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Help-seeking by foster carers for their 'looked after' children: The role of mental health literacy and treatment attitudes

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Summary

Factors that influence the help-seeking steps for looked after children with mental health problems were explored within the context of a help-seeking model, as were foster carers' Mental Health Literacy (MHL) and help-seeking attitudes.

Using a cross sectional and between groups design, data on variables likely to be related to help-seeking by foster-carers were collected from a sample of 113 foster carers and 108 looked after children within the East of England. Results demonstrated that although foster carers had high MHL overall, it did not significantly influence the first help-seeking step of 'problem detection'. More favourable help-seeking attitudes significantly influenced the second help-seeking step of 'perceived need' for Child and Adolescent Mental Health Services (CAMHS). The results from the logistic regression analyses found MHL and help-seeking attitudes, in combination with the presence and impact of a mental health problem, and foster carer education, to be significant predictors of specific help-seeking. Forty-nine percent of children were found to have an apparent mental health problem and were not receiving a service from CAMHS. As such, both MHL and help-seeking attitudes have important roles to play in facilitating CAMHS use by this population.

KEYWORDS: Strengths and Difficulties Questionnaire, foster carers, care pathways, 'looked after' children, CAMHS

Help-seeking by foster carers for their 'looked after' children: The role of mental health literacy and treatment attitudes

'Looked after' children are recognized as one of the most vulnerable groups in society (Minnis and Del Priori, 2001). The term 'looked after' children, introduced by The Children Act (1989) in England, is now widely used to refer to children subject to a care order or those taken into care 'voluntarily', and there is evidence to suggest that the number of children entering the foster care system is increasing (Berridge, 1997; DoH, 2004). There are multiple reasons why children become looked after, with many having more extreme and complex difficulties than those from previous decades (Kelly *et al*., 2003). Consequently, foster families are more likely to be involved in facilitating the provision of care to children who are experiencing emotional and behavioural difficulties (Berridge, 1997; Triseliotis, 1989) placing greater expectations upon foster carers to have the knowledge, expertise and skills to care for such children.

Studies examining the prevalence of mental health problems in looked after children have found high prevalence rates of mental disorder (McCann *et al*., 1996; McCarthy *et al*., 2003; Bonnet and Welbury, 2004), with one British national survey reporting that 45% of looked after children have a mental health problem (Meltzer *et al*., 2002). Given the high prevalence rates of mental health problems amongst looked after children, child and adolescent mental health services (CAMHS) in the United Kingdom are likely to be the main source of support (Wolpert and Wilson, 2003). Rates of CAMHS use by this population have been of interest (Wolpert and Wilson, 2003), but studies in this area have reported significantly lower rates of

CAMHS use than would be expected (Phillips, 1997; Butler and Vostanis, 1998; Minnis *et al*., 2001; Meltzer *et al*., 2002; Bonnet and Welbury, 2004), suggesting that the mental health needs of looked after children are not being met by specialist services.

The implications of untreated mental health problems are numerous (Ward *et al*., 2002), and several studies have examined factors that predict the use of CAMHS using factors such as child age (Halfron *et al* , 1992; Garland *et al*, 1996; Leslie *et al*., 2000; Meltzer, *et al*., 2002), child gender (Leslie *et al*., 2000; Meltzer *et al*., 2002), child ethnicity (Leslie *et al*., 2000), length of time within a care placement (Meltzer et al., 2002), and placement type (Leslie *et al*., 2000), all predicting uptake of CAMHS services. Arcelus *et al*. (1999) found that foster carers often fear that looked after children will be 'labelled', leading to a reluctance to seek help from specialist services, and some disorders, such as depression, were frequently regarded by foster carers to be a 'natural phenomenon'. It has been highlighted that variability in service provision across CAMHS may explain some of the discrepancies in service use (Minnis and Del Priori, 2001). For example, limited resources can result in long waiting lists (Phillips, 1997; Health Select Committee, 1998; Blower *et al*., 2004) and services may resist taking on the complex work needed by looked after children (Richardson and Joughin, 2000). Delays in mental health assessments often occur until placement stability has been achieved (Arcelus *et al*.,1999; Valios, 2002).

Given the mental health difficulties that looked after children may face, coupled with issues associated with specialist service use, an examination of factors which affect help-seeking by this population is warranted. In a number of different

populations, help-seeking pathway models, that detail the steps involved from initial recognition of a mental health problem, to ultimate service use, have been used to explain help-seeking behaviour (Rogler and Cortes, 1993). These models provide a conceptual framework for describing the array of factors that may significantly influence the help-seeking steps (Srebink *et al*., 1996). In specific relation to the foster care population, Landsverk and Garland (1999) reported that pathways research would help identify the factors that facilitated specialist service use by this population.

The process of seeking help from mental health services is complex, and the first step, problem detection, has been repeatedly highlighted as fundamental (Zima *et al*., 2000; Logan and King, 2001; Hill and Thompson, 2003). Foster carers' ability to identify mental health problems in looked after children is crucial in facilitating service use, with non-detection hindering service use (Minnis and Del Priori, 2001; Callaghan *et al*., 2003). This is mostly due to the fact that children themselves often do not initiate help-seeking (Garland and Zigler, 1994; Ping *et al.*, 1999). Whilst foster carers may fail to recognize mental health problems because they have become habituated to working with 'disturbed' looked after children (Minnis and Del Priori, 2001), little guidance on the recognition of early warning signs of psychological distress may underlie an inability to recognise child mental health problems (Logan and King, 2001). It is possible that non-detection of mental health problems in looked after children by foster carers contributes to their low rates of CAMHS use, which may relate to levels of mental health literacy.

Mental health literacy (MHL) is "the knowledge and beliefs about mental disorders, which aid their recognition, management or prevention." (Jorm *et al*., 1997: p.182). Primarily, MHL refers to the ability to recognize specific disorders or different types of psychological distress, but also includes knowledge of services available, attitudes that promote problem recognition, and appropriate help-seeking behaviour (Jorm *et al*., 1997). Jorm (2000) reported that MHL was an important part of help-seeking and a concept that required consideration. Surprisingly, there are few studies measuring the MHL of different populations (Lauber *et al*., 2003), with only one relating to the child population; Stein *et al*. (2008) found that CAMHS health-care professionals had high accuracy rates in detecting mental health problems in children. These rates were also similar to other studies examining the MHL of health-care professionals working with adult mental health problems (Andersen and Harthorn, 1989; Parker *et al.,* 2000).

In contrast, studies using the general population reported that they have a poor ability to detect specific disorders or different types of psychological distress (Goldney *et al.,* 2002). Given this, an inability to detect child problems will inhibit the help-seeking process and ultimately deter their use of specialist services (Zima *et al*., 2000; Logan and King, 2001), while high levels of MHL may promote prevention and intervention of mental health problems (Jorm *et al.,* 1997). Consequently, it seems essential that foster carers are able to detect mental health problems in looked-after children, and initiate appropriate help-seeking behaviour (Arcelus et al., 1994; Minnis and Del Priori, 2001).

Favourable attitudes toward seeking professional help are also likely to affect help-seeking (Fischer *et al*., 1983; Garland and Ziglar, 1994; Fischer and Farina, 1995), and have been linked to formal mental health service use (Cauce and Srebnik, 2003). For example, adults tend to be more likely to become aware of mental health problems if this is suggested by a significant other (Dew *et al*., 1991). Parental attitudes toward seeking psychological help strongly influence their help-seeking behaviour for their children (Tarico *et al*., 1989; Costello and Janiszewski, 1990; Zahner and Daskalakis, 1997; Raviv *et al.*, 2003). A systematic review of parental facilitation of the use of adolescent mental health services confirmed the role of favourable parental attitudes toward seeking help (Logan and King, 2001), and Carpenter (1980) commented that they were likely to play an important role in influencing help-seeking behaviour for looked after children.

Given the influential role significant others have in determining whether or not children and adolescents seek help because of mental health problems, coupled with evidence that looked after children suffer from elevated rates of mental health disorder, we undertook a cross-sectional study of foster carers to explore the factors that influence CAMHS use by looked after children with mental health problems. The MHL and attitudes toward seeking psychological help amongst foster carers were examined, as were other factors that have previously been found to significantly influence the help-seeking process for children. Given that the descriptive utility of a help-seeking pathway model for looked after children had been established using a population from the United States (Zima et al., 2000) this five step model was used as both an organizing and a descriptive framework for the current study and other factors not previously explored were incorporated. Specific hypotheses were that

higher levels of MHL will significantly influence the first and last help-seeking steps of problem detection and specialist service use, and positive help-seeking attitudes will significantly influence the second and last help-seeking steps of perceived need for services and specialist service use. It was also hypothesized that a range of other factors such as: child age, education level, number of social worker visits and the nature and impact of a mental health problem, would influence the help seeking steps.

Method

Participants

One hundred and thirteen foster carers (N=18 males and N=95 females), the majority of whom were White European (N=70) were recruited though a fostering service within the East of England. The length of time the participants had worked in fostering ranged from 2 months to 25 years (*M*=6.5 years; *SD*=5.57), with the total number of looked after children fostered ranging from 1 to 298 (*M*=17; *SD*=38.40). Most were married or co-habiting (N=79), with no previous use of mental health services in their immediate family (N=75). At the time of data collection the foster carers had to have a looked after child, aged between 5 and 15, on placement for a minimum of two months. This was to ensure sufficient knowledge of the child so as to be able to complete relevant measures.

From the foster carers who took part in the study, details relating to 108 looked after children (N=52 males, N=56 females) were obtained. The age range of these children was 5 to 15 years (*M*=10 years, *SD*=3.45), with the majority being White European (57) followed by mixed heritage (17). Most of them had been in placement for a significant period of time (*M*=22.0 months, *SD*=21.41).

Design and Procedure

A cross sectional and between groups designs was employed, sampling as many foster carers as possible, from the East of England. Following a favourable ethical opinion being obtained from South Bedfordshire NHS Local Research Ethics Committee, foster carers were asked to complete a series of questionnaires with the first author, or return them via the postal system. Of the 113 participants who

consented to take part in the study, 86 met with the first author to complete the questionnaires and 27 completed them via the postal system. Following completion of the questionnaires, which took on average one hour, foster carers were provided with the opportunity to discuss any issues (in person or by phone) that may have arisen, and were provided with a £5.00 book voucher.

Measures

Study Specific Questionnaire (SSQ): Demographic and placement-related details of the foster carers and looked after children were collected using the SSQ. Questions were also included to specifically elicit details relating to the steps in the help-seeking process. For example, foster carers were asked if they had any worries of concerns about the mental health of their looked after child and if so, what help had been sought.

The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997): The informant and extended version of the SDQ was used to screen for the presence and impact of child mental health problems. The psychometric properties of this scale have been established (Goodman, 2001) although not for looked after children. A Total Difficulties Score (TDS) is generated as well as five individual sub-scale scores for different problem areas. The extended version of the SDQ includes an impact supplement that provides a measure of overall distress and social impairment. In this study, the presence of a mental health problem was established by a combined TDS and Impact score (referred to as TDS/Impact score) in the abnormal or borderline range. Internal consistency for the TDS (k=0.94) and the Impact Score (k=0.91) were calculated within the current study and found to be excellent.

Mental Health Literacy Vignettes (MHL) (Stein, *et al*., 2002). Ten vignettes were used in this study to measure foster carers' MHL. These vignettes were originally developed to measure adults' MHL of child mental health problems, and eight of these vignettes are based on *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition-Text Revision* criteria (American Psychiatric Association, 2000). The vignettes are followed by a series of questions covering problem recognition and naming accuracy, and a total MHL score is generated with higher scores indicating higher levels of MHL.

Attitudes toward Seeking Professional Psychological Help Scale (ATSPPH) (Fischer and Farina, 1995): The short form of the ATSPPH scale was used to measure foster carers' help-seeking attitudes. The psychometric properties of this scale have been established (Fischer and Farina, 1995; Fischer and Turner, 1970). This scale specifically measures peoples' attitudes toward seeking professional help for psychological problems, and higher scores are indicative of more favourable attitudes toward seeking psychological help. Internal consistency for this measure was found to be excellent within the current study (k=.97).

The Family Crisis Oriented Personal Evaluation Scales (F/COPES) (McCubbin *et al*., 1991): The F/COPES was used to obtain a measure of foster carers' coping strategies. This self-report scale was developed to measure the behavioural strategies and problem-solving attitudes used by families in 'difficult' situations. Five subscale scores create a profile of the different coping strategies used, whilst a Total Scale Score (TSS) indicates how many overall coping strategies are being used. The

psychometric properties for this scale are satisfactory (McCubbin *et al*., 1991). Internal consistency for this measure was excellent within the current study (k=0.92).

Plan of Analysis

Foster carers' ability to detect a mental health problem and 'perceive a need for CAMHS' was established by determining if their response to the problem detection or perceived need question on the SSQ corresponded to their looked after child's TDS/Impact score on the SDQ. Scores on the remaining questionnaires were compared across groups. The relationship between mental health problem and CAMHS use was established by determining whether elevated TDS/Impact scores corresponded with actual CAMHS use. From this, the looked after children were split into two groups of 'using CAMHS' and 'not using CAMHS' and scores were compared across groups. Finally, the ability of each of the factors under investigation to predict each aspect of the help-seeking process was examined using a series of forward stepwise logistic regressions.

Results

Descriptive data obtained from the measures used in this study are presented in Table 1. Most children did not have any previous placements (N=40, 37%), followed by either one (N=20, 19%) and two (N=16, 15%) previous placements, while twenty-nine percent had three or four previous placements (N= 31). Previous placement data was missing for one child. A high percentage of foster carers believed their looked after child had a mental health problem (80%), with a lower percentage feeling that they needed CAMHS (58%), and an even lower percentage having been referred to (48%) or used a service (39%). Foster carers who had either detected a mental health problem in their looked after child (χ^2 (1)=4.22, p=.002), perceived a need for CAMHS (χ^2 (1)=9.17, p=.001), contacted a formal service provider (χ^2 (1)=6.51, p=.001), or had been referred to CAMHS (χ^2 (1)=50.34, p=.000) were significantly more likely to have made use of CAMHS as compared to foster carers who have not taken any of these steps.

The distribution of help-seeking steps and TDS/Impact scores, presented as frequencies and percentages, are described in Table 2. Comparisons between the help-seeking steps of looked after children with mental health problems and foster carers MHL and help-seeking attitudes are also presented in Table 2. This table shows a large percentage of looked after children had TDS/Impact scores in the abnormal and borderline range (63%). Foster carers were significantly more likely to have a 'good ability', as opposed to a 'poor ability,' to detect such problems (χ^2 (1)=22.68, p=.000), although their MHL was a not a significant influential factor (*Mann Whitney U*= 606.50, p=.069). A discrepancy was found between the percentage of looked after children with mental health problems (63%) and CAMHS

use (32% using CAMHS). Looked after children functioning within the normal range but were using CAMHS, were significantly more likely to have a foster carer with higher MHL, than their counterparts using CAMHS (*Mann Whitney U*=62.50, *p*=.026). Given that high MHL assumes an ability to also detect when a mental health problem is not present, this finding was surprising. Further analyses examined whether these children (n=42) had experienced a greater amount of contact with CAMHS thus reducing their TDS/Impact scores, but this was not supported (*r*=-.11, *p*=.244), and whether greater number of sessions incurred by the looked after child (n=55) was associated with increased MHL, but again this was not supported (*r*=.07, *p*=.305).

Foster carers were not significantly more likely to have a 'good ability,' as opposed to 'poor ability,' to perceive a need for CAMHS (χ^2 (1)=.03, *p*=.435), with 28% of the latter group's responses being false negatives. Foster carers with a 'good ability' to perceive a need for CAMHS were significantly more likely to have favourable help-seeking attitudes (*Mann Whitney U*=651.00, *p*=.035). Finally, looked after children who were 'using CAMHS' had significantly higher TDS/Impact scores than those who were 'not using CAMHS' (χ^2 (1)=12.29, *p*=.000), although foster carers' help-seeking attitudes were not a significantly influential factor (*U*=507.50, *p*=.195; *U*=79.00, *p*=.095).

Factors that predict the five help-seeking steps (Zima *et al*., 2000) were examined using a series of stepwise logistic regressions (Table 3). Considering step one, variables were regressed onto Problem Detection Ability, with the presence and impact of a mental health problem emerging as the only significant predictor

(OR:3.17, 95% CI=1.49-6.78). Variables were regressed onto perceived need for CAHMS for the second step and no variables emerged as significant predictors. Considering step three, contact with a formal service provider, three variables significantly predicted referral; help seeking attitudes (OR:1.26, 95% CI=1.03-1.55), MHL (OR:5.32, 95% CI=1.22-24.23), and link worker visits (OR:2.44, 95% CI=1.26-4.73). Step four, referral to CAMHS was predicted by two variables, presence and impact of a mental health problem (OR:4.31, 95% CI=2.23-8.31), and help seeking attitudes (OR=1.10, 95% CI=1.00-1.20). Considering the final step, two variables significantly predicted CAMHS use, presence of a mental health problem, (OR:6.19, 95% CI=2.31-16.61) while no formal education was associated with less CAMHS use (OR: .09; 95% CI: .02-.47).

Discussion

This study explored whether a range of factors, including foster carers' MHL and their help-seeking attitudes, influenced the help-seeking process for looked after children with mental health problems. Although the foster carers were found to have high levels of MHL overall, this was not found to be significantly related to the first help-seeking step of problem detection. As MHL primarily refers to the ability to recognize different types of psychological distress (Jorm *et al*., 1997) this finding was unexpected. Vignettes having been reported to be the most reliable method for measuring problem detection ability (Wilson and While, 1998), however, there is some limited evidence to suggest that results derived from vignette methodologies may be different from results derived from 'real-life' situations (Lucas *et al*., 2009).

Foster carers with a looked after child functioning in the normal range but using CAMHS, were found to have significantly higher levels of MHL than their counterparts who were not using CAMHS. Again this was unexpected as higher MHL is associated with more appropriate service use (Jorm *et al*., 1997). It may reflect the trend for foster carers to over-report the presence of a mental health problem (Callaghan *et al*., 2003), or those having difficulty coping and experiencing burden may be more likely to seek help from specialist services (Verhulst and Van Der Ende, 1997). If this is so, then monitoring of foster carers' coping and experience of burden would be of benefit. These findings indicate that whilst MHL is an important factor in the help-seeking process, and one which most foster carers seemed to have, singularly, it did not influence CAMHS use.

The foster carers in this study tended to have positive help-seeking attitudes, which were significantly related to the second help-seeking step of 'perceived need for CAMHS.' This finding is consistent with previous studies showing that parental help-seeking attitudes have a strong influence on help-seeking behaviour for children (Costello and Janiszewski, 1990; Raviv *et al.*, 2003). Raviv *et al*. (2003) even argued that it was necessary to improve mothers' attitudes toward seeking professional help in order to increase appropriate use of specialist services. Although Carpenter (1980) commented that foster carers' help-seeking attitudes were likely to play a role in their help-seeking behaviour for looked after children, this does not appear to have previously been empirically supported. The findings from this study demonstrated that foster carers were not significantly more likely to have a 'good ability,' as opposed to 'poor ability,' to perceive when CAMHS was needed. Perhaps their ability to determine the crucial second help-seeking step can be explained totally by the influence of help-seeking attitudes. Indeed, unfavourable help-seeking attitudes, such as negative perceptions about the efficacy of professional treatment (Zahner and Daskalakis, 1997) or fears of labelling (Arcelus *et al*., 1999) have been found to influence help-seeking. It is also possible that foster carers have become habituated to working with 'disturbed' looked after children, impacting on their ability to recognise when services are needed (Minnis and Del Priori, 2001).

This study did not find foster carers' help-seeking attitudes were significantly related to the last help-seeking step of CAMHS use. This was unexpected given the reported predictive relationship between favourable help-seeking attitudes and service use (Logan and King, 2001). However, this was significantly associated with

the third and fourth help-seeking steps, suggesting that they have a role to play at these stages, and should be considered when exploring the help-seeking process.

Lower levels of education were less strongly related to help-seeking. Perhaps foster carers with less education are not as aware of what services are available or perhaps they feel less confident to seek help. The presence and impact of a mental health problem was one of the strongest help-seeking predictors and suggests that looked after children with more severe problems are progressing through the help-seeking steps. Whilst this is encouraging, it is important to consider that those with less severe problems may also be experiencing distress and placement-related difficulties (Minnis and Del Priori, 2001) and may not be receiving beneficial services.

Limitations

This study initially assumed a sequential relationship between the help-seeking steps and found that CAMHS use was more likely if the preceding four help-seeking steps were taken. Whilst this suggests that help-seeking pathway models provide an understanding of the processes that occur between problem detection and service use, in reality help-seeking steps can overlay, interact and cycle over each other (Logan and King, 2001). A temporal relationship between steps is also thought to exist and the cross-sectional design of this study did not enable this element to be captured.

Only one informant method was used to determine the 'presence' and 'impact' of a mental health problem. However, the results of the SDQ are commensurate with

previous studies conducted on the foster care population (Triseliotis and Foster, 1997; Schofield *et al*., 2000; McCarthy *et al*., 2003) providing further indication of the high prevalence rates of mental health problems in looked after children in the United Kingdom. However, the importance of using multi-informants and methods to accurately identify mental health problems in children is known (Jensen *et al*., 1999; Laitinen-Krispijn *et al*., 1999). As some of the looked after children had only been on placement for a short time, the reliability of foster carer reports on their behaviour could be questioned (Garland *et al*., 1996). However, in order for participants to be able to complete the measures included within this study, they had to have had a child living with them for at least two months. This may have inadvertently led to another source of unavoidable bias as those children who have severe problems who move placement may not have been included in this study.

It is also important to consider that the sample recruited within this study were self-selecting, and as a consequence, this may have introduced a source of potential bias. For example, participants who volunteered to take part within this study may have done so because of an interest in mental health problems amongst children.

Implications

The results have some implications for guiding practice. One of the most striking findings is that 49% of the looked after children within the current study with an apparent mental health problem were not receiving a service from CAMHS. However, there was a relationship between severity of mental health problems and many of the help-seeking steps investigated, suggesting that children with more

enduring and severe mental problems may be accessing CAMHS. However, this does raise questions about early intervention for mental health disorders which may initially go undetected by foster carers. These children may benefit from CAMHS work which may serve to prevent the exacerbation of any current mental health difficulties.

However, enabling factors which would help to ensure that such children are able to access CAMHS include not only the severity of the problem, but the attitudes foster carers have toward mental health and mental services, as well as their mental health literacy and education level. As a consequence, there are implications for the training of foster carers. Caregivers often refrain from seeking help from CAMHS because of fears about being perceived as inadequate (Phares *et al*., 1996), beliefs that the child will be 'labelled,' (Arcelus *et al*., 1999), or because of negative expectations regarding the process (Ho and Chung, 1996). Providing foster carers with the opportunity to discuss and explore fears and beliefs about seeking psychological or psychiatric treatment from CAMHS might thus be advantageous, and implementing education programmes which focus on improving foster carer mental health literacy and attitude toward mental health treatment would likely have a positive impact upon CAMHS use. This does lend some support for the development of specific mental health services for looked after children and the professionalization of foster carers. This may help to address the gap that remains between the high prevalence of mental health problems amongst looked after children, and CAMHS use.

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Table 1: Descriptive statistics for all measure including comparisons to normative data.

Measure				Total	
SSQ	*M*	SD	Range	Yes (%)	No (%)
Placement details (n=108):					
No. of S/W visits	13.58	15.70	0-72		
No. of L/W visits	11.67	14.39	1-103		
Time on placement (months)	22.00	21.41	1-84		
No. of previous placements	1.94	2.41	0-14		
Non-Kinship placement type				99 (92)	9 (8)
Help-seeking behaviour (n=113):					
Problem detection				86 (80)	22 (20)
Perceived need for CAMHS				63 (58)	45 (42)
Contact with service provider				97 (90)	11 (10)
Referral to CAMHS *(missing data 2 (2%)*				52 (48)	54 (50)
CAMHS use				42 (39)	66 (61)

SDQ	Looked after children (n=108)					Goodman (2001; n=10,438)				
			Normal	Borderline	Abnormal			Normal	Borderline	Abnormal
	M	SD	(%)	(%)	(%)	*M*	SD	(%)	(%)	(%)
TDS	15.44	7.04	(37)	(13)	(50)	8.4	5.8	(82)	(8)	(10)
Impact score	2.73	2.82	(35)	(5)	(60)	0.4	1.1	(83)	(8)	(9)
Emotional symptoms	3.60	3.15	(52)	(12)	(36)	1.9	2.0	(81)	(8)	(11)
Conduct problems	3.53	2.49	(40)	(15)	(45)	1.6	1.7	(76)	(11)	(13)
Hyperactivity	5.03	3.00	(53)	(13)	(34)	3.5	2.6	(78)	(8)	(15)
Peer problems	3.42	2.71	(44)	(7)	(48)	1.5	1.7	(78)	(10)	(12)
Prosocial behaviour	6.89	2.53	(17)	(11)	(71)	8.6	1.6	(95)	(3)	(2)

MHL Vignettes	Foster carers (n=113)				Stein, et al. (2008; n= 52)			
				Total Correct				Total Correct (%)
	M	SD	R	(%)	*M*	SD	R	
Total MHL Score	8.53	.99	6-10	(86)	9.15	1.16	7-10	(91)

ATSPPH	Foster carers (n=113)		Fischer & Farina (1995; n= 389)	
	M	SD	*M*	SD
Total Score (0-30)	19.18	5.90	17.45	5.97

F/COPES	Foster carers (n=113)		McCubbin, et al. (1991; n=2,582)	
	M	SD	*M*	SD
Total Scale Score (TSS)	101.36	17.53	93.34	13.62
Reframing	32.81	5.26	30.24	4.85
Passive appraisal	15.73	3.14	8.55	3.01
Acquiring social support	30.82	7.40	27.19	6.44
Seeking spiritual support	11.38	5.85	16.07	3.05
Mobilising the family	15.96	3.24	11.97	3.37

Table 2: Distribution and comparison of help-seeking steps and TDS/impact Scores:

Variables	**SDQ - TDS / Impact scores**			**Statistics**	
Help-seeking Steps	Normal (%)	Borderline/ Abnormal (%)	Total (%)	χ^2 *(df)*	*P value*
'Good' problem detection ability	25 (23)	66 (61)	91 (84)		
'Poor' problem detection ability	15 (14)	2 (2)	17 (16)		
Total (%)	40 (37)	68 (63)	108 (100)	22.68 *(1)*	.000**
Using CAMHS	7 (7)	35 (32)	42 (39)		
Not using CAMHS	33 (31)	33 (31)	66 (61)		
Total (%)	40 (37)	68 (63)	108 (100)	12.29 *(1)*	.000**
'Good' Perceived need for CAMHS ability	23 (21)	38 (35)	61 (56)		
'Poor' perceived need for CAMHS ability	17 (16)	30 (28)	47 (44)		
Total (%)	40 (37)	68 (63)	108 (100)	.03 *(1)*	.435

* $p<0.05$; ** $p<.001$

Table 3: Significant predictors of the help-seeking steps.

Predictor variables	**Outcome variables**							
	Help Seeking Step One: Problem detection ability							
	b	S.E	Wald (df)	OR	CI (95%)	R^2	-2LL	*p value*
						.22	58.52	
Presence & impact of a MH problem	1.16	.39	8.87 (*1*)	3.17	1.49-6.78			.003*
	Help Seeking Step Three: Contact with a formal service provider							
	b	S.E	Wald (*df*)	OR	CI (95%)	R^2	-2LL	*p value*
						.70	23.52	
Help-seeking attitudes	.24	.11	4.70 (*1*)	1.26	1.03-1.55			.028*
MHL	1.67	.75	4.93 (*1*)	5.32	1.22-24.23			.023*
No. of link worker visits	.89	.34	7.01 (*1*)	2.44	1.26-4.73			.009*
	Help Seeking Step Four: Referral to CAMHS							
	b	S.E	Wald *(df)*	OR	CI (95%)	R^2	-2LL	*p value*
						.41	86.34	
Presence & impact of a MH problem	1.46	.34	18.99 (*1*)	4.31	2.23-8.31			.000**
Help-seeking attitudes	.09	.05	3.88 (*1*)	1.10	1.00-1.20			.046*
	Help Seeking Step Five: CAMHS use							
	b	S.E	Wald *(df)*	OR	CI (95%)	R^2	-2LL	*p value*
Presence & impact of a MH problem	1.82	.50	13.09 (*1*)	6.19	2.31-16.61	.47	77.64	.000**
Education:			8.42 (*3*)					.038*
None	-2.45	.87	7.99 (*1*)	.09	.02-.47			.005*
School level	-1.09	.85	1.67 (*1*)	.34	.06-1.77			.196
Further	-1.26	.89	2.01 (*1*)	.28	.05-2.02			.156

Note: MH=mental health; *significant at $p<0.05$, **significant at $p<.001$