Sawyer, Michael Gifford; Carbone, Josephine A.; Searle, Amelia Kate; Robinson, Phil J. The mental health and wellbeing of children and adolescents in home-based foster care. Medical Journal of Australia, 2007; 186(4):181-184

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The mental health and wellbeing of children and adolescents in home-based foster care

Michael G Sawyer, Josephine A Carbone, Amelia K Searle and Philip Robinson

ABSTRACT

Objective: To identify the prevalence of mental health problems, rates of suicidal ideation and behaviour, and use of professional mental health services among children and adolescents residing in home-based foster care, and to compare these rates with those reported for children and adolescents in the general Australian community.

Design: Cross-sectional survey.

Participants and setting: 326 children and adolescents (aged 6–17 years) residing in home-based foster care in the Adelaide metropolitan region between August 2004 and January 2006.

Main outcome measures: Prevalence of emotional and behavioural problems, suicidal ideation and behaviour, and use of professional services to obtain help for emotional and behavioural problems.

Results: 61.0% of children and adolescents living in home-based foster care scored above the recommended cut-off for behaviour problems on the Child Behavior Checklist and 35.2% of adolescents scored above the cut-off on the Youth Self Report. 6.7% of 13–17-year olds in home-based foster care reported a suicide attempt that required medical treatment during the previous year. Caregivers reported that 53.4% of children needed professional help for their mental health problems but only 26.9% had obtained help during the previous 6 months.

Conclusion: Children in home-based foster care experience high rates of mental health problems but only a minority receive professional help for their problems.

METHODS

Study sample

The sampling frame for the study included all children and adolescents aged 6–17 years residing in home-based foster care in the Adelaide metropolitan region (effectively the Adelaide Statistical Division) under a Guardianship of the Minister court order, whose cases were managed by one of the 10 metropolitan district offices of Families SA (the state child welfare agency), all of which took part in the study. To ensure that caregivers were sufficiently familiar with participating children to complete the questionnaires appropriately, we also required that children had lived with their caregivers for at least a month.

The community comparison group consisted of all children and adolescents aged 6–17 years who had participated in the Child and Adolescent Component of the National Survey of Mental Health and Well-being. Full details of this community sample are available elsewhere.

Procedure

Data collection took place between August 2004 and January 2006. Several approaches were used to ensure that all eligible children and adolescents were identified, including electronic searches of relevant databases in the central office of Families SA, and reviews of records kept in district offices. To ensure that children had not moved between the time that they were identified as potential participants and the time when questionnaires were completed, data were collected from participants in each district in sequence. A research assistant brought questionnaires to the homes of caregivers who had agreed to participate in the study. Informed consent was obtained from caregivers and older children before the questionnaires were completed.

Questionnaires

Mental health problems

The Child Behavior Checklist (CBCL) was completed by caregivers of all children and adolescents, and the Youth Self Report (YSR) was completed by adolescent participants aged 13–17 years. Ratings on each questionnaire are summarised as a total behaviour score comprising all items on the checklist; an externalising problems score, which rates antisocial or undercontrolled behaviour; and an internalising problems score, which rates inhibited or overcontrolled behaviour. Syndrome scores provide ratings in specific problem areas. For the
**1 Proportion of children and adolescents with scores in the clinical range on the Child Behavior Checklist (CBCL) and the Youth Self Report (YSR)**

<table>
<thead>
<tr>
<th></th>
<th>Children and adolescents (aged 6–17 years)*</th>
<th>Adolescents (aged 13–17 years)†</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home-based foster care (n = 323)‡</td>
<td>Community (n = 3255)</td>
</tr>
<tr>
<td></td>
<td>61.0% (3.2)</td>
<td>14.1% (1.7)</td>
</tr>
<tr>
<td>Externalising problems</td>
<td>60.1% (3.2)</td>
<td>12.7% (1.7)</td>
</tr>
<tr>
<td>Internalising problems</td>
<td>44.9% (3.2)</td>
<td>13.3% (1.7)</td>
</tr>
</tbody>
</table>

- * Denominator in some cells varies slightly due to missing responses.

**Suicidal ideation and behaviour**

Adolescent participants aged 13–17 years completed the Youth Risk Behavior Surveillance System questionnaire, which assesses suicidal ideation and behaviour during the previous 12 months.

**Perceived problems and need for professional help**

Caregivers were asked to identify (by a Yes/No response) whether children and adolescents had emotional or behavioural problems, had more problems than others of the same age and sex, needed professional help for emotional or behavioural problems, and whether they received professional help for their problems. These items have been used in several surveys of child mental health, including the Australian national survey. Adolescent participants aged 13–17 years also responded to these questions about themselves.

**Ethical approval**

The research ethics committees of the Children, Youth and Women’s Health Service, the South Australian Department of Health, and the Aboriginal Health Council of South Australia approved the study.

**Statistical analyses**

Data were analysed using SPSS for Windows, version 12.0 (SPSS Inc, Chicago, Ill, USA). χ² analyses were used to test the statistical significance of differences in the rates of mental health problems in the home-based foster care and community samples. Mann–Whitney U tests were performed to test for the significance of differences in CES-D scores, which were not normally distributed. Confidence intervals around estimates are not presented as some children had the same caregiver, which violated independence assumptions.

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**2 Mean scores (SD) for adolescents (13–17 years old) on the Center for Epidemiologic Studies Depression Scale**

<table>
<thead>
<tr>
<th></th>
<th>Home-based foster care (n = 91)</th>
<th>Community (n = 1251)</th>
<th>z</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>All adolescents</td>
<td>15.0 (10.3)</td>
<td>10.9 (10.4)</td>
<td>−4.89</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Boys</td>
<td>14.5 (8.0)</td>
<td>9.7 (9.8)</td>
<td>−5.13</td>
<td>&lt; 0.001</td>
</tr>
<tr>
<td>Girls</td>
<td>15.7 (12.9)</td>
<td>12.2 (10.7)</td>
<td>22.01</td>
<td>0.04</td>
</tr>
</tbody>
</table>

* Score range is 0–60, with higher scores indicating higher levels of depression.

**3 Number (%) of adolescents (13–17 years old) reporting suicidal ideation and behaviour**

<table>
<thead>
<tr>
<th>Suicidal risk behaviour</th>
<th>Home-based foster care (n = 91)</th>
<th>Community (n = 1269)</th>
<th>χ²</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal ideation</td>
<td>13 (14.4%)</td>
<td>149 (11.8%)</td>
<td>0.4</td>
<td>0.55</td>
</tr>
<tr>
<td>Suicide plan</td>
<td>12 (13.3%)</td>
<td>110 (8.7%)</td>
<td>1.7</td>
<td>0.20</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td>9 (10.0%)</td>
<td>54 (4.3%)</td>
<td>5.0</td>
<td>0.03</td>
</tr>
<tr>
<td>Suicide attempt requiring treatment</td>
<td>6 (6.7%)</td>
<td>11 (0.9%)</td>
<td>18.3</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>

* Denominator in some cells varies slightly due to missing responses.
RESULTS

Demographic characteristics

Four hundred and sixty young people were identified as being eligible to participate in the study. Of these, Families SA district office supervisors excluded 35 because they felt the children were too distressed to participate in the study. Caregivers of 85 children declined to participate, mainly because they felt they lacked the time to complete the study questionnaires, and the caregivers of 14 children could not be contacted. This left 326 participating children and adolescents (71% response rate) who were residing with 234 caregivers. Ninety-one of the 124 participants aged 13–17 years completed the self-report questionnaires (73% response rate).

The mean age of participants was 11.4 years (SD, 3.3); 62% were aged 6–12 years; 54% were male, and 15% were identified as being either Aboriginal or Torres Strait Islander. More than half the children (56%) had been in their current placement for more than 4 years; 31% for 1–3 years; 9% for 6–11 months; and 4% for 1–5 months.

The only significant difference between the study group and the comparison group was that a higher proportion of children in the home-based foster care group had a higher prevalence of attention problems (Box 1). Adolescents in home-based foster care had a higher prevalence of mental health problems reported between males and females in the home-based foster care group. However, children aged 6–12 years in this group had a higher prevalence of attention problems (47.8% v 37.7%) and social problems (46.8% v 33.6%) than the 13–17-year-old adolescents.

Mental health problems

Child Behavior Checklist

Children in home-based foster care consistently had a higher prevalence of mental health problems on all the CBCL scales than children in the community group (Box 1). The proportion of children in home-based foster care with problems on the externalising syndrome scales (such as attention problems, aggressive behaviour and delinquent behaviour) was six to seven times that of children in the community group. Within the home-based foster care group, there were twice as many children with problems on the externalising syndrome scales as those with problems on the internalising syndrome scales (such as withdrawn and anxious/depressed). There was no significant (P<0.05) difference in the prevalence of mental health problems reported between males and females in the home-based foster care group. However, children aged 6–12 years in this group had a higher prevalence of attention problems (47.8% v 37.7%) and social problems (46.8% v 33.6%) than the 13–17-year-old adolescents.

Youth Self Report

The prevalence of mental health problems identified on the YSR by 13–17-year-old adolescents in home-based foster care was also consistently higher than that for adolescents residing in the community (Box 1). However, the differences across the groups were somewhat smaller than those identified on the CBCL. This was particularly evident on the thought problems, withdrawn and anxious/depressed scales. Consistent with results on the CBCL, adolescents in the home-based foster care group had a higher prevalence of problems on externalising syndrome scales than on internalising syndrome scales. Once again, there were no significant differences between the prevalences reported for males and females in the home-based foster care group.

Depression

Adolescents in home-based foster care had a significantly higher mean CES-D score than those in the community (Box 2). This difference between mean CES-D scores across the foster care and community groups was particularly evident for boys. There was no significant difference between the mean CES-D scores for boys and girls within the home-based foster care group.

Suicidal behaviour and ideation

A significantly higher proportion of 13–17-year-olds in home-based foster care than in the community reported attempting suicide in the past year (Box 3). Adolescents in home-based foster care also reported much higher rates of suicide attempts that resulted in an injury, poisoning or overdose requiring treatment by a doctor or nurse.

Perceived problems and need for professional help

Significantly more adolescents in home-based foster care than in the community were perceived by caregivers as having emotional and behavioural problems and needing professional help for their problems (Box 4). However, only half of those living in home-based foster care who were identified by caregivers as needing professional help had received it during the previous 6 months. In this area, there was a somewhat different pattern reported by caregivers and adolescents. Among caregivers who reported that their child or adolescent needed help, 50% in the foster care group and 49% in the community group reported that help had been received (χ² = 0.33). However, among adolescents who reported needing help, 65% in the foster care group versus 29% in the community group reported that they had received help (χ² = 7.6; P < 0.01). Adolescents in home-based foster care reported somewhat lower rates of problems than their caregivers did, but the pattern of findings was very similar to that reported by caregivers.

### 4 Proportion of children and adolescents reported as having emotional and behavioural problems, needing professional help, and obtaining professional help during the previous 6 months

<table>
<thead>
<tr>
<th></th>
<th>Caregiver report</th>
<th>Adolescent report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home-based foster care (n = 323)</td>
<td>Community (n = 3272)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>χ²</td>
</tr>
<tr>
<td>Emotional and behavioural problems</td>
<td>69.3%</td>
<td>24.4%</td>
</tr>
<tr>
<td>More emotional/behavioural problems than peers</td>
<td>55.4%</td>
<td>11.9%</td>
</tr>
<tr>
<td>Professional help needed</td>
<td>53.4%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Professional help obtained</td>
<td>26.9%</td>
<td>4.7%</td>
</tr>
<tr>
<td></td>
<td>Home-based foster care (n = 91)</td>
<td>Community (n = 1216)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>χ²</td>
</tr>
<tr>
<td>Emotional and behavioural problems</td>
<td>40.7%</td>
<td>25.8%</td>
</tr>
<tr>
<td>More emotional/behavioural problems than peers</td>
<td>20.9%</td>
<td>14.1%</td>
</tr>
<tr>
<td>Professional help needed</td>
<td>21.9%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Professional help obtained</td>
<td>14.3%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

*Three of the 326 caregiver reports were not properly completed.*
DISCUSSION

We found that the prevalence of mental health problems experienced by children and adolescents in home-based foster care was two to five times higher than that reported in the National Survey of Mental Health and Well-being for children and adolescents in the general population.13 Externalising problems, such as attention problems, delinquent problems and social problems, were more common than internalising problems, such as anxiety and depression. We also found evidence that younger children had higher rates of attention problems and social problems than older children. Rates of serious suicide attempts were much higher than those reported for adolescents in the community.11 and only a minority of those in foster care had received professional help for their problems.

Strengths of our study are its high response rate, the use of two informants to assess mental health problems among adolescent participants, and the availability of a comparison group assessed using the same measures.

Limitations of our study include its focus on a single metropolitan region and the use of self-report measures, rather than structured diagnostic interviews, to assess mental health problems. As most participants had resided in their current placement for several years, it cannot be assumed that the results apply to children or adolescents who spend short periods of time in multiple placements. Furthermore, children identified as being too distressed to participate were excluded. If these groups of children had been included in the study, it is likely that we would have identified an even higher prevalence of mental health problems.

Many children taken into the welfare system have experienced physical or sexual abuse, and major family discord.16 In light of this, it is not surprising that we found a high prevalence of mental health problems. Of particular concern is the high prevalence of disruptive behaviour problems, which often persist into adulthood, cause substantial distress to individuals and their families, and are a significant economic burden on the whole community.17

Our findings provide a major challenge for the community and for welfare services. Australia relies heavily on volunteer caregivers to provide homes for children and adolescents in the welfare system. While home-based foster care remains the preferred alter-

native for the care of these young people, many caregivers are being expected to provide homes for children and adolescents with serious psychiatric disorders. It is unrealistic to expect volunteer caregivers to provide 24-hour care and support for these young people unless they receive high-quality professional support and adequate respite. Welfare staff are struggling to cope with large numbers of children and adolescents with severe mental health problems, declining numbers of suitable placements to accommodate them, and difficulty accessing professional help for them. The relatively high proportion of children and adolescents in both the foster care and community groups who had not accessed professional help suggests that there are generic problems in access to care, rather than a specific problem for those in home-based foster care.

There is a great need to develop and evaluate new interventions to address the mental health problems experienced by these young people.

ACKNOWLEDGEMENTS

The study was funded by the Australian Rotary Health Research Fund. The authors wish to thank Dr Peter Baghurst for his advice about statistical analyses and staff at Families SA for their help conducting the study.

COMPETING INTERESTS

The Australian Rotary Health Research Fund and the Adelaide University Faculty of Health Sciences divisional scholarship provided funding for the study and research support, but had no role in study design, data collection, analysis or interpretation, or writing or publication of the article.

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REFERENCES