

Foster Care, Mental Health of Children in

Description/Etiology

Foster care is temporary substitute care for children in the legal custody of a child welfare services (CWS) agency, most often as a result of child maltreatment. Children in foster care may be placed with relatives, in nonrelative foster homes, therapeutic foster homes, group homes, residential treatment facilities, or emergency shelters. Foster care placement is intended to provide a safe, stable living situation while CWS makes efforts to reunify children with their birth parent(s) or establish permanency through legal custody, guardianship (a more durable form of custody), or adoption. (See series of Quick Lessons and Evidence-Based Care Sheets for more information about foster care).

Children in foster care have significantly higher prevalence rates for mental health disorders than the general population. Mental health conditions identified among children in foster care include depression, conduct disorder, oppositional defiant disorder (ODD), attention-deficit/hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD), mania, anxiety disorders, and reactive attachment disorder (RAD). Most children in foster care have also experienced significant trauma and may exhibit trauma-related symptoms. There is a great deal of overlap between symptoms of mental illness and those of trauma. Trauma-related symptoms may be mistaken for those of mental health conditions. For instance, disorganized and agitated behavior, poor concentration, and sleep problems caused by trauma may mimic ADHD, and irritable, angry responses to trauma may mimic ODD. Alternatively, children may be affected by mental health conditions in addition to trauma, and trauma may cause worsening of the mental health condition.

Research during the past several decades has provided evidence that chronic “toxic” stress in young children, such as in child maltreatment, impacts the structure and functioning of the brain, which in turn can have persistent effects on children’s health and development, including increased incidence of mental disorders. The effects of trauma are understood as existing on a continuum. The majority of children in foster care have experienced one or more traumatic events, including the instance(s) of child abuse or neglect that resulted in their entry into foster care. Highly resilient children may have little difficulty, whereas others exhibit moderate to severe trauma-related symptoms. Complex trauma is defined as trauma that is repeated, chronic, often involves persons whom children would otherwise count on for safety and support, and frequently is experienced in multiple forms simultaneously or sequentially. The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, includes a chapter on trauma- and stressor-related disorders that encompasses several disorders frequently associated with a history of child maltreatment. PTSD is a disorder involving a constellation of symptoms following exposure to a traumatic event. Complex trauma is linked with dysregulation and impairment in many areas of development, and can result in symptoms of PTSD such as intrusive recollections, avoidance of certain stimuli, and hyperarousal, as well as emotional and behavioral dysregulation, disorganized or insecure attachments, relationship disturbances, dissociation, disturbances in identity, and somatic distress. Behavioral outbursts may be triggered by seemingly inconsequential stimuli (e.g., sensory input, places) that may be reminiscent of previous trauma.

Prognosis varies considerably, depending on the type, severity, chronicity, and pervasiveness of maltreatment, the child’s developmental stage at the time of maltreatment and placement in foster care, quality of foster care services (e.g., stable, nurturing placement), whether

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the child receives trauma-informed services, the child's temperament, and resiliency and strength in the birth family and subsequent environments. Although researchers have not consistently found a link between ethnicity and mental health outcomes among adults who were in foster care, female gender has been linked with poorer mental health. Removal from adverse conditions has been linked with decreases in externalizing behavior problems and, to a lesser extent, internalizing problems. Poorer adult mental health outcomes are linked with being older when placed in foster care and experiencing changes in placements.

Facts and Figures

In 2015, approximately 427,910 children were in foster care in the United States (Administration on Children, Youth and Families, Children's Bureau, 2016). In England, 72,670 children were in care as of March 31, 2017 (United Kingdom Department for Education, 2017). In Australia, 46,448 children were in out-of-home care in June 2016 (Australian Institute of Health and Welfare, 2017). A 2013 report from UNICEF estimated that in Eastern Europe and Central Asia 1.3 million children were in out-of-home placement (UNICEF, 2013). Among children in out-of-home placement in the 22 countries that make up Central and Eastern Europe and the Commonwealth of Independent States, over 626,000 are in institutional care (UNICEF, 2010). Mental health problems affect as many as 80% of children and adolescents in foster care (Harpin et al., 2013). Over 25% of all children in foster care, and over 50% of those aged 13 years and older, exhibit trauma-related symptoms (Griffin et al., 2011). In a large study of youth in foster care who were referred to the National Child Traumatic Stress Network for treatment, 11.7% reported experiencing all five types of trauma included in the study (i.e., physical abuse, sexual abuse, emotional abuse, neglect, and intimate partner violence [IPV]), and 70.4% reported experiencing at least two (Greeson et al., 2011).

Risk Factors

Children in foster care are at increased risk of mental health problems due to maltreatment, exposure to multiple psychosocial risk factors, neurobiological vulnerabilities, prenatal exposure to drugs and alcohol, family history of mental disorders, the disruption of being removed from their parents and familiar environments, adjustment to new caregivers, multiple foster-care placements, and, for some, suboptimal care and social discontinuities in foster care. Mental health problems are associated with increased chances of adverse outcomes in foster care, including more placement changes, longer stays in care, and lower chances of achieving permanency.

Signs and Symptoms/Clinical Presentation

Persistent emotional distress, excessive crying, profound sadness, detachment, numbing, daydreaming, depression, anxiety, hypervigilance, behavior changes, developmental lags or regression, academic difficulty, difficulty falling or staying asleep, nightmares, rapid eating, food hoarding, poor appetite, refusal to eat, toileting issues, increased startle responses, aggression, severe tantrums, defiance, self-injurious behaviors, suicide ideation, suicide attempts, animal abuse, fire setting, substance abuse, unhealthy sexual activity, poor social skills, difficulties with attachment and maintaining relationships.

Social Work Assessment

› Client History

- All children entering foster care should receive a comprehensive assessment of their physical, educational, and mental health needs, including screening for trauma, self-harm/suicidality, and substance abuse
- Complete a comprehensive biopsychosocial/spiritual assessment to include information on physical, mental, environmental, social, and financial factors as they relate to the child's care and immediate safety
 - Ask about child's history of prior caregiving, trauma, maltreatment, exposure to violence; family history, circumstances that resulted in the child being placed in foster care, adjustment to placement, history of psychiatric symptoms or issues that might pose risk to self or others (e.g., suicidality, self-harm, substance abuse, aggression, fire setting, running away, sexual perpetration), history of mental health treatment and psychotropic medication, child's involvement with other systems (e.g., school, corrections), family and community supports
 - Ask about household members; siblings and/or other children in the home; parental functioning and risk factors (e.g. substance abuse, mental illness, IPV, child maltreatment, medical or cognitive issues); parental perceptions and feelings about child; parenting practices regarding discipline, supervision, and nurturing; awareness of child's needs; efficacy in parenting role; family and community supports; ability to meet family's basic needs; involvement with other systems (e.g., school, child welfare, corrections)
 - Assess child's patterns of behavior over time, ruling out temporary symptoms related to child's adjustment to changes in his or her living situation

› **Relevant Diagnostic Assessments and Screening Tools**

- Instruments used to screen/assess for trauma exposure and related symptoms include Acute Stress Checklist (ASC-Kids), Adolescent Dissociative Experiences Scale (A-DES), Child Dissociative Checklist (CDC), Child PTSD Symptom Scale (CPSS), Child Report of Post-traumatic Symptoms (CROPS), Child Sexual Behavior Inventory (CSBI), Childhood Trauma Questionnaire (CTQ), Children's Depression Inventory (CDI2), Children's Impact of Traumatic Events Scale (CITES-2), Children's PTSD Reaction Index (CPTS-R1), Clinician Administered PTSD Scale for Children and Adolescents (CAPS-CA), Diagnostic Interview for Children and Adolescents Acute Stress Disorder Module (DICA-ASD), NCTSN CANS Comprehensive–Trauma Version (CANS Trauma), Parent Report of Post-traumatic Symptoms (PROPS), Posttraumatic Stress Symptoms Scale (PSS-1), Trauma Symptom Checklist for Children (TSCC), Traumatic Events Screening Inventory (TESI), UCLA PTSD Reaction Index–DSM-5 Version
- Instruments used to screen/assess attachment include Attachment Q-Sort (AQS), Working Model of the Child Interview (WMCI), Parent Development Interview, Circle of Security Interview
- Instruments used to screen/assess children's behavior include Ages and Stages Questionnaire (ASQ), Child Behavior Checklist (CBCL), Strengths and Difficulties Questionnaire (SDQ)
- Tools used to assess family/systems relationships include genograms and ecomaps

› **Laboratory and Diagnostic Tests of Interest to the Social Worker**

- Toxicology screen for drug and/or alcohol use

Social Work Treatment Summary

- › Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice
- › Internationally, social workers should practice with awareness of and adherence to the social work principles of respect for human rights and human dignity, social justice, and professional conduct as described in the International Federation of Social Workers (IFSW) Statement of Ethical Principles, as well as the National Code of Ethics that applies in the country in which they practice. For example, in the United States, social workers should adhere to the NASW Code of Ethics core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence; and become knowledgeable of the NASW ethical standards as they apply to clients and practice accordingly (NASW, 2008)
- › Social workers should apply an ecological perspective that encompasses complex interactions of individual, social, and transpersonal factors that impact children and their families, leading to the development of appropriate family-centered services and supports. A complete assessment of each family member is helpful to understand the extent and nature of the effect that child maltreatment and foster care have had on the family and their impact on other life areas. This is essential for careful diagnosis, appropriate case management, and successful intervention
- › Treatment for children who have been maltreated often includes education about trauma, coping skills, creating a trauma narrative, and cognitive restructuring. Through treatment, children learn to recognize what specific stimuli trigger memories of trauma and to develop skills to calm themselves, as well as to address negative thought patterns that perpetuate trauma-related symptoms
- › Many interventions considered to be promising and/or evidence-based are available to treat behavioral and mental health needs of children in foster care
 - Trauma-focused CBT (TF-CBT), the most recognized treatment for child trauma, is used with children aged 3–18 years who have PTSD or other emotional problems related to trauma. TF-CBT integrates cognitive and behavioral interventions with trauma-specific interventions such as psychoeducation about trauma and common reactions, parenting skills to manage emotional and behavioral reactions, individualized stress management techniques and coping skills for child and parent, and development of the trauma narrative, in which the child describes in detail the most significant parts of the trauma(s)
 - Parent-child interaction therapy (PCIT) is an intervention used with children aged 2–12 years with serious behavior issues. During sessions, the therapist coaches the parent in practice interactions with the child from an observation room using a wireless earpiece. Initial sessions are child-directed and focused on relationship enhancement, while latter sessions are parent-directed and focused on behavior management skills
 - Child-parent psychotherapy (CPP) involves working with the parent and child to repair and strengthen the parent-child relationship, help the child feel safer in the parent's care, and address the impact of trauma
 - Attachment and biobehavioral catch-up (ABC) is a home-based intervention designed for very young children (0–2 years) who show signs of attachment difficulties related to maltreatment or disruptions in care. Treatment focuses on assisting

caregivers to interpret the child’s signals in a way that elicits a nurturing response, and to provide a sensitive and responsive environment

- Prolonged exposure therapy for adolescents (PE-A) is utilized with adolescents with a history of trauma and/or PTSD and is designed to reduce avoidance and distress associated with trauma
- Structured psychotherapy for adolescents (SPARCS), a 16-session group model for traumatized adolescents, addresses affect and behavioral regulation, attention, self-perception, relationships, somatization, and systems of meaning
- Eye movement desensitization and reprocessing (EMDR) for children and adolescents is an eight-phase standardized psychotherapy process involving a variety of procedures designed to reduce trauma-related distress
- Dialectical behavior therapy (DBT) is a modification of CBT that may be used with adolescents. Treatment occurs through a combination of group, family, and individual sessions focused on increasing skills in interpersonal relations, distress tolerance, emotional regulation, and mindfulness
- Group treatment programs for sexual abuse have been used to provide psychoeducation, processing, and support in a peer group setting
- Mentors, both formal and natural, have proven beneficial in providing social support for children in foster care
- Pharmacological treatment to help stabilize and/or alleviate symptoms of thought disorders, mood disorders, attention disorders, and/or to regulate hyperarousal (e.g., sleep problems, anxiety)
- Therapeutic foster care, such as Treatment Foster Care Oregon (TFCO) is a family-based treatment model for children with severe emotional and/or behavioral issues

Problem	Goal	Intervention
Child is placed in foster care because of maltreatment	Stabilize, provide services to support mental health	Assess for mental health issues, promptly refer for services as indicated; provide age-appropriate information to support child in adjusting to foster care and coping with grief and loss; ensure that connections with birth family, siblings, schools, and communities are preserved whenever possible
Child exhibits trauma-related symptoms	Reduce distress, support resolution of symptoms	Assess for emotional/behavioral issues related to trauma, address maladaptive beliefs about maltreatment, help child feel safe; refer to therapist appropriately trained to address trauma-related issues; teach parents/caregivers about the effects of trauma and how to respond to trauma-related behaviors; ensure that foster parent is adequately informed of child’s history so he or she can recognize symptoms and provide support

Child has an underlying mental health condition	Support resolution of mental health symptoms, enhance adaptive coping	Refer for services as indicated, including evidence-based mental health treatment, substance abuse treatment if indicated, evaluation for psychotropic medication
Child is exhibiting signs of insecure attachment, atypical attachment behaviors	Improve attachment and emotional and behavioral regulation	Ensure stable primary caregiver; improve caregiver and environmental qualities (e.g., parental sensitivity, predictability, responsiveness to needs, stability), provide psychoeducation and interaction guidance, refer for therapeutic services (CPP, ABC)

Applicable Laws and Regulations

- › Each country has its own standards for cultural competency and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (National Association of Social Workers, British Association of Social Workers, etc.) and practice accordingly
- › In the United States social workers are required to report suspicion of child maltreatment to their state’s designated child protective services agency. Details on each state’s statutes are available at the U.S. Department of Health and Human Services website, <https://www.childwelfare.gov/topics/systemwide/laws-policies/>
- › Federal legislation establishes key mandates that govern the provision of foster care services. Recent concern regarding the well-being of children in foster care is reflected in legislation that addresses their mental health needs
 - The Fostering Connections to Success Act of 2008 (P.L. 110-351) required that states ensure coordination of physical, dental, and mental health services for children in foster care
 - The Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34) established the requirement that states strengthen coordination of healthcare needs for children in foster care, specifically including developmental needs, treatment for trauma, and the use of psychotropic medication
- › The Convention of the Rights of the Child (CRC) is an international human rights treaty that recognizes that every child is entitled to certain basic rights, including that the child’s best interests be the primary concern in making decisions that may affect him or her, the right to be raised by his or her parent(s) or cultural grouping, and the right to have a relationship with his or her parent, even if they are separated
- › The Guidelines for the Alternative Care of Children is an international guide for policy and practice that is focused on the well-being and protection of children who are at risk of and/or deprived of parental care

Available Services and Resources

- › California Evidence-Based Clearinghouse for Child Welfare, <http://www.cebc4cw.org/>
- › National Federation of Families for Children’s Mental Health, <http://www.ffcmh.org/>
- › International Society for Traumatic Stress Studies, <http://www.istss.org/>
- › Mental Health Europe, <http://www.mhe-sme.org/>
- › Treatment Foster Care Oregon, <http://www.tfcOregon.com/what-is-tfco/>
- › National Alliance on Mental Illness, <https://www.nami.org/>
- › National Child Traumatic Stress Network (NCTSN), <http://www.nctsn.org/>
- › National Native Children’s Trauma Center, <https://www.nnctc.org/>
- › SAMHSA’s National Registry of Evidence-Based Programs & Practices, <https://www.samhsa.gov/nrepp>

Food for Thought

- › Although children in foster care utilize mental health services at higher rates than children in the community, a relatively small percentage of those in need receive therapeutic services, and even fewer receive trauma-informed therapies
- › Trauma-related symptoms are more strongly associated with neglect and exposure to intimate partner violence than with other forms of child maltreatment

Red Flags

- › The effects of trauma can mimic mental health conditions, potentially leading to inappropriate treatment approaches. When symptoms are ambiguous, trauma should be addressed first
- › Children in foster care are prescribed psychotropic medications at higher rates than other children. The use of psychotropic medication with children and adolescents should be closely monitored. (Refer to the American Academy of Child & Adolescent Psychiatry publication *A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents*, http://www.aacap.org/App_Themes/AACAP/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf, for additional information)
- › Results from one study indicated that 12% of children ages 6 and younger in foster care for over a year had been taking at least one psychotropic medication. The researchers further stated that those children who begin medications such as antipsychotic drugs at a young age take them for longer periods of time than those who start taking them at a later age (DosReis et al., 2014)
- › Some practitioners have used coercive techniques to treat attachment issues. “Holding therapy,” for instance, involves confrontation and physical restraint of the child in order to break through his or her defenses and provide a “corrective experience”; advocates of such practices also encourage parents to use strict, sometimes harsh, parenting practices to maintain control over the child. Such techniques are not supported by evidence, are considered harmful, and have led to several deaths
- › Results from a study of children in foster care ages 8–11 years old indicated that 21% disclosed a desire for self-harm (Hambrick et al., 2015)

Discharge Planning

- › Ensure that children have a safe, stable living situation and that their ongoing safety is monitored as indicated by assessment
- › Provide linkage to community services, such as referrals for medical, financial, childcare, housing, and educational services; counseling; and support groups as appropriate
- › Provide written information to reinforce verbal education; for instance, parent handouts available through MedLinePlus, <https://medlineplus.gov/childmentalhealth.html>

Note

- › A recent review of the literature has found no updated research evidence on this topic since previous publication on May 6, 2016

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