to take part; the exception was one control group FC who filled in an interview replacement survey and responded ‘strongly disagree’ to all three statements asking about the recruitment materials for FCs with no further elaboration. Overall, the FCs reported that the children’s information was suitable to communicate the research. One FC described in particular how appropriate the information was compared to other communications they had had in the past:

> *Yeah, I found that good because it wasn’t all mumbo jumbo, if that makes sense. It wasn’t all over my head, you know, like sometimes when you work with professionals, they send things out and then you’ve got to try and put it into sort of like my terms. So, easy reading and everything I thought that was alright. I remember that.*
>
> *FC, control*

One control group FC, completing the replacement survey, indicated they strongly disagreed that the children’s information was suitable. However, no comments were added to the survey to describe the difficulties experienced.

Three non-trial participant FCs reported that it was important for them that the child was interested in taking part in the project. This shows that, even though the training and involvement in most of the activities is for the adults, whether the child would like to be the focus of the study is an important factor for FCs to consider. A similar point was raised in interviews with two FCs, where one indicated that a specific appeal of getting involved in STrAWB was because the child was involved in data collection, ‘having to answer questions himself . . . I think I felt more comfortable’. Another describes how they checked with the child about getting involved and justified recruitment of FCs first for that reason, so FCs can include children in that decision-making:

> *Because if the child isn’t interested then I don’t think it’s any point in going through school, if the child is gonna say no.*
>
> *FC, STrAWB*

One of the reasons given for not wanting to take part in the survey of non-trial participants was around the actual process of getting involved being off-putting. This may have been related to the way consent was being collected, or the way FCs and DTs were recruited separately but without the other knowing if they were directly getting involved. This speaks to the benefit of FC and DT having an existing positive relationship (explored further below), so they can agree together to take part or not.

How acceptable was the method by which individuals first heard about the study?

Foster carers reported hearing about the programme via e-mail from the fostering service, child’s SW or virtual school, or discussion with someone from their local authority, before hearing from the research team.

One FC described the influence of having that information coming via the local authority:

> *I wouldn’t have done it if it didn’t [come from the SW], or well if it didn’t come from them to start with but they sanctioned it I know I had their approval to do it because otherwise I wouldn’t do it.*
>
> *FC, control*

Two other FCs echoed this sentiment, indicating that they would always want the social care team to support their involvement in a research project and ‘wouldn’t have done it without that’.

When asked whether recruiting FCs via schools or local authorities would be more effective for STrAWB, one FC described how going through the local authority meant the FC knew the project had already been approved. If it had been required for the FC to check back with the child’s SW, it was anticipated that this could slow down the recruitment process:

> *If somebody else contacts me first, I’m not likely to do anything then unless I get something then from the social worker. Or, if I’ve then got to get in touch with the social worker, knowing the way things work, there’s usually quite a delay so I wouldn’t be expecting a quick turnaround, so it would probably miss the boat.*
>
> *FC, control*

We also asked VSs whether the recruitment of the carers and children might be achieved by the schools, rather than the research team. There were mixed views about whether this could work in practice. One VS pointed out the benefit of schools having the information for the SW and the carer more readily available than the VS, and another added that

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the carer would be more familiar with the child's school as a point of contact than with the VS. However, the third felt that this process would become too convoluted.

Interviewees were also asked if they thought either FCs or DTs should be recruited before the other. Of the six interviewees who responded or talked about this, the two DTs indicated it would be best to recruit a DT first, and three FCs indicated that they should be recruited first. Only one FC reported they thought it would not matter which person was recruited first.

We asked the same question of our VS interviewees. All VSs felt that approaching schools first would work well and had benefits over the existing process of approaching teachers and carers in parallel. One VS pointed out that starting with the DTs would enable a more focused effort from the VS, utilising their existing DT networks to achieve sign-up from schools before carers were approached. They also felt that schools could make the initial decision in light of how the study fits with their existing provision; they felt this might even be part of the role of the new Mental Health in Schools practitioners.

Acceptability of the randomisation process

Thirteen children were randomised into the STrAWB condition, and eight into the control group. No carers or teachers refused to participate on the basis of the randomisation results.

Four interviewees (two FCs, a DT and a SW for one of the STrAWB group children) talked specifically about their acceptance of the randomisation used to form the two groups in the trial. More interviewees discussed understanding why a control group was necessary for the trial:

> *It was randomised, which is absolutely fine, that's probably the best way to do it, yeah.*
>
> FC, control

All of those who answered the question about how being in the control group had impacted their participation reported that their engagement in data collection activities was not affected. Two interviewees (one FC, one DT) explained that as part of the control group they felt they were still able to 'help out', or saw that it would still 'benefit children' by responding to the data collection requests. Three interviewees talked about having 'dismissed' (DT) the programme, or 'switching off' (FC) their minds to the programme, typically because there were fewer actions required of them compared to the STrAWB group. Others simply stated that they did not mind nor feel negatively about being in the control group. One DT expressed a small amount of disappointment about not being in the intervention group, but understood how their contribution still had value:

> *I understand it from a research point of view but also I obviously didn't end up in the group I wanted to be in . . . you're researching that this intervention may work. By the time it gets to the stage of trialling it, it's because you're quite confident in it, therefore, I would have enjoyed being in that group. . . . I do understand the benefits, you know, the control group versus the intervention group, I still understand the need for both, and ultimately it will still benefit children.*
>
> DT, control

One DT expressed some confusion from the FC about the role or purpose of the control group, and felt this had not been clearly communicated. They described understanding the process themselves, but thought the FC believed they would receive support through the programme, so when placed in the control group there was some expectation management that the DT had to do:

> *What wasn't clear at the beginning was that there would be a control group, so that wasn't transparent . . . The carer for the relevant child . . . believed they were going to get that support and at the end of that were part of a control group, and the impact of that . . . I've said that this will be worthwhile doing and then 'OK look, you've put time in, you've decided to open up to this and now it's not going to happen', you know. That can affect the trust that people have on my decision-making as well. So, that wasn't helpful.*
>
> DT, control

This was a surprising finding, as the chance of being in a control group and the benefits this would convey were clearly outlined both in the information sheets for carers and teachers, and in a video on the project web pages, and all carers were offered a phone call before consenting to ensure they understood what was involved in taking part. This raises the question of whether these processes were sufficient to provide complete assurance that every participant understood the key information provided in the consent process. However, as mentioned above, the majority of participants felt the recruitment materials were suitable, informative and easy to comprehend.

Most of the control group interviewees (n = 5) indicated that the amount of contact with the research team was just right. Many expressed understanding that the nature of the control group was that there would be less asked of them, so were content at being contacted when action was requested of them:

> *It's interesting that we're in the control group, so there's . . . nothing to do in the interim . . . I think [additional contact] would have become unnecessarily cumbersome and intrusive, I think. . . . I think this worked well; when you need something, contact, otherwise, don't. Perfect.*
>
> *DT, control*

On the other hand, two FCs in the control group indicated they would have liked more 'keeping in touch' e-mails about the progress of STrAWB:

> *I remember thinking that nothing's happening, and thinking it's all gone, sort of, quiet or whatever, so I think that maybe a little reminder in between, you know, things are happening and we'll get back to you or whatever, would probably have been a good idea.*
>
> *FC, control*

Illustrative case studies

Case studies for two families in the STrAWB condition illustrate the substantial challenges that carers and children faced across the duration of their participation in the study (*Box 1* and *Box 2*). These are included to provide detail on some of the contextual factors that might typically affect the ability of children, carers and teachers to participate in any future studies of STrAWB.

BOX 1 Case study for Family A

Family A

Family A included the participating carer, her husband, the two siblings involved in the study and two fostered younger siblings. The siblings involved in the study were in a long-term placement and this was the only placement they had had. The first contact about STrAWB was made in January 2021; the carer explained that life felt chaotic at that time as the two younger siblings, with additional needs, had just moved in and required a high level of care. She asked if she could participate after Easter once the children had settled. The carer was contacted in May and was keen to participate, as was the DT, who knew the carer and siblings well. The carer completed baseline measures for Child A in July and was randomly allocated to the STrAWB group. Due to her busy home life and the needs of the younger siblings, the research team regularly called to remind her to complete the surveys. In September Child B was invited to participate in the study, and the carer swiftly completed a consent form. STrAWB training was completed in October and November. The carer struggled to fit in completing baseline measures for Child B alongside training. Both children struggled to cope with upcoming changes (e.g. time with mum, school holidays, Christmas), which meant that the carer was dealing with increased challenging behaviours. During January 2022 the carer stopped answering phone calls from the researcher assigned to that case. A different member of the research team, who was also a FC, took the primary liaison role. The carer then completed Child B's baseline measures, before starting the post-training measures for both children. Three of the four post-training measures were completed in February, but writing 2-week diaries remained challenging. In March these were initiated, but a problem with reusing the same web link to enter data for a second child meant only one child's data were recorded. The carer was sent hard copies and a prepaid tracked envelope to return them. These were completed in June but later lost in the post. Although there was a tracking number, the delay in returning the diaries meant that tracking was not possible. It also became difficult to contact the carer. This was due to the siblings struggling with contact time, the school holidays and their move to secondary school in September. Then court proceedings and adoption processes for the younger siblings began. In that period of time, and the build-up to Christmas, a decline in the older sibling's behaviour was experienced. This made contacting the carer difficult. In January 2023, the carer answered a call and explained that there had also been a family bereavement. The researcher arranged a time to call the carer back to complete a summary about each sibling to replace the lost diaries. The researcher also arranged another call to complete the 12-month follow-up surveys over the phone. Due to the siblings moving to secondary school, a new DT was invited to complete the follow-up measures, but did not consent to participate in time. It was, however, possible to interview the DT who participated in training about their experience of STrAWB.

BOX 2 Case study for Family B

Family B

The child had been living with the carer and her husband for around 5 years. The carer was contacted in May 2021, giving consent to participate in the study in July. Over the summer the family experienced a bereavement, so the carer was unable to complete the baseline measures until September. They were randomly allocated to the STrAWB group. The STrAWB training was completed in November. The carer submitted the four post-training measures in November and started the 2-week diary mid-December. However, she wanted to capture the impact that birth family time had on the child so delayed completing day 2 of the diary to capture this. Around this time the child became unsettled, having nightmares and night terrors and frequently woke in the night, and became more irritable and withdrawn. The carer noted that the child had previously become very unsettled when told his birth mum was going to court to get him back. She said he recognised that his mum was unable to cope and wanted to stay with his foster family.

The DT said that the STrAWB feedback meeting occurred in May 2022 and that it had been a useful opportunity to discuss the child's strengths and needs. Likewise, the SW confirmed that the feedback meeting was useful to her role. However, in an interview the carer reported that a feedback meeting did not happen. They believed this was because she and the DT already had frequent meetings due to the child experiencing bullying at school. The carer does not think that an action plan was completed for the child. The child moved schools before the 12-month follow-up; it was not possible to get consent from the new DT and so the follow-up measures were not completed.

Feasibility of collecting data on the primary and secondary outcome measures

The number of completed measures at baseline and follow-up matched the number of participants shown in boxes 4, 9 and 10 of *Figure 1*, except where stated below.

On the SDQ, two children at baseline were not able to or did not want to complete the measure. Across all completed SDQs (by children, carers and teachers, and at both time points) there were no missing data on any individual item.

On the PedsQL, one child at baseline was not able to or did not want to complete the measure. Across all completed PedsQLs (by children and carers, and at both time points) there were no missing data on any individual item.

The BERS had small amounts of missing data for carers (one missing answer on four questions at baseline and one missing answer on one question at follow-up). There were also small amounts of missing data for teachers on several questions (one missing answer on nine questions at baseline and one missing answer on one question at follow-up). There were slightly higher levels of missing data for teachers at baseline on 3 questions, each missing 2 answers (out of the 21 completed measures): questions 11 ('Communicates with parents about behaviour at home'), 15 ('Interacts positively with parents') and 36 ('Participates in family activities'). Since these are all questions about home life, it is understandable that 10% of teachers could not answer these questions.

Descriptive statistics on the three measures (SDQ, PedsQL and BERS) as completed at baseline are shown in *Table 2*. Analysis of baseline survey data presented further below is therefore based on 20 children: 12 in the STrAWB group (3 girls and 9 boys) and 8 in the control group (2 girls and 6 boys). There were no significant differences between the scores of the STrAWB and control groups on almost all of the measures and subscales, suggesting randomisation

TABLE 2 Mean scores on the primary and secondary outcome measures

Measure	Possible range	STrAWB group mean (SD)	Control group mean (SD)	Total mean (SD)
Carer SDQ		**(*n* = 12)**	**(*n* = 8)**	**(*n* = 20)**
Emotional problems	0–10	5.00 (2.80)	3.25 (3.15)	4.30 (2.99)[a]
Conduct problems	0–10	3.67 (2.90)	3.88 (2.75)	3.75 (2.77)[a]
Hyperactivity	0–10	6.25 (2.73)	4.88 (2.64)	5.70 (2.72)
Peer problems	0–10	3.75 (4.03)	2.63 (2.39)	3.30 (3.44)[a]
Prosocial	0–10	6.50 (1.45)	7.13 (2.30)	6.75 (1.80)[a]
Total difficulties	0–40	18.67 (10.21)	14.63 (9.30)	17.05 (9.82)[a]
Impact[b]	0–10	3.00 (2.92)	3.00 (3.06)	3.00 (2.89)[a]
Child SDQ		**(*n* = 11)**	**(*n* = 7)**	**(*n* = 18)**
Emotional problems	0–10	4.18 (3.40)	3.86 (1.35)	4.06 (2.73)
Conduct problems	0–10	2.91 (2.51)	3.57 (2.57)	3.17 (2.48)
Hyperactivity	0–10	5.82 (2.52)	4.71 (2.21)	5.39 (2.40)
Peer problems	0–10	3.09 (2.74)	1.86 (2.04)	2.61 (2.50)
Prosocial	0–10	8.18 (1.54)	8.71 (0.95)	8.39 (1.33)
Total difficulties	0–40	16.00 (9.11)	14.00 (6.38)	15.22 (8.01)
Teacher SDQ		**(*n* = 12)**	**(*n* = 8)**	**(*n* = 20)**
Emotional problems	0–10	2.83 (2.69)	1.88 (3.36)	2.45 (2.93)
Conduct problems	0–10	1.83 (1.80)	1.75 (1.75)	1.80 (1.74)
Hyperactivity	0–10	5.33 (3.58)	5.13 (3.87)	5.25 (3.60)
Peer problems	0–10	2.83 (2.59)	1.63 (1.41)	2.35 (2.23)
Prosocial	0–10	6.58 (2.31)	7.00 (2.93)	6.75 (2.51)
Total difficulties	0–40	12.83 (8.89)	10.38 (9.15)	11.85 (8.84)
Impact[b]	0–6	2.60 (2.27)	1.71 (2.63)	2.24 (2.39)[a]

Measure	Possible range	STrAWB group mean (SD)	Control group mean (SD)	Total mean (SD)
Carer PedsQL		**(*n* = 12)**	**(*n* = 8)**	**(*n* = 20)**
Physical functioning	0–100	69.53 (31.70)	83.59 (17.66)	75.16 (27.33)
Emotional functioning	0–100	54.17 (28.75)	55.63 (19.17)	54.75 (24.79)[a]
Social functioning	0–100	54.58 (30.93)	70.00 (20.87)	60.75 (27.82)[a]
School functioning	0–100	60.00 (20.11)	71.88 (17.72)	64.75 (19.63)
Total quality-of-life score	0–100	59.57 (23.62)	70.27 (16.63)	63.85 (21.30)[a]
Child PedsQL		**(*n* = 11)**	**(*n* = 7)**	**(*n* = 18)**
Physical functioning	0–100	74.15 (26.78)	90.18 (7.31)	80.38 (22.48)
Emotional functioning	0–100	63.64 (30.34)	53.57 (15.47)	59.72 (25.52)[a]
Social functioning	0–100	63.64 (28.82)	79.29 (19.46)	69.72 (26.14)
School functioning	0–100	58.64 (20.38)	65.00 (19.15)	61.11 (19.60)
Total quality-of-life score	0–100	65.01 (21.77)	72.01 (14.34)	67.73 (19.07)[a]
Carer BERS	Standardised:	**(*n* = 12)**	**(*n* = 8)**	**(*n* = 20)**
Interpersonal strength	M = 10, SD = 3	7.25 (2.42)	7.63 (2.33)	7.40 (2.33)
Family involvement	M = 10, SD = 3	8.33 (2.96)	8.75 (2.43)	8.50 (2.70)
Intrapersonal strength	M = 10, SD = 3	6.67 (2.96)	8.13 (1.96)	7.25 (2.65)
School functioning	M = 10, SD = 3	6.83 (2.59)	8.88 (3.31)	7.65 (3.00)
Affective strength	M = 10, SD = 3	8.08 (2.87)	8.88 (3.09)	8.40 (2.91)
Overall strength index	M = 100, SD = 15	82.25 (14.62)	89.38 (14.44)	85.10 (14.61)[a]
Teacher BERS[c]	Standardised:	**(*n* = 12)**	**(*n* = 8)**	**(*n* = 20)**
Interpersonal strength	M = 10, SD = 3	9.33 (2.90)	10.50 (2.78)	9.80 (2.84)
Family involvement[a]	M = 10, SD = 3	9.30 (1.95)	10.13 (2.70)	9.67 (2.28)
Intrapersonal strength	M = 10, SD = 3	9.50 (2.78)	10.13 (2.80)	9.75 (2.73)
School functioning	M = 10, SD = 3	9.00 (3.16)	10.13 (3.60)	9.45 (3.30)
Affective strength	M = 10, SD = 3	9.25 (2.99)	9.50 (3.78)	9.35 (3.23)
Overall strength index[a]	M = 100, SD = 15	91.60 (14.37)	100.25 (19.46)	95.44 (16.88)

SD, standard deviation.

a Scores lie more than one SD outside of published norms.

b The impact subscale of the carer and teacher SDQs is only calculated for children whose difficulties are judged to impact on their daily lives. Scores here are based on 19 children for the carer SDQ (12 STrAWB and 7 control) and 17 children for the teacher SDQ (10 STrAWB and 7 control).

c The family involvement subscale and overall strength index of the teacher BERS are based on data from 18 children (10 STrAWB and 8 control), given missing data for 2 children on the items needed to calculate these.

had been effective. The only exception was on the child self-report version of the PedsQL, in which children in the STrAWB condition on average rated their physical functioning lower than those in the control condition ($p = 0.04$).

In comparison with published norms for the SDQ,[70] our sample scored substantially higher on average (more than one SD) on almost all subtypes of difficulty, total difficulties and impact on daily life, as rated by carers. On the child self-report and teacher measures, differences

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from published norms were less pronounced, with the exception of teacher-rated impact. Descriptive statistics relating to established classification cut-off points as completed at baseline are shown in *Table 3*. In comparison with the distribution of classifications published by Youthinmind,[71] and across all three types of informants, our sample was less likely to have a total difficulties score that was 'close to average' and significantly more likely to have a 'very high' score.

The sample scored substantially lower than published norms[63] on the emotional functioning (carer and child) and social functioning subscales (carer only), and the total quality-of-life score (carer and child) of the PedsQL. Children's strengths as measured by the BERS fell into the 'average' category from the published norms[64] on the teacher version; the overall strength index on the carer version fell into the 'borderline' classification.

As shown in *Tables 2* and *3*, there were a number of discrepancies between informants on the individual scales and subscales. On the SDQ, conduct problems were on average rated lower by teachers than by carers or children; teachers were less likely to state that difficulties were having an impact on children's daily lives than were carers; and prosocial behaviour was rated higher on the child self-report than by carers or teachers. Teachers gave higher scores of children's strengths than carers did, on all but one subscale (affective strength) of the BERS, and on the overall strength index. Drawing out any differences between informants' ratings for individual children in the STrAWB group formed an important part of the feedback process.

Comparison of acceptability on the two primary outcome measures

As noted above, completion rates were high for both measures, and there were no missing data on any individual items, indicating that both were feasible for use in a trial. There was one more child unable to complete the SDQ than the PedsQL, although it was unclear whether this was due to a lack of comprehension or for other reasons. On the other hand, in terms of collecting multi-informant data, the SDQ has the advantage of having a teacher version, which the PedsQL does not.

Three DTs described being comfortable with the forms they were asked to complete. Another control group DT did not recall the process of filling in any forms for the data collection, and could not recall when prompted in the interview. One DT in a secondary school had anticipated delegating the form-filling to a head of year who knew the child better; however, when viewing the forms, he decided he could respond to all items. One DT in a primary school asked the child's class teacher to complete the forms, feeling that they had a 'better relationship' with the child than she did and so were better placed to complete the form.

Overall, carers reported that the SDQ and PedsQL were straightforward to complete, and none of the items were consistently highlighted as being difficult to answer. They also found the tools to be relevant for their child's age. The only difficulties discussed were about the ability of the FC to interpret the behaviour and feelings of the child accurately. One carer describes how they believe their child will mask 'true' emotions:

> *FC: So, some of these questions . . . were really tricky for me to answer because like for instance, 'I get angry and often lose . . .' like, he is never angry . . . You never see a true emotion from him. He will smile. . . . He never gets angry. Which is just not real, is it? We all get angry. And so, he's constantly restrained and controlled.*
> *Interviewer: That's really interesting and maybe this tool doesn't get at that.*
>
> *FC: No, it doesn't.*
>
> *FC, STrAWB*

Another FC described that interpreting the child's behaviour expressed and understanding the feelings behind it can be 'a bit challenging to think about' when responding to the items on the forms. This sentiment was expressed by a DT who described that sometimes

TABLE 3 Distribution of classifications on the SDQ by informant

Measure	Close to average, %	Slightly raised, %	High, %	Very high, %
Carer SDQ: total difficulties	33.3	8.3	8.3	33.3
Child SDQ: total difficulties	55.6	5.6	0.0	38.9
Teacher SDQ: total difficulties	55.0	20.0	0.0	25.0
Published norms[71]	80.0	10.0	5.0	5.0

for 'some of our children the only way they are able to show their emotions is physically, so something on that would have been helpful'. They indicated that a potential gap in the tools' assessment is around children's physical behaviour (e.g. aggression and violence), since they believe this is a method of emotional expression for children.

Commenting on the difficulty carers and teachers might have in interpreting children's emotions – especially where masking occurs – one of the mental health experts noted that this is why objective behavioural measures such as the SDQ are useful. They stressed that having all three informants completing the SDQ in the study meant the limitations of the measure for adult informants were mitigated by its strengths in the child self-report. They felt that not having one dominant viewpoint is 'a huge strength of STrAWB'.

Five FCs preferred the PedsQL, and two FCs preferred the SDQ scale. Reasons for preferring the PedsQL related to the variety of areas covered by the scale, and the relevance of the tool. Two carers also expressed their preference for having more response options for each item: five in the PedsQL, compared to the SDQ's three response options. One control group carer indicated that the PedsQL allowed her to reflect on a breadth of relevant areas, which she suggested helped her give a more rounded view of the child she cared for:

> *I'm a big fan of this form and I hope that this comes out and replaces the strengths and difficulties one because this is so much better. It gives you so much more about the child that could come up . . . a lot of the questions I might be answering might be 1's. And then you get one or two, you say 'no, definitely not' and that really gives me the opportunity to answer questions that cover more about her whole character and person.*
>
> *FC, control*

Another control group carer described how they felt the tool was more specifically about the child so felt it was a more useful tool than the SDQ to represent the well-being of the child:

> *I think the questions, sort of, get to the point a bit quicker, . . . this one, it seems a lot clearer about, you know, 'feeling angry', so, it's not necessarily looking at how they get on with everybody else. 'Is that child feeling angry, are they sad or are they scared', umm, seems more direct to me . . . it seems a bit more relevant.*
>
> *FC, control*

Shortcomings of the PedsQL were also voiced in interviews with carers. One carer highlighted the American language in the form (e.g. 'walk more than one block') and described having to translate that into meaningful terminology for the child to complete their version of the form. Another carer, who did prefer the PedsQL, shared a concern that the tool was entirely focused on 'problems with' each item. They explained this might be difficult for the child themselves to complete the form:

> *I can't see any positives there, if I was giving it to my child, I want to see some positives because so much focuses on the negative. . . . Inject some positives, because it's hard for a kid doing things like that, isn't it? Because these are children that have problems with their emotions and you're asking them all about negative things.*
>
> *FC, STrAWB*

The only other direct critique of the PedsQL, which was also described as an issue with completing 2-week diaries, was the time frame that the carers were asked to consider while filling in the form. As one carer describes, over a year 'life is a roller coaster ride especially for children living in care' which makes designating any time frame on an assessment tool difficult for carers to be sure they are capturing an accurate representation of how the child is:

> *So, I don't know how valuable it is putting a month in. I think it's just too short a time for a child. I would say something like over the last, I don't know, 6 months maybe that's a better window for looking at it.*
>
> *FC, STrAWB*

The carers who preferred the SDQ (one control and one STrAWB) explained the preference came either because they were familiar with it (through being regularly asked to complete it by Children's Social Care) or because, due to the way they used the tool, it helped in their understanding of their child. For one carer, with the PedsQL they reported that when the child completed the form, due to having more response options, they 'just ticked the boxes', indicating they completed the form more carelessly than when they completed the SDQ. They also explained that they did not 'know if he [the child] understood what "almost never" meant'. However, for this carer, completing the SDQ was a more valuable experience, as described in the second quote below:

> *He told me more information, because he picked 'certainly true' on one of them, and I was like, 'oh, that surprises me, why did you say that?' and I got lots of*

> *further information out, I don't think I'd have found out otherwise, I don't think he would have told me about it.*
> *FC, control*

On balance, the evidence suggested carers might prefer the PedsQL over the SDQ as a measure of looked-after children's well-being. Given the comparably low levels of missingness on both measures (albeit in a small sample), the PedsQL appears to be both feasible and acceptable as a measure of the primary outcome, provided it is also able to detect change over time.

Acceptability and usefulness of measure of service use

A detailed report of responses on the CSRI is available in *Appendix 2*. Overall, only a few responses were missing, which mainly referred to the open text category for 'other services'. All of the suggested categories of services (e.g. extra help from teacher, educational psychologist/SENCO) were reported to be used by at least three children and all response categories were used, suggesting that those were adequate. The free-text option was an important inclusion, as carers listed additional services that were being used frequently. Adding examples to the category of 'other service' such as breakfast club or 'after-school lessons' might be useful to increase the comprehensiveness and consistency of responses.

Very few carers reported that the child had used health services. It might be possible to shorten this section if needed, for example summarising the three options in one or two and perhaps removing the distinction into face-to-face versus online as response options. This needs to be balanced against implications on the accuracy of cost estimates, since unit costs for the services in this category can vary substantially.

Responses regarding other services suggested that it might be useful to make a clearer distinction between the question that refers to professional support and the one that refers to informal and privately organised (and paid) support, including leisure activities. It might also be possible to group different types of therapists with similar unit costs (e.g. occupational therapists and speech and language therapists).

The final question asked about 'other services'. It might be good to focus this question on specific types of informal support known to have a cost attached. Another possibility would be to link this to questions about FCs' payments for different supports, which would allow establishing cost estimates.

Overall, this adapted version of the CSRI appeared highly acceptable and feasible. There are small changes to the questions that could be made to potentially increase the number of accurate responses; it is common that service use is heavily centred around a few individuals and so leaving out categories is generally not advisable. A clearer distinction between categories of other services would be useful.

Discussion and conclusions

Implications for training and assessment connecting education and social care

In general, for the small number of participants who completed the STrAWB intervention package, feedback on STrAWB was positive. The time and effort involved in completing the training and assessments were considered to be challenging at times, but manageable. Conversely, survey respondents who had decided not to participate in the trial most frequently cited lack of time as an explanatory factor. Future attempts to deliver STrAWB or similar interventions would therefore benefit from consideration of how fostering services and schools might support carers and teachers to take part, for example through the provision of respite care or classroom cover, so that the intervention's reach is not restricted to those who are more able (or enabled) to find the time.

The COVID-19 pandemic necessitated major adaptations to the intervention, primarily the move from in-person to online training. This took a substantial amount of time to achieve, but all aspects were tested by our Project Advisory Group and the feedback from study participants suggested that the online version of STrAWB was acceptable and easy to access. Teachers noted that the online format offered a saving in terms of time and costs.

Feedback from those completing the training suggested that the content was not entirely new to them, but the opportunity for carers and teachers to learn the same messages about well-being and to have devoted time to discuss the child's needs were highly valued. Future iterations of STrAWB and other types of training bringing professionals together might benefit from dedicating a greater proportion of time to discussion, as opposed to information delivery. The face-to-face version of the training that was used in the previous pilot study had allowed for more discussion time and deeper engagement with the material; offering this as an option in future might therefore be beneficial.

Some participants – particularly carers – said they would value the opportunity to mix with other carers in the training. Although only one carer expressed a preference for face-to-face events, this was with the understanding that in-person group sessions were not possible during the period of the study. This reflects findings from studies on the move to online therapeutic options during the pandemic,[72] which showed a mix of limitations (in terms of internet access and the time taken to build rapport) and advantages (making it more accessible to some and representing an effective use of practitioners' time). As the country moves forward from the more restrictive environment of lockdown, it will be useful to explore the relative benefits and limitations of online versus face-to-face versions of STrAWB and other training programmes, recognising that priorities might differ between carers and teachers.

The mental health experts appreciated the richness of information provided by carers, children and teachers that enabled them to produce individual child profiles. Suggestions for possible amendments to the measures were minor, and virtual schools in particular saw the value of having a multi-informant assessment that included the child's perspective. In line with previous recommendations,[33,34] this study highlights the benefit for future interventions of capturing well-being information from different perspectives and across the home and school contexts.

Interview findings on the feedback sessions suggest these were underused and their benefit was unclear. In the pilot study, a researcher facilitated these sessions. They were able to direct the conversation, for example by pointing out where carers, children and teachers had given contradictory scores on the measures. For the present study, feedback sessions had always been planned to take place without researcher facilitation but with the provision of written guidance – this was not just due to COVID restrictions. However, the findings suggest that a researcher's presence or perhaps a personalised video from the research team highlighting the key points for discussion, and the importance of completing the action log, would be useful in future.

Overall, notwithstanding the wider challenges with recruitment, retention and scheduling of activities (discussed below), the findings suggest that it is possible to deliver a programme of well-being training and assessment online. The increase in children's mental health difficulties in the light of the COVID-19 pandemic[38] and the resulting backlog in the mental health system[40] suggest that programmes like STrAWB, which can identify well-being needs at an early stage and inform the support strategies that are put in place, are needed now more than ever.

Recommendations for research with primary-aged children in care

The RCT design appeared to be acceptable, and participants allocated to the control group understood the reasoning for this. This might have been aided by the knowledge that they would receive access to the online training materials at the end of the study, as well as a summary of their child's scores on the baseline and follow-up measures, suggesting that a similar design would be appropriate in future.

It was not possible to achieve the target sample size. This was largely due to the context of COVID, which had two major impacts: the research team were unable to attend in-person carer groups or DT training days to recruit participants, a strategy that had worked well in the pilot study; and a number of carers and DTs were overwhelmed by the responsibilities of home-schooling or finding teaching cover. This echoes findings from surveys of carers by The Fostering Network[42] and Research in Practice,[43] who also reported the strains of increased responsibilities and the worsening of some children's mental health during lockdowns.

A considerable amount of researcher time was expended on contacting carers and teachers, particularly during the recruitment phase. In interviews we explored the option of moving to a recruitment model where schools were approached first for consent; most agreed this would be sensible and would save the team from chasing up schools where the carer would ultimately decline. There was disagreement about whether schools could subsequently recruit carers and children into the study. The most appropriate model, therefore, appears to be a staged approach, with the research team getting consent from schools and then approaching the carers and SWs of their eligible children.

There was substantial instability in our target cohort. Some school moves were planned – the change of schools for those children who progressed from year 6 to year 7 was expected, but the process of obtaining consent and follow-up measures from the new school's DT was more difficult than anticipated. The desire to include a greater spread of ages, including those with more advanced literacy levels to assist with the completion of the self-report measures, should in future be weighed against the likelihood of attrition in this year group. Other children changed school mid-year. Research conducted for the Children's Commissioner's most recent Stability Index[73] showed that just over 11% of looked-after

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children in state-funded schools experienced a mid-year school move.

There were also high levels of instability in terms of children's social care (a number of children moved placement and/or changed SW during the course of the study) and education. Government statistics show that in the 2 years covered by the period of the study (2020–2), 30–31% of children in care in England experienced at least one placement change during the year, and 10% experienced at least two placement changes.[1] The Stability Index for looked-after children[73] showed that the rate of multiple placement moves in the year among children aged 5–11 years was increasing faster than the actual rate of children of this age group who were in care. They also found that around 1500 children – 3% of those who were in care in both 2018 and 2019 – had experienced sustained placement instability of two or more moves in each year; this sustained instability was more likely for children with an identified social, emotional or mental health need. The previous Stability Index[74] also included SW changes and showed that 21% of children had experienced two or more changes of SW in the previous year while in care. While 5% of children had experienced all three types of instability (at least one change of school, placement and SW in the previous year), almost three-quarters (72%) of looked-after children had experienced any of the three types of instability in the same period. Arguably, these experiences of instability would make the STrAWB child profile even more valuable, as it could travel with the child and provide important information on their well-being and mental health for their new carers, schools and SWs.

As in the present study, the Mental Health Assessment Pilots for looked-after children[49] also struggled with recruitment, achieving 116 child assessments across seven sites between July 2019 and March 2021, from a target of 350. Although there was a pause in fieldwork during 2020, the report notes that the issue arose in 2019, before the pandemic. Echoing our findings, some sites in the pilots identified lower than anticipated numbers of eligible children. Decisions to exclude were also made where the child's circumstances were not felt to be suitable, such as in the context of an unstable placement.

Professor Janet Boddy[75] uses the concept of 'liquid modernity' to describe the context of constant uncertainty for families, and its impact on research in child welfare. She points out that increasing precarity within families as services respond to austerity has implications for the type of research design (including RCTs and quasi-experimental studies) that are based on assumptions of 'control'; the same might be said for the foster families in our study, and the response of services to both increasing budget cuts and the COVID-19 pandemic. Instability clearly has implications for recruitment and retention in this vulnerable group, suggesting that future studies should aim to recruit in numbers well over their target sample in order to retain sufficient levels of data at follow-up.

The impact of instability was compounded by the time taken to contact participants at each stage of the study. Key milestones in the intervention and the research had been carefully planned, with short timescales between the completion of baseline measures and training, between attending training and completing post-training measures, and between follow-up contact from the team and completion of follow-up measures. At each stage, numerous attempts were needed to contact carers and teachers. The resulting slippage in the timelines meant the whole process took longer than expected, leaving a longer period of involvement within which instability might occur. Feedback from the research team suggested that, in general, carers preferred to be contacted by phone and teachers by e-mail, though there was individual variation. We would recommend that future research on STrAWB or similar programmes should establish with individual participants at the outset their preferred mechanism for the research team to keep in touch (including options such as text messaging), to speed up this process.

In conclusion, the RCT research design used did not prove feasible in this study. However, it is impossible to separate out the extent to which this was due to the context of the COVID-19 pandemic and its impact on children, carers and schools, as opposed to broader issues around capacity and instability that would affect any study of interventions that seek to bring together children's social care and education. We are unable to mitigate for the former; however, we have suggested potential strategies to minimise the effects of the latter in any future work in this area.

Dissemination to participants and related communities

We will feed back our findings to study participants, schools and local authorities. Care-experienced consultants from Coram Voice will co-produce a child-friendly summary, which will be sent to study participants. In addition, we are working with them to explore creative methods for dissemination. Participating local authorities will be offered the option of an online meeting to talk through the findings. A short PDF briefing will be posted on the websites of the Rees Centre and the University of Sussex. Young people, FCs and teachers who sit on the Project Advisory Group will be invited to work with researchers on these pieces.

We will write an article for a peer-reviewed journal about the lessons learnt on this and two related projects (on attachment and trauma training for schools, and the Mockingbird Family Model of foster care), focusing on the challenges of conducting research with children in care in the context of COVID-19.

Additional information

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Data-sharing statement

Due to the sensitivity of the data (on children's well-being and mental health), and agreed uses as stated in the study's consent forms, there are no data that can be shared.

Ethics statement

The study was approved by the Social Sciences Division Research Ethics Committee at the University of Oxford [approval references R62926/RE001 (24/04/2020) to R62926/RE007 (18 October 2022)]. It was also submitted to relevant local authority research governance procedures.

Information governance statement

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Disclosure of interests

Full disclosure of interests: Completed ICMJE forms for all authors, including all related interests, are available in the toolkit on the NIHR Journals Library report publication page at https://doi.org/10.3310/NGXR5244.

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This synopsis was published based on current knowledge at the time and date of publication. NIHR is committed to being inclusive and will continually monitor best practice and guidance in relation to terminology and language to ensure that we remain relevant to our stakeholders.

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List of abbreviations

A&E	accident and emergency
BERS	Behavioural and Emotional Rating Scale
CAMHS	Child and Adolescent Mental Health Services
CSRI	Client Service Receipt Inventory
DT	designated teacher
GP	general practitioner
PDF	portable document format
FC	foster carer
PEDSQL	Paediatric Quality of Life Scale
PEP	personal education plan
PSSRU	Personal Social Services Research Unit
RCT	randomised controlled trial
SDQ	Strengths and Difficulties Questionnaire
SENCO	special educational needs co-ordinator
STrAWB	Shared Training and Assessment for Well-Being
SW	social worker
VMHL	virtual mental health lead
VS	virtual school staff member
VSH	virtual school head
WBP	well-being profile

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Appendix 1 Programme delivery costs

Annette Bauer, Care Policy and Evaluation Centre, London School of Economics and Political Science

Introduction

This chapter presents the findings of an exploratory evaluation of the costs of delivering STrAWB as part of real practice (rather than research). The programme had the following components of care which were provided by the different professional groups, which were considered in the cost calculations.

Professional groups and roles

Teachers had a designated teaching role under the Looked After Pupils England Regulations 2009; for a number of teachers in the study this was part of their assistant head teacher position, which had a senior leadership team role in the school. The role comes under a salary band of L8–L12 (starting from £52,000); in practice, it can be taken on by another qualified teacher within the meaning of section 132 of the Education Act 2002(3), which would mean a substantially lower salary (about £20,000 less).

As part of the study, training was provided by a postdoctoral research fellow on grade 7.7 (salary: £40,322). In practice, training should be led by a professional with expertise on children in care, the impact of trauma, and mental health and well-being. This could be a professional trainer (with the right knowledge), or a looked-after-children's psychologist. The salary grade is likely to be the same as the postdoctoral research fellow.

Mental health professionals in the study were a consultant psychiatrist and a consultant clinical psychologist. In practice, the role could be taken on by a CAMHS practitioner nurse on band 7.

Method

The cost of the delivery of the programme was calculated based on information about time and other resource inputs from the study and unit costs for staff time (i.e. hourly rates for staff that include salaries, salary on-costs and overheads). Unit costs for health and social care staff were taken from the Personal Social Services Research Unit (PSSRU) Unit Costs for Health and Social Care (2021),[76] and unit costs for school staff were taken from a recently published peer-reviewed economic evaluation of a youth counselling intervention.[77] Other resource inputs were valued with their market prices (i.e. the price or amount someone is willing to pay in the market). To establish the resource inputs for delivering the programme, a pro forma for the different cost components, including questions about durations and number of activities, was developed, which was completed by senior staff and researchers who developed and ran the programme. Following standard approaches, costs included those as they relate to direct expenditure (e.g. for the handbook) as well as opportunity costs (which give a value to the time that a person spends on an activity because they are giving up time which they could otherwise spend pursuing other things that have a value to them or others). We valued professionals' and FCs' time for participating in the different components of the programme. We did not attach an opportunity cost to children's time, assuming their time was free. We estimated programme cost and cost per participating child or FC.

While some of the components (such as training) had specified durations as set out in the programme's manual, others were flexible. For the latter, we took experience-based estimates as observed by researchers. *Table 4* shows the durations for the different components or activities.

To estimate the unit costs shown in *Table 5*, some assumptions were made. For mental health professionals, it is assumed this refers to scientific and professional staff on band 7, which includes various (mental) health staff groups employed by the NHS, including practitioner nurses, counsellors and therapists. The same unit cost was also taken for the trainers. For DTs, two options were considered. For the initial 'base-case' scenario, it is assumed the role is taken on by an assistant head teacher and thus the unit cost of an assistant head teacher is applied. For a second, alternative, scenario it is assumed that the role is taken on by a regular class teacher and the unit cost of a class teacher is applied. While there is no standard approach for valuing FCs' time, it is important to value their time inputs as they provide care that would need to be replaced and require the involvement of much more costly publicly funded services. While foster or kinship carers receive allowances, these reflect payments made for children's household costs, food, clothes, travel and school dinner and other things required to look after the child and do not reflect the opportunity cost for the work they are doing. Some FCs receive additional payments, which range between £50 and £200 per week; however, those payments do not adequately reflect the costs of care they provide. We took instead the unit cost for a volunteer. The costs include the costs for managing volunteer (here: foster care) programmes. SWs' time was valued using an average unit cost for a children's services SW.

Results

Tables 6–12 present the information about time and resources inputs, unit costs applied to inputs and resulting costs for the components for the main (base-case) scenario.

For the base-case scenario, total cost per FC or child of the STrAWB programme was £1496. This included cost

TABLE 4 Durations of components of the STrAWB programme

Component	Duration (range)
Online training course for foster (or kinship) carers and teachers	Three sessions at 1 hour Two or three sessions at 1.5 hours[a]
Assessments completed by FCs, parents and children; children complete assessments with the help of FCs	Two at 20 minutes[b]
Clinical reviews (child profiles) conducted by a mental health professional	2.5 hours
Production of a child-friendly version of the child profile ('All About Me')	1 hour
Feedback talk (1×) completed by FC with child	1 hour
Feedback review meeting (1×) of FC, teacher and SW	1.25 hours (1–1.5 hours)

a FCs attend three sessions; teachers attend two sessions
b Duration varies by each assessment form; detailed information presented further below in the chapter.

TABLE 5 Unit costs for professionals and FCs participating in STrAWB

Professional/ FC	Unit cost per working hour	Data source and details
Mental health professional	£65.00	PSSRU;[76] refers to 9. Scientific and professional staff band 7
FC	£26	PSSRU;[76] refers to costs for a volunteer (per intern; section 11.8)
DT	Upper value: £96 Lower value: £57	Cooper *et al.* (2021)[77] Upper value: refers to deputy assistant head teacher £96; lower value: refers to class teacher
Trainer	£65.00	PSSRU;[76] refers to 9. Scientific and professional staff band 7
SW	£52	PSSRU;[76] 11.2 refers to SW for children's services

TABLE 6 Time inputs, unit costs and cost: self-study sessions (online) per programme – FCs and teachers

Professional/FC	Number of sessions	Duration of session	Unit cost per hour	Cost per FC/child
FCs	3	1 hour	£26	£78
Teachers	3	1 hour	£96 (£57)	£288
Total				£366

TABLE 7 Time inputs, unit costs and cost: facilitated sessions (online) per programme – FCs and teachers

Professional/FC	Number of sessions	Duration of session	Unit cost per hour	Cost per FC/child
FCs	3	1.5 hour	£26	£117
Teachers	2	1.5 hour	£96 (£57)	£288
Total				£405

TABLE 8 Time inputs, unit costs and cost: assessments/completing forms – FCs and teachers

Activity	Average duration per assessment (range)	Unit cost per hour, £	Cost per FC/child, £
WBP overview	10 (8–12) minutes	26	4.3
WBP activities	6.5 (3–10) minutes	26	2.8
WBP strengths	14.5 (9–20) minutes	26	6.3
WBP diary	151 minutes	26	65
Help child with home-based assessment	9 (3–15) minutes	26	4
Home-based assessment	9 (3–15) minutes	26	9
Mulberry Bush Social and Emotional Development Scale	5 (2–8) minutes	96	8
Total			100

TABLE 9 Time inputs, unit costs and cost: mental health professionals' time for creating child profile/clinical review and researcher's time for creating child-friendly version 'All About Me'

Activity	Duration (in hours)	Unit cost, £	Cost per FC/child, £
Child profile	2.5	65	162.5
All About Me	1	65	65
Total			227.5

TABLE 10 Time inputs, unit costs and cost: feedback (meetings and review)

Activity	Duration	Unit cost per hour, £	Cost per FC/child, £
FC's talk with child	1	26	32.5
FC's participation in review	1.25	26	26
Teacher's participation in review	1.25	96	120
SW's participation in review	1.25	52	65
Total			244

This synopsis should be referenced as follows:
Luke N, Banerjee R, Dunn V, Douglas N, Kelly Á, Trivedi H, *et al.* Well-being package for foster carers and teachers of looked-after children aged 8 to 11 years: the STrAWB feasibility RCT [published online ahead of print March 26 2025]. *Public Health Res* 2025. https://doi.org/10.3310/NGXR5244

TABLE 11 Time inputs, unit costs and cost: costs for trainer's (researcher's) time per course

Activity	Number of sessions per course	Duration of sessions	Time for preparation and debrief for each session	Unit cost, £	Cost per course, £	Cost per FC/child, £[a]
Training	3	1.5	2.5 hours	65	731	146

a While in the trial the trainer covered just one FC/teacher pair, in practice one trainer can cover five pairs, and so the cost per course was divided by 5.

TABLE 12 Costs for equipment and material

Element	Cost, £	Cost per FC/child, £
Handbook	6.80	6.80
Padlet licence	100 per year (unlimited)[a]	1[b]

a https://en-gb.padlet.com/memberships; refers to the charge per year for uploading lessons per year, which includes an unlimited number of uploads.
b We assumed that 1 year would cover 100 FCs.

to the education sector of £704, costs to the children's social care sector of £410 and additional £382 for costs that occurred for the training and intervention provider (e.g. mental health service provider). If a lower cost for the DT was taken (of £57 per hour), the total cost reduced to £1210.

Discussion

We estimated the costs of delivering STrAWB as it could be delivered in practice rather than as it was delivered as part of the research project. There are, however, challenges linked to this, and we had to make assumptions about how the programme could be delivered, and by whom. An important question is who in school should be participating in the programme. Engaging an assistant head teacher is costly but might be necessary to get the buy-in needed to run programmes successfully. There were certain costs that could not be included in the costing but that might be relevant to consider in future evaluations of this kind. For example, the STrAWB programme seeks to maximise the knowledge and responsivity of FCs and teachers to children's well-being support needs; any resulting behavioural changes that might require additional time commitments were not necessarily observed in the study. Future evaluation might benefit from capturing the longer-term costs and benefits linked to such behavioural changes. In addition, we did not assign an opportunity cost to children's time even though their time is highly valued by those running programmes. Future methodological developments are needed to find ways to assign an opportunity cost to children's time in economic evaluations.

Appendix 2 Report on the use of the Client Service Receipt Inventory

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Background and aims

The aim of this short analysis is to assess the likely acceptability and feasibility of applying a version of the CSRI[67] which was adapted to be used in the STrAWB randomised feasibility trial. The CSRI[78] is a tool used to collect information on the whole range of services and supports study participants may use. The data can be used for a wide range of purposes, including for estimating the costs of service receipt. It is therefore commonly used in economic evaluations. For the STrAWB trial, the CSRI was adapted to capture the service use of children who are in foster or kinship care in the last full school term, including general and mental health services, social care and education support, as well as informal help from voluntary organisations. The adapted questionnaire can be found at the end of *Appendix 2*. This version was informed by the Project Advisory Group and several recent trials and pilot studies in school settings.[68] In the STrAWB trial, foster or kinship carers completed the survey on behalf of the child whom they look after at two time points: at the study's baseline and again 12 months later.

We analysed the responses that were provided by the participating foster or kinship carers at baseline and at follow-up. Since the number of responses was too small to usefully conduct standard statistical or even comprehensive descriptive analysis, we instead focused the analysis on describing response completions for each question. The aim was to analyse response patterns and assess potential issues with answering questions which can then be used to inform the further adaptation of the CSRI for any larger trial going forward, and assess the feasibility of estimating cost for service receipt for this population. An additional aim was to understand whether certain services or supports were not being used by any of the children, which could indicate access problems but also might suggest that asking about services might be less useful.

Overall responses

At baseline, all 20 participants completed the questionnaire. The average time to complete the survey was 16 minutes and 47 seconds. The shortest duration was 2 minutes and 18 seconds, and the longest was 23 minutes and 14 seconds, with 70% completing within 10 minutes. Overall, only a few responses were missing which mainly referred to the open-text category for ‘other services’. At follow-up (an average of 15 months after baseline), six participants completed the questionnaire.

Section: school support

With regard to questions in section 1 on school support, at baseline most (80%) FCs reported that children were receiving extra help at school. All types and categories of services (extra help from teacher, teaching assistant, school nurse, tutor or mentor at school, learning support/behavioural support assistant, educational psychologist/SENCO, pastoral care, counsellor, after-school club; other) were reported to be used by at least three children. All response categories (about once per day, about once per week, about once per month, less than once per month, once on the last school term, not at all) were used, suggesting that those were adequate. At follow-up only two out of the six participants reported that their children used extra help. The only service that was used by both children was the after-school club. While one child used in addition only the school nurse, the other used a range of school support including teaching assistant, school nurse, tutor or mentor, pastoral care and counsellor.

The most used categories were ‘about once per day’, ‘about once per week’ and ‘not at all’, highlighting that when the service is being used, it is used frequently. The services reported to be used by children most frequently (i.e. ‘about once per day’) were ‘extra help from teacher’ and ‘teaching assistant’. The services for which the highest proportion of participants reported they were ‘not at all’ used, were ‘counsellor’ and ‘school nurse’. The free-text box on ‘other services’ was used by three participants, and responses included ‘nurture class’, ‘after-school lessons’ and ‘breakfast club’. These three services were used ‘about once per day’ or ‘about once per week’, thus highlighting the importance of having this free-text option in this section of the survey since a few children are using these services frequently. For this free-text option, four participants did not enter a response. It might be that not all caregivers are able to recall ‘other services’ without further help. Adding examples to the category of ‘other service’, such as breakfast club or after-school lessons, might be useful to increase the comprehensiveness and consistency of responses.

Section: general health care

With regard to the question in section 2 of the survey on general practitioner (GP), GP nurse and health visitor or community nurse, at baseline only 1 of the 20 participants reported that the child had used a health service in this category. The service used was the GP nurse, which the child used twice face to face in the last school term. At follow-up, two of six participants reported that children used a service in this category; specifically, this referred to a GP visit and a face-to-face contact with a nurse.

It might be possible to shorten this section if needed, for example summarising the three options in one or two and perhaps removing the distinction from face-to-face versus online as response options. This needs to be balanced against implications on the accuracy of cost estimates, since unit costs for the services in this category can vary substantially.

With regard to the question on medication use, at baseline four participants reported that children were using medication. All four participants entered a response in free text with regard to the type of medication they were using. At follow-up, two participants reported use of medication.

Both at baseline and at follow-up, all participants responded ‘no’ to question 3, about whether children had stayed in hospital overnight in the last full school term.

Section: various services (general health, mental health, social care, criminal justice)

With regard to services listed under question 4, at baseline and follow-up three services (speech therapist, Youth Offending Team, telephone help line) were reported not to have been used. At baseline, all other services had been used; while at follow-up, additional services that had not been used included: accident and emergency (A&E) or minor injuries unit, occupational therapist and police officer.

Responses that were missing at baseline referred to: (1) participant who reported the use of 'respite care' and 'short breaks' but did not state the number of contacts/time; and (2) participants who reported that the children had attended a youth club but did not state the number of contacts/time. At baseline, all participants reported that children received support from a 'social worker', while at follow-up, one participant reported that the child was not receiving support from a SW. Other services that were reported to be used by most children included: family contact (*n* = 12 children) and respite care (*n* = 12 children). All other services were used by five participants or fewer. Services for which participants reported they were used most frequently included: family contacts (altogether 38 face-to-face contacts, with 1 participant reporting 18 contacts and another one 12 online contacts); SWs (altogether 34 face-to-face contacts and 15 online contacts); child psychologist or psychiatrist (altogether 25 face-to-face contacts, with 1 participant reporting 14 contacts and 1 participant reporting 10 contacts); and respite care (21 face-to-face contacts). At follow-up, the following services were used: child psychologist or psychiatrist at hospital (by 1 participant using 28 face-to-face contacts); outpatient hospital services, used by 2 children (1 visit each); SW (14 contacts, out of which 1 child received 8 contacts); family contacts (9 contacts by 4 participants); respite care (2 contacts by 1 participant); short breaks (1 contact by 1 participant); activities as party of local authority fostering programme (2 participants having 2 contacts each); CAMHS (used once by 1 participant); and youth clubs (2 participants reporting 2 contacts).

At baseline, three participants reported the use of other support: therapists, football, and local and county cricket clubs. At follow-up, three participants reported the use of other support: extracurricular activities, dentist and optician. Since some of those responses at baseline refer to leisure activities rather than services, it is possible that the question was misunderstood, which also means that there is potentially less distinction of responses provided to the next and final question (question 5), which asks about 'other services' but includes contact with someone else (without specifying the nature of contact). It might be helpful to ensure that those two open questions are distinct, for example specifying that one refers to professional support while the other refers to informal and privately organised (and paid) support including leisure activities. It might be possible to group different types of therapists with similar unit costs (e.g. occupational therapists and speech and language therapists). Especially as unit costs are quite similar between these different types of therapists, this is likely to be a feasible option that does not negatively impact on the accuracy of the cost estimates. It might also be useful to consider having 'counsellor' as a separate option since some children seemed to access therapy outside of CAMHS.

Section: other services

Under question 5, at baseline five participants reported they used other types of services as well as leisure activities (horse therapy, independent visitor, summer school project, drama, looked-after child meeting, martial arts). At follow-up, participants reported the use of a play therapist, independent visitor, orthodontist, dentist and opticians. It might be good to focus this question on specific types of informal support that are known to have a cost attached. Another possibility would be to link this to questions about FCs' payments for different supports, which would allow us to establish cost estimates.

Conclusion

Overall, this adapted version of the CSRI appeared highly acceptable and feasible. There are small changes to the questions that could be made to potentially increase the number of accurate responses: it is common that service use is heavily centred around a few individuals and so leaving out categories is generally not advisable. A clearer distinction between categories of other services would be useful.

Adapted Client Service Receipt Inventory

Please tell us about the help your foster child had in the last full school term.

The last full school term means the term before this one.

Q1. Did your foster child have any extra help at school during the last full school term?

Yes ☐ No ☐

If yes, please fill in this table. Thinking about the last school term, how many times did they see this person?

	About once per day	About once per week	About once per month	Less than once a month	Once in the last full school term	Not at all
Extra help from form teacher						
Teaching assistant						
School nurse						
Tutor or mentor at school						
Learning support/ behavioural support assistant						
Educational psychologist/ SENCO						
Pastoral care service/other pastoral care						
Counsellor						
Pastoral care service/other pastoral care						
After school club						
Other: ___________________________						

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Q2. In the last full school term, did your foster child see…

GP	Yes ☐ No ☐	**If yes**	How many times face to face?………..	How many times virtual?………..
GP nurse	Yes ☐ No ☐	**If yes**	How many times face to face?………..	How many times virtual?………..
Health visitor/ community nurse	Yes ☐ No ☐	**If yes**	How many times face to face?………..	How many times virtual?………..

Has their GP given them a prescription for medicine in the last full school term?

Yes ☐ No ☐

If yes, what's the medicine for? ………………………………………………………………………….

Q3. In the last full school term, have they stayed in a hospital overnight?

Yes ☐ No ☐

If yes, How many nights? ……………..

Q4. Have they been in contact with any of these other services in the last full school term?

Yes ☐ No ☐

		If yes:	How many times face to face?………..	How many times virtual?………..

Child psychiatrist/ psychologist (hospital)?	Yes ☐ No ☐			
Other outpatient service (hospital)?	Yes ☐ No ☐			
A&E Department or Minor Injuries Unit	Yes ☐ No ☐			
Social worker	Yes ☐ No ☐			
Support for family contact	Yes ☐ No ☐			
Respite care	Yes ☐ No ☐			
Short breaks	Yes ☐ No ☐			
Activities as part of LA fostering programme	Yes ☐ No ☐			
Occupational therapist	Yes ☐ No ☐			
Speech therapist	Yes ☐ No ☐			
A person from the CAMHS team	Yes ☐ No ☐			
A person from the youth offending team	Yes ☐ No ☐			
Police officer	Yes ☐ No ☐			
Telephone help-line	Yes ☐ No ☐			
Youth club	Yes ☐ No ☐			
Other:				

Q5. Did they see anyone else or use any other service that was important to them? If yes, please tell us who they saw and how often they saw them

………

………

………

…………………………………………

THANK YOU FOR ANSWERING OUR QUESTIONS

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