

Mental Health and Foster Children Facts, figures and Answers to Common Questions

Mental health problems in children

20% of all children will have a psychiatric condition or disorder; for half of those children their problems will significantly interfere with functioning.

Common diagnoses:

ADHD	5-7%
Disruptive behavior disorders	5-8%
Depression	2-3%
Anxiety	5-8%

Most children who have one of these diagnoses will have more than one (be co-morbid).

Rare but serious neurodevelopmental disorders

Schizophrenia	>1%
Bipolar	>1%
Autism	>1%

Foster children's mental health

Foster children, compared to other children have higher rates of the more common mental health conditions/disorders

Not all foster children have mental health disorders and conditions; for those who do, most have problems that can be managed or successfully treated if they receive the right kind of treatment

A small group has serious, multiple problems that are very difficult to manage and for which there are not clear-cut guidelines for effective treatment yet. These children likely require specialized settings and will often continue to have some impairments even with good treatment

Why do foster children have more problems?

Many children come from families with mental illnesses or problems that have a genetic component. Usually they have been exposed to or raised in families where they did not receive consistent nurturing care. In most cases they have been abused, neglected or exposed to violence. Their families were unwilling or unable to care for them.

These are risk factors for mental health problems and conditions in all children but foster children are more likely to have more risk factors and therefore more likely to develop mental health problems.

Simply placing these children in a positive, caring, non violent environment will not usually be enough to eliminate their problems once they have a condition or disorder

What is the DSM and why is a diagnosis so important?

The DSM is the Diagnostic and Statistical Manual produced by the American Psychiatric Association. It is the manual used by all mental health professionals in the US to determine the condition of the child based on the diagnostic criteria. It is similar to the manual used by doctors to decide on a medical diagnosis

The DSM is the result of deliberations by experts for each diagnosis. They review the scientific literature and decide based on the best available evidence what makes a condition or disorder. As evidence changes, diagnostic criteria or categories can change.

What is the purpose of giving a diagnosis?

A diagnosis is intended to give direction for the appropriate treatment. It is supposed to work in the same way that it is important for a doctor to decide whether a person has a virus or an infection because antibiotics work for infections but not viruses. For example, it is important to determine if a child really has ADHD because medication is the correct treatment for ADHD.

Is a diagnosis the whole story?

Absolutely not. If it is not used to help guide treatment then it is irrelevant. And some issues that children have do not fall into diagnostic categories. But the point of an assessment and diagnostic formulation is to help decide what the proper course of treatment is.

What about situations where children are given many different diagnoses?

It is common for children to have more than one diagnosis. But when children are given many diagnoses it may mean that they have multiple problems that cross diagnoses or don't fit into the standard diagnostic categories. The diagnostic system does not work for all children and sometimes multiple diagnoses are a sign of this.

Tips for dealing with questions about diagnosis.

Common sense is a good guide for deciding when to ask more questions. If the diagnosis doesn't seem to fit your experience with the child, if you are not sure what a diagnosis means and especially when children are given more than two diagnoses, that is the time to ask for more explanation. Keep in mind that a diagnosis should not be given if a child does not meet the specific criteria listed in the DSM. The criteria include lists of specific symptoms or behaviors that the provider must have assessed to be present by talking to the child, the caregiver, and sometimes others such as the school and in some cases by the

results of standardized tests. It is perfectly reasonable to ask the provider to describe exactly what symptoms or behaviors led to the diagnosis.

Basic Therapy Principles and Facts:

Therapy happens in the context of a relationship between the mental health professional and the child and family, but the relationship is the vehicle for change not an end in itself. Therapists should not substitute for positive adult relationships in a child's life, nor do they need to spend months establishing the relationship before active therapy begins. The purpose of establishing a therapeutic relationship is so that the child and family is willing to talk openly about problems and needs and becomes motivated to engage in the activities that will lead to change.

Motivation to change is an essential ingredient for therapy to work. No matter how effective the therapy, if the child or family is not interested or willing to do something different, therapy will be ineffective. All therapies are collaboration between the therapists and the clients. For example, medication may be an effective intervention for a condition but if it isn't taken in the right dose and regularly it won't work. The same is true for psychosocial interventions. Effective interventions all involve clients "taking the medicine" in between sessions.

It is not uncommon for children to be unmotivated to change. They may not think they have a problem, think the problem belongs to others or believe it is hopeless to even try. Helping children and families be willing to do something to change is part of a therapist's job. A good therapist will work with the foster family to identify and remove barriers to motivation and engagement.

Effective therapies are relatively short term (< than 6 months in most cases), are structured, target specific problems, and involve teaching new skills that must be practiced in between sessions.

Therapy with children always involves caregivers to some degree in active treatment. Children cannot be "fixed" by a mental health professional because the most important influences on emotional and behavioral problems are the family and the environment.

Effective approaches to treatment of common diagnostic categories.

- **ADHD**

Attention problems that meet the diagnostic criteria are best treated with medication. There are hundred of studies proving that medication works. However, most children with ADHD also have disruptive behavior problems. These problems are treated with psychosocial interventions, either parenting interventions or child skills interventions.

Evidence-based treatment: Medication. There are standards set for what kinds of medications at what dosages are appropriate and what to try if a particular regimen is not

working for the ADHD symptoms. The American Academy of Child and Adolescent Psychiatry is the best reference.

- **Depression and anxiety**

These are mood problems. Depression is treated with antidepressant medication and/or psychosocial interventions. The psychosocial interventions focus on changing negative thoughts, increasing positive activities and/or improving interpersonal skills. Anxiety is primarily treated with psychosocial interventions that focus on teaching anxiety management skills, changing irrational fearful or worrying thoughts, and gradual exposure to the situation or thoughts that are frightening in a safe environment until the fear is conquered. Medication can be helpful in some circumstances. Caregivers need to be involved in the treatment to learn how to help children manage their emotions and carry out the new skills they are taught.

Evidence-based treatments:

Depression: There is some uncertainty in the field at this time about the best approach to treating childhood depression. Studies show that antidepressant medication is helpful especially when combined with Cognitive Behavioral Therapy (CBT). Other studies show that Cognitive Behavioral Therapy or Interpersonal Therapy for Adolescents alone are helpful. But these therapies do not seem to work for all children or work for a while and then the depression reoccurs. It is not clear yet exactly why this is. Some current research is studying ways to improve the effectiveness of CBT. But the best evidence is for one or a combination of these specific therapies. There is also evidence that treating maternal depression with antidepressants improves child depression.

Anxiety Disorders: The effective treatments for anxiety are different versions of Cognitive Behavioral Therapy. There is strong evidence that CBT works well for the variety of anxiety disorders including Posttraumatic Stress Disorder. It is believed that the most important ingredient of CBT for anxiety is some effort to directly confront the thing or situation that is causing the unreasonable level of fear or anxiety. This usually means gradually thinking about, talking about, or practicing being in the situation when it is safe and the child has learned coping skills. For example, for posttraumatic stress, which is a form of anxiety, the fear is for the memory or reminders of the abuse or trauma. That is why talking about it in a safe environment is an important part of the treatment. Over time the connection between fear and the memory wears off.

What is CBT?

CBT is an approach to therapy based on a theory that thoughts, feelings and behaviors are interconnected and influence each other. For example, in depression children often have helpless and hopeless automatic thoughts, feelings of sadness or despair, and the behavior of withdrawal and disengagement from others. Or for example, anxious children have unreasonable ideas about situations or things, feelings of anxiety or worry, and the behavior of avoiding. These negative thoughts, feelings and behavior reinforce each other and keep them going. CBT specifically targets the thoughts, feelings and behaviors to

interrupt these connections. For example, in anxiety, children are helped to have more realistic and helpful thoughts, to learn skills to calm down, relax and manage anxiety, and to approach their fears instead of avoiding them.

CBT treatment will contain a component that explains these connections, a component that teaches children strategies to handle negative emotions, a component that identifies unhelpful or inaccurate thoughts and replaces them with more accurate and helpful thoughts, and a component that teaches skills for new and different ways to behave. Depending on the type of problem, the CBT will target different kinds of thoughts, feelings and behaviors and may emphasize one over the other. In between sessions, children will be asked to practice the new ways of thinking, handling negative emotions and behaving.

CBT is a structured and specific treatment. Children and caregivers are informed about the thought, feeling, behavior connection and the different components. Caregivers have a very important role because they are the ones who help the children practice the new thoughts, emotion management and behaviors.

Disruptive behavior disorders (defiance, disobedience, aggression, anger outbursts, rule breaking behavior).

The primary focus of treatment for these problems is children's relationships with others and the environment. This involves changing the way parents or caregivers respond to the child's behavior, increasing caregiver supervision to keep children away from negative influences, teaching families and children specific skills to solve problems or communicate, and connecting children to positive social experiences including school. Caregivers must be involved and be willing to do things differently for treatment work with these types of problems.

Evidence-based treatments:

Younger Children: Parent Behavior Management programs. There are a number of different proven programs that have somewhat different formats. Examples are Parent Child Interaction Therapy, The Incredible Years, Triple P, and Parenting Wisely. They are all based on the same theory and teach the same basic skills but may be delivered slightly differently.

The interventions focus primarily on helping parents understand and then change the environment's response to the children. Parents learn how children have developed a pattern of behaving badly either to get something they want or to avoid something they don't like. For example, in many children for some reason they have learned to act up, be obnoxious, or refuse to do what they are told as a way of getting caregivers attention. Even though the attention is negative, for young children that is better than no attention. In other cases children have learned that if they just refuse for long enough or make life difficult, their caregivers will give in. Once this pattern has started it can take on a life of its own.

There are 4 main skills that caregivers learn in Parent Behavior Management: consistently praising children (even for just doing what they are supposed to in the beginning), actively ignoring irritating or obnoxious behavior so it gets no attention, giving effective instructions so children will do what they are told, and how to deliver consequences in a way that works.

These interventions focus mainly on working collaboratively with the parents because the goal is to increase the authority and effectiveness of caregivers in managing their children because caregivers are more important to children than other people including therapists. Sometimes it is helpful to also teach children skills to handle their behavior better. For example, when the behavior is anger outbursts in older children, a CBT approach that teaches them to change thoughts about others hostile intent, how to calm down, and the behavior of taking a time out can help. But it doesn't seem to be effective without the Parent Behavior Management Component.

The most important clue to whether the evidence based approach is being used is whether the caregiver is the main person working with the therapist to improve the children's behavior.

Older Children: Multidimensional Treatment Foster Care (MDTFC), Functional Family Therapy (FFT) and Multi-Systemic Therapy (MST). These are all very specific packaged interventions that are only delivered by those who have special training and are authorized to deliver them. These treatments have all been found to be effective with very high risk and difficult adolescents. However, they all are based on similar principles and contain similar components. So variations on these therapies may be offered but without calling them by the copyrighted names.

MDTFC. This is a model for foster care in which the foster home becomes the therapeutic milieu and the foster parent is the primary change agent. Only one child is in the foster home. The foster parents work with a consultant and others to develop a behavior management plan for the child and the consultant is in contact several times a week with the foster parents to help with any problems in carrying out the plan.

FFT. This is a family focused treatment that has 3 phases. In the first phase the therapist helps the adolescent and the caregivers to come to an agreement that both have to do something different to bring about change. In the second phase the family learns some specific skills for problem solving or communication. In the third phase they practice the skills in other situations. The key is learning the specific skills and using them in real life.

MST. This treatment was developed for adolescent offenders with very serious problems. The therapist is available 24/7 to respond to the family and all interventions take place in the natural environment. The first step is a detailed analysis of what is contributing to the child's misbehavior. Then there is a plan to do something about each of the elements that are contributing. Typical targets are increasing parental supervision, getting children away from peers who are a bad influence, and reconnecting kids with normal activities such as school. The idea is to focus specifically on the factors that are connected to bad behavior and replace them with positive alternatives.

Not all families will have access to these copyrighted interventions, but the elements of them are very similar and can be part of any therapy plan. The key things to look for are an analysis of what is contributing to the problem behavior, specific identification of targets, getting an agreement to work on solving the problems, teaching new skills, and changing the child's every day activities to decrease connections to negative influences and increase connections to positive elements.

What to keep in mind for less common but very worrisome or difficult conditions or disorders.

Severe mood swings

These children sometimes get diagnosed with Bi-Polar disorder which they may or may not actually have. What is important is that they are having extreme difficulty handling strong negative emotions. The main strategies are to teach kids skills to manage negative emotions and teach caregivers how to support kids in using their skills and to make sure that the environment does not accidentally reinforce these reactions by giving in on expectations and rules. It is also important to make sure that there are safety plans to handle out of control behavior safely. Medication can be helpful if carefully monitored by a child psychiatrist. For some of these kids there is no known effective treatment

Self harming behavior or suicidality

The behaviors of concern are intentional behavior that is self harmful such as cutting; and thoughts or plans to kill self. They should always be taken seriously and evaluated by a mental health professional.

Intentional self harming behavior is often motivated by wanting to stop feeling bad or not knowing how to decrease intense negative feelings. Although it might seem strange, cutting or hurting oneself can actually temporarily make psychological pain go down. Sometimes it is a way of telling other people how bad it feels. The approach to treatment is to teach children skills to lower distress or to learn to tolerate it without self harm. It is also important to create an environment where children's psychological pain can be heard so they do not need to take such drastic measures. A professional can work with caregivers to devise a system for responding to these behaviors that acknowledges the distress of the child without accidentally reinforcing these behaviors.

In many cases children who have suicidal thoughts are depressed and they have helpless and hopeless thoughts about feeling better. Effective treatment of depression with medication or therapy can lower the feelings and therefore the suicidal thoughts. Occasionally the risk of harm is so great that hospitalization is necessary for protection. But hospitalization is generally a very short term way to stabilize the child. Most of the treatment will need to take place in the community so the child learns to manage situations, feelings and thoughts in a more constructive way.

Serious antisocial behavior

Aggression or law breaking behavior usually leads to involvement in the legal system. In most cases youth will stay in the community or be returned to the community after a short time. There are specific effective treatments for these problems that are becoming more available. The treatments always involve caregivers in a primary role and generally seek to change the environment by doing such things as getting youth away from deviant peers, increasing adult supervision, connecting youth to school and other normal activities and keeping them busy with constructive activities. Individual therapy is not an effective treatment for these behaviors.

Attachment problems

Many children who have been abused or grow up in non nurturing environments are affected in their ability to form and maintain positive relationships. They may develop different ways to adapt to the disappointment they have experienced with caregivers. Some become excessively anxious, demanding and clingy, while others are overly reserved and independent, whereas others become manipulative and superficial. It helps if caregivers can understand these behaviors as ways of coping instead of taking them personally. It may take quite a long time for children to really believe that new caregivers will be different, and in some cases children will have been permanently affected and caregivers will need to make some adjustments in their expectations. Just moving to a new, safe and caring environment will not always be enough to bring about significant change. Treatments that can help involve steady, inconsistent efforts to promote positive interactions. Coercive treatments that involve forcing kids to become connected do not work and can be harmful.

Working with mental health professionals: What foster parents, biological parents and caseworkers should expect

The mental health professional works collaboratively with the foster parent, the biological parents and the caseworkers at all stages of the process. The foster parent is respected as having a very important role in the child's care and efforts are made to identify and address caregiver concerns, barriers to treatment and goals. If there is any plan for the child to return to the biological parents, they are offered the opportunity to participate in the process and informed of what is happening. The caseworker is informed of the diagnosis and treatment plan.

There is an assessment process before treatment starts. This process includes the foster parent in interviews, asks biological parents their views, and makes sure that the caseworker has an opportunity to provide relevant information. The foster parent is informed of the results of the assessment, including the explanation of the diagnosis and discussion of treatment recommendations. When appropriate, the biological parents are also provided this information. The caseworker always receives feedback about the diagnosis and treatment plan.

There is a written treatment plan that targets specific behaviors or symptoms that are identified in the assessment process. It is clear how the treatment will reduce or change the symptoms or behaviors. In most cases it should be clear that there will be some homework or activities that suggested practicing new skills in between sessions.

The foster parent is involved in the treatment process including attending treatment sessions and receiving treatment along with child in order to help address the problems. Typically the younger the child, the less time therapists should spend alone with the child and the more information foster parents should be given about what the child says or does in treatment sessions. Older children need more privacy in their communications with therapists, but foster parents should always is fully informed about progress and concerns.

There is a crisis plan for emergencies in between sessions.

Issues and solutions

Issue: The mental health professional does not provide information, consult with the foster parent, or include them in the care of the child. The same is true for the caseworker.

Solution:

Foster parents. Accompany the child to all treatment sessions, expect and if necessary insist on meeting with the therapies for some or all of the session. Directly ask for answers to specific questions write your questions down and expect answers.

Caseworker: Contact the therapist and ask questions.

Examples of questions:

- Please explain the diagnoses that you have given and the specific symptoms or behaviors that go with the diagnoses?
- What are the specific symptoms or problem behaviors that the treatment will be targeting?
- Describe the specific treatment strategies that you plan to use to help with these symptoms or behaviors?
- How will you be measuring whether the child is improving or benefiting by this treatment?
- What specific actions can I take to help with your treatment plan?

Issue: The child has been going to treatment for many months, doesn't seem to be getting better and mostly just seems to be playing or having a relationship with the mental health professional.

Solution: When children are not making progress after a few months, it is time to stop and reevaluate the treatment plan. It is reasonable for the foster parent or caseworker to request a review of the treatment plan. The foster parent and the caseworker should be involved in discussing possible barriers to progress, and coming up with solutions. When

the foster parent suspects that a child is not benefiting for a particular reason (e.g., child does not seem to have the cognitive capacities to understand the treatment), it is reasonable to expect the treatment provider to explain what adjustments can be made to accommodate the special needs of the particular child. Continuing the same plan should not be an option. When a child has been in therapy for more than a year without progress, it is reasonable to ask for a second opinion since this suggests that the child is either not receiving the appropriate treatment for their problems or that the child has exceptional or extraordinary needs that require a special plan.

Questions to ask:

- I have not noticed any improvement; can you explain why you think X is not making progress?
- I am aware that evidence based therapies usually show improvement after several months, why do you think that is not happening in our situation?
- What do you think could be done to increase the effectiveness of the therapy?
- This therapy does not seem to be working, what are your plans for changing the treatment plan or focus?

Issue: The mental health professional is not familiar with or does not practice the newer more effective therapies.

Solution: The foster parent brings research, articles or information about proven treatments to the attention of the therapist and asks for a discussion of the therapists training, background and familiarity with the treatments. Since not all treatments that are claimed to be effective on the internet or in other media really are proven, it is important that foster parents be open to a frank discussion. Many mental health professionals in public mental health have not received training or supervision to deliver the newer, more effective therapies. In this case, foster parents may need to advocate beyond the individual therapist to the organization, to the agency that placed the child with them or even to advocacy organizations.

Questions to ask:

- I am aware that there are evidence based interventions for different problems. Can you tell me about your training in any of these treatments? Tell me the treatments that you have training to deliver.
- My understanding is that evidence based treatments ordinarily measure progress on the treatment goals using specific measures or standardized assessment instruments. Please tell me how you are measuring progress?
- I am aware that CBT or Parent Behavioral Management are the proven treatments for the diagnosis you have given our child, is that the treatment you are delivering?
- You say you are doing CBT, but my understanding is that CBT involves several specific components and you have not discussed these with me. Can you please tell me about the specific CBT components of the treatment and what my role is?

At the End of the Day

Treating foster children with significant mental health problems is no easy job. The children have ample reasons to have developed problems and for many it will continue to be difficult to accept that their parents could not or would not fix the problems that got them into foster care. No type of therapy can really overcome the blow that this is for children. The bottom line is that some children will do better than others at living with it.

For others, the damage that was already done will not be able to be fully remediated. They will always have a harder time in life and their prospects for happy outcomes diminished no matter how well foster parents, caseworkers, and others do their jobs. Sometimes, it will be necessary to make adjustments in expectations. This does not mean giving up it simply means recognizing that for some children life will always be harder and they will always need extra help.

The service system that exists to help these children and their caregivers is not adequate. Many who work in that system have never received proper training, are poorly paid, do not have high quality supervision, and have never been trained in the evidence based treatments. They are mostly well meaning, caring people doing the best they can within that context.

That does not mean accepting substandard care. It does mean that foster parents and caseworkers should reasonably expect adherence to basic principles of practice that include involvement in children's care and a collaborative, respectful approach. Every provider can do this. It also may mean that foster parents and caseworkers will have to be the force that pressures the public mental health system into delivering the types of mental health care that we now have evidence will make a difference.