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Children in care have a high risk of mental illness as adolescents and young adults

Research question What happens to the mental health of children who are in some form of care before they reach 13 years?

Answer They are at least four times more likely than their peers to develop a serious psychiatric problem or to attempt suicide later on

Why did the authors do the study? Some evidence indicates that children who need foster care have a high risk of suicide later in life. But there are few large scale studies looking at the link between welfare (usually fostering) and other mental health outcomes, including attempted suicide. It's also unclear how these children compare with children who are adopted from abroad, which is a common practice in Sweden.

What did they do? They studied everyone born in Sweden between 1973 and 1982 including 22 305 people who had been in care (usually with foster parents) for at least a short time before the age of 13 years. They also studied another 12 240 people who had been adopted from abroad before the age of 7 years. The authors compared what happened to these children by deriving risk ratios standardised for age and sex and focusing on suicide attempts and admissions to hospital for any psychiatric illness. All their data came from publicly maintained national registers, including a register of all hospital discharge diagnoses, and a register of children who needed welfare interventions such as fostering. They looked particularly at what happened to children while they were still under the jurisdiction of the child welfare authorities (ages 13 to 17), and afterwards (ages 18 to 27).

What did they find? Those who had been in care as children were four to five times more likely than their peers to attempt suicide as an adolescent or young adult. They were five to eight times more likely to be admitted to hospital with a mental illness in their teenage years, and four to six times more likely to be admitted with a mental illness in early adulthood. Children in long term foster care had the worst outcomes (risk ratio 7.5, 95% CI 6.3 to 9.0 for any mental illness). The excess risk associated with childhood care fell to around double when the figures were adjusted for mental illness in the birth parents and birth parents' social circumstances. Generally, those who had been in care did worse than children who had been adopted from abroad. Risk ratios were between 1.5 and 2.3 for most measures comparing these two groups.

What does it mean? Swedish children who are in care for even a short time have a high risk of serious mental illness later on. It may be even higher than these findings suggest because these authors were able to study episodes that needed admission to hospital only.

Children in long term care (>60 months) did worst of all. The authors say these children should be monitored more closely for signs of mental illness, and be treated urgently when signs do occur. It might also help to give foster parents better training in mental health.

Vinnerljung B, et al. *J Child Psychol Psychiatry* 2006;47:723-33

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Editor's choice

Can we tame the monster?

What can we learn from the *New England Journal of Medicine*'s correction last week of its study on rofecoxib (*BMJ* 2006;333:12, 1 Jul)? The simple message is that increased cardiovascular risks were visible as early as four months into treatment, rather than the 18 months that Merck had claimed. But rofecoxib was withdrawn two years ago, so why all the fuss?

Well, reputations are at stake. The journal wants to show that it had made no mistakes in peer reviewing the study. And Merck, having already incurred financial loss, needs to protect its share price. But the stand-off between journal and drug company is just one symptom of a wider disease: an overpowerful, under-regulated drug industry and a research establishment and publishing industry in its thrall.

Between the interests of the public and the commercial interests of drug companies stand two potential safeguards—journal peer review and drug regulation. The pressures on journals to publish drug industry trials include the need for newsworthy content and revenues from reprint sales. These pressures are intensifying, and recent examples of selective reporting and data manipulation have made clear that peer review in its current form is unequal to the task. Writing in *PLoS Clinical Trials* (2006;1:e6) in May, Richard Smith and Ian Roberts proposed a different model for disseminating the results of clinical trials. Protocols and analyses would be prespecified and posted for discussion, and full datasets would be uploaded on completion of the trial. The role of journals would be limited to providing commentaries. Is this feasible? Is it the answer?

Drug regulators too seem unequal to their task. Critics focus on their close relationship with industry; their lack of transparency; their lack of systematic post marketing surveillance; and an emphasis on efficacy over patient safety, which favours industry. In this week's *BMJ*, David Healy examines how the regulators failed to highlight the risks of selective serotonin reuptake inhibitors in depression (p 92). The US Food and Drug Administration has taken steps to reform, but critics want more. Writing in the *New England Journal of Medicine*, Wayne Ray and colleagues call for the establishment of three independent centres in charge of drug approval, postmarketing studies, and drug information (2006;354:194-5). As for the UK Medicines and Healthcare Products Regulatory Agency, it is seen by many as unaccountable, slow, and lacking the necessary expertise. It too needs urgent review and reform.

I suggest a more radical solution. As with most good ideas, it is not mine alone. Marcia Angell (personal communication) and Des Spence (*BMJ* 2006;332:1155-6, 13 May) have also had it, but here is my version. Drug companies should not be allowed to evaluate their own products. To get their products licensed they would contribute to a central pot for independent, publicly funded clinical trials. Is this feasible? Is it the answer?

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