



Mental Health of Children in Out-of-Home Care in NSW, Australia



NSW Department of
Community Services

Introduction

This Research to Practice Note is based on the findings of the *Children in Care Study* (CICS), (2005) led by Michael Tarren Sweeney, Senior Lecturer in Child and Family Psychology, University of Canterbury (NZ), and Conjoint Senior Lecturer in Psychiatry, University of Newcastle. This study reports on the mental health of children in court-ordered foster and kinship care in New South Wales (NSW). The study is ongoing and present findings are taken from the baseline survey which has been reported on in a number of papers.^{1,2,3}

Background

Children living in alternate care in the United States and Europe have high rates of psychiatric disturbance well in excess of that observed among children in general. Studies show that this is attributed to exposure to early maltreatment, emotional deprivation and disrupted attachments.^{4,5,6,7,8} Australian children are exposed to similar adversity and are therefore likely to face similar difficulties.

However, overseas studies cannot account for the different experiences of Australian children. These studies report on diverse populations and vary to Australian studies in terms of age at entry into care; exposure to maltreatment; reasons for entry into care; type of care (kinships, foster and residential) permanency planning (such as adoption); length of time in care and other developmentally significant factors.

Yet very little research has been conducted on the mental health of Australian children in out-of-home care.^{9,10} One significant Australian study, a three-year longitudinal prospective study of children entering out-of-home care, was specific to South Australian children and cannot be generalised to other states.¹¹ Additionally, differences in out-of-home care practice and legislation among Australian states may result in different mental health outcomes of children in out-of-home care.

The Children in Care Study

The CICS sought to obtain more comprehensive estimates, than prior studies, of the mental health of children in court-ordered and kinship care and relationships between a large number of pre-care and in-care risk factors.^{12,13} The study recruited 347 children, aged four to eleven years. It obtained estimates for mental health, self esteem, social competence and risk exposure via a state-wide mail survey of foster parents and kinship carers and by reviewing the child welfare database.

Measures

Measures of the mental health and socialisation of children in the study were estimated using two carer-report checklists. The Child Behaviour Checklist (CBCL) was the principal outcome measure, due to its validity and reliability as well as its comparative data for high risk populations and adaptation to Australian norms. The second checklist measure was the Assessment Checklist for Children (ACC), a carer-report psychiatric rating scale which measured behaviours, emotional states, traits and manners of relating to others, as shown by children in care.

The ACC was developed to measure a range of behavioural issues specifically for children in OOHC that are not adequately covered by standard survey instruments (such as attachment and peer relationship difficulties, anxiety and dissociative responses to trauma, sexual behaviour and self-injury).¹⁴

Poor mental health of children in care in NSW

Children in the study were reported as having exceptionally poor mental health and social competence, relative to the general population and to other populations of children in care. More than half the boys and girls in the study were reported to have clinically significant mental health difficulties. They presented with complex disturbances, including multiple presentation of:

- conduct problems and defiance
- attachment disturbance
- attention-deficit/hyperactivity
- trauma related anxiety
- sexual behaviours.

The only non-clinical population likely to have poorer relationship and behavioural functioning than foster and kinship care children were children living in residential institutions and late-adopted children raised from infancy in residential care.

A number of factors partially accounted for the relative high levels of mental health disturbance for these children. First, the children in the study experienced higher exposures to social and biological adversity prior to entering care, particularly emotional deprivation and maltreatment relative to normative and in-care samples.

Second, the study sample under-represented children in care placed at an early age in stable, long-term 'adoptive type' placements which may have contributed to the significant mental health estimates. This is in contrast to the United States, where permanency planning often leads to children in alternate care being adopted by their foster parents and therefore exiting care.

The most significant contributor to the higher numbers of disturbed children living in foster care placements today is the closure of residential and group homes in the early 1990's. Previously, children with severe disruptive behaviour and attachment disorders were most likely to be seen as 'non-fosterable' and placed in state residential facilities. By implication, more seriously maladjusted children may be entering foster care now than in previous decades.

Gender differences

The CBCL scores of boys and girls in the study differed in magnitude yet they had similar patterns of problem behaviour. This suggests that boys and girls develop similar complex psychopathology in response to exposure to multiple biological and social risk factors.

In contrast, boys and girls had similar total ACC scores but presented with different patterns of disturbance in interpersonal behaviour. The data suggests that, given similar adverse experiences, boys are more likely to develop emotionally withdrawn, inhibited attachment responses, as well as dissociative responses to pain. Girls, on the other hand, are more likely to develop precocious, controlling, pseudomature attachment behaviour and age-inappropriate sexual behaviour.

Predictors of mental health

Principle independent predictors of mental health problems for children in the study included:

- developmental problems
- reading difficulties
- reported intellectual disability
- younger maternal age at birth
- older age at entry into care
- placement insecurity
- exposure to a higher number of recent adverse life events
- exposure to specific forms of maltreatment (contact sexual abuse, physical assault and emotional abuse).

Experiences prior to care

Age at entry into care is a strong predictor of children's mental health outcomes. Several studies have reported that older age is associated with poorer mental health outcomes.^{15, 16, 17} This was partially supported in the study. However, further analysis showed that the poorer mental health of older children in care is largely attributed to later-placed children entering care with high levels of pre-existing disturbance.

Many children in out-of-home care have experienced a number of adverse and stressful events prior to care entry. Child protection histories of serious and chronic maltreatment suggest that these children reside in dysfunctional family environments for most of their pre-care lives. A broad indicator of exposure to adversity is the time between the child's birth and departure from their parent's care.

One of the key findings of this study was that children who entered care before the age of seven months had fewer attachment problems than children placed at older ages. Children who entered care between the age of seven and 30 months had a moderate risk of mental health and attachment problems and those who entered after 30 months had a much higher risk.

This is consistent with attachment theory. By age three, the most critical aspects of attachment development are either successfully negotiated or have led to aberrant development. Attachment theory would suggest that children who enter care before the age of six to nine months are likely to develop normal, secure attachments to their foster or kinship carers. The study's findings are consistent with this expectation, that children who entered care prior to seven months had significantly better mental health and fewer attachment problems than children placed at older ages.

Placement Security

Placement security can influence the development and well being of children in-care. In the study, placement security or longevity was a strong predictor of mental health outcomes for children after controlling for age at entry into care and anticipated placement breakdown.

In an alternate care environment permanency cannot be guaranteed. Foster carers have no substantive guardianship or custody rights to maintain children in placements and endorsed permanency plans have no legal status. Placement security and permanency can directly affect the attachment security of children in long-term care, via their perceptions of permanence and the influence on their carers' attachment systems.

Children who enter care at an older age may be more likely to have a restoration plan, or short-term care order influencing 'carer anticipated restoration' as well as their own self perceptions of permanence and placement security. This may lead to placement breakdown and as a consequence children with mental health problems may be restored to parents who cannot appropriately care for them.

Mental health service delivery

The study showed that the scale and diversity of problems indicated by children in care in NSW are great and that more attention on prevention, assessment and treatment services is required.

Self-injury and food related disorders (excessive eating, food acquisition and hoarding food, without concurrent obesity) are less common problems but also exist. For many children in care, disturbances in self-concept and relationship capacity are intertwined with their experience of anxiety and depression, and aggressive and defiant behaviour.

In general, treatment modalities are generally based around the construct of discrete disorders, rather than complex bio-psychological phenomenon.

This can lead to children in care in NSW being referred to multiple clinical services to address a discrete set of symptoms, leading to multiple (and sometimes conflicting) diagnoses. It is important that clinicians see these problems in their entirety and not as separate conditions.

Caregivers and caseworkers, for example, can seek a referral for a child, based on the perceived consequences of harm (for example, sexual contact and physical abuse) or the child's subjective distress. The effectiveness of treatments of the mental health problems among children in care is unknown and not all counselling is designed to improve mental health. However, children may benefit from counselling to strengthen their identity, obtain a better sense of their background, seek advice about relationships and educate themselves about making better friendships.

Clinicians with an understanding of infant attachment can assist children and carers to use interventions designed to prevent the development of psychopathology. Psychological support for children and their carers is an essential secondary prevention strategy.

Practice issues and implications

The key findings from the *Children in Care Study* suggest a number of implications for alternate care practice and for clinical work with children in care. These can be summarised as follows:

- Child welfare agencies should seek to identify children, especially infants, who are in genuine need of long-term care at earlier stages to reduce their exposure to deprivation and maltreatment. With earlier detection comes the added risk of removing the wrong children. The challenge is to develop methods for accurately identifying children at risk and improving risk assessments so as to increase true positives (not false positives) and avoid unnecessary delays, particularly for infants.
- Permanency and restoration plans need to be timely and quickly resolved, to reduce the potential for attachment difficulties especially for young children.
- Clinicians require specialist knowledge and training to conduct assessments of the attachment status and mental health of children in care. Assessment data should only be interpreted within the context of children's individual developmental histories, by clinicians who have an understanding of attachment and trauma theories.

- For children removed from their parents, surrogate parenting by sensitive foster or kinship carers, provides a second chance for a child to develop a coherent sense of self, and the capacity to love, particularly in early childhood. A foster carer requires a significant amount of assistance to bond to a child who is detached, avoidant or indiscriminately affectionate.¹⁸ Increasing the viability of placements, and strengthening carers' relationships with vulnerable and disturbed children, is therefore important.

Conclusion

The study showed that children living in alternate care, whether placed with relatives or foster parents, are disadvantaged in regard to their prior exposure to adversity, subsequent development and mental health problems. Children in care were found to have multiple and complex mental health problems.

Placement insecurity independently predicts poorer mental health. Placing children at a younger age in care reduces their overall exposure to adversity and attachment difficulties. Risk factors for exposure to adversity included emotional abuse, physical assault, contact sexual abuse and recent adverse events.

Entry into care before age seven months and before age 30 months was a specific protective threshold.

The DoCS Research to Practice program aims to promote and inform evidence-based policy and practice in community services.

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