'It must be because ...'

Non-biological care and mental health

Part I. Setting the context

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This article (the first of a series of three) reviews the research and literature on the connections between non-biological care (adoption, permanent care, foster care and residential care) and mental health and relates this to the policy context in Victoria.
The implications of the over-representation of children who have experienced non-biological care in a mental health setting are explored.

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THE CHANGING CONTEXT

This article, the first of three, sets out to present an overview of the policy context, research and literature on children who have experienced non biological care[1], from a mental health perspective. This is followed by a discussion of some of the systemic issues which are inherent in both context and research. A second article will detail an analysis of referral rates for this group of children at a metropolitan child and adolescent mental health service in Melbourne. The final article will analyse who refers children to child and adolescent mental health services and what prompts referral. Throughout the three articles, the underlying theme is:- are children who have experienced non biological care different or are they just expected to be different?

THE VICTORIAN CONTEXT

Adoption, permanent care[2] and foster care are all systems of care which have experienced marked change in the 1980s and 1990s. They are also cost effective options for the community, which is increasingly placing some of the most emotionally damaged children in the child welfare system with private families.

The numbers of healthy infants placed for adoption has decreased steadily from a peak in the 1960s and early 1970s and, although some families adopt young children from overseas, these numbers are not high – over 50 inter-country adoptive placements are made in Victoria each year and, of these, at least 25% would be over the age of one year and with significant health and emotional needs.

The current policy direction away from using large institutions and reducing family group (or 'cottage') home placements has radically altered the boundaries of who is even considered for permanent family placement. In effect, this means that the groups of children who are now available for placement in families have been redefined on the basis of a move away from other kinds of care, not necessarily on the basis of an evaluation of their particular needs.

The children who are readily available for adoption and permanent care are those with 'special needs'[3]. As a group, they are likely to have had a large number of moves between caregivers and less overall experience of a consistent family environment. Traditionally,

[1] The term 'non biological care' describes any situation in which a child is not being cared for by his/her birth family.

[2] Permanent Care Orders, within the Victorian Children and Young Persons Act 1989, offer a care option which sits between adoption and foster care.

[3] Those children who are past infancy at the time of placement; are actually, or potentially, disabled; or whose genetic and social background is characterised by psychiatric illness or drug abuse. The majority of these children will also have experienced significant and multiple disruptions which will affect their attachment potential; and may also experience developmental delays and associated learning difficulties.

the 'practice wisdom' (Scott, 1990) within adoption agencies has been that a small number of these children are too emotionally damaged to be able to benefit from family based care and that they are therefore better cared for in an environment which does not demand a level of intimacy which they cannot meet.

In the years 1992-94, 171 Victorian children[4] with 'special needs' were placed in adoption or permanent care. These numbers have been rising steadily for some years. In addition, each year, approximately 6000 Victorian children are placed in foster care and, with the introduction of mandatory reporting, the demand for foster care has substantially increased.[5] Significant numbers of these children will move on from foster care to permanent care or adoption in the future, although it should be noted that foster care agencies have been reportedly reluctant to convert foster care placements to Permanent Care Orders, due to the lack of long-term funded support for the families involved.

The community belief that a good loving family will necessarily be able to repair a child's profound emotional disturbance is not congruent with the experience of many families and agency professionals. This group of children is more at risk of having a range of difficulties in the areas of identity and attachment – that is, the areas which are likely to be most central to new parents (Drury-Hudson, 1994; Howe, 1995; Rushton & Mayes, 1997).

Not all parents who care for children from disrupted backgrounds are going to need the children to provide them with the level of intimacy or primary attachment identification which they would expect with their own biological children. However, some will and the potential for a misfit between a child's capacities and a parent's needs is more apparent than it has been in the past (O'Neill, 1994; Rushton et al, 1993).

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Placement disruptions, which previous research identified as occurring in at least 13.5% of special needs placements during the 1980s in Victoria (O'Neill, 1993b), cost the state in excess of $20,000 for the first 6-7 months following the disruption. If the child is not subsequently re-placed in another family[6] and therefore grows up in state-funded care, this cost grows markedly – foster care costs approximately $10,000 per child per year, while family group home care costs approximately $35,000 per child per year.

Other changes which have introduced greater complexity into the area of adoption and permanent care are the advent of contact between birth families and permanent families since the 1980s (O'Neill, 1993a) and the growing numbers of children who will be cared for in Community Placements with relatives or family friends.

Intensive short-term (generally up to 18 months) supervision and support of these placements is undertaken by the Victorian Department of Human Services and community agencies until the placement is legalised under the Adoption Act 1984 or The Children and Young Persons Act 1989. However, the provision of post-legalisation support (until the children reach independence) is variable and characterised by situations where:

- foster parents generally receive more long-term support than adoptive or permanent care parents, due to funding provisions;
- city families have greater access to support than those living in the country; and
- wealthier families, who are able to pay for private services, receive more support than those on lower incomes.

THE RESEARCH

Longitudinal comparisons (from Europe and the United States) of adoptive, foster and other kinds of placements indicate that, on the whole, outcomes for foster children are more negative than for adopted children (Bohman & Sigvardsson, 1990; Triseliotis & Hill, 1990), although the experience of placement difficulties and disruptions tends to be similar for foster and adoptive parents (Aldgate & Hawley, 1986; O'Neill, 1993b).

Most of the adoption research has involved an earlier generation of adopted children, who were largely placed in families as infants. However, as very few infants are now placed with permanent families, most placements in the 1980s and 1990s have involved older children, sibling groups or those with special physical and emotional needs (Berry, 1992). Many of them are placed in out-of-home care as a direct result of psychiatric illness and substance abuse (Besharov, 1990; DeBettencourt, 1990; Ribton-Turner, 1992). In fact, it is estimated (from anecdotal evidence, based on the 1992-3 placement statistics from permanent care agencies) that up to 75% of Victorian special needs permanent placements occur as a direct result of drug and alcohol and mental health problems, which are frequently also associated with child abuse (Darivakis, 1993).

Large studies in the United States have shown that, while adoptees form 2% of the population, they account for 4-5% of patients using outpatient mental health facilities and 10-15% of those in residential psychiatric care. In addition, they are significantly over-represented amongst children with a diagnosis of

[4] Figure from Department of Health and Community Services statistics. This figure does not include intercountry children with special needs, as these children are not differentiated in the statistics.

[5] This figure, provided by the Children's Welfare Association of Victoria, includes short-term, as well as long-term placements, adolescent community placements and shared care. There are no overall statistics available which differentiate these placements.

[6] There are increasing numbers of emotionally damaged children, who are not able to be placed in families.

attention deficit disorder (Brodzinsky, 1990), as well as in special education classes (Berry, 1992). This over-representation seems to be due not only to the belief that adoptees have more psychological problems, but also to a greater parental and caregiver readiness to refer them for help (Warren, 1992).

Similar research in the UK confirms that adoptees (whether adopted as babies or as older children) are far more likely to be referred to psychiatric services than those children and adolescents who grow up in their biological families (Howe & Hinings, 1987; Triseliotis & Russell, 1984).

The situation is similar for young people in foster care and residential care – in recent Canadian research, up to 63% of the 248 children studied were in the pathological range for one or more psychiatric disorders (Stein et al, 1994). An Australian study of the educational needs of children in residential care has found that more than half of the sample population of 487 children and adolescents were below average age levels in literacy, numeracy, social skills and emotional and behavioural development (Cavanagh, 1995).

Further research has linked mental health problems in adoptees, such as antisocial personality, alcohol and drug abuse, affective disorders, schizophrenia and criminality, with their genetic inheritance from birth parents for whom psychiatric illness and drug abuse were also problems (Cadoret, 1990). However, other researchers have cautioned against accepting a purely genetic explanation for this situation and hypothesise that both environmental and genetic factors are likely to be involved (Sullivan et al, 1995).

Australian research has demonstrated that there are connections between homelessness, psychiatric disability, alcohol abuse, drug abuse and crime (Absler, 1993; Burdekin et al, 1989; Herrman et al, 1991; McDermott & Pyett, 1993). Recent research on 1671 homeless youth across Australia (Jordan, 1994) has found that 1.2% were adoptees, 1.4% were foster children, and 2.7% were in relative placements.

Hirst's research in Victoria has found that 59% of homeless young people (0-15 year olds) are Wards of State (Hirst, 1989), while Carter estimates that up to half of homeless young people in Australia are Wards of State (Carter, cited in Taylor, 1990, p. vi.). Many of these children will have experienced disrupted foster and adoptive placements.[7]

It is ironical that young people who have experienced difficulties and disruptions in their relationships with biological and alternative families are frequently discharged from wardship to independent living well before their eighteenth birthday with very little, or no, family support (Hirst, 1989; Stein & Carey, 1986).

There are more questions raised, than answered, by this brief overview of context and literature. One of the most important of these is why *children in non-biological care are over-represented in child and adolescent mental health facilities.*

As it is likely that this trend will increase, growing numbers of adoptive and foster families (as well as institutional carers) will be caring for children with significant records of abuse and mental health problems (Bauer et al, 1990; Coon et al, 1992; Garland et al, 1996; Grotevant & McRoy, 1990), leading to an anticipated increase in permanent placement disruptions (Festinger, 1990), placement drift, substance abuse and homelessness (Burdekin et al, 1989; Green, 1993; Preston, 1993).

[7] In a study of placement disruptions which occurred in Victoria in the 1980s, seven out of thirteen children were not replaced in families due to their age, number of previous placements and emotional difficulties (O'Neill, 1991).

DISCUSSION

There are more questions raised, than answered, by this brief overview of context and literature. One of the most important of these is *why* children in non-biological care are over-represented in child and adolescent mental health facilities. As Howe and Hinings (1987, p. 47) state:

> Statistics provide a backcloth. But unravelling the threads that bring adopted children to the attention of health and welfare practitioners requires an altogether more subtle and delicate instrument.

The factors which need to be considered must include not only the perceived mental health status of the child, but also the context in which the child exists. Issues we might consider are:

- At what point in the child's life does the referral to a child and adolescent mental health service occur? Is it prior to, during, or after his/her separation experience?
- Who is responsible for the referral to the mental health service? Who notices and identifies the child's distress?
- For children who have experienced difficulties for many years, why is the child being referred now? What has occurred in this child's environment to trigger the referral? Who is unsettled by his/her behaviour?

Looking at the adoption end of the placement continuum, Warren (1992) found that adoptees were more likely to be referred for help, even when they displayed relatively few problems, compared to a group of non-adoptees. She hypothesises that this may be because:

- Parents see their adopted children as being potentially at risk for mental health problems;
- Mental health problems in an adoptee may be experienced as somehow more disruptive to family identity than would similar problems in a biological child; or
- Adoptive families may be more attuned to family welfare resources than other families.

At the other end of the continuum, children who are disruptive and/or have

attachment difficulties in short term non-biological care are commonly referred for a mental health assessment or for psychotherapy by workers in the protective care system. This may be driven by a range of factors including the pressure experienced by protective workers for the 'expert opinion', which may assist decision making in a potentially adversarial case planning or court process.

In child and adolescent mental health services, the 'gate keeping' system which controls entry is administratively different for children living in biological families and stable long term non-biological placements, who enter through the general intake system, than for children under the direct responsibility of the Department of Human Services.

For this latter group of children, a specific protocol has been developed in Victoria which requires a written referral to the Director of the Child and Adolescent Mental Health Service from the relevant Department of Human Services Protective Team. There is also frequently a consultation with the referring workers. In this process, the following areas are addressed – the nature of the requested service; how appropriate it is for the child at this time; and the expectations of the Child and Adolescent Mental Health Service for the duration of the assessment and any subsequent treatment.

The referral of a child living with his or her biological or permanent family tends to be seen as more straightforward because it is a clinical service only which is being requested. In contrast, children in short term care bring with them complex and painful issues relating to future living arrangements.

Underlying this 'gatekeeping' process is the sometimes uncomfortable boundary between the child welfare and mental health systems and the associated issues of who the 'expert' is and who takes responsibility for these children (Hatfield et al, 1996).

Our statistics (reported in the second article of this series) show that children in non-biological care are referred to Melbourne's Alfred Child and Adolescent Mental Health Service in far greater numbers than their prevalence in the community would suggest. Further questions which arise from this finding include:

- Is this under-representation or over-representation? Should more, or even all, children in this group be referred to a child and adolescent mental health service?
- Should there be more training and consultative services provided to professionals in the child welfare field to ensure that children in need of mental health services are routinely referred for them?

These questions of course raise issues not only of resources, but also of partnership between the child welfare and mental health systems (Luntz, 1994,1995; Sheehan, 1997). In the years since the research was undertaken, a number of innovative service delivery models have been established where mental health workers and child welfare staff operate either as members of the same team or work far more collaboratively than occurred in the past. It will be important to track how these new system developments impact on the attendance of children living in non biological care at Child and Adolescent Mental Health Services.

We welcome these new developments because they introduce the possibility of mental health input at a range of points along the case planning process for each child, a situation which will hopefully minimise decisions to seek mental health consultation largely as a result of crises and/or administrative factors. Effective mental health consultation is not only related to the question of whether a child requires a clinical assessment or treatment, but is also an important contribution to all aspects of the planning and decision-making process for a child's future.

Mental health treatment delivered in a clinical setting is only one of a range of possible services for troubled children. Children (and their families) who are referred to child and adolescent mental health services, as well as those who are never referred, may benefit from different kinds of support (O'Neill, 1992). Support to care givers (Hatfield et al, 1996), teachers and other community professionals, group work and increased involvement in community activities have important therapeutic functions for children with difficulties. □

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