coramBAAF ADOPTION & FOSTERING ACADEMY

BRIEFING

NHS South London and Maudsley NHS Foundation Trust

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The Assessment of Children and Young People for Adoption Support

The evidence from 20 referrals to the National Adoption and Fostering Team at the Maudsley

Introduction

The Adoption Support Fund (ASF) has opened up a range of opportunities for adoptive and special guardianship families in England to access therapeutic services for their children. From a prototyping year in 2015, approximately £20M has been available for each year after that. Growth in accessing the ASF developed rapidly, with a list of "approved" therapeutic interventions, largely based on administrative rather than evidence-based formulations. Over the last year, the introduction of a "fair access limit" to ensure the available budget is not overspent has resulted in some re-alignment and a degree of frustration in those seeking to access the ASF.

A previous CoramBAAF Briefing Note considered these issues with an explicit exploration of the introduction of an evidence-based programme – 'Video-feedback intervention to promote positive parenting' – at the Tavistock and Portman NHS Trust (Dugmore and James, 2017). A second Briefing Note explored the joint local authority and CAMHS service in East Sussex (Roy, 2017).

Significant questions continue to be raised about the quality and robustness of the professional assessment process that enables families to access the ASF. The framework used currently is largely driven by the administrative framework used by the ASF administrators. This has raised some questions about the knowledge and skills of social workers and the support available to them, including direct access to other professionals such as psychiatrists, psychologists and psychotherapists, as they engage with children and young people and their parents. Multi-professional co-operation and working in partnership should be core to providing adoption support effective interventions, but it is not clear that this is possible or available. This Briefing Note adds to the developing picture of adoption support issues by analysing data on 20 children and young people consecutively referred to the special adoption and fostering service at the Maudsley – a well-respected and established national CAMHS service. The analysis of the 20 consecutive cases includes the reasons for referral, the original formulation of the issues and the interventions provided. This is then compared to the reformulation of the diagnosis and the resultant services and/or interventions by the Maudsley team. The contrast is striking.

While this is a small-scale analysis, the issues raised are highly significant. They reinforce the importance of the ASF specifically and other services more generally developing a more robust interdisciplinary perspective on the challenges facing adopted and special guardianship children, informed by experience and expertise. The ASF has opened a significant opportunity but it has not so far enabled

the development of a coherent strategy informed by evidence. This Briefing Note indicates just why this needs to happen.

The mental health of adopted children

The mental health needs of UK adopted children have become high profile in the sector but are subject to a wide range of formulations and explanations that lack evidence and coherence (Woolgar and Baldock, 2015). International research evidence is difficult to directly draw on due to differences between the UK adoption cohort and those in Europe and the USA. Children adopted in the UK are primarily drawn from the under-fives looked after children population as a result of abuse and/or neglect, with a very small number of young children "relinquished" by their parent/s or adopted from other countries. A study using the national data (Meltzer *et al*, 2003) indicated that almost half of looked after children have a mental health disorder, with elevated rates of behavioural, neurodevelopmental and mood disorders, compared to the normal population and to children living with their birth families where there was elevated social economic risk. These figures indicate the high risk that many adopted children are likely to present with.

The service

The National Adoption & Fostering Service (www.nationaladoptionandfosteringclinic.com) is a national, multidisciplinary NHS CAMHS service that specialises in providing services to adopted and looked after children, from infancy to adulthood and typically with complex care histories and a diffuse range of presenting problems. The service specialises in comprehensive mental health and educational assessments, based on a comprehensive and holistic assessment of children's and young people's needs, including the family context within which the child lives, their friends and the engagement with education and school. The ethos is to understand adoptive and looked after children as individuals, personalising assessments and treatment recommendations to each family, avoiding "top-down" or "one-size-fits-all" approaches, and making use of psychiatric diagnoses but also individualised biopsychosocial formulations (Woolgar and Pinto, 2016).

As a national service, the NHS costs of all referrals are funded by local commissioners or more recently, as with this data, by the ASF.[1]

1 The cases reported here were all funded by the ASF, with the children having been in care at some point.

The method

The sample

The data reported here were taken from children or young people referred between 2015–2016 and whose cases were funded by the ASF. The first 20 cases consisted of 11 boys with a mean age at referral of 11.65 years (SD = 3.56, range, 4–18). A total of 18 of the cases were of White British heritage; the remaining two cases were of white European heritage. Of these, 14 attended a mainstream school and three were in a Specialist School or Pupil Referral Unit. The remaining three cases were not attending education at the time of referral.

A total of 16 of the children were adopted by heterosexual couples, three by single female carers, and one by a lesbian couple. Of these cases, 10 had siblings present within their adoptive households (three were living with their adoptive parent's birth children, three had been adopted with genetically related siblings, and four had unrelated adopted siblings within their household).

Seventy-five per cent of cases (n=15) had previously been seen by local CAMHS, and at assessment 55 per cent (n=11) were deemed to be at high risk at the time of referral (e.g. suicide risk, self-harm, sexual exploitation) and 15 per cent at high risk of adoption breakdown (see Table 1).

Data analysis

The reasons for referral were identified from the presenting symptoms detailed in referral letters. Information regarding previously received diagnosis, treatment and outcomes was taken from previous CAMHS and social care reports. Current diagnoses and care plan data were extracted from the service's assessment reports. All data were transferred to a standardised proforma.

The results

Referral letters were inspected for the presence of presenting symptoms such as mood, behavioural and social difficulties (see Table 1). Behavioural concerns were identified most frequently among referrals. A total of 19 cases were referred with issues regarding challenging, oppositional and/or aggressive behaviour. Three of these cases were also identified to present with "sexualised behaviour".

A total of 15 children were referred with concerns regarding mood, the majority of which (n=13) identified difficulties in emotional regulation and had aggressive outbursts. Social difficulties, including problems in developing and sustaining peer relationships and

Reasons for referral

Table 1: Percentage of referral letters with each presenting complaint (n=20)

Presenting complaints	Referral letters (%)
Emotional difficulties (presenting with any of the below)	**75**
Anxiety	*30*
Depression	*25*
Emotional regulation/aggressive outbursts	*65*
Behavioural difficulties (presenting with any of the below)	**95**
Challenging behaviour (including aggression and oppositional behaviour)	*95*
Sexualised behaviour	*15*
Social difficulties	**50**
High risk (presenting with any of the below)	**55**
Risk of online sexual exploitation	*15*
Substance misuse	*10*
Aggressive behaviour requiring police involvement	*15*
Suicide attempts and/or self-harm	*30*
Learning needs (including language delays)	**20**
Sleep issues	**10**
Comorbid physical issues (presence of more than one issue)	**30**
Adoptive placement breakdown	**15**

social disinhibition, were identified in 50 per cent of the sample (n=10).

It was further noted whether referrals detailed behaviours that were identified as “high risk”, including incidents of severe self-harm and/or attempted suicide; exchanging explicit content online; engaging in substance misuse; and presenting with aggression to the point of police intervention. Over half (55%) of referrals presented with at least one of these “high risk” behaviours, the most frequent of which was suicidal and/or self-injurious behaviour (30%) with histories of attempted suicide and/or severe self-harm. A further 15 per cent of children were referred following a breakdown in their adoptive placement. The numbers of cases referred with learning needs, sleep difficulties and comorbid physical issues were also recorded.

Diagnoses received prior to an assessment were identified from an analysis of previous CAMHS reports. The number of cases with each diagnosis following assessment was then identified by comparing this information with assessment outcomes, particularly with regards to ruled out and newly identified diagnoses. These figures are presented in Table 2 alongside, where applicable, the rates of increase/decrease in diagnoses following assessment (where a figure was 0, the change is based on 1 – e.g., 0 to 4 is four times as many, 1 to 4). There was a significant under-identification of mental health issues, e.g. behavioural (19 times); neurodevelopmental (2.7 times); mood (3 times); and elimination diagnoses (3.5 times) identified post-assessment.

Overall, 15 formal psychiatric diagnoses had been identified before the assessment and 71 afterwards – this is an average of 3.5 disorders per child but also an average of 2.8 new identified disorders per child, indicating a high level of psychiatric complexity (or comorbidity), as well as a significant rate of under-diagnosis of formal mental health disorders in this sample.

None of the children (50%) who had previously been identified to have either a formal attachment disorder or attachment problems were found to meet formal diagnostic criteria for either reactive attachment disorder or disinhibited social engagement disorder (a 10-fold reduction).

Of the six children previously identified and/or treated for non-specific “trauma”, only two were diagnosed with post-traumatic stress disorder (PTSD) (a threefold reduction). All six of these referrals, however, were found to meet diagnostic criteria for a behavioural disorder of either conduct disorder or oppositional defiant disorder. Furthermore, four of these cases received additional neurodevelopmental diagnoses of either ADHD or autism spectrum disorder.

Assessment outcome

Table 2: A comparison of diagnoses received before and after an assessment with the National Adoption & Fostering Clinic

Diagnosis		Cases pre-assessment (N)	Cases post-assessment (N)	Rate of increase post-assessment
Behavioural	***Total***	***0***	***19***	**19 times**
	Oppositional defiance disorder (ODD)	0	7	7 times
	Conduct disorder	0	12	12 times
	with limited prosocial emotions	*0*	*4*	*4 times*
	without limited prosocial emotions	*0*	*8*	*8 times*
Neurodevelopmental	***Total***	***10***	***27***	**2.7 times**
	ADHD	5	14	2.8 times
	Autism	2	8	4 times
	Mild learning difficulties	3	5	1.67 times
Mood	***Total***	***6****	***18***	***3 times***
	PTSD	0	5	5 times
	Depressive episode	2	4	2 times
	Generalised anxiety disorder	0	1	1 time
	Agoraphobia	0	2	2 times
	Bulimia	1	1	No change
	Emotional personality disorder (EPD)	0	1	1 time
	Phobia	0	2	2 times
	Anxiety disorder (unspecified)	3	0	Decrease
	Separation anxiety disorder	0	1	1 time
	Social anxiety disorder	0	1	1 time
	* Includes the three cases with anxiety disorder unspecified, although this is not a formal disorder			
Elimination	***Total***	***2***	***7***	***3.5 times***
	Enuresis	1	4	4 times
	Encopresis	1	2	2 times
	Sleep disorder	0	1	1 time
Attachment	***Total***	***10***	***0***	***Decrease***
	Attachment disorder (reactive)	2	0	Decrease
	Attachment disorder (disorganised)	1	0	Decrease
	Attachment issues/traits (no diagnosis)	4	0	Decrease
	Attachment disorder (not specified)	3	0	Decrease
Trauma				
	Unspecified	6	0	Decrease

Treatment

An analysis of previous CAMHS and social care reports enabled a comparison to be undertaken between interventions already received and those recommended following assessment in the service (see Table 3).

Table 3: Interventions received prior to assessment and recommended following assessment (n=20)

Intervention		Cases receiving intervention prior to assessment (%)	Cases recommended intervention following assessment (%)
Therapeutic			
Evidence-based			
	Social skills	0	90
	Life story work	15	65
	Trauma-focused CBT	0	25
	Systemic family therapy	0	35
	Dialectic behavioural therapy	5	5
	Cognitive behavioural therapy	5	50
	Cognitive analytical therapy	5	0
	Encopresis behavioural intervention	0	5
Other			
	Psychotherapy	20	0
	Art therapy	10	0
	Drama therapy	5	0
	Family therapy	20	0
	Play therapy	30	0
	Regressive play therapy	5	0
	Equine therapy	5	0
Parenting			
	Social learning theory-based parenting for conduct	10	90
Other			
	Therapeutic parenting/Dyadic Developmental Psychotherapy	35	0
	Model not specified/ unknown by parents	10	0
Medication			
	Medication for mood	15	25
	Medication for ADHD	30	65
	Medication for sleep	5	10
Physical intervention			
	Sensory integration	5	0
	Speech therapy	5	0
	Occupational therapy	20	10
	Speech and language therapy	25	0
	Physiotherapy	5	0
Psychoeducation			
	Psychoeducation for sleep	0	5
	Psychoeducation for substance misuse	0	20
Educational			
	Tailored learning plan	0	65

There was a marked increase in the number of evidence-based individual therapeutic and behavioural interventions recommended. Most notably, 90 per cent of children were identified to benefit from a formal social skills intervention; no children had received this prior to assessment. Furthermore, 50 per cent of children were recommended Cognitive Behavioural Therapy (CBT) for specific disorders, whilst only five per cent had previously received this intervention. Apart from this one case, those identified as likely to benefit from CBT had either not previously received individual therapy or received non-evidenced-based interventions, including “regressive play” or “play therapy”.

Following assessment, 90 per cent of children were recommended evidence-based parenting interventions for conduct problems. Whilst a total of 55 per cent of cases reported previously receiving parenting work, only 10 per cent reported a social learning theory-based parenting, as per NICE guidance. A total of 35 per cent of cases reported receiving parenting work that was therapeutic and/or underpinned by Dyadic Developmental Psychotherapy (DDP). A further 10 per cent of cases reported receiving parenting work but with a lack of clarity in the details regarding the theoretical model that underpinned it.

With regards to medication, the most notable increase was in the number of children recommended medication for ADHD. A total of 30 per cent of children were medicated for ADHD prior to assessment; however, 65 per cent were recommended to continue or commence a trial of medication following assessment. This reflects the increase in the number of children identified with this diagnosis post-assessment.

With regards to education, 65 per cent of children were identified to benefit from an individualised and personalised curriculum as a result of the psychometric testing conducted as part of their assessment.

Discussion

From this small review of 20 cases referred and funded at the start of the ASF, several clear patterns emerged. On the plus side, there was good evidence that adoption social workers were seeking referrals where there were high levels of risk (55%) and with very high levels of mental health need – the average number of disorders diagnosed in this sample was 3.5, and 2.8 new ones per child.

However, the data revealed a significant level of underdiagnoses of common mental health problems, especially for behaviour problems but also neurodevelopmental difficulties as well as mood and trauma. This was so even though three-quarters of them had had a recent CAMHS assessment.

Secondly, a large number of children received non-specific, or “quasi” diagnoses that do not have any obvious care pathway within CAMHS services. Finally, as a consequence of this, few children had received appropriate, evidence-based interventions in local services before they had been referred up to the national service.

This is not to say that psychiatric disorders are the only factors influencing a child’s difficulties, but for a truly holistic account of the child’s presentation the psychiatric disorders need to be part of a broader biopsychosocial formulation. Knowing about common mental health disorders permits timely access to evidence-based treatments that could address those specific disorders. In the national service, the identification of mental health disorders took place in the context of a broader biopsychosocial formulation beyond the diagnoses.

A fully comprehensive approach to these children’s and their families’ difficulties may well include some of the treatments that the family were already having, but if so then treating the mental health disorders that run alongside these is likely to make those other approaches more successful – and to release the therapeutic potential of permanency in an adoptive family.

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Note about the authors

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