‘They don’t meet the stereotypes in the boxes...’

**Foster carers' and clinicians' views on the utility of psychometric tools in the mental
health assessment of Looked After Children**

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Accepted for publication in ‘Adoption and Fostering’ in March, 2019

Abstract

Background: Looked-after children (LAC) frequently experience greater mental health challenges than the general child population. There has been a call for greater focus on early preventative interventions and priority access to specialist mental health support for this population. Brief mental health screening tools often provide the gateway to services and yet there is a lack of suitable assessment tools available for LAC. The current study is the first to explore the perspectives of foster carers and CAMHS clinicians’ in relation to the use of two brief screening tools; the Strengths and Difficulties Questionnaire (SDQ) and the Brief Assessment Checklists (BAC’s).

Method: Qualitative data was collected via semi-structured telephone interviews and face-to-face focus groups with female foster carers (N=13) and clinicians working in a CAMHS setting (N=9).

Results: Thematic analyses generated six themes which were organised into three superordinate themes centred around: 1) relevance to LAC, 2) using measures to inform care planning and; 3) current problems when using psychometric measures within the LAC population. Foster carers and clinicians emphasised the need for a comprehensive understanding of LAC given the complexity of their difficulties. There was acknowledgement that psychometric measures could facilitate and contribute to this by highlighting difficulties, providing accurate feedback to carers and clinicians, and enabling access to support. However, both groups seldom felt that current measures were nuanced enough to adequately capture the needs of LAC.

Conclusion: Screening tools play a crucial role in identifying the mental health needs of LAC and facilitating access to services. Further research is needed to establish the ability of such measures to increase the sensitivity of the complex needs’ assessment of LAC. A number of

clinical recommendations are also discussed in relation to the assessment of mental health in the LAC population.

Keywords: looked after children, mental health, assessment, qualitative methods

Introduction

The terms looked after children (LAC) or children in care describes young people aged 0 to 18 years old who are unable to live in their family home due to significant concerns about their safety and well-being. The reasons for this vary, but in most cases, the child has been exposed to abuse, neglect or family violence. When a child is placed in care, there is a legal order to support the child living away from home (either temporarily or permanently) and the type of care the child receives includes out-of-home care, foster care, kinship care, permanent care and/or residential care. Throughout the current paper, the term looked after children or LAC will be used to refer to this group of children.

In recent years, there has been greater focus on LAC due to the increasing evidence that this population are more likely to experience poor physical and psycho-social outcomes later in life such as homelessness, unemployment, teenage pregnancy and criminality (DoE, 2017; Courtney, Dworsky, Brown, et al., 2011). LAC are also reported to be up to four times more likely than the general child population to exhibit clinically significant mental health difficulties; with roughly half meeting the criteria for a formal psychiatric diagnosis in a recent meta-analysis which included studies from five different Western countries (Bronsard et al., 2016). LAC and care leavers are also at higher risk of self-harm as well as both attempted and completed suicide (Hjern, Vinnerljung & Lindblad, 2004; Vinnerljung, Hjern & Lindblad, 2006).

Alongside this, several studies have highlighted the long-term impact that early life trauma (e.g. maltreatment) has on brain development, physical well-being and mental health (D’Andrea, Ford, Stolbach, Spinazzola & van der Kolk, 2012). Research has demonstrated that children who have been exposed to maltreatment are at greater risk for complex mental health presentations often spanning several diagnostic criteria (D’Andrea et al, 2012). In the

neuroscience field, emerging evidence has uncovered physical changes in the brains of children who have experienced maltreatment which may indicate a hidden vulnerability to later mental health difficulties (McCrory, Gerin & Viding, 2017). In particular, the Adverse Childhood Experiences (ACES) studies in the US and UK has greatly increased public awareness around the prevalence and impact of childhood trauma on an individual’s health (Felitti et al., 1998; Anda et al., 2005; Bellis et al, 2016). With this, many Western governments have called for services which consider the prevention and/or early treatment of ACES.

LAC will have experienced several childhood traumas including removal from their birth family, separation from their primary caregiver and in over 60% of cases, exposure to some form of abuse and neglect (DfE, 2017). In one US study, over 70% of previously LAC reported five or more adverse childhood experiences (Bruskas & Tessin, 2013). Therefore, the growing evidence base regarding maltreatment must be considered within this population. To add to this complexity, there is also a high incidence of neurodevelopmental conditions in LAC such as fetal alcohol spectrum disorders (Lange, Shield, Rehm, & Popova, 2013), autistic spectrum conditions, attention-deficit hyperactivity-disorder, tic disorders and/or learning difficulties (Dinkler et al, 2017). Therefore, the importance of identifying mental health needs in LAC and improving access to high quality services for this population has been recognised by researchers, clinicians and policymakers worldwide.

Access to mental health services

Despite the recognition of need, evidence suggests that LAC do not access specialist child and adolescent mental health services (CAMHS; Minnis & Del Priore, 2001). One Scottish study found that only 18% of LAC had contact with CAMHS even though there were high rates of reported mental health difficulties (Minnis et al., 2006). This was higher (~31.2%) in a recent Norwegian study, though still more than half of LAC with high scores on the Strengths and

Difficulties Questionnaire (SDQ) were not in receipt of support from CAMHS (Larsen et al., 2018). Service use increased to 40-60% for LAC in an Australian cohort although the definition for what constituted mental health support was much broader (Tarren-Sweeney, 2010).

So, why aren’t LAC accessing services for mental health difficulties? Given that CAMHS have historically focused on diagnostic criteria to gain entry, in the UK it has been proposed that LAC are unable to access mental health support as they do not meet diagnostic thresholds based on the current classification system (House of Commons, 2016). There appears to be a tension between evidence suggesting LAC are reportedly more likely to meet the criteria for a recognised mental health disorder (Bronsard et al., 2016) and other evidence suggesting that the emotional and behavioural difficulties exhibited by LAC do not always fall within current diagnostic categories and/or adequately consider their early experiences (DeJong et al., 2010; Tarren-Sweeney, 2010). Several studies have demonstrated a consistent constellation of symptoms and behaviours evident within those children who have been maltreated spanning seven key areas including; interpersonal difficulties, dissociative responses to trauma, inattention and impulsivity, and sexualised behaviour (Van der Kolk, 2005; D’Andrea et al, 2012).

This has led to the emergence of the theorised ‘Developmental Trauma Disorder’ (DTD) which conceptualises the difficulties of children with chronic trauma histories using an attachment and interpersonal framework (van der Kolk, 2005). Those in support of DTD argue that without an appropriate understanding and diagnostic label for these particular difficulties, individuals do not receive appropriate recognition and treatment (van der Kolk, 2014). Furthermore, without a sound assessment and formulation, clinicians run the risk of applying ineffective treatment approaches. For example, Post-Traumatic Stress Disorder (PTSD) is not the most common diagnosis among children who have experienced developmental trauma (Copeland et

al., 2007) and yet they are often in receipt of interventions based on the PTSD construct (Pynoos et al., 2008). However, DTD remains controversial and it was not accepted as a formal diagnosis within DSM-V due to its overlap with existing well-established syndromes e.g. reactive attachment disorder, conduct disorder and borderline personality disorder (for a review see Schmid, Petermann, & Fegert, 2013). Some have also contended that its existence would focus too heavily on the trauma-related aspects of the condition and prevent children from accessing current evidence-based care pathways and psycho-pharmaceutical treatment options (Woolgar & Baldock, 2015).

The alternative to the DSM-5, the World Health Organisation’s International Classification of Diseases (ICD) released its’ eleventh version this year which includes a new diagnosis of Complex PTSD. This includes three additional symptom clusters including emotion regulation, negative sense of self and disturbances in relationships. This diagnosis is based on adult psychopathology and its applicability to children is yet unknown. Furthermore, it requires individuals to meet criteria for PTSD first which may not apply to victims of developmental trauma (DeJong, 2010). This leaves professionals and carers challenged to find the means to secure meaningful help and support for LAC who either have several disorders or do not meet criteria for any common disorders.

The role of psychometric measures in LAC

Psychometric measures play an important role in screening for mental health difficulty and evidencing the effectiveness of services (Happell, 2008). As such, they have become routine in the child and adolescent mental health services in the UK, Australia, New Zealand, Denmark and Norway (Kwan & Rickwood, 2015). These tools also regularly aid decisions about access to services. The most commonly used tool, the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997), is a short questionnaire designed to measure emotional and behavioural

difficulties in children between 2-17 years old. It is considered to have high sensitivity and specificity in several clinical and general child populations (Goodman et al. 2004). The SDQ has been the measure of choice for LAC in many Western countries. However, there are limited studies investigating the utility and validity of the SDQ within LAC (Jee et al., 2011; Marquis, & Flynn, 2009) and a UK LAC Expert Working Group recently concluded that the SDQ alone is not an effective way of measuring the emotional and behavioural needs of LAC (SCIE, 2017).

Despite the popularity of the DTD construct in some areas, only a handful of measures have been designed to capture the psychological sequelae associated with developmental trauma as highlighted by a literature review (Denton et al., 2016). Current measures were criticised for using samples that were ill-defined (e.g. failing to differentiate between victims of single- and multiple-trauma histories) or focusing on one particular trauma type (e.g. sexual abuse) (Denton et al, 2016). Furthermore, several potentially useful tools do not have published research data to evidence their reliability and validity. For example, the BERRI is a tool used clinically within parts of the UK and although the measure claims to have good clinical utility by its developers, currently there are no published data to demonstrate its utility, validity or reliability as a tool for LAC.

In fact, following a systematic search only two measures which consider the specific needs of LAC were identified; the Assessment Checklist’s (Tarren-Sweeney, 2007; Tarren-Sweeney, 2013b) and the Brief Assessment Checklist’s (BAC, Tarren-Sweeney, 2013a). Both measures were developed in Australia within a large LAC population to assess the frequency and severity of emotional and behavioural difficulties theoretically underpinned by a developmental trauma framework. The measures have since been validated in a Dutch population (Goemans, Tarren-

Sweeney, Geel & Vedder, 2018) and have been used within several studies of LAC and adopted children (DeJong, Hodges & Malik, 2016; Goemans, van Geel & Vedder, 2018).

Despite good internal consistency, the BAC’s have not been evaluated within a UK population or from the perspective of foster carers or clinicians working in the field. Given the lack of research investigating current LAC targeted measures, the current study therefore aimed to explore the following research question: *How do foster carers and clinicians understand the use of psychometric measures, such as, the SDQ and the BAC’s in the assessment of LAC?*

Method

The present study was part of a larger research project which aimed to evaluate the validity of the SDQ (Goodman, 1997) and the BAC’s (Tarren-Sweeney, 2013a) in a LAC population. The choice to include the SDQ was partly due to its popularity as a clinical tool and also due to its established validity and reliability in non-LAC populations (Goodman, 2001; Goodman et al., 2000). The BAC’s were selected because they were designed specifically for LAC. Qualitative data was collected via semi-structured telephone interviews or face-to-face focus groups with foster carers and clinicians. All discussions were audio-taped and transcribed verbatim by the researchers.

Participants

Foster carers. The study was advertised to foster carers through nineteen local authorities, fifteen independent fostering agencies/charities in the UK and nationally via social media platforms. For inclusion in the study, foster carers were defined as an individual approved to provide temporary care to a child by a local authority or independent fostering agency (DfE, 2011). Foster carers with a child aged 4 to 17 years currently in placement for at least 4 months were invited to take part in an online survey which related to the larger research project. At the end of the online survey, participants were invited to express an interest in the present study by

providing an email address. Researchers contacted interested participants to arrange either a face-to-face or telephone interview. Owing to distance only two participants were able to attend a face-to-face meeting held at the University. Participants were reimbursed for their travel and parking costs.

Clinicians. CAMHS clinicians were recruited from one NHS Trust in the South of England. They were required to have at least one-year post-qualification experience and to have worked in the service for at least one year to ensure participants had sufficient experience to comment on the utility of questionnaires for this population. Participants provided informed consent and ethical approval was gained from the University Faculty Ethics Committee and the NHS Trust Research and Development department. The clinicians were invited to take part in the study by circulation of an email which included details of the study and an information sheet and consent form. Participants opted into the study by emailing the researcher. Focus groups were arranged at two separate NHS CAMHS sites where clinicians were invited to look at the measures and discuss them.

Measures

The SDQ parent version (Goodman, 1997) is a 25-item screening measure of mental health difficulties completed by carers of children aged 4 to 17 years old. Items pertain to five subscales: Emotional Problems, Conduct Problems, Hyperactivity/Inattention, Peer Relational Problems, and Prosocial behaviour. Questions take the form of short phrases such as ‘*considerate of other people’s feelings*’ and ‘*rather solitary, tends to play alone*’. The SDQ uses a three-point scale of ‘Not True’, ‘Somewhat True’ or ‘Certainly True’. Scores are summed to give a Total difficulties score. The maximum score being 64 with scores above 14 considered ‘borderline’ and above 17 ‘abnormal’. Within the general child population, it is reported to have good reliability and validity (Goodman, 2001; Goodman et al., 2000). A one-

point increase in Total score is correlated to an increased risk of psychiatric diagnosis with odds ratios between 1.14 and 1.28 (Goodman & Goodman, 2009). Given these psychometric properties it has become the most widely used child and adolescent screening measure for mental health difficulties.

The Brief Assessment Checklist’s for Children (BAC-C; 4-11 years) and Adolescents (BAC-A; 12-17 years) (Tarren-Sweeney, 2013a) are 20-item psychometric measures designed to measure common emotional and behavioural difficulties specific to LAC that are not present within existing measures e.g. SDQ. The measures were developed with data from state-wide mail surveys of foster parents and kinship carers and from the state child welfare database measuring a large number of developmental, pre-care and in-care study factors. Difficulties include interpersonal, attachment-related difficulties, insecure relating and trauma-related anxiety and dissociation rated by the child’s carer. Questions include ‘*Fears you will reject him/her*’ or ‘*Lacks empathy/guilt*’. The first 16 questions are scored on a 3-point Likert style scale from 0 to 2 and the final 4 questions are scored on a 3-point time rating scale. Ratings on the measure are totalled to give an overall score. Scores exceeding the cut-off score of 5 out of 20 indicate that ‘further clinical assessment is warranted’; and good reliability and validity was reported for both measures when they were developed (Tarren-Sweeney, 2013a).

Procedure

A semi-structured interview schedule was designed for both participant groups comprising broad, open questions related to the utility of psychometric measures for LAC with prompts identified for specific items (Smith, 1995). The interview schedule was developed within the research team of clinicians and researchers (two qualified registered psychologists and two trainee psychologists) prior to interviews and re-evaluated following the first couple of

interviews as recommended by Braun and Clark (2013). No constraints were placed on the focus of the discussion allowing all participants to contribute their unique perspectives.

Data Analysis

Data was analysed using thematic analysis as outlined by Braun and Clarke (2013). A critical realist ontological position (Cook & Campbell, 1979) was adopted for analysis, interpretation and evaluation. A ‘theoretical’ approach (Braun & Clarke, 2006) was selected for coding and analysis due to the researcher’s primary goal of investigating a specific qualitative research question. A two-step deductive-coding process (Braun & Clarke, 2006) was selected due to the primary goal of investigating a specific research question. Initially, data were coded separately by two researchers (CF and RD) using a ‘complete coding’ approach to identify data of interest or relevance to the research question (Braun & Clarke, 2013). Data was then reviewed for latent content; producing both semantic- and researcher-derived codes. Initial patterns were provisionally identified through consideration of all the secondary codes and initial themes were mapped visually to explore potential implicit or hierarchical relationships between them.

Given the similarity of the initial themes between foster carer and clinician data, the decision was made to combine the dataset and one researcher (CF) continued to map these themes visually. Differences between the two participant group perspectives were noted. Following this, the data and codes were revisited to explore how well the candidate themes fit the data. Themes were also checked against the data and discussed between all authors over the course of the analytic process. The researchers’ (CF and RD) subjective influence was considered throughout data gathering, coding and analysis via reflective journal.

Results

A total of thirteen UK foster carers agreed to take part; two via group interview and eleven via telephone interviews (Table 1). This was approximately four percent of the total sample of

foster carers in the larger study. All participants were female and were given pseudonyms during analysis to protect their anonymity. Two clinician focus groups comprised nine participants (two males, seven female) (Table 2). In order to protect anonymity, clinicians were referred to as clinician 1, clinician 2, etcetera. Thematic analyses generated six individual themes, which were organised into two superordinate themes, as summarised in Figure 1.

Within the narrative, foster carers and clinicians emphasised the need to gain a comprehensive understanding of the LAC. The BAC’s and SDQ were believed to aid this process. However, potential short-falls and problems around how information from these measures are used to facilitate support were discussed. Points of divergence between foster carer and clinician perspectives are highlighted within the text.

Theme 1: Relevance to LAC

Within this theme, there were two subordinate themes describing the arguments for and against the ability of the BAC’s and SDQ to capture the key emotional and behavioural difficulties in LAC. Foster carers suggested that the measures were important for organising how information about LAC was captured and for facilitating a process of communication between themselves and professionals. For clinicians, the measures were described as useful in providing a framework from which to base discussions with foster carers. In particular, the BAC’s were identified as particularly important for junior members of staff who had less experience of working with attachment and trauma issues. On the other hand, LAC were recognised as having complex needs which were difficult to capture and this limited the utility of both measures.

Measures can ‘flag up’ key difficulties. Foster carers frequently talked about questionnaires as a way to raise concerns or ‘*flag up*’ (Sarah) difficulties a child might be experiencing. Gathering critical information at the outset was also highlighted as important by clinicians. Many felt the measures had a role in providing a ‘*snapshot*’ (C2) of information about a child

at the referral stage which could help the professional to think *‘in a sharper, more focused way’* (C5). A number of clinicians also suggested that the information provided by short questionnaires can be useful as a *‘screen’* (C4) particularly when completed by multiple informants.

Almost all of the foster carers praised the BAC’s for including difficulties that they felt were not acknowledged by the SDQ. These difficulties were described as relating to problems with *‘emotion’*, *‘relationships’*, *‘abuse’*, *‘trauma’* *‘sexualised behaviour’* and/or *‘attachment difficulties’* and for some, seeing these difficulties in a measure was *‘comforting’* (Barbara) and *‘reassuring’* (Lisa).

Norah: *‘...it appears to be more geared to my child... it’s got questions on there about the sexualised behaviour and the intensity of new relationships... and emotions that it hasn’t got on the other one.’*

Clinicians also acknowledged that the BAC appeared to gather information related to *‘trauma’* and *‘attachment’* which could have a range of clinical benefits. Some suggested they could use this information to provide less experienced staff members with a *‘good list of things’* (C11) to explore in terms of attachment and trauma whilst others proposed that this could *‘guide parents or carers to think reflectively or mindfully about behaviours.’* (C3). By way of contrast, the SDQ was recognised as being more adept at identifying externalising or *‘acting out’* (Barbara) behaviours by foster carers, and symptoms related to specific diagnostic criteria by clinicians.

Laura: *‘I think the BAC one seems to be more around emotion. Whereas the other one, there’s a lot more physical behaviours...’*

Barbara: *‘If they were acting out then the other one (SDQ) would probably be better’.*

Measures cannot capture the complexity of LAC. Foster carers and clinicians alike raised concerns about the brevity of the questions whilst also acknowledging the challenges of attempts to summarise complex difficulties experienced by LAC. The BAC’s and SDQ were considered to lack sufficient detail and this resulted in the majority of foster carers stating they would prefer to talk to a professional. Some also wanted to provide more information in order to feel understood, such as Karen when discussing the SDQ: *‘I ticked two boxes and wrote notes...’* Several clinicians suggested that LAC were likely to score highly on questionnaires and as such, wondered how useful they would be when attempting to *‘gauge the seriousness of the difficulties or differentiate between children who are fighting for resources’* (C1).

In relation to the specific foci of the questionnaires, the SDQ was criticised for overlooking key behaviours such as relational difficulties and trauma by foster carers, and attachment and dissociation by clinicians. In contrast, information related to somatising behaviour, self-harm and mood issues were missing from the BAC’s as described by Sarah: *‘... none of the questions would necessarily draw out the symptoms of depression’*. Foster carers also highlighted key difficulties that were missing from both questionnaires such as controlling behaviour (p10, p11), bed-wetting (P8), violent behaviour (p3, p4, p11) and suicidality (p7).

P11: *“I don’t think there’s a lot about control and my experience is that these children try to control lots of things because they’ve had so much control taken away...”*

Foster carers also expressed concern over the measures’ inability to capture subtleties and the limitations of responding to items using a 3-point scale, for example, Lisa commented on the BAC’s *‘...there isn’t room to not be black and white’*. This was similar for clinicians who felt that they would *‘...want much more qualitative information than just ‘yes’ ‘no’*’ (C3) to be able to make meaningful recommendations.

Theme 2: Using measures to inform care planning

Questionnaires were believed to have the potential to enhance care plans by facilitating a way of monitoring outcomes, providing feedback to foster carers, planning subsequent action and facilitating access to CAMHS. However, the perspectives of foster carers and clinicians were different when considering the ability of the two measures to do this.

Facilitating access to CAMHS. Whether or not questionnaires could facilitate access to CAMHS was discussed at length by both participant groups. Several foster carers commented that LAC were atypical and capturing their difficulties posed a challenge when completing questionnaires believed to be the gateway to services. At times, this prevented their LAC from accessing support.

Lisa: *‘I’ve never been able to get my answers to quite fit with the types of things they ask (on the SDQ).’*

Many suggested that children who communicated their distress through externalised or challenging behaviour were more likely to be identified by the SDQ; however, children who communicated their distress in other ways, for example, those who *‘shut down completely’* or *‘comply, do well at school and are quiet’* (Karen), were missed. Foster carers often felt they had to reach a *‘crisis’* point (Lisa) or to experience *‘violence’* from LAC (Karen) before help was provided. As such, foster carers hoped that the use of measures specific to LAC, such as the BAC’s, would be a *‘starting point’* (Elizabeth) or *‘stepping stone’* (Laura) that would help them to *‘fight for my children’s corner’* (Laura) when requesting further support. A key advantage of using questionnaires was to have concerns *‘on the record’* (Karen) or *‘in writing’* (Elizabeth).

However, within the clinician’s discussions, some reported that even if emotional and behavioural difficulties specific to LAC were identified through additional measures e.g. the BAC’s, the service would not be able to provide support to the family as it was not commissioned to work with complex attachment presentations or non-diagnosable mental health conditions. Thus, the assessment of these difficulties would ‘*open the flood gates*’ (C5).

Using measures to monitor change. The ability of the questionnaires to track and monitor behaviours within LAC was highlighted as an important function. Foster carers often talked about using measures to gain objective ‘*feedback*’ (Elizabeth) on the child in their care and to observe the progress they have made. Some suggested questionnaires should be used routinely, for example at six-monthly reviews, to inform ‘*what therapy*’ (Sarah) or determine ‘*how we manage behaviour*’ (Irene).

Norah: ‘*I think they’re, they’re really useful... I use them because I can then look back on them and I can see if there’s improvements or patterns or changes*’

Another felt this would document important information to share with professionals and future foster parents:

Emma: ‘*wherever they go, whoever’s going to get them and read them, at least there’s some sort of, you know, a baseline of what these children are like*’

The main advantage of using questionnaires for clinicians was the ability to demonstrate change following therapeutic input.

C4: “*You’d hope that somebody who’s been referred in and who is impulsive or lacks guilt... after some therapy, (the score) it’s going to go from ‘mostly true’ to ‘partly true’ ...*”

However, clinicians recognised that the length of questionnaires and frequency of their use could be detrimental to this process. Furthermore, a number of clinicians queried whether change could be monitored in attachment difficulties by any measure.

C2: “You have to know whether or not to expect to see scores go down with attachment problems as to whether or not you even could actually use it in that way... as a routine outcome measure”.

Theme 3: Current problems when using measures with LAC.

The third superordinate theme comprised two sub-themes; one depicting both participant group concerns regarding interpretation of the questionnaires and a second subtheme which emerged solely from the foster carers relating to the failure to integrate information from questionnaires into the LAC’s care plan.

Interpretation of the questions vary. There was a worry that items on both measures were open to misinterpretation or could be influenced by the foster carers’ level of experience and value-system.

Charlotte: ‘If you’ve got a newly qualified foster carer...you know, yeah he craves attention or does he? No he doesn’t come for kisses, but they don’t realise that the attention is actually the fact that he’s swinging off the roof or stealing from the kids at school and you know they don’t think, what does that mean?’

Although foster carers generally reported that the questionnaires were ‘clear’ (Norah) and ‘easy to read’ (Karen), frequent examples were given about items being interpreted differently depending on the context. Jessica commented when discussing the SDQ item ‘Shares readily with others’:

‘One of the young people that’s placed with me would share her makeup at the drop of a hat because she thinks that’s fun, ask her to share her food and you’d get a fork in the back of your hand’.

Clinicians queried whether items on both tools were ‘*too broad*’ (C6), ‘*subjective*’ (C1), would be taken ‘*literally*’ (C2) and/or would require the foster carer to know a lot about the ‘*internal world*’ (C3) of the child. Some clinicians discussed the potential disparity between clinician and foster carer perspectives on clinically significant behaviour and as a result felt that further discussion with the respondent was often necessary. Furthermore, particular items such as ‘*too jealous*’ or ‘*too friendly with strangers*’ on the BAC’s were picked out as subjective and inherently negative by clinicians in one focus group.

Information is not engaged with. A theme emerging solely from the foster carers was related to the perceived insignificance of questionnaires as they received little or no feedback about how these were utilised. The majority of foster carers believed that information was not acted upon and many referred to questionnaires as merely a ‘*tick box exercise*’ (Norah). One foster carer stated that she would be more likely to complete questionnaires if she believed it would add value to the children in her care. Whilst others held a belief that the measures went into a void with no action subsequently taken.

Emma: *‘I don’t think the paperwork I do is ever looked at’*

Norah: *‘I find it a bit frustrating really ...but they just don’t use it.’*

Discussion

The present study sought to contribute to the field of mental health assessment in LAC by gathering data from the perspectives of foster carers and clinicians working in CAMHS. The thematic analysis uncovered three overarching themes which included: discussion about

whether brief measures, such as the SDQ and BAC’s, can identify relevant emotional and behavioural difficulties in LAC; how these measures might be useful to inform care planning; and the potential problems arising with the use of these measures with the LAC population. It was noteworthy that both foster carers and clinicians were broadly in tune with one another regarding the merits and the challenges of psychometric measures.

Identifying mental health needs in LAC

The findings appear to suggest that both clinicians and foster carers have mixed views on the potential utility of the BAC’s and SDQ. Both groups saw their merits and would appear to endorse their continued use; albeit with some caution. There also appeared to be a consensus that these measures could have utility in being able to identify difficulties and monitor change over time. However, foster carers and clinicians had concerns about whether the measures were fit for purpose as it was unclear whether the SDQ or BAC’s could capture and represent the breadth and complexity of presenting difficulties in LAC. The theoretical frameworks underpinning the SDQ and BAC questionnaires are different. The SDQ is underpinned by a developmental theoretical framework (Goodman, 1997) whilst the BAC was developed with attachment and trauma theories in mind (Tarren-Sweeny, 2013a). From the participants’ perspective, neither questionnaire was able to provide the necessary and sufficient profile of the young person to be able to develop an effective care plan. More broadly, foster carers highlighted that key difficulties observed in their LAC were often absent from psychosocial measures including; difficulties in relationships (e.g. lying and stealing), seeking control, violent behaviour, toileting problems, emotion regulation difficulties, self-harm and suicidality. Furthermore, one foster carer highlighted that learning problems and other neurodevelopmental difficulties are often missing in brief screening tools despite the knowledge that these problems are more prevalent in LAC (Dinkler et al., 2017).

Many clinicians have warned against an overreliance on narrow assessment tools in LAC; arguing for a broader and more sophisticated conceptualisation of their needs such as psychological formulation (DeJong et al., 2010; Golding, 2010). Many participants suggested that using a combination of different measures would be more helpful rather than either measure on its own. A similar conclusion was made by the UK Expert Working Group (SCIE, 2017) which highlighted that the SDQ alone was not an effective way of measuring the emotional and behavioural needs of LAC and thereby recommended that the assessment process is supported by a broader set of measures. This was mirrored in the US as several groups of clinicians have developed trauma-based mental health assessment models, such as the Chadwick Center for Children and Families Trauma Assessment Pathway (TAP; 2009), which aims to provide a comprehensive assessment of complex trauma using a number of measures tailored to the individual, family context and culture.

The current study data from the UK suggests that the current theoretical frameworks supporting the two measures under examination need to be expanded to allow for the development of a more comprehensive measure. Constructs embedded within DTD could potentially be usefully operationalised and integrated alongside material from the SDQ and BAC to provide a holistic measure. Alternatively, the Assessment Checklist’s (Tarren-Sweeney, 2007; Tarren-Sweeney, 2013b) could be investigated further. These measures provide longer and more comprehensive versions of the BAC’s and incorporate symptoms of DTD. For that reason, they could address some of the concerns raised by foster carers and clinicians in the present study. However, the measure is more time-consuming and may pose a challenge when used as part of routine practice.

Trauma-informed services

The themes to emerge from the research suggest existing questionnaires may not be sufficiently sensitive in identifying needs specific to LAC. This may go some way to explain why LAC are frequently denied access to mental health services (Minnis & Del Priore, 2001). Despite recommendations that LAC should be able to access service provision in a timely manner, there is a serious challenge to identify measures and assessment processes that can facilitate the development of meaningful formulations. Currently, there is no clear care pathway for LAC who do not meet criteria for psychiatric diagnosis and yet require therapeutic input (Rao, Ali & Vostanis, 2010) leaving a population of young people unserved by mental health services.

With the increased awareness of ACE’s, there is a growing movement towards trauma-informed care which Conradi and Wilson (2010) describe as “*a wider system impacting children and families, with multiple components designed to meet the varying needs of traumatized individuals who are receiving services*”. These include collaboration across public service agencies, with a grounding in contemporary knowledge and understanding of trauma and how it presents. Emerging evidence suggests that the development of trauma-informed systems in education and social care may be effective in building resilience in these children (Ko et al., 2008), as well as offering a more integrated approach to care (SCIE, 2017). Although this is clearly positive, it adds to the complexity of ensuring multiple perspectives are captured in order to comprehensively identify the LAC needs. If the envisaged changes to systems are also supported by the adoption of broader measures alongside the SDQ, such as the BAC’s or Assessment Checklists, an increased understanding of the LAC is likely. Embedding this within a person-centred assessment with the commensurate discussions to explore the data, may enable the development of a more sophisticated formulation, leading to more effective interventions and associated long-term relationships with subsequent improvements in outcomes.

Limitations

The results were analysed within a critical realist approach and therefore the findings need to be considered as reflective of the participants recruited at a particular time. The group of foster carers’ (whilst all female) were drawn from across the country and are therefore not organised by one particular service framework and the associated access arrangements. It may be that those who were particularly interested in the use of these measures and/or mental health needs of LAC were more motivated to participate in the study. Furthermore, the clinician sample was recruited from one mental health trust and although clinicians had a range of roles and experiences of working with LAC, future research should replicate the present findings in a larger sample.

Summary and Recommendations

The mental health of LAC has been highlighted as a clinical priority in several Western countries. Despite recommendations that the views of LAC, carers and clinicians should form the heart of service design and development (NHS Taskforce, 2014; Australian Government, 2011a; Australian Government, 2011b), little empirical research has been undertaken to explore foster carers and clinician’s perspectives of mental health assessment for LAC. The findings from the current study highlighted the complexity of this issue when reviewing two specific psychometric measures and participants seldom felt that the needs of LAC were adequately captured by existing measures in isolation. This may go some way to explain why LAC are frequently unsupported by mental health services.

When working with children and young people whose life histories are complex and challenging, it is crucial that mental health assessments incorporate different perspectives (e.g. the child, parents, teachers and social workers) and use multiple assessment tools (e.g. attachment-based measures, trauma-specific measures, interview and observations) to build the

fullest picture of the child and their context. To aid this process, a number of assessment tools may be necessary and complex trauma assessment models, such as the Chadwick Center for Children and Families TAP (2010), may provide a useful guide for clinicians when selecting assessment tools. The current study also highlights the importance of offering carers the opportunity to write notes, expand on their answers, and provide further qualitative feedback and explanations about their LAC during the assessment process. Finally, it is unclear what the future holds for DTD or how the Complex PTSD diagnosis will apply to children and young people in care. Although diagnosis can facilitate access to support, to help the individual and their family understand their needs, a psychological formulation may be the most useful way forward given that it includes multiple biopsychosocial factors, maintaining factors and strengths - from which to develop a bespoke treatment package for the young person.

Acknowledgements

Study funding: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sector.

Conflicts of interest: The authors have declared that they have no competing or potential conflicts of interest.

Contributorships: All authors share responsibility for the final version of the work submitted and published. Dr. Frogley and Dr. Denton were responsible for the collection and analysis of original data; and therefore, take responsibility for the integrity of the data and the accuracy of the data analysis. Ms. John and Dr. Querstret were responsible for the supervision and assistance regarding the following: the development of the study project, data analysis and interpretation, and assistance with the writing of this article. Dr. Frogley took responsibility for drafting the final research article and the remaining authors provided assistance towards the final research article.

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