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Why Current and Former Recipients of Foster Care Need High Quality Mental Health Services

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Abstract This commentary presents data about the emotional, behavioral, and substance abuse disorders of youth in foster care and former recipients of foster care ("alumni") in the United States to underscore the reasons why high quality mental health services are essential.

Keywords Emotional and behaviorial disorders · Foster care · Foster care alumni · Foster care outcomes

Introduction

The authors in this special journal issue have made an empirical and ethical case for why major changes are needed in the design, funding, implementation, and measurement of mental health services. There are many special groups of people that need these services, including children and their parents who are involved in the child welfare system because of poor mental health functioning.

In this special journal issue Horwitz, Chamberlain, Landsverk, and Mullican outline some of the reasons why effective mental health interventions are needed in child welfare. They also discuss some of the barriers in schools of social work and child welfare agencies to using these evidence-based practices like Multi-Dimensional Treatment Foster Care, Trauma-focused Cognitive Behavior Therapy, and Project Keep for training and supporting foster parents.

Highly efficacious parent training programs are available, have been tested in child welfare agencies and a range of programs is available. I agree with their assertion that infrequent use of evidence-based parent training programs and mental health interventions for both parents *and* children in child welfare is a missed opportunity to improve the lives of hundreds of thousands of children, including foster care alumni. Thus this commentary will focus on the children in foster care and foster care alumni.

Child Maltreatment and Out-of-Home Placement in the United States

The mission of child welfare has long been to respond specifically to the needs of children reported to public child protection agencies as abused or neglected, at risk of child maltreatment, or are a risk to themselves or others because of emotional or behavioral problems. During Federal fiscal year 2007, an estimated 3.2 million U.S. children were reported as abused and neglected, with 794,000 confirmed victims (U.S. Department of Health, Human Services 2009, p. xii.). Child maltreatment often results in delayed physical growth; neurological damage; and mental, emotional and psychological problems, such as depression, substance abuse, eating disorders, violent behavior, and posttraumatic stress disorder—all which may impede development to adulthood (Kendall-Tackett and Giacomoni 2003; National Research Council 2009; Shonkoff and Phillips 2000).

When a child's safety cannot be assured in the home, he or she is often removed by Child Protective Services (CPS). The United States federal government estimated that 463,000 children were placed in foster care in family

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and non-family settings as of September 30, 2008 with about 748,000 children served during the 2008 federal fiscal year.[1] This commentary argues that high quality mental health services provided by agencies accountable for their *quality* and *results* are urgently needed. To that end data about the emotional, behavioral, and substance abuse disorders of children in foster care and former recipients of foster care ("alumni") are summarized.

Emotional/Behavioral Impairment and Length of Stay Have Important Implications

Most children enter foster care because of child abuse or neglect (Berrick et al. 1998; DHHS 2008a). However, a considerable proportion (18%) of children enter care because of behavioral problems; this rises to 50% among children ages 11 and older (James Bell Associates 2004, quoted in Barth et al. 2006), with an even higher proportion of children placed in group care for these reasons.

Although preventing the placement of children in foster care and minimizing their length of stay are child welfare priorities, many children spend a substantial amount of their childhood living in foster care (DHHS 2008b; Wulczyn et al. 2005; Wulczyn et al. 2007). Nearly half of the children who are placed in foster care will remain in care for a year or longer with an average length of stay of 2 years. Of those children in foster care on September 30, 2008, 54% had been there for 12 months or longer. Of those leaving care in fiscal year 2008, *17% had been there for 3 years or more.*[2] Over 26,000 older youth emancipate to adulthood from a foster care setting every year (DHHS 2008b). Children placed in group care have lengths of stay and exit patterns that differ, on average, from those in family foster care (Wulczyn et al. 2007). The substantial length of stay for many children results in greater state responsibility for child well-being, including mental health functioning (Wulczyn 2008; Wulczyn et al. 2009).

[1] These data are from the federal Adoption and Foster Care Analysis and Reporting System (AFCARSs)—which used data from 45 states and other jurisdictions, including Washington, DC and Puerto Rico, to derive these estimates. For total children served in 2008, see: http://www.acf.hhs.gov/programs/cb/stats_research/afcars/trends.htm Note that AFCARS data are periodically updated, therefore, the data cited may not match the data on the current website.

[2] The most accurate and comprehensive length of stay and other placement data, however, are not from point-in-time snapshot studies, but from cohort or administrative data base studies that follow children over time to pick up the dynamics of change. With these data, we see that infants and adolescents spent longer periods in care (Wulczyn et al. 2007).

Effects of Child Maltreatment on Child and Adolescent Mental Health

As Horwitz, Chamberlain, Landsverk, and Mullican mention in their paper in this issue, while many maltreated youth show resilience in the face of adversity, others struggle with mental health problems, risk taking behavior, social disadvantage, and physical health problems. The pathways through which the consequences of maltreatment are manifested are complex, sometimes direct but other times mediated by other maltreatment effects (Kendall-Tackett and Giacomoni 2003). Indeed, increases in aggressive, delinquent, and antisocial behaviors have been noted for children in the general population when exposed to many forms of child maltreatment (Kendall-Tackett and Giacomoni 2003). The next sections presents data from a cross-section of studies of youth in foster care and former recipients of foster care (alumni).

Prevalence of Emotional and Behavioral Disorders among Youth Placed in Foster Care

Rates of Emotional, Behavioral, or Substance Abuse Disorders

As Pecora et al. (2009) observed, most youth in foster care have traumatic family histories and life experiences that result in increased risk for emotional and behavioral disorders. Some of these children develop psychological problems as a result of prior trauma or an accumulation of traumatic stress in their lives (Cook et al. 2007; Walker and Weaver 2007).

Children in foster care are faced with the loss of their birth parents, extended family, and familiar environments. They face challenges of living in the foster care system, which may contribute to or exacerbate behavioral and emotional problems such as placement changes, rejection by foster parents or siblings, the stigma of being in care, and other factors. For example, self-reports of mental health functioning made by older adolescents in foster care have indicated rates of approximately 25% for borderline clinically significant internalizing behavioral problems and 28% for externalizing behavioral problems (Auslander et al. 2002). This is significantly higher than children in the general population.

Other mental health findings are summarized in Table 1. For example, the results from the CFOMH study are similar in many areas to the Midwest Study of 17 year old youth in care in Iowa, Illinois and Wisconsin and what was found in a foster care study of 373 17 year-olds in Missouri, which used the Diagnostic Interview Schedule for DSM-IV. This study, by McMillen et al. (2005), found that three in five youth (61%) had at least one lifetime mental

Table 1 Emotional, behavioral and substance abuse disorders among youth in foster care

Study and sample	Selected findings
National Survey of Child and Adolescent Well-Being (NSCAW): Stahmer et al. (2005) studied a sample of children being served by child welfare who were under the age of six (mean age 2.6 years)	• Based on the Vineland adaptive behavior scale screener (Sparrow et al. 1984), fewer children had difficulty with adaptive behaviors; however, preschoolers (14.9%) were significantly more likely to have adaptive behavior risk than infants and toddlers (6.2%)
	• Behaviorally, approximately 25–30% of the children in both age groups scored in the at-risk range, making this the most prevalent area of difficulty
	• Nearly half (47.9%) of the children aged 2–14 years ($N = 3{,}803$) with completed child welfare investigations had clinically significant emotional or behavioral problems; measured using the Child Behavior Checklist (Achenbach 1991)
Washington State: Brandford and English (2004), in a study of 19–20 year olds	• Although most young adults participated in counseling services, about two in five (42%) had indicators for depression
California: (Clausen et al. 1998) studied 267 children	• Consistently high rates of emotional and behavioral disorders among children in foster care were found using the Child Behavior Checklist, with rates of children in the borderline or clinical range at 2.5 times that found in a general population).
The dosReis et al. (2001) study of 15,507 children receiving medical assistance	• The rate of emotional and behavioral disorders among children in foster care was twice that of youth who were receiving Supplemental Security Income (SSI) and close to 15 times that of children who were receiving other forms of medical assistance
Missouri: A study of 373 17 year old youths in foster care in that used the Diagnostic Interview Schedule for DSM-IV (DIS; McMillen et al. 2005)	• 37% met DSM-IV criteria for a psychiatric diagnosis in the past year and 61% met similar criteria for a lifetime disorder, with the highest rates for disruptive disorders (Conduct Disorder and Oppositional Defiant Disorder), Major Depression, and Attention-Deficit/Hyperactivity Disorder (ADHD). These DIS data were provided through interviews with the youth
The Casey Field Office Mental Health Study (CFOMH) included a sample of 188 14-17 year old adolescents in Casey foster care using the CIDI—the Comprehensive International Diagnostic Interview (White et al. 2007)	• About three in five (63.3%) youth being served by Casey had at least one lifetime CIDI diagnosis and about one in five (22.8%) had three or more lifetime diagnoses
	• The most common lifetime diagnoses were Oppositional Defiant Disorder (29.3%), Conduct Disorder (20.7%), Major Depressive Disorder (19.0%), Major Depressive Episode (19.0%), Panic Attack (18.9%), and Attention-Deficit/Hyperactivity Disorder (ADHD) (15.1%)
	• Over one-third of youth served by Casey (35.8%) reported symptoms indicative of a mental health disorder in the past year, and a much smaller percentage (7.7%) had symptoms indicative of three or more past year mental health problems
	• The most common past year conditions were Major Depressive Disorder (10.9%), Major Depressive Episode (10.9%), Post-Traumatic Stress Disorder (9.3%), Intermittent Explosive Disorder (8.6%), and Conduct Disorder (8.3%)

health disorder (compared to 63.3% in CFOMH) and just over one-third (37%) had at least one past year disorder (compared to 35.8% in CFOMH). The highest rates were for disruptive disorders (Conduct Disorder and Oppositional Defiant Disorder), Major Depression, and ADHD. As Horwitz, Chamberlain, Landsverk, and Mullican mention, over 3 in 4 (77%) of youth in foster care in the Missouri sample had been placed in a residential treatment setting at one time or another. This is sobering and concerning finding, given the level of restrictiveness, mixed effectiveness, and cost of residential treatment care.

Rates of Mental Health Disorders Among Alumni of Foster Care

Horwitz, Chamberlain, Landsverk, and Mullican rightfully focus on the parents and children currently in foster care. But post-permanency mental health services are woefully underdeveloped and are not well-funded, along with services to adult foster care alumni. Data for adult alumni of foster care using well-recognized standardized measures of mental health functioning are rare. The Midwest Study, Northwest Alumni Study, and Casey National Foster Care

Table 2 Emotional, behavioral and substance abuse disorders among foster care alumni

Study and sample	Selected findings
The Midwest Evaluation of the Adult Functioning of Former Foster Youth ("Midwest Study") used of a prospective longitudinal design to assess the mental health of the 17, 19 and 21 year-olds in their sample using the lifetime and 12 month version of the CIDI. (Courtney et al. 2005, 2007)	• The most prevalent lifetime emotional and behavioral disorders in the Midwest Study for the 19 year olds were PTSD, major depression, and alcohol dependence • 14.2% of young women and 4.6% of young men reported symptoms of at least one mental health disorder • Young men (23.2%) in the Midwest Study were more than twice as likely to have an alcohol or other drug diagnosis as their female counterparts (9.2%) • By contrast, young women in the Midwest Study were far more likely than their male counterparts to have a diagnosis of depression (7.6 vs. 1.1%) or post traumatic stress disorder (PTSD) (7.9 vs. 3.8%)
The Northwest Alumni Study ("Northwest Study"), examined outcomes for 479 alumni of foster care ages 20–33 (Pecora et al. 2005, 2010). This study compared the mental health functioning of alumni ages 20–33 who spent 1 year or longer in foster care as adolescents with individuals of a similar age, gender, and race/ethnicity in the general population (from the NCS-R)[a]	• The alumni lifetime prevalence of mental health disorders exceeded the general population on all nine mental health disorders assessed. The prevalence of lifetime PTSD was significantly higher among alumni (30.0%) than among the general population (7.6%)[b] • The prevalence of lifetime major depression was significantly higher among alumni (41.1%) than among the general population (21.0%) • Over one in five alumni had at least one of the following during his or her lifetime: panic syndrome, modified social phobia, or drug dependence
The Casey National Foster Care Alumni Study ("Casey National Study"), presents data collected from case records and interviews about the life experiences, educational achievements, and current functioning of more than a thousand Casey foster care alumni who were served in 23 communities across the country for 1 year or longer between 1966 and 1998. They ranged in age from 20–51 years old. (Pecora et al. 2003)	• Mental health outcomes among alumni appear to be disproportionately poor in comparison to the general population. For example, the 12 month rate of post-traumatic stress disorder (PTSD) among alumni was nearly five times that of the general population and, at 21.5%, exceeded the rates for American war veterans for recent campaigns (Afghanistan—6%; and the first U.S.-Iraq conflict—12-13%)[3] • The twelve-month rate of panic disorder among alumni was over three times that of the general population • Alumni experienced over seven times the rate of drug dependence and nearly two times the rate of alcohol dependence experienced in the general population • The alumni rate of bulimia was seven times higher than in the general population.

[a] The Northwest Study and the NCS-R assessed lifetime and 12 month mental health prevalence rates using the CIDI

[b] The Northwest Study lifetime PTSD rate was comparable to Vietnam War veterans (30.9% for male and 26.9% for female veterans; Kulka et al. 1990

Alumni Study are three recent examples that used large samples. (See Table 2).

For many diagnoses, rates among alumni in the Northwest Study were very concerning. For example, the rate of past year PTSD in the Northwest Study was 25.2% (see Pecora et al. 2010), compared with 9.3% in the Casey CFOMH study, and 7.9% for females and 3.8% for males in the third wave of the Midwest Study which focused on 21 year olds (Courtney et al. 2007).

Discussion

As emphasized by some of the articles in this special journal issue, recent data about the emotional, behavioral, and substance abuse disorders of youth in foster care and alumni underscore the reasons why high quality mental health services are urgently needed. These youth and adults need well-trained and carefully supervised practitioners who can deliver brief but effective interventions while encouraging them to pursue other forms of healing such as participation in social events, sports and the arts, hobbies and clubs. The higher rates of disorders among alumni compared to youth suggests that alumni of foster care may be more at risk for mental health problems than youth still in care. This may be because unresolved issues surface in the difficult years after emancipation, when young adults may not have the means or supports to address them properly (Pecora et al. 2009).

Refinements in screening checklists and diagnostic tools might provide more cost-effective assessment approaches because many youth in care are coping with one or more

[3] For PTSD rates of American war veterans see: Kulka et al. (1990); and Hoge et al. (2004).

emotional or behavioral disorders. The need goes beyond mental health services: What can child welfare systems do with research-based interventions, staff/foster parent training and professionalization of foster parenting to strengthen the capacity of foster parents and child welfare staff to better deal with conduct disorder, affect regulation problems, educational deficits? While there is evidence of some culturally and linguistically competent mental health services (e.g., Huey and Polo 2008), how can more mental health interventions be effective for children of color in foster care?

In many cases, youth are not helped by the current services approach in foster care or mental health, and it is unlikely that improvements in children's mental health services will have much effect unless foster care systems become more therapeutic as discussed in the Horwitz et al. article in this issue and others (Landsverk et al. 2006; McMillen and Raghavan 2009; The REACH Institute, Casey Family Programs and Annie E. Casey Foundation 2008, 2009). With greater dissemination and implementation of research-based interventions for youth and their caregivers, and more careful monitoring, it is expected that more youth who are placed in care will make steady progress and have higher rates of sustained recovery. But that will depend on the availability of an adequately-funded, well-staffed, and a well-trained workforce that has low enough caseloads and the drive to provide high quality services.

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