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'They shouldn't have to ask': Exploring the need for specialist mental health services for care experienced and adopted children and their families

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'They shouldn't have to ask': Exploring the need for specialist mental health services for care-experienced and adopted children and their families

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Abstract

This article reports on a study conducted in two counties in the Republic of Ireland designed to elicit the views of fostering and adoption stakeholder groups on the mental health needs of the children, young people and families for whom they are responsible. Included in these groups are young people, adoptive parents, foster carers and professionals who manage and deliver mental health services or refer cases to them. Focus group methodology was employed to ascertain participants' views. The emerging data was analysed thematically and the key findings include: the need for a universal and integrated system offering mental health services; the importance of an attachment- and trauma-informed approach, incorporating a 'whole-family' perspective; the difficulties many families face in accessing timely and appropriate services with the associated risk of destabilising placements; the tension created by the balance between crisis responses and

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longer-term therapeutic support; poor levels of communication and collaboration between services; and a general aspiration to fashion a dedicated therapeutically focused service open to all foster and adoptive children and their families. Findings and recommendations are discussed in light of the existing models of good practice for providing integrated mental health services.

Keywords

Fostering, adoption, mental health, well-being, CAMHS, trauma

Introduction

Higher prevalence of mental health issues

It is well-established in international literature that children in state care¹ are a vulnerable population who are at greater risk of experiencing poor mental health (Fisher, 2015; McNicholas, et al., 2011; Tarren-Sweeney, 2008). They often come from disadvantaged families and experience complex attachment- and trauma-related difficulties (Dejong, 2010; Hiller, et al., 2020). A review of the physical and mental health of looked after children in Northern Ireland found that 40% had been diagnosed with behavioural problems, 35% with emotional ones and 21% with depression or anxiety and many of them had difficulty accessing appropriate services (McSherry, et al., 2015). These rates are approximately double those for the general child population in Northern Ireland (Bunting, et al., 2020) and similar to those reported in international studies (Larsen, et al., 2018; Lehmann, et al., 2013). Yet despite these high figures, there is a fear that the complex range of needs of children in care are inadequately represented by medical psychiatric diagnostic criteria. Care-experienced children often present a combination of difficulties, each of which may fall below the clinical threshold for a single psychiatric diagnostic category but which, if taken together, reflect considerable impairment (Dejong, 2010; Tarren-Sweeney, 2008, 2013). For instance, Evans and colleagues (2017) conducted a systematic review and meta-analysis comparison of children's suicidal ideation, suicide attempts and suicide among care and non-care populations. They found that the estimated prevalence of suicidal ideation among those in care was more than double that of their peers who were not in care (24.7% compared to 11.4%) with the prevalence of suicide attempts four times greater (3.6% compared to 0.8%).

Similar concerns are revealed in the Republic of Ireland. A 2012 Health Service Executive report estimated that approximately one in three children attending child and adolescent mental health services (CAMHS) had a history of contact with Tusla, the child and family agency with national responsibility for child welfare services. Furthermore, national enquiries following the deaths of young people in care in Ireland (National Review Panel, 2011, 2012) note the striking paradox that CAMHS were involved with children with less severe difficulties than those helped by community child protection services (Department of Children and Youth Affairs, 2012), despite the latter having no formal mental health training (McNicholas and Bandyopadhyay, 2013). Thus, the mental health and well-being of

adopted children in the UK and Ireland follow a similar trajectory to that of their peers in foster or residential care with regard to histories of adversity and complex developmental challenges (Fisher, 2015).

In the Irish state, legislative complexities and the legacy of Roman Catholicism have meant that few children have been adopted from the care system, resulting in the vast majority of adoptions to date being ‘intercountry’, that is, children adopted from outside of Ireland (Palmer and O’Brien, 2019). As a result, and given the timescales involved, children are rarely adopted in infancy, and the quality of care they received in their country of origin is variable. In a longitudinal study of these children, Greene and colleagues (2008) found that they had a higher rate of mental health and behavioural difficulties than Irish children with up to a third of them displaying persistent emotional, behavioural and attachment-related difficulties, findings that are mirrored in other international contexts such as Norway (Larsen, et al., 2018; Lehmann, et al., 2013).

The importance of engaging stakeholders in service design

The marked differentials just described raise concerns about the provision of targeted mental health services for care-experienced and adopted children, not only in Ireland but also elsewhere. However, to date, there has been little exploration of the views and experiences of the full range of stakeholders involved (McElvaney and Tatlow-Golden, 2016). This article addresses this gap by reporting the findings of a study designed to listen to those offering support to looked after and adopted children in two Irish counties. It charts the perspectives of a wide range of professionals, children’s caregivers (foster carers and adoptive parents) as well as young people with the aim of obtaining a clearer understanding of the challenges experienced in accessing mental health support. This approach accords with the ‘bottom-up’ model of service design, which asks everyone involved in a service to participate in building a model of care that addresses clients’ needs (de Stampa, et al., 2010) with the aim of building on existing community strengths and stimulating community–government collaboration (Wessells, 2015). The advantage of this approach is the interconnection between policy makers, providers and service users in service design and development. To this end, the Children and Young People’s Services Committees in the two counties jointly commissioned this study, and ethical approval was obtained from Tusla Ethics Committee.

Methodology

Focus group methodology (Andrew and Jonathan, 2006) was used to facilitate an in-depth and interactive exploration of stakeholders’ views and participants were selected by the respective Children and Young People’s Services Committees. This created a risk of bias, but any limitation was outweighed by the enhanced access to participants and mitigated by the study design, which ensured that the commissioning group members did not know all of those involved. Potential candidates were given information about the study and asked to give their consent.

A purposeful sample of 34 participants was recruited. They all defined themselves as ethnically white and of Irish nationality, and 28 identified as female and six as male. Sociodemographic information (such as age, gender, ethnicity, nationality, professional

discipline, role, agency context and length of service) was gathered to help understand the views expressed. Given the localised nature of the study, limited identifiers are attached to the quotations below to ensure anonymity.

Six focus groups were conducted:

- adoptive parents (six participants);
- foster carers (seven participants);
- young adults with care experience, who had mental health needs as children (five participants, four of whom were fostered and one of whom was adopted);
- professionals who routinely refer children to mental health services (five participants, including social workers, nurses, education welfare officers and family support workers);
- providers of mental health services (six participants, including those involved in CAMHS, social work, nursing and primary care psychology);
- senior agency managers (five participants, including those who worked for Tusla, CAMHS, adoption services and primary care psychology).

The young adult group with care experience had the youngest age range of between 18 and 29 years whereas the majority of the adoptive parents, foster carers, referring professionals and service managers were in the 50–65 age category. The majority of service providers were aged between 30 and 49.

Focus group discussions were facilitated by four ‘starter’ questions, which explored:

- participants’ experiences, and the views of the mental health needs of care-experienced and adopted children;
- access to mental health support services;
- the quality and effectiveness of the current provision;
- ideas about service improvements.

In addition, the adoptive parents and foster carers were invited to discuss the impact of children’s mental health issues on them and their wider family.

The discussions were audio-recorded, transcribed and anonymised. Thematic analysis as specified by Braun and Clarke (2006) was then undertaken to highlight the key messages that arose both from each individual group and across all groups, thus enabling a set of supra- and sub-themes to be identified.

Findings

The seven key emergent messages are presented and illustrated through selected participant quotations. These are structured to correspond to the four focus group starter questions, although discussions on one topic inevitably sparked off others on related issues.

The discussion of findings begins with a distinct section on an issue specific to adoptive parents and foster carers, namely: the effect of children’s mental health difficulties on them and their wider family. This portrays the ‘real-life’ impact of inadequate services, which may have remained latent had a ‘bottom-up’ design not been employed.

'You don't know what's going to happen': The impact of children's mental health difficulties on the carers and their wider family

A number of adoptive parents described the impact that children's difficulties had on all aspects of family life with consequences for their employment and family holidays as well as feelings of stress and exhaustion. Some adopted children were reported to require constant attention well into adulthood. This, carers stated, could leave them feeling depleted and lacking the energy needed to respond to new crises when they arose:

Where are his batteries? How do you turn him off? Straight away he was like 24 hours' work in a day. (Adoptive parent)

Your energies are expended because you're trying to deal with this crisis... and in a lot of the cases, it's the whole family that's involved obviously, and the tension between the parents as well, and it has a knock-on effect on the other children. (Adoptive parent)

Although difficulties were reported to impact the family network in different ways, some participants noted that children tended to direct their frustration at particular family members who were seen as bearing the brunt of children's anger or distress:

He [adopted child] takes it out on me probably more than anybody else, even though I have a really good relationship with him. We always did, but I would be the one that he would really take it out [on]. His sister, he started really being really nasty to her, he'd say horrible things to her. (Adoptive parent)

All foster carers described living with high levels of unpredictable behaviour from some of the children they looked after and stressed that this was not always fully understood by others, including professionals. They explained how this unpredictability took its toll on their own well-being and that of their families:

And every day I'd pick him [foster child] up from school, you don't know what's going to happen, you don't know how you're going to get him home, you don't know whether he's going to pull your hair in the car, you don't know if he's going to stop the car. (Foster carer)

To other people, he [foster child] probably looks really spoiled, but they said it is to do with attachment... like he wants this pen, and if I said, no, he can't have it, well, 'I'm going to get it'. And you're there and you think: 'Is he going to hit me?' 'Is he going to kick me?' 'Is he going to run to the shop?' Invariably challenging all the time. So, that's every day. (Foster carer)

While sensitive to the children's traumatic histories and its impact on their behaviours, a number of foster carers described feeling fearful of some of the children they looked after, particularly as they became older and stronger in their teenage years and when behaviours were exacerbated by drug use. There were reports of threats of violence from foster children as well as episodes of significant physical violence:

I've been punched, I've been kicked, I've had shoes thrown at me, he's got out of the car in the middle of the road, I've had knives [held at me], he's hit his sister, he's been on the roof of the car. (Foster carer)

Such experiences often contributed to the breakdown of the placement, which, unfortunately, worsened the outlook for the child, stressing the need to acknowledge the risks of harm to everyone – including the foster carers, their own family, other foster children and the looked after child – if remedial action was not forthcoming.

'They shouldn't have to ask': The need for routine mental health provision for all care-experienced and adopted children

Care-experienced and adopted children's mental health and well-being needs were discussed by all focus group participants in broad terms rather than in reference to psychiatric diagnostic categories. Participants agreed that all children in these circumstances are likely to have long-term mental health needs not only as a result of significant adverse life experiences and past trauma but also from their care experience which, for many, included the deleterious impact of multiple placements and staff changes:

Obviously, there's reasons why the children have gone into care, but for the children themselves, there's the huge bond in that family, and the children are often very traumatised by the severance of that bond . . . I think sometimes people, or services, don't realise the extent of that, those feelings around that time . . . That can have an effect on the children . . . it can be quite traumatic for both sides. (Referring professional)

Given this perception of children's longer-term need to recover from adversity and trauma, it was considered inevitable by the great majority of participants that most children would require additional mental health support at some point in their lives:

It's become apparent to us that the separation trauma involved with separation from a birth mother is in itself massive for any child, even if they're a newborn. So, generally we feel that all children who have been adopted, no matter what age, they require supports. (Senior service manager)

Foster carer participants were of the firm belief that mental health support and services should be offered to all children as they argued that many do not have the language to articulate their needs or to ask for help. This was echoed by one young care-experienced participant who stated:

I just think like kids in foster care, they shouldn't have to ask: 'Can I have help?' They should be asked: 'Do you want help?' . . . I think it should be one of the first questions, like we shouldn't have to come forward and say it (Young adult).

Children's mental health needs were described by participants across the focus groups as 'complex' and 'multiple' with different needs becoming apparent at different times as children grow and develop:

[There are] attachment issues, emotional issues, developmental issues, issues in relation to social engagement . . . issues in relation to managing themselves in groups, confidence issues, self-esteem issues, identity issues that can grow and grow as the child grows. (Service manager)

A number of foster carers also expressed their perception that children's mental health was frequently destabilised by routine social work practices such as being told repeatedly about their birth-family experience and the reasons for their entry into care, often precipitated by a change in social worker:

So, his family weren't ever involved. So, for him, every six months, a new social worker would repeat to him his whole story, write the whole thing down, go through it again, and that is what tore that child's head up. (Foster carer)

Such experiences illustrate how system interventions, while well-meaning, can inadvertently re-traumatise children if they are not implemented with due care and attention (McElvaney and Tatlow-Golden, 2016).

'That's a big gap': Accessing mental health services

In contrast to perceived need, it was clear in all the focus groups that adoptive parents, foster carers, professionals and young people alike often struggled to access timely and effective mental health services. The lack of available support was said to leave adoptive parents and foster carers feeling that they were coping alone in very difficult situations, frequently including significant self-harming behaviours and threats of, or actual, violence, which could jeopardise placements. This sense of being alone and not knowing who to approach for help was particularly noted by adoptive parents who tended to have no contact with social services:

That's what I found really hard: 'Who do I go to?' 'Who do I talk to?' ... So, it was like, go to the Yellow Pages. There was no back-up there. There was no even checking in to see how things are going, and whatever. It was like, there's nothing there. (Adoptive parent)

Participants across the focus groups described current pressures on statutory CAMHS that resulted in very long waiting times. This meant that children and families often did not get help when they needed it with adoptive parents tending to resort to private therapists or psychologists:

... all the services are just under resourced, there's huge referrals, everything has waiting lists. (Referring professional)

It was a waiting list of two years ... we just go private. (Adoptive parent)

Participants' views about the position of CAMHS within the range of service provisions available to care-experienced and adopted children and their families highlighted several issues that reverberated throughout the system. It was unanimously agreed that CAMHS provide a good service for acute mental health crises involving severe self-harm, suicide risks or clearly diagnosable conditions:

[Foster child] was cutting himself very badly ... the child was covered, and I mean stomach, back, arms, legs ... he was in CAMHS the next day. (Foster carer)

However, they noted that in less acute situations this support often came ‘too late’ to support the child or, indeed, the placement:

... our experience with CAMHS was that once you get in, they’re fairly good, they do have the services, but you always seem to get in when it’s at breaking point, which is too late... we were crying for help. (Foster carer)

Participants expressed an additional concern that CAMHS were not currently designed or well-resourced enough to address the longer-term attachment difficulties or emotional distress resulting from children’s disrupted relational histories. Some referring professionals expressed frustration about a lack of understanding about which referrals would be accepted by CAMHS, in particular those children who displayed concerning mental health difficulties or challenging behaviours but did not have a diagnosed condition. Even the CAMHS professionals themselves expressed frustration at the limited types of mental health presentations that meet referral thresholds:

You almost need to have that kind of episodic-illness-type presentation, that’s where we fit, but... that’s the tip of the iceberg, there’s the whole layers underneath that I think that could properly be seen as mental health but could not meet our bar for admission to CAMHS.... (Service provider, CAMHS)

This lack of clarity about what CAMHS could provide resulted in confusion for carers and professionals alike about where to refer children who were causing them concern. CAMHS participants recognised the unsatisfactory nature of this situation and said they sometimes felt under pressure to accept a child for treatment due to the lack of availability of more appropriate services and in the face of increasingly risky behaviours. They noted that they were often put in the untenable position of being expected to ‘fix’ difficulties that needed long-term attachment-based work for which they were not equipped:

It can sometimes be a lot of pressure. People are referring in and kind of saying ‘Well, you’re CAMHS, you should be able to fix that’. You know, the child is distressed, the child is upset, they’re threatening self-harm and then you go ‘But there’s a reason for that’, you know. (Service Provider, CAMHS)

It seemed, therefore, that mental health services for looked after and adopted children were seen as lacking in supporting both children and their carers, as well as missing a significant number of children in need who were displaying less extreme behaviours:

So, it’s always, not always, but generally the high-end children [who get the services]... we put them in a huge amount of resources that are a lot of the time not very effective... I think we’re missing a cohort of children... you could be on the waiting list for a year or two years. Or just not get seen, and that’s a big gap. (Referring professional)

‘There’s no joined-up thinking’: Poor inter-service communication and collaboration

Professional participants almost universally reported poor communication and coordination between services, which they thought negatively affected the support received by

children and their carers. Some noted how they struggled to find the time to go to case discussions, resulting in less knowledge of one another's services, referral pathways and arrangements for service liaison:

Sometimes the referral pathways are impacted by misunderstanding of what services can or should do. So, everybody has a view that whatever service people are in, well, Tusla should be doing that or Family Support should be doing that or CAMHS should be doing that. Sometimes the perception of what they should be doing isn't necessarily based on the remit of the service or what's actually going to be the best particular outcome for the young person. (Senior manager)

This was thought by some to have been exacerbated by a range of factors, including the operation of Tusla as a separate agency, data protection regulation and the increase in online rather than face-to-face training.

The impact of poor service coordination and the perceived lack of joined-up thinking was also highlighted by adoptive parents and foster carers:

We've felt that we were getting pushed out... it's not that [service providers] are doing it on purpose. It's just, like, there's no joined-up thinking... A doesn't know what B is doing... it's like, well, 'I have my little service here and you're not getting in on it'... there is no communication... That's a huge issue... there is good people out there. It's just they all need to be together. (Foster carer)

'They're the big, big key': The importance of a 'whole-family' approach to children's mental health

All participants spoke of the importance of support for children's carers who were widely seen as the primary promoters of their mental health:

It's not just looking at the mental health needs of the young people, it's also looking at the mental health needs of the adults in their lives and seeing how that is affecting their care of young people. (Service manager)

This was mirrored in the young adult group's discussion with one young woman passionately describing how her experiences with her foster family had been the most significant factor in her resilience and emerging identity:

[My foster carers and sibling] have always been there for me in all different aspects and they've always made me feel at home... that's what makes me the person I am today... They've built me up to be this strong, independent person and they've told me not to care about what other people think because I am who I am, and that's only a part of who I am. So, they're the big, big key to who I am now. (Young adult)

A wide range of participants spoke of the value of promoting a 'whole-family', early intervention approach to preventing mental distress and promoting the well-being of care-experienced and adopted children. It was acknowledged that this would require a shift in

thinking towards supporting adult carers, including the birth family, and children together as opposed to providing interventions targeted at ‘fixing the child’:

... if we could shift from ‘The child needs to be fixed’ as opposed to ‘What can the adults do to help this child’ ... So, if we could shift our thinking ... we overwhelm parents and carers sometimes, but also it is not the child that needs it. (Referring professional)

Consideration of birth family relationships was echoed by the young adults with care experience who emphasised the need for promoting a positive relationship between the birth family and foster carers. One young participant poignantly described her confusing experience of feeling the need to ‘take sides’:

... if my biological mum didn’t get along with my foster mum, they’d be like talking bad things about each other, I wouldn’t know who to believe ... and that would cause conflict and the child would be left in a state of confusion: ‘Whose side do I take: this woman shows me love; this woman is my biological mother’. (Young adult)

It was widely recognised that positive care placements did not ‘just happen’. Instead, it was considered essential for adoptive and foster carers to receive continuous training and support in order to sustain high-quality care. Trauma- and attachment-based concepts were identified as the most helpful contemporary frameworks with which to understand children’s mental health needs and provide a common language for carers and professionals to discuss children’s welfare:

One woman said to me this is like learning a whole new language, it’s something they never thought about and it took them a long time ... but it benefits everybody. (Service provider)

I think we are coming to understand more about the impact of developmental trauma on children on their behaviour, and the meaning of their behaviour. Then how the foster carer is able to support or to parent the children because they need a different type of parenting. (Referring professional)

Group-based training courses, such as Nurturing Attachments (Golding, 2008), were described as particularly helpful by carers, providing them with both knowledge and skills as well as peer support:

You meet with like-minded people who have the same problem as you as parents, and here are two people [facilitators] who completely get you, they completely get your children ... they give you tips just to live your day-to-day life coping with these children. (Adoptive parent)

‘A difference between black and white’: The need for specialist trauma and attachment-informed services

Specialist trauma-informed and attachment-focused therapeutic interventions, including Dialectical Behaviour Therapy, Theraplay and Dyadic Developmental Psychotherapy, provided by some clinical psychologists, occupational therapists, counsellors and social

workers, were perceived by professional participants, foster carers and adoptive parents as highly effective in meeting children's mental health needs:

Whether it be a public service or a private service...when that person understood and knew what they were doing [providing an attachment perspective], it was a difference between black and white. So, professional competency and a deep understanding of what that is... that made a huge difference. (Adoptive parent)

Participants particularly valued practitioners who were knowledgeable about adoption and services that offered long-term engagement and consistency of staffing. Referring to the Barnardo's post-adoption service, one participant noted:

They have the education, they have the right people, and it's long-term people... not changing, the staff isn't changing, so the kids get settled. (Adoptive parent)

However, the provision of such specialist interventions was frequently described as sporadic and determined by the interest and post-qualifying training of individual workers rather than embedded as a core element of Tusla, primary care psychology, CAMHS and voluntary services. With limited specialist services and training and no agreed priority for care-experienced and adopted children, service provision was described as ad hoc, and children often missed out on getting an appropriate service or being discharged once the acute phase of their problems was over:

I think what's offered by primary care psychology is very variable... nationwide, I think you have a huge diversity of approaches and experience and knowledge among psychologists about working with the population of children in care. (Service provider, Primary Care)

We had [an employee] who was skilled and interested who would do that piece of work, you know loosely preventative or more nourishing than we can provide. But then if that person leaves, it becomes strict, it's not part of our job actually... we're not going to drop our criteria, but we will prioritise, but you still need to be meeting our criteria. (Service provider, CAMHS)

Once that person has started doing better, I have heard that so many times over the years... because they did so well, [they are] discharged out, and that person is rock bottom at the moment. (Adoptive parent)

While most of the adult discussions focused on structural and systemic aspects of services, the young people often praised the specific interventions and practical help that they had received. For example, two spoke favourably about the counselling that enabled them to talk about difficult life experiences that had not been aired before and to learn positive ways to respond to challenges:

[Counselling] gives you a sense of voice that you're not alone and [allows you] to actually speak out because being silenced for years, now I have a voice. It's good to let it out. (Young adult)

I suppose [counselling] had helped me, like coming from, I wouldn't say toxic, but I'd say a difficult background, it had been shown in my relationships. And I'd been in a very toxic

relationship for a while, and it's helped me seek a path out of there . . . it allowed me to see other people and [learn] how to maintain relationships with them. (Young adult)

'You shouldn't have to wait for it to be a crisis': The need for a dedicated integrated service

There was strong support in all focus groups for a dedicated mental health service for care-experienced and adopted children made up of specialist practitioners who could undertake mental health screening, respond flexibly to the needs of the children and their families and sustain necessary support over extended periods. Integrated multidisciplinary assessment at care-entry or adoption was proposed as a means of early intervention, allowing families to access increased help when needed and thus preventing difficulties from escalating:

I do think there is a place for all children going into care to be screened, both by a paediatrician and . . . OT [occupational therapist] . . . I think there is something about targeting and identifying children at risk . . . those that are at the greatest risk from a mental health point of view. (Referring professional)

We should have integrated multidisciplinary teams surrounding every child that enters care and then . . . you shouldn't have to wait for it to be a crisis, there should be an assessment of that child's needs at point of entry to care. (Service provider)

The big thing is that there's ongoing support from the HSE [Health Service Executive], whoever it may be. Because when things get really rough, it's very difficult to access something when you really need it. (Adoptive parent)

Foster carers thought that a dedicated integrated service could increase access to the 'right' services at the 'right' time, improving unclear referral processes to specialist services and preventing delayed responses. In their view, this would demonstrate recognition that the majority of children and young people in the care system have mental health needs which are expressed in different ways and at different times. This aspiration was echoed by referring professionals who argued that it would reduce the negative impact of multiple referrals from the care system:

We [referring professionals] are guilty sometimes, I think, of referring children to every service under the sun, and referring parents to every service under the sun . . . sometimes we've overwhelmed parents and foster carers by saying they need to go here, there and everywhere. Sometimes we maybe just need to stop and think. (Referring professional)

Further, foster carers could see a dedicated integrated service resolving the problem of young people 'falling between' services with one service insisting they be seen by another in the first instance, for example mental health and addiction services:

It's very hard to separate the addiction problem, or the mental health problem. So, they can fall between two boxes because one service say they should be dealt with by another service.

Then another service can't take them on because they have an addiction issue. That can be very difficult, [for] the family or whoever it is, is trying to . . . support the young person. (Foster carer)

Service providers concluded, therefore, that a bespoke multidisciplinary service should be developed for care-experienced and adopted children and their families that could be operated at a lower threshold of need in relation to children who might not otherwise meet CAMHS referral criteria. It was envisaged that this service could sit within Tusla and provide easy access to a range of professionals (such as psychologists, general practitioners, occupational therapists and social workers) for guidance, training and therapeutic work to prevent children's status deterioration. Such a dedicated service could provide an early comprehensive assessment of a child's needs and ongoing access to support throughout their care pathway:

We should have integrated multidisciplinary teams surrounding every child that enters care and then it shouldn't be something that . . . you shouldn't have to wait for it to be a crisis, there should be an assessment of that child's needs at point of entry to care. (Service provider)

Senior service managers could also see that the rigid demarcations between services undermined the efficiency of service provision for children with complex needs, particularly those who needed assessment and intervention from multiple professionals. Agencies as 'separate entities, were each doing separate pieces', meaning that some children had a 'multitude of visits' that could be both stressful and stigmatising:

People sit in the silos and work under their piece as best they can. The strength of the silo actually kills efficiency and costs more money. (Senior manager)

The overriding desire, therefore, was for a unified and streamlined response for care-experienced and adopted children which offered 'really good, comprehensive, integrated and multidisciplinary assessment' and 'the capacity to have a creative and flexible response'. This would ideally engage with the child and carers from the beginning of the child's placement in care, involve all family members and adapt to changing needs:

Our focus needs to be on not just the child, but on the parents, siblings as well. If we'd hold them from the beginning and support them at the beginning in the hope that we can actually prevent some of the issues arising for the child along the way. (Senior manager)

Discussion

This study explored the experiences of a wide range of professional stakeholders in adoption and fostering services, alongside those of foster carers, adoptive parents and young adults with care experience. Overall, there was a high level of agreement on the universal longer-term mental health needs of children in care and those who were adopted and the barriers to timely, accessible and effective 'whole-family' specialist support services. While positive experiences were described where timely mental health support had provided a lifeline for the child and family, particularly at a time of crisis, these were outweighed by accounts of

difficulty in accessing services and resulting placement breakdowns. These findings from Ireland echo those of a recent report on foster carers' perspectives conducted in England:

Results showed that foster carers saw a lack of communication between services, poor support from services and poor access to child and adolescent mental health support as key barriers to them providing effective support to young people in their care, who were struggling with behavioural and emotional difficulties. (Hiller, et al., 2020: 9)

Similarly, Harlow's (2019) evaluation of post-adoption services in one area of England noted comparable barriers faced by adoptive families seeking appropriate support, namely: uncertainty in defining the problem and knowing whom to approach; ambivalence about seeking help due to fear of being perceived as failing; professionals' uncertainty in knowing how to respond; and the scarcity of resources. The researchers perceive these structural weaknesses as indicative of a 'traumatised and traumatising system' that further compounds children's trauma legacy (McElvaney and Tatlow-Golden, 2016: 62).

This resonance between experiences in Ireland and England gives an indication of the commonality of these issues across jurisdictions. The findings in much national and international research are supported by this study, including the high prevalence of mental health difficulties among care-experienced and adopted children, the structural barriers to accessing effective support when needed, and the risks of carer stress and placement breakdown (Moran, McGregor and Devaney 2017). Particularly significant are the barriers that prevent children from seeking help, resulting in feelings of stigma, embarrassment, insecurity, guilt and fear (Fargas-Malet and McSherry, 2018).

Conclusion

The central message from this study is the importance of the 'ordinary care' setting for children's long-term well-being. This indicates the need to invest in supporting high-quality 'everyday' care provided by foster and adoptive parents and their families. This needs to comprise a 'whole-family' approach to young people's mental health, recognise the vital role that parents, carers and siblings play in supporting young people's mental health, and appreciate the interrelationships between family members and how these impact on individuals within the family (Department for Education, 2010). This is in keeping with the perspectives intrinsic to the Think Family agenda, a project whose vision is to improve outcomes for parents with mental health issues and their children and whose principles are 'no wrong door' to facilitate working with both adults and children, building on family strengths and providing tailored support (Cabinet Office Social Exclusion Unit Taskforce, 2008).

The study findings also support calls for priority status within CAMHS for adopted children and those in care, reiterating the recommendations of the UK House of Commons Education Committee's 2016 report which refuted the CAMHS practice of refusing or delaying seeing children whose placement is unstable or uncertain.

Given the importance of concepts like attachment and trauma in understanding the needs of many looked after and adopted children, it would be beneficial to provide additional specialist training for professionals across the child-focused health and social care workforce. A programme similar to the Training for Adoption Competency (Atkinson and Riley, 2017) could offer a template for such training. It would help further if this knowledge were

backed up by a system providing access to timely consultation with mental health specialists when difficulties arise. This would go some way towards addressing the concerns expressed by the focus groups.

Several models of good practice relevant to this discussion are described in the literature. For example, The Stargate Early Intervention Program, developed in Australia (Milburn, Lynch and Jackson 2008), and The Integrated Service for Looked After and Adopted Children in the UK (Golding, 2010). But, as Golding warns, reform is likely to be difficult:

Bringing together agencies means bringing together different professional cultures, languages, roles and responsibilities, often against a backdrop of historical difficulties between those agencies... commitment from senior management will be an important part of creating a culture of both optimism and realism about what services might achieve. (Golding, 2010: 582)

Thus, improvement may have to be based on more modest ambitions requiring a lesser level of re-organisation and investment. These are listed in recommendations 1–5 in the following list with more fundamental changes suggested in numbers 6–8.

Recommendations

The following recommendations are made on the basis of this study, supported by the wider literature:

1. Increase support for foster carers and adoptive parents.
2. Provide routine early mental health screening for care-experienced and adopted children.
3. Provide additional trauma and attachment training opportunities for CAMHS, child welfare and education practitioners.
4. Increase capacity to provide specialist therapeutic services.
5. Improve inter-agency communication and collaboration.
6. Adopt a ‘whole-family’/household ‘ordinary care’ approach in relation to addressing the mental health needs of care-experienced and adopted children.
7. Instigate a degree of assessment priority within CAMHS in light of the high risk of harm faced by children in care and those who are adopted.
8. Create a dedicated specialist attachment- and trauma-informed therapeutic service for care-experienced and adopted children and their families.

Study limitations

This is a small study, and the findings would have been strengthened by a greater number of focus groups, better representation of young people, coverage of additional geographical areas and the addition of one-to-one interviews. The study was also conducted prior to the Covid-19 pandemic, which has not only impaired the operational capacity of CAMHS but also led to higher rates of depression and anxiety in young people (Loades, et al., 2020; Patrick, et al., 2020), making the current situation somewhat different. Nevertheless, the strengths of this study lie in the broad range of stakeholders involved and the fact that the findings are consistent with the international literature.

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Note

- i. In Ireland, the term 'state care' refers to children in 'out-of-home' care. This corresponds with the term 'looked after children' used in the UK. The term 'children' is used throughout this article even though many of those discussed are adolescents and young adults.

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