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 well designed 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

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Birth family</th>
<th>High Risk</th>
<th>ONS LAC</th>
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<tbody>
<tr>
<td>Any disorder</td>
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<td>14.6%</td>
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<tr>
<td>Anxiety disorders</td>
<td>3.6%</td>
<td>5.5%</td>
<td>11%</td>
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<tr>
<td>PTSD</td>
<td>0.1%</td>
<td>0.5%</td>
<td>2%</td>
</tr>
<tr>
<td>Depression</td>
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<td>1.2%</td>
<td>3%</td>
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<tr>
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<td>39%</td>
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<tr>
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<td>1.3%</td>
<td>9%</td>
</tr>
<tr>
<td>ASD</td>
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<td>0.1%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Neurodevelopmental</td>
<td>3.3%</td>
<td>4.5%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Learning disability</td>
<td>1.5%</td>
<td>1.5%</td>
<td>10.7%</td>
</tr>
</tbody>
</table>
Comparing ONS LAC data with Tier 4 Adoption & Fostering Service (AFS)  
(Woolgar & Baldock, 2014)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>ONS LAC</th>
<th>N&amp;S Adoption &amp; Fostering</th>
<th>CAMHS Referrals</th>
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<td>31%</td>
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<tr>
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<td>3%</td>
<td>1%</td>
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<td>4%</td>
<td>1%</td>
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<td>55%</td>
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</tr>
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<td>9%</td>
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<td>Neurodevelopmental</td>
<td>12.8%</td>
<td>12%</td>
<td>0%</td>
</tr>
<tr>
<td>Learning disability</td>
<td>10.7%</td>
<td>10%</td>
<td>3%</td>
</tr>
</tbody>
</table>
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)

Environmental factors such as maltreatment, neglect, care, parenting, and peers affect various levels:

- **Biological**
  - Brain
  - Genes
  - Immunology

- **Psychological**
  - Cognition
  - Attachment
  - Memory
  - Motivation

- **Behavioural**
  - Aggression
  - Crying
  - Avoiding
  - Prosocial

These levels are interconnected, highlighting the complex interplay between environmental factors and psychological outcomes.
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)

- Autism Spectrum
- ADHD
- Behavioural
- Learning disability
- Social skills deficits
- School problems
- Anxiety
- Trauma
- Mood
- Attachment
- Autism Spectrum
- School problems
- Learning disability
- Social skills deficits
- Anxiety
- Trauma
- Mood
- Attachment
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