Understanding practitioners’ and young people’s views of a risk calculator for future psychopathology and poor functioning in young people victimised during childhood

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ABSTRACT

Background: Although children who are exposed to victimisation (including abuse, neglect, domestic violence and bullying) have an increased risk of later psychopathology and functional impairment, not all go on to develop these outcomes. Risk calculators that generate individualised probabilities of a victimised child developing future psychopathology and poor functioning have the potential to help practitioners identify the most vulnerable children and efficiently target preventive interventions.

Aim: This study explored the views of young people and practitioners regarding the acceptability and feasibility of potentially using a risk calculator to predict victimised children’s individual risk of poor outcomes.

Methods: Young people (n = 6) with lived experience of childhood victimisation took part in two focus groups. Health and social care practitioners (n = 13) were interviewed individually. Focus groups and interviews were audio-recorded, transcribed and thematically analysed.

Results: Ten themes were identified, organised according to the three main topics of discussion: (i) identifying risk (risk factors, current practice, accuracy, implementation, response); (ii) protective factors and prevention (individual, environment, preventative intervention); and (iii) communication of research (stakeholders, methods).

Conclusion: Risk calculators have the potential to enhance health and social care practice in the United Kingdom, but we highlight key factors that require consideration for successful implementation.

Introduction

Childhood victimisation, including abuse, neglect, exposure to domestic violence, and bullying by peers, is a pervasive and serious public health concern (Radford et al., 2013). Longitudinal studies of the consequences of victimisation suggest that exposed children have poor long-term outcomes. For example, childhood victimisation has been associated with externalising psychopathology including attention-deficit/hyperactivity disorder, conduct disorder and substance use disorders (e.g. Braga et al., 2017; Capusan et al., 2016; Lansford et al., 2010), internalising psychopathology such as depression and anxiety (Li et al., 2016; Nanni et al., 2012; Takizawa et al., 2014) and psychotic symptoms (Arseneault et al., 2011; Fisher et al., 2013). Furthermore, victimised children are more likely than their non-victimised peers to have lower educational attainment (Currie & Widom, 2010), be unemployed or “Not in Education, Training or Employment” (NEET; Brimblecombe et al., 2018; Jaffee et al., 2018), engage in criminal offending (Malvaso et al., 2018), be teenage parents (Herrenkohl et al., 1998), and experience further victimisation (Ports et al., 2016) and loneliness (Matthews et al., 2017) in adulthood. Such adverse outcomes may have negative and long-lasting implications for the individual’s health, wellbeing and life-opportunities as well as entailing significant costs for communities and public services.

Although victimisation is a key risk factor for later psychopathology and poor functioning, there is significant heterogeneity of outcomes among victimised children. Indeed, some individuals demonstrate very positive outcomes despite their negative experiences (Cicchetti, 2013; Rutter, 2013). Research seeking to understand why some victimised children are vulnerable to poor outcomes whereas others are resilient has identified a wide range of moderating factors at the level of the individual (e.g. intelligence, personality), family (e.g. socio-economic status, parental warmth) and community (e.g. peer relationships, social support) (Afifi &
This knowledge is important to identify potentially modifiable factors to target to reduce the detrimental impact of victimisation and to help identify children who may be at greater risk and in need of support.

Crucially, these studies inform us about the factors that increase or decrease victimised children’s risk of poor outcomes on average. However, it cannot be assumed that such knowledge can be directly applied to accurately forecast outcomes for individual victimised children (Danese, 2020). As such, these findings are of limited practical use to health and social care practitioners who assess individual children and therefore seek insight into that particular child’s level of future vulnerability or resilience. Our recent work to translate this current knowledge into a risk calculator screening tool that makes individual-level predictions is therefore notable (Latham et al., 2019; Meehan et al., 2020). Although this tool needs to be validated in external samples before being implemented, our initial evidence demonstrates its potential to support practitioners to accurately identify which victimised children are at high risk of developing poor outcomes at the transition to adulthood. In turn, this could promote a more cost-effective allocation of resources by enabling practitioners to target preventative interventions to those children who are most in need and, therefore, most likely to benefit.

However, the implementation and use of a risk calculator by practitioners to predict adverse outcomes among children exposed to victimisation may not be straightforward. For example, there is a need to consider who should administer the tool and in what setting. Furthermore, it may raise issues regarding the implications of a victimised child being identified as “high risk” which will need to be carefully thought through to ensure the tool is implemented sensitively. Therefore, it is vital to investigate what the key considerations are from those practitioners who might use the risk calculator (e.g. social workers, psychiatrists) as well as those with whom it would be used (e.g. children exposed to victimisation).

Thus, this qualitative study aimed to explore the views of young people with lived experience of childhood victimisation or mental health problems, and practitioners from health and social care about the potential use of a screening tool to identify those victimised children who are at highest risk of developing psychopathology and poor functional outcomes. Their opinions were gathered via focus groups (with young people) and individual interviews (with practitioners). The main aspects focused on were how to best integrate such a screening tool into health and social care services in the United Kingdom (UK), the potential benefits and issues that may arise when implementing and undertaking the screening, and how risk prediction would be best communicated to children and their families. We also explored with the young people how our risk calculator research could be communicated effectively to children, their families, practitioners and the wider public. The findings are intended to provide valuable information to inform future studies aimed at implementing and evaluating the use of such a risk calculator in practice.

Materials and methods

Participants

Young people were recruited to take part in two focus groups. For inclusion, they had to be aged 18–25 years, reside in the UK, and self-identify as either having mental health problems and/or childhood exposure to abuse, neglect, domestic violence or bullying. Recruitment was undertaken in collaboration with the McPin Foundation—a London-based mental health charity—who shared advertisements via Twitter and via email with their network of young people.

Practitioners aged over 18 years who resided in the UK and worked in health or social care services supporting children or young people who have been exposed to victimisation were also recruited. Advertisements were circulated via email to local Child and Adolescent Mental Health Services (CAMHS) and National Society for Prevention of Cruelty to Children (NSPCC) Service Centres, shared through Twitter and via the research recruitment websites of King’s College London and the South London and Maudsley NHS Foundation Trust.

Procedure

Full ethical approval for the study was granted by the Psychiatry, Nursing, and Midwifery Research Ethics Subcommittee at King’s College London (ref.: HR-18/19-10547) and all participants provided informed written consent. Young people were invited to attend two semi-structured focus groups held at the McPin Foundation offices in London. Participants completed a brief demographic questionnaire at the beginning of the sessions. The focus groups were co-facilitated by a member of the McPin Foundation (RKT) and a King’s College London researcher (RML). Each group lasted no longer than three hours, was audio-recorded and then transcribed. Young people received a £90 voucher for their participation in a focus group and were reimbursed for their travel expenses.

Initially, we invited practitioners to take part in a focus group. However, due to difficulties identifying a mutually convenient time that a sufficient number of practitioners could attend, we instead conducted semi-structured individual interviews with each participant to ascertain their views. These one-to-one interviews typically lasted for approximately one hour and were audio-recorded and then transcribed. Practitioners were offered a £10 voucher in return for their participation.

Materials

Semi-structured topic guides (see Supplementary Materials) were developed to guide the focus group discussions and interviews. These outlined open-ended questions related to identifying risk, protective factors and prevention, and for the young people’s focus groups—communication of the risk calculator research. Example questions included: “What factors in a child’s life do you think might increase their
A second researcher (HLF) independently coded one third of the transcripts and any differences were resolved by discussion and repeated inspection of the data until a consensus was reached.

**Results**

**Sample characteristics**

Two focus groups with young people were held. The first group comprised four participants and the second group included an additional two participants, all of whom had lived experience of mental health problems and childhood victimisation. Participants were predominantly female and aged 20–21 years old (see Table 1).

Thirteen individual interviews were conducted with practitioners. The majority of whom were female, white British, and most commonly aged 30–39 years old. Approximately, half of the practitioners worked in health care and half were social workers (see Table 2).

**Thematic analysis**

From the two focus groups and 13 interviews, 10 main themes were identified. These themes were organised according to the three topics of discussion: (i) identifying risk (risk factors, current practice, accuracy, implementation, response); (ii) protective factors and prevention (individual, environment, preventative intervention); and (iii) communication of research (stakeholders, methods). Several of these themes also included subthemes (see Figure 1 for an overview of the thematic structure).

Full details and explanations of the themes and subthemes are provided in Table 3 with illustrative quotes from the young people and practitioners. We found that themes were largely similar across the two stakeholder groups.
1. Identifying risk
1.1. Risk factors
   1.1.1 Presence of stressors
   1.1.2 Lack of support
1.2. Current practice
   1.2.1 Emphasis on present need
   1.2.2 Consideration of the future
   1.2.3 Improving practice
1.3. Accuracy
1.4. Implementation
   1.4.1 Lack of resources
   1.4.2 Setting
   1.4.3 Transparency
   1.4.4 Interpretation
1.5. Response
   1.5.1 Practitioner
   1.5.2 Family

2. Protective factors and prevention
2.1. Individual
2.2 Environment
   2.2.1 Social
   2.2.2 Socio-economic
   2.2.3 Role of schools
   2.2.4 Effective support services
2.3. Preventive intervention
   2.3.1 Existing interventions
   2.3.2 Risks

3. Communication of research
3.1. Stakeholders
   3.1.1 Public Services
   3.1.2 Youth organisations
   3.1.3 Public
3.2. Methods
   3.2.1 Online
   3.2.2 Policy
   3.2.3 Training & education events

**Figure 1.** Thematic structure overview with all codes that were used to designate themes and sub-themes.

**Discussion**

This study explored the views of young people and practitioners regarding the acceptability and feasibility of implementing a risk calculator to identify children who are most at risk of developing psychopathology and poor functioning following victimisation. Thematic analysis revealed significant commonality between the considerations of these two key stakeholder groups. We discuss below the implications of our findings for future work aimed at implementing the screening tool.

Our study suggests that the risk calculator would be a relevant and novel addition to practitioners’ toolkits when working with victimised children (theme 1.2. “current practice” and subtheme 1.4.2. “setting”). Even though children’s current presentation was often the primary focus of practitioners’ assessments, many also considered what their future needs may be. We found that practitioners typically relied on their professional experience and knowledge to do this. Some people did also identify tools – including the Adverse Childhood Experiences (ACEs) questionnaire (Felitti et al., 1998) and the Risk and Resilience Matrix (Daniel & Wassell, 2002) – that they believed could be used to inform their assessment. However, the suitability of these tools for forecasting individual outcomes is limited. For example, although research on ACEs is important for highlighting the association between childhood adversity and poor outcomes, not everyone follows the average pattern. That is, many individuals who score high on the ACE checklist do not show poor outcomes therefore it cannot be assumed that screening for ACEs will give accurate information of individual risk prediction within groups of victimised children (Danese, 2020). Similarly, although the Risk and Resilience Matrix encourages practitioners to consider the presence of protective factors alongside the child’s experience of adversity, it does not translate this information into a prediction of vulnerability or resilience related to a specific future outcome. Using the matrix to forecast a victimised child’s future mental health and functioning thus requires subjective interpretation by the practitioner. Our findings therefore suggest that an individualised risk calculator for future psychopathology and poor functioning fills an important gap that could help these practitioners to assess and support the future wellbeing of children who have experienced victimisation.

Our study also showed that young people and practitioners were positive about the notion of early intervention to try and prevent psychopathology and functional problems from developing among individuals exposed to childhood victimisation (subthemes 1.2.3. “improving practice” and 1.2.2. “consideration of the future”). Although this approach was endorsed by young people as well as practitioners in both social work and CAMHS, most CAMHS services are not currently set up to provide preventative mental health intervention as their limited resources are concentrated on those with existing and severe psychopathology instead. This has important implications for how effectively the risk calculator could be implemented into UK health and social care services. It is vital that a victimised child who is screened and identified as being at high risk of developing mental health problems has access to appropriate support regardless of whether they have already developed psychiatric disorders. Our findings cast some doubt on whether this would currently be the case (subtheme 1.2.1. “emphasis on current need”), suggesting that a shift towards preventative intervention may be required (together with allocation of enough resources) for successful implementation and utilisation of other sectors, such as schools, primary care or charities (subtheme 1.4.2. “setting”). However, we posit that it is also possible that use of the tool could contribute to this shift as it has the potential to provide a more effective means of allocating preventative resources to those who are most in need and therefore most likely to benefit (subtheme 1.2.3. “improving practice”).

The availability of preventative intervention was found to be important not only for the effectiveness of the risk calculator, but it was also fundamental to practitioners’ acceptance of it (subtheme 1.4.1. “lack of resources”). In the absence of appropriate intervention, screening children to see who is most vulnerable for developing poor outcomes was viewed as unacceptable; practitioners deemed it to be unethical and potentially detrimental to the child due to the risk of fuelling feelings of hopelessness and negative self-fulfilling prophecies (Merton, 1948). There are a wide range of
interventions and support currently available to promote the mental health and functioning of children who have experienced victimisation (subtheme 2.3.1. “existing interventions”). These include initiatives that are delivered in schools and communities (e.g. mentoring), targeted support for specific victimisation experiences (e.g. the NSPCC’s “Letting the Future In” for sexual abuse survivors) and therapeutic support through CAMHS (e.g. cognitive behavioural therapy). More work will be needed to establish a solid evidence base for early interventions in victimised children (National Institute for Health Care and Excellence, 2018). Importantly though, we note the context of limited resources in which these services operate resulting in long waiting lists, restrictions on the duration of support, and variability in what services are available in different geographic areas, all of which could impact the effectiveness and acceptability of the risk calculator.

Another key consideration that we identified for the potential use of the risk calculator was the transparency with which the tool would be used with victimised children and their caregivers (subtheme 2.4.3. “transparency”). Our findings revealed a tension between a desire to work openly with families by involving the child in the screening and sharing the resulting risk score information, and a desire to protect them from feeling overburdened by numerous assessments and frightening information. Young people expressed similarly mixed feelings about whether or not risk scores should necessarily always be shared with children and their caregivers. There is likely not a “one size fits all” solution to this; instead we suggest that a decision may be best made on a case-by-case basis taking account of factors such as the child’s age and level of understanding, any legal obligation to share information with the child’s parents, and the potential for increasing risk further. Making such sensitive judgements about what and how information should be shared with vulnerable children and their caregivers is certainly not unique to the use of this risk calculator but is a core part of health and social care practitioners’ training and day-to-day work. Thus, they are likely well-placed to determine what level of transparency and involvement is...
Table 3. Thematic analysis of young people’s \( n = 6 \) and practitioners’ \( n = 13 \) views regarding the potential use of a risk calculator to identify victimised children most at risk of developing psychopathology and poor functioning in young adulthood.

| Theme | Subtheme | FG | \( N (\%) \) | Explanation | Illustrative quote(s)* |
|-------|----------|----|-------------|-------------|------------------------|
| 1. Identifying risk | 1.1. Risk factors |  |  |  | |
| 1.1. Presence of stressors |  | ✓ | 8 (62) | Young people identified the negative impact that expectations from themselves and others could have on children’s outcomes following exposure to victimisation. | "Feeling there’s always an expectation on me, I can always do better. So, pushing myself too hard, getting to crisis point, and then feeling even worse because there’s still the expectation on me." (FG2) |
|  |  |  |  | Young people and practitioners identified low socio-economic status and financial pressures as increasing the risk of victimised children developing poor mental health and functioning. | "Sometimes… parents don’t have time for their kids because they’re working… I had to take care of my younger brother… my parents will leave at four am in the morning and they will come back at ten, and they would be shattered and they would just go back to sleep…." (FG2) |
|  |  |  |  | Young people and practitioners felt that a family history of mental health problems could increase children’s risk of poor outcomes following victimisation. | "… if someone is either working multiple jobs or they have to work very long shifts or they have to work away, it’s quite difficult even arranging joint meetings sometimes, or sessions with the child and carer, and then you see well that clearly impacts the relationship [between parent and child]." (P4) |
|  |  |  |  | In addition to parental mental health, practitioners also identified that parents’ own unresolved trauma could increase children’s risk. | "If there’s pre-existing mental health issues within your family, that might make you more likely to go on and suffer with mental health issues as well." (FG2) |
|  |  |  |  | Practitioners suggested that exclusion or absence from school increased victimised children’s risk of developing poor outcomes. | "Yeah, I think definitely parental mental health is the number one…." (P9) |
|  |  |  |  | Practitioners also recognised the co-existence of multiple stressors in a victimised child’s life as increasing their risk for poor mental health and functioning. | "And actually that is something we see a lot: parents who have a lot of unresolved traumas of their own and I think that makes it much harder to be able to support their child and it’s probably going to be quite triggering for them what their child is experiencing." (P8) |
| 1.1.2. Lack of support |  | ✓ | 10 (77) | Young people identified that victimised children who did not have a trusted adult who they could talk to were at greater risk of having poor future outcomes. | "I think young people who kind of struggle in school, academically or in terms of attendance, um because then they’re not enjoying school or not going to school then there’s so much more opportunity for them to slip through the net and it doesn’t give them opportunities to be involved in like positive, enriching activities." (P8) |
|  |  |  |  | Practitioners also identified poor relationships as being a risk factor and typically focused on poor family relationships. This was recognised by young people too. | "There’s a sort of co-existence of a certain number of factors so whether that be a learning disability, or a conduct disorder, and mental health issues, and financial issues, and exploitation…." (P4) |
|  |  |  |  | "One factor I feel could put children most at risk is probably the lack of a trusted adult. I say that, because in my experience… the person I had… was so key for me." (FG1) |
|  |  |  |  | "I think a really key factor is, yeah, like family relationships, erm especially like parental relationships and whether or not you feel you can express and communicate yourself to your parents." (FG1) |
|  |  |  |  | "It’s those who don’t have a family network where parents are really present in their life, erm, or able to put boundaries in place, or to really connect with…" (FG1) |

*Illustrative quotes are from the FG sessions and are used to provide context for the thematic analysis.
## Table 3. Continued.

| Theme | Subtheme | FG | N (%) | Explanation | Illustrative quote(s)* |
|-------|----------|----|-------|-------------|------------------------|
|       | 1.2. Current practice |    |       |             |                        |
|       | 1.2.1. Emphasis on present need | ✔  | 7 (54) | Practitioners also felt that children who lacked peer | “If they don’t have an outlet to think about what’s going on for them and to talk to their friends and see what’s going on in other people’s families … having that lack of a social support network, um, has a really big impact.” (P3) |
|       |       |    |       | relationships could be at higher risk. |                        |
|       | 1.2.2. Consideration of the future |    | 11 (85) | Practitioners and young people felt that barriers to | “I know from my own experience, originally I am from [town name] right out in the country, so it’s very difficult to access any mental health services anyway, just in terms of location.” (FG2) |
|       |       |    |       | accessing support services increased victimised | “I’ve seen cases where the family don’t seek out help because of the stigma in the community, that has a massive effect on the young people.” (P7) |
|       |       |    |       | children’s risk of developing poor mental health and |                        |
|       |       |    |       | functioning. |                        |
|       | 1.2.3. Improving practice | ✔  | 12 (92) | Young people and practitioners suggested that using | “The NHS is so reluctant to do early intervention … I know friends who have been turned away from hospital because they’re not suicidal enough.” (FG1) |
|       |       |    |       | the risk calculator could help bring different | “…we’re just screening for what we think they have now.” (P1) |
|       |       |    |       | professional agencies together by providing a | “…most of what I’m doing is assessing for current mental health risk around suicide and deliberate self-harm, self-care … do you meet the criteria for the mental illnesses that fit our criteria.” (P6) |
|       |       |    |       | common focus and language. | “Not really in a sort of formalised way … I might, particularly with a younger child, if I was thinking there’s going to be future needs, highlight those needs to the carer or whatever agency … [for example] we know that for children who have experienced sexual abuse, um there may be some trigger points developmentally where they’re going to be more vulnerable than a child who has not had that victimisation experience.” (P5) |
|       |       |    |       | practitioners noted that they used their professional | “…based on experience and general knowledge of the field rather than an actuarial or specific analysis … I suspect that the answers we give are rough approximations.” (P13) |
|       |       |    |       | judgement (i.e. knowledge & experience) to inform | “…the ACEs screening … I’m aware it’s there and is being used in a slightly predictive sense.” (P2) |
|       |       |    |       | their thinking of victimised individuals’ future risk for | “We have a risk and vulnerabilities matrix, essentially you plot the risks and the vulnerabilities, and you work out are they balanced? And see what services you can fit in to support the young person.” (P1) |
|       |       |    |       | poor mental health and functioning. | “My school didn’t talk to my diabetes clinic; my diabetes clinic didn’t talk to my psychiatrist … different groups that I was trying to work with did not work together, whereas this could be like a linking tool of like ‘oh we’ve done this thing, she’s X percent at risk’ … and actually push them to talk together more. I think that’s a … good thing for young children … having all the people around them talk together around this tool.” (FG1) |
|       |       |    |       | Some practitioners also identified existing tools that | “It would give multi-agencies a common language … [be]cause even though we’re meant to |
|       |       |    |       | might be used to help inform professionals’ thinking |                        |
|       |       |    |       | about a child’s current and future risk. |                        |

(continued)
Young people and practitioners felt that the risk calculator could – at least in theory – help procure early intervention which they considered to be positive.

Furthermore, young people and practitioners considered that the risk calculator could encourage a shift at the service-level towards a more desirable focus on early intervention and prevention.

At the practitioner-level, young people thought that the numerical risk score may obligate practitioners to act.

Similarly, practitioners thought the risk score might help them evidence their concerns and help them secure services for the child.

Practitioners felt that the risk calculator could help ensure they didn’t overlook any victimised children who are at high risk.

Some practitioners also suggested that the risk calculator could be used to help identify service need and plan provision.

have common assessment frameworks, everyone still uses different language and ideas." (P2)

"If you get there in the early stages, you can help prevent it getting further and you can direct that person to the right support. So, if someone’s at risk of crime, for example, and you work with them in the early stages, they’re less likely to commit crime." (FG2)

"If there is such a thing as predictors then we could get early intervention in and… improve things for young people before they potentially occur, so those would be massive advantages if it’s possible … to determine the categories that will be reliable [predictors]." (P4)

"…[if they] sort of give the NHS this tool, and they’ll be like ‘well we have to do something now because they’re X number at risk’… maybe forcing people to actually recognise early intervention can help more, if you put numerical values to it.” (FG1)

"I think it’s only going to be useful at the practitioner level if it’s being used to shape, kind of, the rules of the service, I suppose … but I think a tool like this could, you know, things have to come from lots of different angles and … if you have a way of more finely tuning where you should direct early intervention then maybe it would get, kind of, yeah, used more.” (P1)

"I also think that the fact of a number can push practitioners along, because it’s a number, it’s there, and you have to act on it in a way. Like, if you don’t act on it, ‘oh I’m leaving this person at risk’… it’s an incentive factor.” (FG1)

"It might add weight certainly to, if it’s a tool that you can get, um, sort of managers to agree or services agree could be part of a like recognised thing, then how do they, um, how do they ignore it? It’s much harder isn’t it? If you can then attach something to your email to say ‘this is how this person scored, it’s a horrendously high score for this poor outcome, and I’m suggesting I think this should happen and I need you to help me fund it’, I think that would add a much greater weight to the argument.” (P12)

"…you may not have seen it because you didn’t know that a certain answer, or you weren’t fully aware that that thing could make them greater risk, or that particular behaviour or problem … we’re not perfect, are we? So, we might not realise that that behaviour could contribute to poor mental health or whatever outcomes so that could be helpful from that point of view." (P12)

"Perhaps it would be beneficial for identifying service need and therefore possibly, kind of, creating that access to resources or more resources being created..."
Table 3. Continued.

| Theme          | Subtheme               | FG | N (%) | Explanation                                                                                                                                                                                                 | Illustrative quote(s)* |
|----------------|------------------------|----|-------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| **1.3. Accuracy** |                        | ✓  | 9 (69)| Young people and practitioners expressed concern about the ability of the risk calculator to correctly identify victimised children who are – and are not – at risk.                                                  | If there’s something numerical, empirical that said like this number of children need access to this service then maybe that’s an easier way of showing governments where funding [is needed].” (P8) |
|                |                        |    |       | Practitioners noted that the accuracy of the risk calculator would be reliant on the input of accurate information which could be limited.                                                                       | “If certain lower socioeconomic groups have poorer mental health outcomes and maybe, like, I’m from a poor background and I have a really ‘ok’ mental health, but I’m going to be put as ‘at risk’ because I’m at that low group… I think like a solution to that is… having more people put data into it, like a wide group of people.” (FG1) |
|                |                        |    |       | Young people and practitioners were dubious about the comprehensiveness of the risk calculator.                                                                                                              | “What is the accuracy of it? And are you potentially setting somebody up to suggest they’re going to have poor outcomes when maybe they might not? And there’s always… those that don’t follow those patterns… how do you work out those anomalies? … Are you labelling people, by doing that, into a bracket that they don’t even necessarily belong in?” (P12) |
|                |                        |    |       | Some young people and practitioners perceived human behaviour and mental health to be more complex and less predictable than physical health. They felt that this limited comparisons between this risk calculator and those used in medical practice. | “To me it’s about the thoroughness of the ability of the people filling it in and the systems that they have, also that work across boroughs, across health districts, across different professionals. You know, systems are only as perfect as the human systems behind them.” (P6) |
|                |                        |    |       |                                                                                                                                                                                                           | “It doesn’t account for everything. So, like, if a child has very niche things, like they’re disabled, if they are from a different ethnic group, it doesn’t account for all of that.” (FG1) |
|                |                        |    |       |                                                                                                                                                                                                           | “If we don’t consider these children as individuals then we may miss something… I’m not a psychologist or a statistician, I just find it hard to imagine that we could reduce young people and their outcomes to a certain number of categories of questions and how we would determine those.” (P4) |
|                |                        |    |       |                                                                                                                                                                                                           | “I think, we have to be careful to equate it fully with physical health in the sense that it’s an individual, it’s not, like, a medical problem just to be dealt with, like, from that perspective. I think there’s a lot more to a human being and they need to look at them as a whole human being.” (FG1) |
|                |                        |    |       |                                                                                                                                                                                                           | “People and mental health and all of the factors that impact on that are so much more complex than sort of a physiological assessment and therefore it could be that certain factors aren’t representative of what’s actually happening or it might be that actually somebody is high risk of developing a mental health difficulty but if they don’t tick those boxes then it might not show up as high risk.” (P8) |
| **1.4. Implementation** | 1.4.1. Lack of resources | ✓  | 9 (69)| Young people and practitioners identified that a lack of resources could impede the utility of the risk calculator and many practitioners expressed their unwillingness to use the risk calculator unless they | “It could be the best thing ever… but if the nurse isn’t there, if the psychiatrist isn’t there, if anti-depressants aren’t there, it’s not going to work in the end.” (FG1) |

(continued)
### Table 3. Continued.

| Theme | Subtheme | FG | N (%) | Explanation | Illustrative quote(s)* |
|-------|----------|----|-------|-------------|------------------------|
|       |          |    |       | were able to offer appropriate intervention to those that were identified as high risk. | “I wouldn’t want to just, personally, be… using something that was just going to come up with a score … it’s important to offer a service, you know? Otherwise it’s just, potentially just another, you’re feeding the sort of ruminating and the low mood.” (P5) |
|       |          |    |       | Practitioners and young people spoke of existing resources and services being overstretched. | “… the waiting list is so long, like, I’m on one right now for [Institution name] mental health, and I’ve been on it since the start of this September, and I still haven’t seen anyone … it is like I’m being pushed back and pushed back.” (FG1) |
|       |          |    |       | Some practitioners believed the risk calculator could be helpful in this context of limited resources by helping to better allocate resources to those who most need it. | “I think it’s always helpful to have, I guess, if you’re thinking about preventative work, a sense of who might most benefit from it and I guess in terms of social care budgets at the moment, the fact that a lot of the money is not necessarily spent on the right people. It’s really hard to quantify who should get that support so having something like that [could help] to narrow it down.” (P11) |
| 1.4.2. Setting | ✓ | 12 (92) | Young people debated the merits of using the risk calculator in schools, social care, GP and youth club settings but, ultimately, they felt that it should be completed with whoever the individual felt most comfortable with. | “… some young people have really good relationships with their social worker but it’s not always the case so it’s one of those things where perhaps it could be flexible with who does it.” (P11) |
|       |          |    |       | Although one practitioner suggested the tool could be used by whichever professional had the best relationship with the child, the majority identified school and social care as potential settings for the risk calculator to be implemented. | “I think social care settings absolutely because it’s really relevant, but I wonder what it would look like if it was rolled out in schools and youth centres and things like that … It might be helpful to give schools that resource because then it helps them to think about what support they need for a child or even to understand like how vulnerable they are.” (P8) |
|       |          |    |       | Practitioners believed there were benefits of the tool being implemented by more than just one professional and being used in multi-agency settings. | “… and schools also do Team Around the School Meetings where it’s often like a headteacher or a SENCO [Special Educational Needs Coordinator] … someone from tier two social care, someone from CAMHS ideally, school nurse, they get together and talk about all the families they’re worried about. So actually, something like this [risk calculator] would probably be quite useful in those settings as well.” |
### Table 3. Continued.

| Theme          | Subtheme | FG | N (%) | Explanation | Illustrative quote(s)* |
|----------------|----------|----|-------|-------------|------------------------|
| **1.4.3. Transparency** |          | ✓  | 12 (92) | Participants reflected on whether practitioners should involve children in completing the risk calculator and whether they should share the resulting risk score with them or simply use it to inform their own work with that individual. There was a tension between wanting to protect the child from any potential negative impact of the risk calculator, their desire to work openly and honestly with them, and the child’s right to access information about themselves. | “I know obviously it is not very ethical, but like, is it helpful to say to a child, like, you’re at risk of developing mental health issues, when actually they haven’t even raised that they’re having any problems. So, maybe [it is] just something to have in mind or considered.” (FG1) |

Several CAMHS practitioners believed that they were too late in the chain of events for the risk calculator to be implemented effectively in their role. They felt that it was better suited to schools and/or social care settings.

| Practitioners suggested the risk calculator could be integrated into existing ways of working. | “I don’t think it would be appropriate [to my role] simply because the young people on the ward they come with quite severe mental health problems anyway … I think this is more of like an earlier stage.” (P7) |

| Some practitioners identified the potential for the risk calculator to disrupt the relationship between practitioner and child. | “I’m not sure how it would work in my role because I’m seeing patients in clinic … I’m not sure because a screening tool is pre-clinical … I’m too far down line.” (P13) |

| Practitioners and young people suggested using language and visual images to communicate risk to children and their families. | “If you could kind of do it, and just do it as a professional network … to try and contain the impact of the results on the young person, because if it’s, I don’t know, but then, because if it came out as ‘you’re five percent likely’, that might be nice for them. I guess I’m wondering about not sharing [the risk score information], um and kind of implications of that, whether or not that’s, you know, possible.” (P3). |

*Illustrative quote(s)* indicate the researcher who provided the quote.
| Theme        | Subtheme | FG | N (%) | Explanation                                                                                                                                                                                                 |
|-------------|----------|----|-------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1.4.4. Interpretation |          | 6  | 46    | Practitioners highlighted their need for guidance about how to interpret risk scores. Practitioners believed the risk calculator should be used alongside — not in place of — professional judgement and referred to examples of existing tools that explicitly promoted this. |
| 1.5. Response | 1.5.1. Professionals | ✓  | 4     | Young people expressed concern that practitioners may have an overly medicalised response to children's risk score.                                                                                      |
|             |          |    |       | Practitioners expressed concerns about how the risk score could be used by some practitioners as well as the potential for organisations and private businesses to (mis)use the risk score information.   |
|             | 1.5.2. Family | ✓  | 12 (92) | Young people and practitioners identified the potential for parents to have a negative response to a child’s risk score. Young people felt that parents may respond in ways that are unhelpful whereas practitioners also empathised that parents may feel blame and guilt. |

Practitioners and young people identified the need for professionals to be very sensitive in their communication with children about their risk.

I think an issue such as [self-fulfilling prophecy] is more to do with the interaction between the practitioner and the patient, rather than the tool itself … and more to do with their training and interpretation of it.” (FG1)

“… how do they explain that to me? How do I go away from that feeling that I want to change something as opposed to it terrifying me and then feeling I'm never going back?” (P6)

1.5. Response 1.5.1. Professionals

Young people expressed concern that practitioners may have an overly medicalised response to children’s risk score.

“Maybe some people just need like support … to talk to someone that they trust … maybe they don’t need anti-depressants, or, erm, like psychological intensive therapy … maybe, they literally just need someone to just say ‘I feel really rubbish at the moment’ or ‘I’m going through something really difficult’ … I think, we have to be careful to equate it fully with physical health.” (FG1)

“I can imagine some very crude care planning happening on the back of a score.” (P2)

“[if] the young person is perhaps high risk … what the impact could be for them in terms of employment and insurance and, I don’t know, all sorts of things, whether there’s the potential for that to be misused or to experience discrimination as a result?” (P4)

1.5.2. Family

Young people and practitioners identified the potential for parents to have a negative response to a child’s risk score. Young people felt that parents may respond in ways that are unhelpful whereas practitioners also empathised that parents may feel blame and guilt.
### 2. Protective factors and prevention

#### 2.1. Individual

| Theme | Subtheme | FG | N (%) | Explanation | Illustrative quote(s) |
|-------|----------|----|-------|-------------|-----------------------|
|       |          |    |       | very cautious to have another thing that’s in these families’ lives that’s going to be a knock, like another potential blaming tool for them.” (P9) | |
|       |          |    |       | You’re just going to think to yourself that I’m always going to be at risk, there’s no point of me trying to better myself.” (FG1) | |
|       |          |    |       | “It has to come with a package [of support] because otherwise that child is then left on their own and it’s almost like ‘well it’s inevitable. I’m going to have these poor [outcomes].’” (P9) | |
|       |          |    |       | “It gives young people kind of a greater opportunity to become self-aware with their experiences and what they’ve gone through . . . I think it is good for the young person to come to terms with what they’ve been through, erm, but actually feel in control of that and like they can change.” (FG1) | |
|       |          |    |       | “It could be that drive that families need to see.” (P9) | |
|       |          |    |       | “Having a structured routine, you get up at this time, you go to school and work at this time, and that sort of helps you out because you have to get out of bed for work, it gives you a very subtle incentive.” (FG2) | |
|       |          |    |       | “…something to focus on, to channel their energy.” (P5) | |
|       |          |    |       | “I didn’t want to go through teen pregnancy. I didn’t want to go through really awful menial jobs. I wanted to have something better, like, a better life.” (FG2) | |
|       |          |    |       | “Academic intelligence is probably the best opportunity that somebody could have to get out of a situation that’s really poor.” (FG2) | |
|       |          |    |       | “Higher level of intelligence … I don’t always agree with that because I think that’s about how you process things, how you think. You can have a very high level of intelligence and no life-skills.” (P6) | |
|       |          |    |       | “…young people who are, I suppose, getting a lot of validation and feeling good about themselves from achieving, um, creates a protective factor, a resilience for them.” (P5) | |
|       |          |    |       | “…clubs and activities . . . like organised sports clubs and events for young children to get people into kind of interacting with others through their environment.” (FG2) | |
|       |          |    |       | “A sense of connection as well with their community, whether that’s their school community, their peer group, or whatever out-of-school activities, I mean we really encourage that because it’s about engaging with life isn’t it?” (P5) | |
|       |          |    |       | “[A] supportive social network, so, having supportive friends and family who can almost like, motivate you or support you if you’re struggling with things.” (continued) | |
### Table 3. Continued.

| Theme | Subtheme | FG | N (%) | Explanation | Illustrative quote(s) |
|-------|----------|----|-------|-------------|------------------------|
|       | 2.2.2. Socio-economic | ✓ | 4 (31) | Young people and practitioners identified the role that a higher socio-economic status plays in protecting victimised children from developing poor outcomes. | “Having a safe adult… somebody who is a positive influence and has genuine care for them and isn’t embroiled in the chaos and whatever else is going on. I think that’s definitely key.” (P10) “… the option of private health care is there, if you’re better off….” (FG2) “If you’re living in a neighbourhood where there’s not high levels of crime, or youth violence, or poverty, or deprivation then your ability to thrive is going to be higher.” (P8) |
|       | 2.2.3. Role of Schools | ✓ | 4 (31) | Young people and practitioners believed that schools could increase children’s knowledge and awareness of protective factors and mental health. | “Education about relationships and sort of healthy social relationships in school.” (FG2) “I think it becomes part of how the system at school, you know how you have like physical checks in school and stuff like that, I think it’s important to get young people to understand that mental health should be seen in the same way as physical and to have those check-ups on a regular basis. Um, I think that would also help raise awareness around mental health in general.” (P7) |
|       | In particular, the potential for Personal Social and Health Education (PSHE) lessons to do this was highlighted by young people. |       |       | “When I was at school like we had different PSHEs for different things… and sometimes we would have people come in and talk… different clubs could come in and talk and it could be like a way to create connections between like whatever charity it is, whatever organisation, whatever it may be.” (FG2) “Mental health specialists working in a school ties so well in with like having mental health check-ups because in an ideal world we would have… a team of mental health specialists to work in schools… if we can identify a need for it by doing these sort of check-ups, then we can have appropriate stuff to handle it all.” (FG2) “… you don’t have a mental health nurse in school, I don’t think you do, well we didn’t. And I feel like young people are having many more mental health problems rather than physical at the moment but nothing’s changed and there hasn’t been a shift in that as of yet. So, I think that could help.” (P7) |
|       | Young people and practitioners felt that schools should provide mental health support. |       |       | “I was just like, ‘I want to leave, I just want like a night out, or week out and then I’ll be fine if I like, take a break.’ And, I think that ability to take a break… would have helped me out a lot more…. maybe if I got a week out I could have had a lot more constructive behaviour.” (FG2) “I think one of the things we know is that people’s responses to young people can be key, you know the speed with which they receive a supportive and believing, where that’s relevant, response from an appropriate adult who then takes action to ensure their safety and promote, well I’ll call it ‘recovery.”’ (P4) |
|       | 2.2.4. Effective support services | ✓ | 7 (54) | Young people and practitioners identified the importance of a timely response from support services to prevent the problems escalating. | “I just think that ability to take a break… would have helped me out a lot more… maybe if I got a week out I could have had a lot more constructive behaviour.” (FG2) “I think one of the things we know is that people’s responses to young people can be key, you know the speed with which they receive a supportive and believing, where that’s relevant, response from an appropriate adult who then takes action to ensure their safety and promote, well I’ll call it ‘recovery.”’ (P4) |
Table 3. Continued.

| Theme                      | Subtheme                  | FG  | N (%) | Explanation                                                                 | Illustrative quote(s)* |
|----------------------------|---------------------------|-----|-------|-----------------------------------------------------------------------------|------------------------|
| Practitioners highlighted the need for support services to be flexible to suit individuals’ needs. | 2.3. Preventive interventions 2.3.1. Existing preventive interventions 11 (85) Practitioners identified preventive interventions for children who had been exposed to specific types of victimisation | 11 (85) | 11 (85) | “… giving families the opportunity to re-access a service rather than saying you’ve done that now, you can’t use us again for another five years.” (P10) | “… giving families the opportunity to re-access a service rather than saying you’ve done that now, you can’t use us again for another five years.” (P10) |
| Practitioners’ spoke of close multiagency working being beneficial to supporting victimised children. | 2.3. Preventive interventions 2.3.1. Existing preventive interventions 11 (85) Practitioners identified preventive interventions for children who had been exposed to specific types of victimisation | 11 (85) | 11 (85) | “… it is having a strong package of support, it’s a systemic response where multi-agencies are working together and everybody has a shared understanding, you know, there’s no judgement on the young person everybody is working.” (P3) | “… it is having a strong package of support, it’s a systemic response where multi-agencies are working together and everybody has a shared understanding, you know, there’s no judgement on the young person everybody is working.” (P3) |
| Young people highlighted the need for parents to be knowledgeable about what support services are available to them. | 2.3. Preventive interventions 2.3.1. Existing preventive interventions 11 (85) Practitioners identified preventive interventions for children who had been exposed to specific types of victimisation | 11 (85) | 11 (85) | “Knowing … what you could do to help your children, what services are available to you … so, like free healthcare, free childcare.” (FG2) | “Knowing … what you could do to help your children, what services are available to you … so, like free healthcare, free childcare.” (FG2) |
| Young people and practitioners spoke of the importance of services to support the parents of children who have been victimised. | 2.3. Preventive interventions 2.3.1. Existing preventive interventions 11 (85) Practitioners identified preventive interventions for children who had been exposed to specific types of victimisation | 11 (85) | 11 (85) | “I feel like a lot of parents don’t know how to deal with children exhibiting, maybe, undesirable and desirable behaviours. Teaching them how to appropriately deal with that.” (FG2) | “I feel like a lot of parents don’t know how to deal with children exhibiting, maybe, undesirable and desirable behaviours. Teaching them how to appropriately deal with that.” (FG2) |
| 2.3. Preventive interventions 2.3.1. Existing preventive interventions 11 (85) Practitioners identified preventive interventions for children who had been exposed to specific types of victimisation | 2.3. Preventive interventions 2.3.1. Existing preventive interventions 11 (85) Practitioners identified preventive interventions for children who had been exposed to specific types of victimisation | 11 (85) | 11 (85) | “… to assist parents and carers in particular to understand some of the behaviours perhaps of the perpetrator, or whatever, in order that it helps raise awareness and appreciate why certain things may be triggers for their child.” (P4) | “… to assist parents and carers in particular to understand some of the behaviours perhaps of the perpetrator, or whatever, in order that it helps raise awareness and appreciate why certain things may be triggers for their child.” (P4) |
| 2.3. Preventive interventions 2.3.1. Existing preventive interventions 11 (85) Practitioners identified preventive interventions for children who had been exposed to specific types of victimisation | 2.3. Preventive interventions 2.3.1. Existing preventive interventions 11 (85) Practitioners identified preventive interventions for children who had been exposed to specific types of victimisation | 11 (85) | 11 (85) | “The good lives model is something that I like, Some narrative therapy, so kind of ‘thickening-up’, so if the young person has had these traumatic experiences in childhood and it’s left them with negative self-image, feelings of worthlessness, um, a lack of hope, things like that so kind of thickening-up their narrative to have their trauma as one part of them but also these are the resiliencies I have, these are the resources I have … it’s a really nice creative way to think about your past, your present, your future.” (P3) | “The good lives model is something that I like, Some narrative therapy, so kind of ‘thickening-up’, so if the young person has had these traumatic experiences in childhood and it’s left them with negative self-image, feelings of worthlessness, um, a lack of hope, things like that so kind of thickening-up their narrative to have their trauma as one part of them but also these are the resiliencies I have, these are the resources I have … it’s a really nice creative way to think about your past, your present, your future.” (P3) |
| They also identified more general preventive interventions that were not targeted to specific types of victimisation experience. | 2.3. Preventive interventions 2.3.1. Existing preventive interventions 11 (85) Practitioners identified preventive interventions for children who had been exposed to specific types of victimisation | 11 (85) | 11 (85) | “… but every borough has different services, it’s a post code lottery.” (P9) | “… but every borough has different services, it’s a post code lottery.” (P9) |
| Practitioners noted that the preventive interventions that are available to victimised children varied across geographic locations. | 2.3.2. Risks 13 (100) Practitioners acknowledged that preventive interventions do carry some risk of labelling and stigmatisation but felt that this could be minimised by sensitive communication and delivery of the intervention. | 13 (100) | 13 (100) | “I guess you could be [stigmatising], I’d like to think though that any work that was done with a child wouldn’t necessarily be massively obvious to stand out, label them to peers or anything like that so if anything was done it would be done as part of their school day or to help them integrate as much as possible or be done out of school altogether at some sort of appointment or meeting that they would go to.” (P12) | “I guess you could be [stigmatising], I’d like to think though that any work that was done with a child wouldn’t necessarily be massively obvious to stand out, label them to peers or anything like that so if anything was done it would be done as part of their school day or to help them integrate as much as possible or be done out of school altogether at some sort of appointment or meeting that they would go to.” (P12) |
| Some practitioners felt that stigmatisation was more of a risk in families of particular cultural or socioeconomic backgrounds | 2.3.2. Risks 13 (100) Practitioners acknowledged that preventive interventions do carry some risk of labelling and stigmatisation but felt that this could be minimised by sensitive communication and delivery of the intervention. | 13 (100) | 13 (100) | “So, I don’t necessarily think stigma would be a problem although there are some who I think, definitely some communities as well it’s still kind of looked down on.” (P11) | “So, I don’t necessarily think stigma would be a problem although there are some who I think, definitely some communities as well it’s still kind of looked down on.” (P11) |
| Despite this potential risk, the apparent acceptability of preventive intervention among children was noted. | 2.3.2. Risks 13 (100) Practitioners acknowledged that preventive interventions do carry some risk of labelling and stigmatisation but felt that this could be minimised by sensitive communication and delivery of the intervention. | 13 (100) | 13 (100) | | |
### Table 3. Continued.

| Theme                                                                 | Subtheme                      | FG | N (%) | Explanation                                                                 | Illustrative quote(s)* |
|----------------------------------------------------------------------|-------------------------------|----|-------|-----------------------------------------------------------------------------|------------------------|
|                                                                      | Practitioners' highlighted the importance of ensuring preventive interventions are appropriate for the child in terms of content, timing and support available to them in order to minimise unintended negative consequences. |    |       | “... mental health seems so much more talked about and accepted in schools and among young people than it was before.” (P8) |                        |
|                                                                      | Practitioners also identified the withdrawal of support at the end of a preventive intervention as carrying risks for the child and family. |    |       | “… you don't carry on with an intervention because it's for you, you're negotiating it and you're also managing the risk of ‘ok this means you don't sit your exams but this will be for a short period of your life and then you will able to access education and it will help you' versus ‘this isn't the right time for you.'” (P6) |                        |
|                                                                      | Practitioners noted the potential for an intervention to impact negatively on an individual's willingness to seek help in the future. |    |       | “I guess the first thing that came to my mind was the support withdrawing and how do families manage the withdrawal of support, there's potentially got them to a place where they're feeling confident and obviously it would be, well I don't know because if it's funding, you may get your six months and then regardless of where you are and regardless of if you're ready or not that support may have to be withdrawn and you could be stepped down but you know transitions tend to be very difficult for chaotic families.” (P3) |                        |

### 3. Communication of the research

#### 3.1. Stakeholders

| Subtheme                      | FG | N (%) | Explanation                                                                 | Illustrative quote(s)* |
|-------------------------------|----|-------|-----------------------------------------------------------------------------|------------------------|
| 3.1.1. Public services       | ✓  | 0 (0) | Young people suggested that professionals from health, education and social care sectors would be interested in the research findings. | See Figure 2(A)        |
| 3.1.2. Youth organisations   | ✓  | 0 (0) | Young people suggested that youth clubs and organisations such as the National Citizenship Service (NCS) would be interested in the research findings. | See Figure 2(B)        |
| 3.1.3. Public                | ✓  | 0 (0) | Young people suggested that people with lived experiences of mental health problems and negative life events would be interested in the research. | See Figure 2(C)        |

#### 3.2. Methods

| Subtheme                      | FG | N (%) | Explanation                                                                 | Illustrative quote(s)* |
|-------------------------------|----|-------|-----------------------------------------------------------------------------|------------------------|
| 3.2.1. Online                 | ✓  | 0 (0) | Young people suggested using blogs, social media and webinars as a means of communicating the research findings. | See Figure 2(D)        |
| 3.2.2. Policy                 | ✓  | 0 (0) | Young people thought that incorporating the research findings into policy would be beneficial. | “I mean like, essentially getting it into policy, so in schools it becomes like systematic.” (FG2) |
| 3.2.3. Training & Education  | ✓  | 0 (0) | Young people suggested communicating research findings via workshops, seminars and professionals' training courses. | See Figure 2(E)        |

FG: focus group; ✓ a theme or subtheme was evident in the young people's focus group discussions. N (%): number (and percentage) of practitioner interviews in which a theme or subtheme was evident. *The source of a quote is denoted by the focus group number (FG#) or practitioner number (P#).
appropriate for a particular child they wish to screen whilst upholding core ethical values of honesty, openness and protecting from harm.

Finally, our findings suggest that successful implementation of the risk calculator will require training for the practitioners who will use it. We found that people were very knowledgeable about the wide range of factors that could buffer or accentuate the risk of poor outcomes following exposure to victimisation (themes 1.1. “risk factors”, 2.1. “individual” and 2.2. “environmental”). However, awareness of this complexity and of individual differences in response to victimisation gave rise to scepticism about whether a statistical tool could accurately predict such outcomes (theme 1.3. “accuracy”). Increasing practitioners’ understanding of the risk calculator as a means of individual – rather than average – prediction and evidencing its accuracy will therefore be critical in promoting their acceptance of the tool. This is consistent with the What Works for Children’s Social Care recommendation for the use of prediction models and their limitations to be included in social worker training (Leslie et al., 2020). Additionally, practitioners will need to be trained in how to interpret the risk scores. In particular, further work is needed to determine a clinically appropriate cut-point to guide practitioners regarding what they should interpret as a “high” risk score that requires action (subtheme 1.4.4. “interpretation”).

Limitations

We acknowledge some limitations of our study. First, our sample of young people was relatively small. Second, the self-selecting and predominantly female sample may limit the generalisability of findings as those who volunteered may have a greater interest in research and a proclivity towards the use of a screening tool. However, the views of our young people and practitioners were not unequivocally positive with regards to the acceptability and implementation of a risk calculator. Moreover, men are indeed under-represented in health and social care roles in the UK (Les, 2017; Skills for Care, 2017) such that our practitioner sample reflects the female-dominated gender composition of these professions. Despite attempts to achieve a balanced gender composition of young people, the low number of males means that this sample is not representative of children who experience victimisation (Radford et al., 2013). Third, our study did not include parents/careers or teachers who also have a key role in supporting children and young people who have experienced victimisation. Ascertaining the views of these stakeholders is also important, particularly given our finding that schools and/or multi-agency meetings may be a useful setting for the risk calculator to be used. Finally, this qualitative study was undertaken while the risk calculator is still in the early stages of development and validation. Therefore, we were unable to demonstrate to participants exactly what the risk calculator would look like or how well it performs in external samples. Nonetheless, finding out what young people and practitioners’ feel are the main considerations is critical to inform the further development of the risk calculator and future implementation efforts.

Conclusion

Notwithstanding these limitations, the findings of the current study provide useful insights into the acceptability and feasibility of implementing a risk calculator to identify victimised children who are most at risk for developing psychopathology and poor functioning. Overall, young people and practitioners recognised the potential for an accurate screening tool like this to enhance health and social care practice but also highlighted key considerations and challenges related to its successful implementation. This will be useful to inform future work in this area.

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Disclosure statement

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