South London and Maudsley NHS
NHS Foundation Trust

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National Services
A resource for mental health professionals

Promoting individualized, evidence-based mental health care for Adopted Children

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"Adoption? It's hardly an illness is it?"

…from an adult psychiatrist in specialist psychosis service facing huge cuts

No not an illness, but an **opportunity**

–With the right support, right place & right times

- Not "an illness" and definitely not a single disorder with a single treatment
- So what should a specialist NHS mental health adoption service do?

What are the likely common disorders in adopted children?

- Poor mental health data for UK adopted children
  - A need for <u>well designed</u> research…
- But UK adopted children largely from Looked After Children (LAC) & have experienced maltreatment / neglect
  - Excellent epidemiological data for UK LAC
    - From the Office of National Statistics (ONS) study

Mental Health in UK LAC, Ford et al 2007

	Birth family	High Risk	ONS LAC
Any disorder	8.5%	14.6%	46%
Anxiety disorders	3.6%	5.5%	11%
PTSD	0.1%	0.5%	2%
Depression	0.9%	1.2%	3%
Behavioural disorders	4.3%	9.7%	39%
ADHD	1.1%	1.3%	9%
ASD	0.3%	0.1%	2.6%
Neurodevelopmental	3.3%	4.5%	12.8%
Learning disability	1.5%	1.5%	10.7%

Comparing ONS LAC data with Tier 4 Adoption & Fostering Service (AFS)

(Woolgar & Baldock, 2014)

	ONS LAC	N&S Adoption & Fostering	CAMHS Referrals
Any disorder	46%	66%	31%
Anxiety disorders	11%	9%	5%
PTSD	2%	3%	1%
Depression	3%	4%	1%
Behavioural disorders	39%	**55%**	**4%**
ADHD	9%	**38%**	12%
ASD	2.6%	4%	4%
Neurodevelopmental	12.8%	12%	0%
Learning disability	10.7%	10%	3%

General CAMHS services for adoption & fostering

- CAMHS services especially under-identifying
  - Behavioural problems
  - Neurodevelopmental problems
    - ADHD
    - Global learning disability
    - Neurodevelopmental issues (e.g., tics etc)
    - Specific learning disability (e.g., dyslexia)

‘The allure of rare disorders’ in maltreated children (Haugaard, 2004)

‘Although more common diagnoses, such as *ADHD*, *Conduct Disorder*, *PTSD*, or adjustment disorder, may be less exciting, they should be considered as **first line diagnoses** before contemplating any rare condition such as RAD or an unspecified attachment disorder…’

Chaffin et al, 2006 (APSAC)

Looking at the science

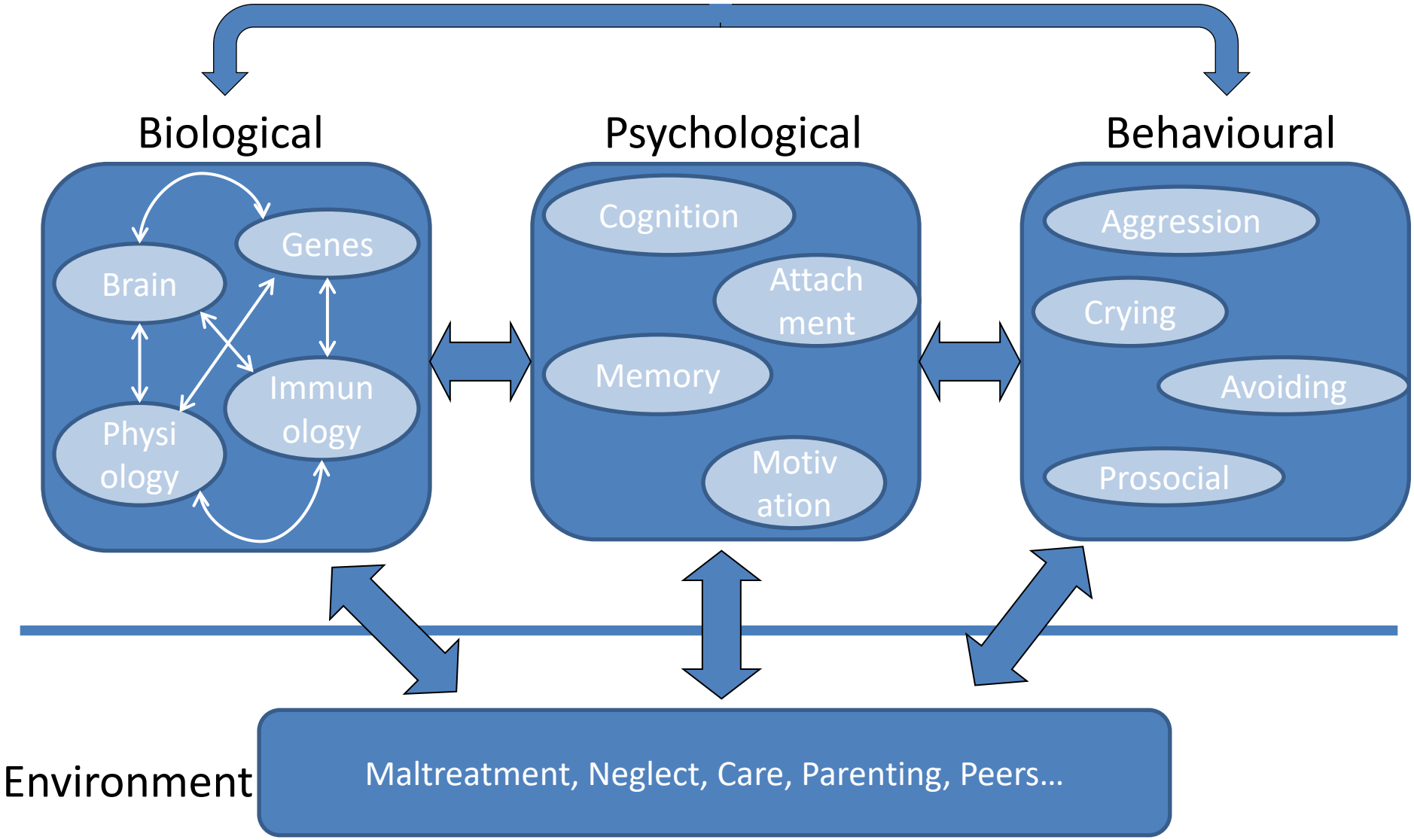
- Children are individuals, not defined by adoption
- Maltreatment and neglect can make children more different than similar!!
  - Not just 'brain damage' – not just the brain and not just damage… [adaptation??]
  - Huge Individual Differences in response to early experiences
  - Quality of early experiences highly varied anyway...
- Need to focus on individuals & their specific history

Each child is unique

- Each Adopted child has a unique history & formulation: avoid simplistic ‘neuro’ accounts
- Complex, individual specific pathways…
- Cannot lump all Adopted Children together
  - Different ages/different types/different gender…
- “Because she is adopted she is X…”
    - Traumatised
    - Brain different
    - Attachment problems
    - Anxious
    - Shameful
    - Without even seeing her, I can tell you she needs ‘Y’

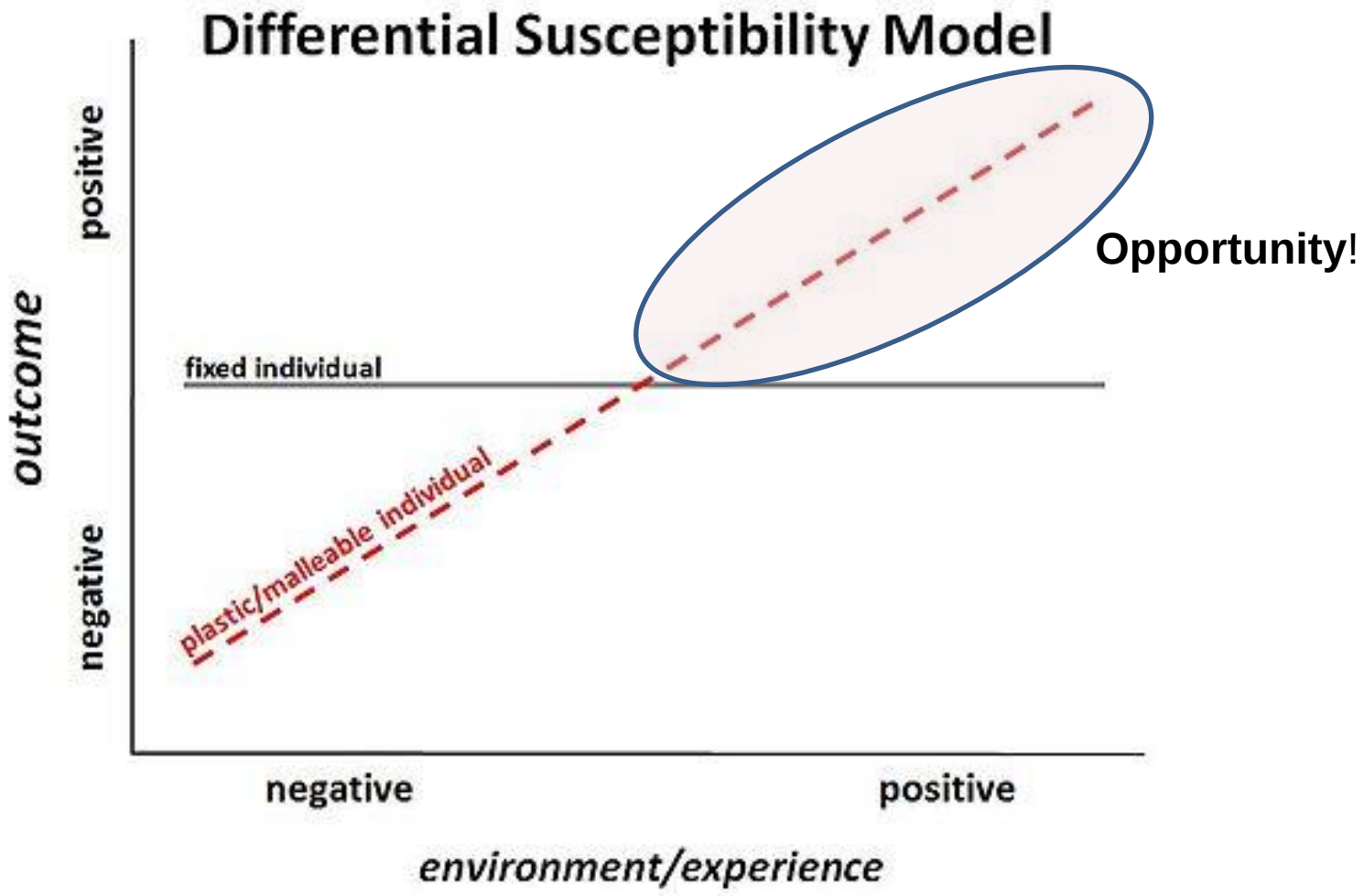
Maltreatment impacts upon many levels

(Woolgar 2013)



Differential Susceptibility

People differ [e.g., genetically] in how much they respond to **both** positive & negative experiences (Belsky & Pluess, 2009)



Responses are Individual

- A bigger dose of stress is worse on average

- But response to stress varies
  - Susceptible child may show big problems from 'only a small dose' of maltreatment [*Orchid*]
  - 'Fixed' child may be resilient to a large 'dose' [*Dandelion*]
- But response to treatment can also vary
  - Susceptible child may respond rapidly to small intervention: **if** precisely tailored to his/her needs
  - Resilient child may show much smaller response

Differential susceptibility in siblings

- Boy is older & was exposed to significantly higher level of maltreatment but doing okay now
  - Great effort expended to address his greater trauma
  - Not bothered either way by treatment so far
  - [Dandelion]

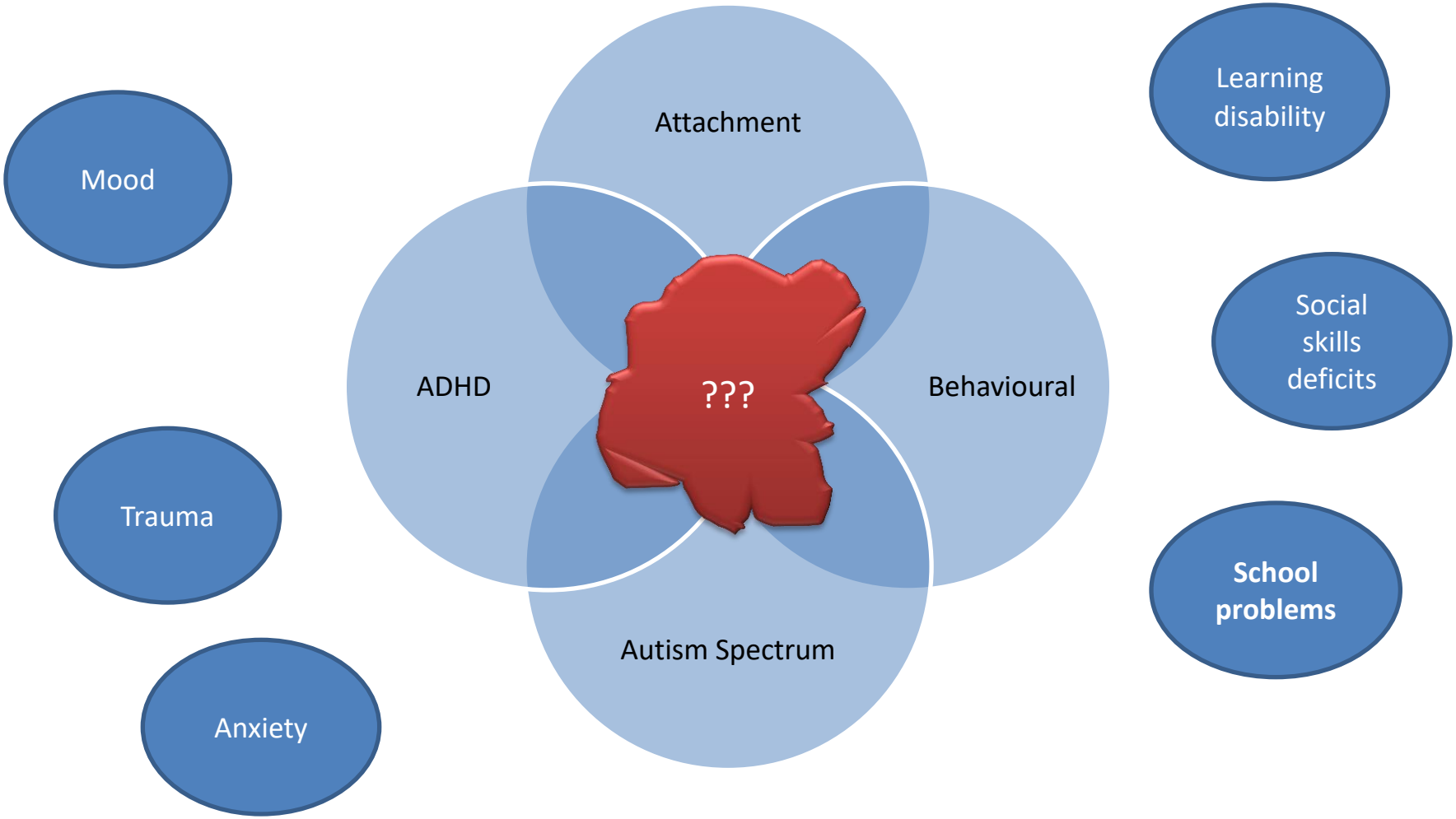
- Younger girl had ‘less’ maltreatment, yet struggling in all domains, except with some peers
  - Challenging to family & system [“needy” & volatile]
  - Very keen for treatment – sensitive, curious & rewarding
  - Great potential, but how to help her…? [Orchid]

Summary of what we know

- Clear & marked risk for common mental health disorders for children adopted from care
- Complex and individual bio-psycho-social presentations can emerge from maltreatment
  - So much more than ‘just’ a damaged brain
- Unique and subtle presentations with individual responses to **extent** [dose] of maltreatment
  - Biology responds to adversity with diversity
- Cannot lump together all Adopted Children’s needs
  - Need a **personalised** approach to service delivery

Unusual & unique presentations

(in which common disorders still identifiable)



What is needed for specialist CAMHS assessment?

- Children exposed to maltreatment & neglect who may have attachment problems:
- Need for expert assessment and differential diagnosis & adoption specific formulations / care plans, based on current evidence
  - "Treatment… should be based on a careful assessment conducted by a qualified mental health professional with expertise in differential diagnosis and child development" (Chaffin et al, 2006, p87)

NHS National & Specialist (Tier 4) Adoption Service model

http://www.nationaladoptionandfosteringclinic.com/

- Multi disciplinary assessment
  - Personalised bio-psycho-social formulation
  - Prioritise common disorders, even if low threshold
- Develop personalised care plan (& revisit)
- Liaise with network, especially school
- Primary therapeutic input is the **Carers**, but various evidence based treatments can support them in this task by addressing complexity.

Complexity in practice: 10 year-old adopted boy

- 'help with school; they just don't get him'
- Domestic violence in utero & polysubstance misuse; 3 week detox in SCBU; adopted by his first carer
- History of multiple NHS CAMHS contacts
  - Series of Tier 3 assessments over 5 years, discrepant diagnoses each discounting the previous ones
    1. ADHD, no autism
    2. Autism, no ADHD
    3. ADHD again, but no autism
    4. Behavioural problems & poor parenting, but no ADHD or autism
  - Not meeting high CAMHS thresholds – so no treatment
  - Parent bemused, angry & let down

NHS National & Specialist (Tier 4) Adoption Service Assessment

- Few problems at home
  - Mother very clear & uses visual aids to help understanding

- School 'hate' him [evidenced in their report]
  - Disagree that he has any mental health issues [he has several]
  - Blame mother's parenting [No, just her committed advocacy]
  - Low academic expectations [but normal IQ, so school **failing**]

- Outcome
  - Complex but **subtle** neurodevelopmental profile
  - Several common disorders, low threshold but cumulative high needs
  - Requires substantial school support
  - Liaison with school to explain profile – not a 'horrid' child
  - Support School Action/Statementing processes

Working with complex (developmental) trauma

(Bodinetz, Pinto & Woolgar, in prep)

- Teenage girl, adopted >8 years old
  - Unusually extreme & sadistic physical / sexual abuse
- Seen in CAMHS for nearly 3 years, but 'supportive' interventions [first referral to our clinic at the time of adoption was not permitted]
  - Saw several therapists; system overwhelmed by her traumatic story
  - When referred to us we were requested by the current service not to ask her about trauma in case it upsets her
- Complex range of problems but with defiant & disruptive behaviour parents' primary concern at presentation

Working with trauma - II

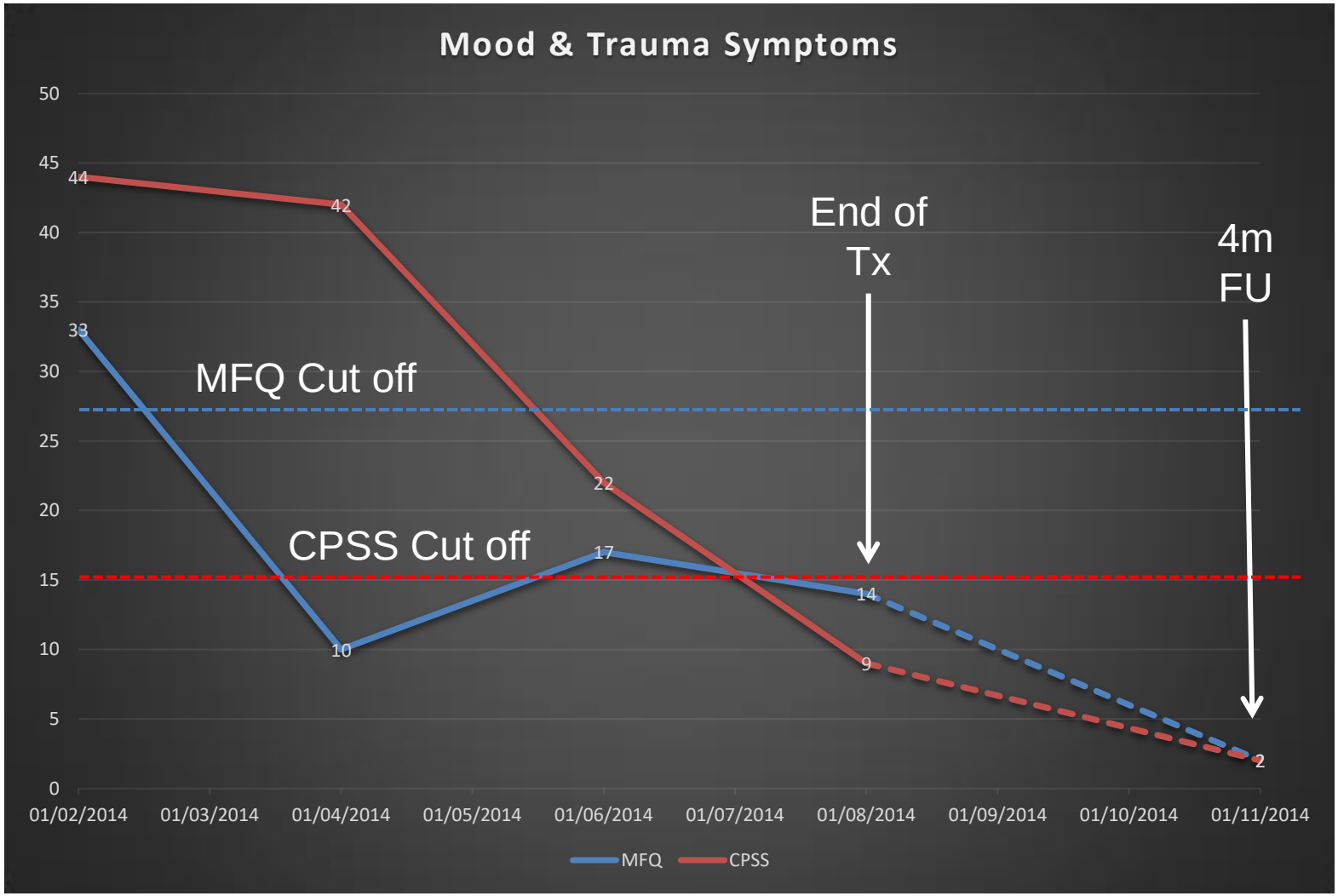
- Asked in first session about her trauma history
  - “Please can I talk about it…!” [listen to me… please don’t be scared of it]
  - Teens know you know their history – being open is honest
- Assessment showed
  - Depressed mood
  - Significant behaviour problems @ home & school
  - Full blown PTSD [mood & behaviour ‘secondary’ to trauma]
- High IQ, but unable to function in school
  - Encouraged to know something worth working towards

Working with trauma - III

- **PTSD** [current reliving, avoidance, 'hyperarousal' etc of trauma] headline problem; Trauma focussed CBT
  - First stage – Mood Stabilisation [CBT & Mindfulness] 2 months in – mood back to normal levels
  - Second stage Trauma Focussed CBT [Narrative Exposure] below cut-off by 4 months [included a trial]

- **Conduct problems** Social Learning Theory approach, to support parents to manage behavioural problems, plus help them with:
  - Extreme responses to small triggers – discriminate trauma features from being a teenager?
  - Facilitate communication between girl & parents, as she understands more about her mood and her behaviour

Outcomes for weekly EBT over 8 months



Building effective services

Complexity & individuality

- Adopted children with mental health problems may need comprehensive expert assessment & biopsychosocial formulation because of their complexity & **individuality**
- But not all will need such assessments
- Single "One size fits all" services inefficient – need an open mind & relentless curiosity about diversity
- The science promotes a diverse & flexible model
- Likely to need a range of different services, at different times, in different settings, from different providers working together for the child

Readings

- **Chaffin, M., Hanson, R., Saunders, B. E., Nichols, T., Barnett, D., Zeanah, C., et al. (2006). Report of the APSAC Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems. *Child Maltreatment, 11*, 76-89.**
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