How can foster carers help children with complex mental health and attachment problems?

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Abstract

The mental health difficulties of looked after children are complex and may be based in early attachment difficulties. There is little literature on which therapeutic interventions are effective for looked after children, but interventions in which the foster carer is the main agent of therapeutic change have been shown to be beneficial. For example research undertaken with the Glasgow based Foster Carers' Training Project in 1999-2001 suggested that attachment-based training of foster carers might make modest improvements in the mental health of looked after children. As a result of this and other Glasgow-based research, from 2003, a new mental health team for looked after children in Glasgow screens all children entering an episode of care. Intervention is now more often made by supporting the systems of care, for example, by offering consultation to foster carers, than by directly intervening therapeutically with the child. Such models are beginning to influence mental health practice for looked after children across the UK.

Key words: Looked after children, Reactive Attachment Disorder, therapeutic foster care

Introduction

The Glasgow-based Foster Carers' Training Project set out to answer two questions: "What problems do children in foster care have?" and "Can we train foster carers to reduce children's problems?". I became interested in these questions when I worked as an orphanage doctor in Guatemala, before going into psychiatry. Because I had a dual remit – as doctor for the orphanage and also as the GP for the surrounding villages, I could see a qualitative difference in the way orphanage children interacted socially. For example, when a stranger entered the orphanage, they would be surrounded by children looking for hugs and would have to peel children's fingers off their arm. In contrast when I, as a stranger, entered a family home, children of the same age would run *away* from me towards their mother's legs – which is much more normal. Many of the children in the orphanage had been street children and had been sexually, physically and emotionally abused. Interestingly, there was a well thought-out belief among the Guatemalan staff members that it was bad for children to talk about their past traumas and that we should help them forget about the past and start life afresh. I realised that, in the West, we had a belief that it was therapeutic for children to talk about their past traumas, but that this was equally untested. When I returned to the UK, I realised that many

looked after children had had similar experiences to the children in Guatemala and that the question was just as relevant. This stimulated the idea of testing the effect on children's mental health of an intervention aimed at improving foster carers' communication skills – The Foster Carers' Training Project.

The Foster Carers' Training Project

The Foster Carers' Training Project (Minnis et al., 2001; Minnis & Devine, 2001) recruited 121 foster families from across the Central Belt of Scotland – the area with the greatest population density. These families were randomly divided into two groups – one group received whatever standard services were being offered locally by their local authority and the other group received our training programme in addition to the standard services. The training, which ran over three days, was based on Communicating with Children (Richman, 1993) – a Save the Children publication which had been much used in developing countries with children who had survived trauma and loss. Claire Devine, an experienced social worker/trainer who delivered the training, introduced some theoretical material, at the beginning of each day, about attachment, separation and loss and then followed this up by inviting carers to give examples from their own experience of looking after children. The training was based on principles of adult learning and Claire asked foster carers to metaphorically "bring a child into the room" when thinking about the meaning of the theoretical material for themselves and their families. The aim was to help carers understand their child's behaviour by putting it in the context of the child's past experiences and to help them develop skills for responding to children's communications about themselves and their past (Minnis & Devine, 2001; Minnis, Devine & Pelosi, 1999).

Participants were asked to complete questionnaires before and after the training. These were questionnaires about mental health problems, self-esteem and Reactive Attachment Disorder (RAD). Because there was, at that time, no validated measure for Reactive Attachment Disorder, we developed a questionnaire which asks about RAD symptoms as described in the psychiatric classification systems. Children with Reactive Attachment Disorder can be overfriendly and disinhibited – like the children I described in Guatemala, or can be unpredictably aggressive and withdrawn. These symptoms are very familiar to social workers and mental health workers.

Focussing firstly on the baseline results, which were published in Adoption and Fostering in 2001 (Minnis & Devine, 2001), 97% of the children were known to have been abused and/or neglected. Using a screening tool called the Strengths and Difficulties Questionnaire (Goodman, 2001), 60% had symptoms of mental health problems: 50% had symptoms of hyperactivity, 60% had symptoms of conduct disorder, 45% had symptoms of anxiety or depression and 50% had problems with peer relations. Because no-one had previously measured symptoms of Reactive Attachment Disorder, we also recruited a group of Glasgow school children as a comparison group. We had hoped that this would be a representative sample of the general population, but our schools were in inner city Glasgow and, in the event, our comparison group was from a similar socio-economic background to the fostered children. As can seen in Figure 1, despite the high level of deprivation, the looked after children had significantly higher scores for Reactive Attachment Disorder than the school control children ($p < 0.0001$). The results were similar for self esteem with the looked after children having significantly lower self-esteem compared to the school controls ($p = 0.002$).

We found a significant association between a history of sexual abuse and RAD ($p = 0.02$). This initially seemed surprising as, theoretically, one might expect neglect to be the most po-

tent factor in the development of RAD, however it is equally possible that having an attachment disorder – being disinhibited and liable to approach strangers in the street – would make a child more *vulnerable* to sexual abuse. A controversial point, but one worth investigating further in future research. We did not find significant associations between emotional abuse ($p = 0.56$), neglect ($p = 0.83$) or physical ($p = 0.30$) abuse and RAD symptoms, perhaps because the prevalence of neglect, emotional and physical abuse was so high in the sample that it was impossible to make a true comparison with those looked after children who had not been neglected or physically abused. Both sexual and emotional abuse were associated with other mental health problems. Unsurprisingly, children with a higher number of previous placements were more likely to have mental health problems as has been shown in other research. More surprisingly, there was an association between current mental health problems and the birth father having had a criminal record ($p = 0.03$). The reasons for this are not clear from the study, but could include genetic factors or greater family disharmony in families with a criminal father. We found, incidentally, that foster carers who had looked after many children previously were more likely to experience break-down of the current placement. There are various possible reasons for this: burnout in foster carers, who do not get paid holidays or weekends off, more disturbed children being placed with "experienced" carers or even that carers who are not successful in "holding on" to children therefore have places for more children. We also found that when foster carers lived in more deprived areas, they had a lower breakdown-rate ($p = 0.03$). During our feedback to participants, foster carers suggested that this is perhaps to do with social geography: a child moving to a foster carer in a deprived area may be able to go to the same school, play with the same friends and take part in more familiar activities.

The results of the trial were published in Archives of Disease in Childhood in 2001 (Minnis, Pelosi, Knapp & Dunn, 2001). The control group only attended an average of 6 hours of training provided by the local authority and nearly half attended none at all. In our intervention group, just over half of those offered training attended. From discussions with social workers experienced in organising training for foster carers, it appears that this rate of attendance is better than would usually be expected for attendance rates for this kind of group training. Reasons for not attending the training were wide ranging but were usually connected to the extremely complex lives foster carers lead, such as a child being unexpectedly excluded from school.

Those who did attend were very positive about the training. They enjoyed it, thought they learned a lot from it, thought it helped them to be better carers, thought that they got on better with the child and that the child was better behaved as a result of the training. However, the Foster Carers' Training Project was analysed as an "intention to train" study. In other words, we included the results of all those who were offered the training in the analysis, regardless of whether or not they actually attended. This is standard practice in the analysis of randomised controlled trials: the effect of the intervention is measured as if it were being offered to a whole population in the real world and the results on the whole population are evaluated, whether or not they actually "took the treatment". Despite this, questionnaire scores all changed for the better in the group who were invited to the training. There was a reduction in symptoms of mental health problems including Reactive Attachment Disorder and an improvement in self-esteem in those offered the training. The results were not statistically significant although, as can be seen from Figure 2, it is tempting to suspect that had the sample size been a bit larger we may have seen significant differences.

The Foster Carers' Training Project was unusual in its attempt to evaluate effects on RAD symptoms. RAD is a relatively newly described syndrome which is poorly researched but which has recently attracted much debate and controversy (O'Connor & Zeanah, 2003). One of the reasons for the controversy is that, unusually for a psychiatric diagnosis, the "cause" is

included in the diagnosis: in order to fulfil diagnostic criteria, a child has not only to have symptoms of RAD, but also has to have a history of "grossly pathogenic care". Our group, in Glasgow, are carrying out ongoing research into RAD in both the general population and in looked after children. Preliminary findings suggest that symptoms of RAD are not rare in the general population and can be associated with care which is less-than-optimal rather than frankly abusive or neglectful. Symptoms of RAD are associated with the full range of mental health problems (Minnis, Rabe-Hesketh & Wolkind, 2002), which suggests that the long-term outlook for sufferers is likely to be poor. The recent Office for National Statistics surveys of child and adolescent mental health in the UK have highlighted the high prevalence of mental health difficulties among looked after children (Meltzer et al., 2003), but traditional forms of service delivery may be unsuitable for these children, many of whom have problems rooted in early intimate relationships (Arcelus, Bellerby & Vostanis, 1999).

The literature on interventions which attempt to improve the mental health of looked after children is sparse, but those interventions which have shown clear benefits in good quality studies have involved the foster carer as the main agent of therapeutic change. Chamberlain's team, in the US, evaluated a highly intensive programme of therapeutic foster care for some of the most disturbed young people who would otherwise have been in state psychiatric institutions. It involved increased remuneration, a high level of support and supervision for foster carers and mental health input as required. Chamberlain's group were able to demonstrate significant and cost-effective improvements in the mental health of young people in the programme (Chamberlain, Moreland & Reid, 1992). In various parts of the UK, specialist mental health teams have begun to develop in recognition of the fact that traditional CAMHS may not be the appropriate model for children whose difficulties are rooted in early relationship dysfunction, separation and loss.

The Greater Glasgow Mental Health Service for Looked After Children

The Greater Glasgow Mental Health Service for Looked After Children is a new specialist service for looked after children which was developed in an attempt to provide a more appropriate therapeutic model for looked after children. The team includes psychiatry, psychology, family therapy, nursing, psychotherapy and social work staff and much of the intervention is through ongoing consultation with foster carers and residential workers. There are three major arms to the project – universal early intervention, mental health support to those involved in systems of care and a clinical service: all looked after children now have a full psychological screening six weeks into an episode of care and a recommendation will be made as to whether the team needs ongoing involvement through either supporting those involved in the child's care or, occasionally, through direct therapeutic intervention with the child.

Workers in the team have already identified two main types of request about looked after children. Firstly, a proportion of carers want help with understanding the child. This kind of request often results in fruitful discussions with carers which can result in mental health benefits to the child. Secondly, carers are asking for help in "sorting out" the child. Some of these carers will have identified an important and previously unrecognised mental health problem, such as depression or ADHD, which can be treated. For others, this request may be a manifestation of their own difficulties, or of serious difficulties in their relationship with the child. These latter issues are complex and are the subject of ongoing research in various centres. For example, a study at the Anna Freud Centre in London is examining Adult Attachment Patterns in adoptive parents in relation to the success of the adoption. This is costly and time-

consuming research and it is likely to be some time before the results can be integrated into routine clinical practice in fostering and adoption.

Conclusion

In Glasgow much research is ongoing, or is planned for the future, on RAD and there are many as yet unanswered questions. For example, what exactly are the diagnostic boundaries of RAD? How common is it in the general population and among looked after children? What is the longterm prognosis? and, most importantly, how can it be prevented and treated? When McCann's study demonstrated the very high prevalence of mental health problems in looked after children in 1996 (McCann et al., 1996), there was a sense of hopelessness about the outlook for these young people. Since then there have been some important advances in our understanding of the nature of these young peoples' difficulties but, more importantly, radical changes in the way we address their difficulties clinically. The idea that foster carers should be seen as therapists rather than as ordinary parents is gaining credence (Dozier 2003). In some areas of the UK, foster carers are now seen as an integral part of the therapeutic team around a child and are getting both better support and better remuneration. This will inevitably have positive effects on some of our most vulnerable young people.

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