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Moira Szilagyi

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The Pediatric Role in the Care of Children in Foster and Kinship Care

Moira Szilagyi, MD, PhD*

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Educational Gap

In September 2010, 408,425 children and adolescents resided in foster care. Recent legislation highlights an increasing focus on involving pediatricians in supporting children in foster care and defines specific requirements relevant to the role of pediatricians.

Objectives After completing this article, readers should be able to:

1. Understand the purposes of foster care and the problems associated with pre-placement childhood trauma and foster care placement.
2. Know the basics of how foster care systems work.
3. Recognize that children in foster care are by definition children with special health-care needs.
4. Understand that many children in foster care have behavioral problems that can lead to placement instability that, in turn, can exacerbate those problems.
5. Understand the physician's role in foster care.

Foster care is intended to provide a temporary haven for children during a time of family crisis when children are at imminent risk for harm. The goals of foster care are to promote child health, safety, permanency, and well-being. Foster care also has the mission of building on family strengths and providing birth parents with the services they need to reconnect (reunify) with their children. Because children fare best in stable and nurturing families, there has been an increased emphasis in the past decade on shortening the time to permanency through reunification, placement with relatives, and adoption. Foster care also has the obligation to prepare youth for independent living when none of these permanency options is possible.

The Impact of Kinship Care on Foster Care

In some states, more than one third of children in foster care are in court-ordered (formal) kinship placements, arrangements in which the related (kin) caregiver may or may not be a certified foster parent. Even outside the child welfare system, somewhere between 4% and 8% of children reside with members of their extended family, neighbors, or friends for a variety of reasons.

During the past decade, several studies were published reporting that children experience greater placement stability in kinship care than in nonrelative foster care, and that kin caregivers report fewer child behavior problems. Other data indicate that children in kinship care have as many issues as children in foster care, and that kinship caregivers are older, are less healthy, and have less access to services than nonrelative foster parents. However, recognizing that maintaining a child's ties to his or her family of origin holds advantages for the child, relatively more children are being placed in kinship care as a result of child protective investigation.

Other children are spending brief amounts of time in foster care while child welfare attempts to identify and investigate kinship resources. The definition of kin has expanded to include nonrelatives, such as family friends, acquaintances, and neighbors. There is little information about the outcomes of reunification with parents or kinship care, including child health and mental health outcomes and the percentage of kinship homes that undergo disruption. The vast majority of kinship placements are without oversight or subsidy,

*Starlight Pediatrics, Rochester, NY.

although recent federal legislation was intended to improve financial support for this group of caregivers.

Health Issues of Children in Foster Care

Children in foster care are classified as children who have special health-care needs by the American Academy of Pediatrics (AAP) because of their high prevalence of medical, emotional, behavioral, developmental, educational, and dental health-care problems. Most pediatric practitioners will encounter children and adolescents in foster or kinship care in their practices. It is important that pediatricians be familiar with the effects of childhood trauma and adversity, separation from family, and ongoing uncertainty on child behavior, mental health, and development.

Pediatricians are in a unique position to identify problems, make appropriate referrals, and offer support and advice to caregivers. Foster care ideally should be developmentally appropriate and child-centered, and pediatricians can play a crucial role in offering developmentally sound advice and emotional support to caregivers about parenting traumatized children and children who have significant behavior problems. Pediatricians also should suggest ways to promote placement stability and successful permanency.

Most maltreated children are not removed from their birth parents, but they appear to have the same health issues as children in foster and kinship care. The knowledge and skills that pediatricians bring to the care of children in foster and kinship care also apply to the larger population of children whose families are involved with child welfare agencies.

Epidemiology

Of 3.3 million child abuse and neglect reports in 2010, 436,321 (22%) were substantiated, and 254,000 children were removed to foster care. Over the past decade, the increasing trend toward keeping children with their birth parents or with kin caregivers after child protective investigation has reduced the total number of children in foster care. In the United States, on September 30, 2010, 408,425 children and adolescents resided in foster care, 26% in a relative (kinship) foster home, 48% in a nonrelative foster home, and 9% in either a group home or residential care setting. Of the remainder, 4% lived with a preadoptive family, 5% were on a trial discharge with their parents, and 2% were listed as “run-away.”

Estimates suggest that more than 700,000 individual children have spent some time in foster care during the preceding 12 months. Census data indicate that approximately four to eight times as many children and teenagers live in informal, unregulated kinship care without

child welfare involvement. Approximately 40% of those in foster care are teenagers, whereas 30% are children under age 5 years. Children in foster care range in age from birth to 21 years, although 47 states still emancipate adolescents at age 18 years.

Minorities are represented prominently in foster care. In 2010, 29% of children were of African American heritage, 21% Hispanic, 41% white, and 5% of two or more races. Significant concern exists that the overrepresentation of minority children reflects bias in child protective referrals, investigation, and removal, as well as a lower likelihood of reunification after removal.

Discrete subpopulations in foster care that present with unique health needs include children who have multiple handicaps, teenagers involved with juvenile justice, pregnant and parenting teenagers, and unaccompanied refugee minors from countries ravaged by war or severe internal strife.

The average length of stay in foster care in 2010 was 25 months, with a median of 14.5 months. The lower median is attributed to more intensive permanency planning, resulting in shorter times to reunification or placement with extended family. However, the higher mean is affected by the 25% of children who remain in care for years.

Length of stay is affected by several factors: the biological family's cooperation with the individualized case plan for their family; the availability of appropriate extended family to care for the child; diligence in permanency planning by child welfare; and the challenges of finding adoptive resources for older children, minority children, large sibling groups, and children who have significant behavioral and developmental problems.

Longer stays in foster care are associated with a reduced likelihood of reunification and an increased number of placements. Approximately 50% of children and teenagers will experience more than one foster care placement, with approximately 25% having three or more placements.

In 2010, of the 254,114 children who exited foster care, 51% returned to their parents and 14% went to a relative or guardian, whereas 21% were adopted and 11% aged out of foster care. The vast majority of the 27,854 individuals who aged out were emancipated at age 18 years.

Childhood Trauma and Risk Factors for Placement

Because the long-term benefit of foster care placement is uncertain, admission to foster care is and should be difficult.

Almost all children entering foster care are placed involuntarily by court order after child protective investigation.

Child neglect, including lack of supervision or neglect of basic nutritional, educational, and medical needs, is the most commonly cited reason for placement. Overall, approximately 70% of admissions are for maltreatment. Teenagers tend to be placed for disruptive behaviors through either the juvenile justice system or as persons in need of supervision. Voluntary placements constitute less than 1% of admissions and often are made by families as a means of accessing treatment services for a child or teenager who has complex mental health or medical problems.

Families whose children reside in foster care come from all walks of life, but financial poverty remains a pervasive common factor underlying foster care placement (>50% of children live with impoverished families before foster care). Poverty, however, extends beyond the financial to the lack of the normal, predictable, nurturing environment that promotes good developmental and emotional health. Most children have experienced childhood adversities beyond maltreatment, including exposure to significant violence in their homes (84%) or communities (48%).

At placement, investigators report that 84% of caregivers have significantly impaired parenting skills, coupled with mental health problems (46%), substance abuse (48%), criminal involvement, or cognitive impairment (12%). Parents often lack social supports, have limited education and high unemployment, and are single.

Approximately one third of birth parents admit to being abused or neglected as children, and about the same percentage spent time in foster care. Children often have had multiple caregivers even before placement in foster care. Removal of a child often follows prolonged involvement with child welfare agencies, with the removal occurring after preventive strategies have been exhausted, when the child's health and safety are at imminent risk.

The Impact of Childhood Trauma

Mounting evidence indicates that early childhood trauma or multiple adverse childhood experiences, and chronic stress are associated with poor short- and long-term mental health, developmental, and physical health outcomes. Trauma exposure and chronic stress, especially in the absence of ameliorating protective factors, alter the neurobiology of the brain, especially in a very young child. Chronic stress predominantly alters those areas of the brain involved in cognition, rational thought, emotional regulation, activity level, and attention.

Thus, children entering foster care with their cumulative early life traumas and adversities are children who have immense emotional, developmental, and physical

health needs. Studies on resiliency and recovery are just now accumulating, but early data indicate that stability in a nurturing and responsive family promotes healing after childhood traumatic experiences.

Entry into foster care is fraught with uncertainty, upheaval, and losses for children. Despite high levels of family dysfunction, removal from the family of origin and all that is familiar is another emotionally traumatizing experience for many children, whereas, for other children, placement in foster care may be the first time they have felt truly safe. Although stable placement in a quality foster home can promote healing, the ongoing uncertainties and losses endemic to foster care may erode a child's sense of well-being over time.

Recent Foster Care Legislation

Recent legislative activity highlights an increasing focus on involving pediatricians in supporting children in foster care. The Fostering Connections to Success and Increasing Adoptions Act of 2008 (www.fosteringconnections.org) requires foster care agencies to identify kinship resources at entry to foster care, promote and support kinship care, maintain children in their schools of origin, support Native American tribes in keeping children within tribal foster care systems, and enhance resources for youth, with a goal of independent living.

Most significantly for pediatric health professionals, Fostering Connections requires states to develop health systems for children in foster care, involve pediatricians in the development of such health systems, improve health-care coordination, promote the use of medical homes, monitor psychotropic medication use, and measure health outcomes.

The Foster Care System: Important Roles in Caring for Children in Foster Care

The foster care system is simple in its concept of providing needy children with nurturing families, but also complex in practice. Federal legislation determines patterns of funding and regulatory guidelines, but responsibility for the implementation of foster care programs resides with state social service agencies, which may, in turn, delegate daily management to county or private child welfare agencies. Despite Herculean efforts by dedicated professionals, the foster care system remains burdened by huge caseloads, limited funding, birth parents who have multiple intractable problems, and bureaucratic, legal, and ethical demands that sometimes appear to be in conflict with each other.

ROLE OF CASEWORKERS. Each child welfare agency is responsible for hiring and training caseworkers for what is

a complex job, requiring multiple skills commensurate with masters' level social work. Most casework positions are, however, entry-level jobs requiring no more than 2 years of college education in many agencies. As case managers for the biological family, caseworkers must engage parents around the care of their children while making *diligent efforts* to assist them with securing whatever educational or service resources are necessary (eg, housing, mental health, parenting education, medical care, and drug and alcohol rehabilitation) to promote reunification.

Meanwhile, caseworkers also must coordinate educational, developmental, medical, and mental health services for children, and support the foster parents in their care. When birth parents are noncompliant or unable to undertake the work necessary for reunification, caseworkers have the delicate task of supporting them through the process of alternate permanency planning. Caseworkers also are expected to help children develop secure attachments and a sense of belonging to a different family than their family of origin.

Caseworkers also recruit, train, monitor, and annually recertify foster parents. They must have a working familiarity with the legal system in their state, particularly family court and the juvenile justice systems. Within 72 hours of removing a child from a family, the caseworker must prepare a court petition documenting the reasons for removal. For the child or adolescent remaining in foster care, the caseworker must return to court at designated intervals to provide ongoing documentation for the continuation of placement and to detail their own efforts on behalf of parents and children toward reunification.

THE LEGAL SYSTEM. Every child in foster care is represented in court by a law guardian (guardian ad litem), who may or may not be an attorney, depending on the state. In some states, in particularly difficult cases, the court also may designate a court-appointed special advocate on behalf of the child. As trained volunteers who are not attorneys, court-appointed special advocates devote many hours to investigating the child's circumstances for presentation to the court.

Ultimate oversight resides with the judicial system. Family court judges have the compelling task of deciding, based on information presented to them in court, whether a child remains in out-of-home placement after removal or not; ordering services for biological parents; and rehearing at set intervals the case for a child in out-of-home care to determine whether continued placement or an alternative permanency arrangement is warranted. Ultimately, the court decides the permanency

outcome, with the hope that such a decision is based on the input from attorneys, all caregivers, child welfare agencies, mental health and other professionals, and the youth who is of sufficient age and developmental capacity to speak on his or her own behalf. Education for the legal profession regarding child development, parenting, and early childhood trauma remains limited.

FOSTER PARENTS. Foster parents are the heart and soul of the foster care system, and foster parenting is the major therapeutic intervention. Foster parents come from all walks of life, but, on average, tend to be married, be of lower middle income, have at least a high school education, be employed, and have children of their own. Many have strong religious affiliations, and most are driven by a desire to do something positive for children. Some people become foster parents with the hope of eventually adopting. A small percentage of foster parents are same-sex couples, and laws are evolving to ensure that same-sex couples can both foster and adopt children.

Approximately 5% of foster families undergo specialized training to act as resources for severely emotionally disturbed or medically fragile children. However, most foster parents receive very little education about parenting children who have significant trauma histories and attachment issues. There are some elegant studies demonstrating that specific education and supports for foster parents and birth parents (such as Treatment Foster Care, and evidence-based parenting education for foster parents) improve outcomes for children, but these programs have not achieved widespread use.

Reimbursement for foster parenting varies widely. Families are paid a daily board subsidy for each child in their care that is set by individual states. The rate is determined by the child's age, health needs, and the complexity of the parenting tasks. The board subsidy is expected to cover food, shelter, personal needs, recreation, and most transportation and educational costs. A recent study shows that board subsidies cover only approximately two thirds of the cost of parenting a child in foster care.

Recruitment, education, and retention of suitable foster families are some of the most compelling tasks facing child welfare agencies. Boundaries are blurred in the foster care system in terms of authority, responsibility, and accountability. Foster families retain the bulk of the daily responsibility for children and teenagers, but are accountable to caseworkers, the legal system, and the birth family for the child's care. Legal custody remains with the birth parent until a child is freed for adoption, but the foster care agency is responsible for ensuring that a child's needs are met and the child is well cared for.

GROUP CARE. Approximately 20% of youth in foster care, mostly adolescents, reside in residential or group home placements, which can cost upward of \$100,000 per child annually. Mental health services usually are available on-site, but staff turnover is high. The outcomes of group care have not been well studied, and there appears to be wide variability in the quality of such care.

Important Processes in Foster Care

VISITATION. Although consistent visitation of a child with his or her biological parent is the best predictor for reunification, visits may be difficult for the parents and child. The tenor of the parent-child relationship is variable. Children who have been abused or severely neglected by their parents may not feel safe even in a supervised visitation setting. Birth parents may not understand the need to focus on the child during visitation and instead focus on their own issues or problems with child welfare. Birth parents may attempt to sabotage the relationship of the child with the current caregivers, and vice versa. Parents may visit inconsistently, which is confusing and frightening for children, and parental no-shows reinforce rejection and abandonment. When the parent does come, the visit ends with separation that may be challenging for both parent and child.

Visitation usually progresses through stages, beginning with visits supervised by caseworkers in a neutral setting. Visits then transition to a community setting or the parent's home, where the visit is monitored before eventually becoming unsupervised. Kinship placement may allow for more frequent contact with the birth parent, but kin caregivers also may face unique challenges if they harbor resentment toward the birth parent, are conflicted about visitation, or have to enforce court-ordered restrictions to which the parent and other relatives object.

Evidence is mounting for models of visitation in which a mental health professional helps parents identify their child's cues, understand their child's developmental capacities, practice parenting skills learned in parenting education classes, and respond to their child in an appropriate manner. Evidence-based models, such as child-parent psychotherapy or child-parent interactive therapy, still are not widely used, because such models are time- and labor-intensive and require specialized training. Another promising model is Visitation Coaching, in which trained visitation specialists prepare birth parents for visits, help the parent stay on track during the visit, and debrief with them afterward.

CRITICAL JUNCTURES IN FOSTER CARE. In addition to the challenges associated with visitation, children may

encounter other adversities in foster care. Disruptions in foster care placement, disruptions in school or child care placement, separation from siblings, the presence of other children entering or leaving their foster home, unkept promises by birth parents, a poor relationship with their foster caregiver, being teased or bullied, and court dates are but some of the potential difficulties children may face. For an already stressed child, even one additional seemingly minor transition can be sufficient to overwhelm coping skills.

RECIDIVISM. Recidivism is defined as the return of a child to foster care after reunification, placement with extended family or guardian, or adoption. Depending on the locality, 20% to 30% of children return to foster care, mostly as a result of a disruption of reunification with their birth parents. An unknown but small percentage of adoptions undergo disruption, usually during an adoptee's adolescence.

TERMINATION OF PARENTAL RIGHTS. Legally, parents retain guardianship of their children residing in *the care and custody* of the state or county commissioner of social services. Guardianship can be terminated only as part of a legal process, in which the commissioner becomes the child's legal guardian until the child either reaches the age of majority or is adopted. Biological parents sometimes choose to surrender their children for adoption; but, more often, termination of parental rights (TPR) occurs involuntarily after diligent efforts at reunification have failed. The TPR process can take years, during which time concurrent, but conflicting, efforts at reunification and alternative permanency planning occur.

Time constraints imposed by federal legislation in 1997 require states to begin TPR once a child has been in foster care for 15 of the past 22 months and when there is no compelling reason not to start the process. States and localities vary in the rigor with which they follow this federal mandate. Although child welfare, as a result of the growing body of scientific studies on childhood trauma, early brain development, and placement stability, has moved toward a child-centered approach to foster care, the judiciary is not required to decide permanency based on the "best interests of the child."

ADOPTION OUT OF FOSTER CARE. Adoptions out of foster care (public adoption) peaked several years ago. Over 60% of children adopted out of care are adopted by their foster parents, and 30% are adopted by kinship caregivers. According to the most recent available data, there were 107,011 children awaiting adoption out of foster care in 2010, of whom 64,084 were freed for adoption and

13,603 resided in preadoptive homes. Fostered children without an identified adoptive resource tend to be older, minority children, to be part of large sibling groups, or to have significant disabilities, especially emotional and behavioral problems, that continue to be great impediments to achieving permanency.

Birth Parents

Birth parents most often view child welfare efforts as an intrusion into their lives and the reason for the disruption of their family. Although some parents cooperate with child welfare agencies, others either fail repeatedly to complete rehabilitation programs, remain with a violent partner, or engage in criminal acts that delay reunification. Some blame the child for the removal, whereas others express great remorse over the disruption of their family and express appreciation for the resources that child welfare helps them access. Many birth parents have trauma and loss histories extending back into their own childhoods that have remained unspoken and untreated. Many lack the most basic of parenting skills, and removal of their children may reinforce their feelings of failure and inadequacy.

Experiences of Children in Foster Care

Child welfare agencies may initially place children in a shelter, an emergency foster home, or the home of a relative, pending the outcome of the initial court hearing after child protective investigation. Placement with kin caregivers is assumed to be less traumatic if the child already has a meaningful relationship with them. The first few days in foster care may be filled with a host of strangers, from child protective personnel to police officers, health providers, and members of the foster home.

Children new to foster care often are wary for the first several weeks, a stage viewed by most child welfare professionals as a time of emotional withdrawal for the overwhelmed and confused child. Children who have severe trauma histories may begin to display behaviors that were adaptive in their previous environments, but dysfunctional in the new setting. The majority of children are simply overwhelmed by feelings they do not understand and cannot control or express in healthier ways.

Children in foster care often deny awareness about why they are in foster care, and children may even blame themselves for the disruption of their families. They worry about the well-being of their parents and siblings. Uncertainty, powerlessness, and guilt pervade their lives. They rarely know how long they will be in care, whether or when their parents will come for visits, or when

a parent will get out of jail or rehabilitation. Birth parents may make promises they do not or cannot keep. Other children tease them about being in foster care, contributing to their already poor self-regard and sense of alienation.

Younger children and infants quickly form attachments to foster parents and may view their less frequently seen birth parent as a stranger. Differences in parenting styles, or outright conflict between caregivers, create confusion for children and teenagers. Children may not be adequately prepared for discharge from foster care or transition to a new placement.

Changes in foster care placement almost always are traumatic for children, given that each transition involves a loss that reinforces feelings of rejection and worthlessness. Reasons for disrupted placements vary but include child behavior problems, limited foster parent skills, conflict between birth and foster parents, and agency administrative decisions. Rarely, a foster home may be abusive or neglect a child's needs, resulting in removal.

When foster care goes well, it is because the care is truly child-centered. A responsive and nurturing foster parent creates a zone of comfort and safety for the child, allowing the child to grieve the loss of family and adjust to the new home. The foster care placement is stable during the child's time in care. The foster and birth parent minimize conflict and work together on behalf of the child. The birth parent appears consistently for visits, behaves appropriately at them, and takes advantage of the services offered by child welfare. Child welfare helps the birth parent identify and build on the family's strengths, and the crisis that led to the family's disruption is ameliorated. Children receive appropriate trauma-informed mental health services, and their parents participate in those services as needed. Unfortunately, the foster care experience usually does not go this well.

Adolescents in Foster Care

Adolescents in foster care are a varied group. Some have grown up in foster care, whereas others enter foster care through the juvenile justice system or are placed by a parent unable to manage their behaviors or to access appropriate mental health-care services. Adolescents tend to have the greatest placement instability; they experience a variety of foster care settings over time (foster family homes, group homes, residential care) or move back and forth between foster care, home, and/or juvenile justice. A small percentage of teenagers are intellectually disabled and have significant behavior issues. Intellectually competent teenagers may lack the educational background to succeed in school.

Pregnant or parenting teenagers are another small group who may be living with their children or placed separately from them if they have significant mental health issues or constitute a risk to their offspring. Some teenagers enter foster care as unaccompanied refugee minors, having immigrated to the United States from a variety of countries after surviving war, rape, injury, slavery, or the death of their families.

The majority of adolescents in foster care reside in group-care settings, where their activities are restricted, education is structured, and they receive mental health services and substance-abuse treatment, if needed.

In general, adolescents in foster care have experienced similar childhood traumas, including maltreatment, as younger children in foster care. They have accumulated losses and transitions; but their high-risk behaviors, including substance abuse, risky sexual activity, school truancy, and petty criminal mischief, may be challenging enough that the reasons underlying them remain unattended.

Adolescents in foster care are less likely to find permanency, either through reunification or adoption. Some return to parents or relatives, but many age out at age 18 years, run away, or are moved to another agency or placement setting (residential care or group home care). Exposure to normalizing activities and preparation for independent living is largely inadequate. After-care resources are essentially nonexistent. Foster or kin families who remain invested in youth are their best resource, and youth who identify and remain connected to foster parents, kin, or other adult mentors appear to fare better.

What is known about the outcomes of youth who have aged out is discouraging. Within a year of aging out, most youth have spent at least one night homeless, and many young women have had an unintended pregnancy. Young adults who are a decade removed from foster care are underemployed, undereducated, have difficulty with trust in intimate relationships, and have high rates of mental health problems, including posttraumatic stress disorder and substance abuse. Prevalence studies indicate that adults with a history of foster care are overrepresented among the homeless and incarcerated populations.

Adolescence is the time during which the individual is supposed to form a stable identity rooted in self-esteem, a sense of autonomy rooted in self-efficacy, and a larger sense of commitment and comfort in relatedness to peers. For young people in foster care, especially minority youth, negative self-concept, lack of self-esteem, and a lack of self-efficacy are likely outcomes of early adverse

experiences, the accrual of multiple losses over time, and a sense of helpless dependence is developed from living in the uncertain world of foster care.

Early abuse and neglect, coupled with impaired caregiving, repeated separation and losses, unpredictability, and a lack of role models for healthy relationships result in a high prevalence of young adults who are isolated, alienated, dependent, and prone to distrust.

Less well studied are those former foster youth who are resilient and create a meaningful life despite multiple childhood adversities.

Health-Care Issues of Children in Foster and Kinship Care

The health issues of children in foster care are rooted in their histories of trauma, neglect, and loss. Chronic and multiple adverse childhood experiences and early childhood trauma, coupled with the lack of protective factors, underlie the poor health status of children in foster care. The AAP defines children in foster care as *children with special health-care needs* because of their high prevalence of chronic medical illness, developmental disabilities, educational disorders, dental problems, and behavioral, emotional, and mental health problems (Table 1). In addition, almost 100% of children in foster care have issues related to family functioning.

Studies about the health status of the foster care population have yielded fairly bleak results. At entry to care, 30% to 45% have at least one chronic medical condition,

Table 1. Health Issues of Children and Adolescents at Entry to Foster Care

Health Problem	Percentage of Population
Chronic medical problems	30%–45%
Complex medical/developmental ^a	10%
Mental health	48%–80%
Developmental delay	60% of children <6 y old
Educational issues ^a	45% in special education or with individualized educational plan
Dental problems ^a	35%
Family dysfunction	100%

^aUnpublished data from Starlight Pediatrics, Rochester, NY. Other data from a variety of sources.

and approximately 10% have complex chronic health problems. The reasons for the high prevalence of physical health conditions include medical neglect or lack of access to health services before foster care; genetic susceptibility; inability of the parent to cope with child's health needs, resulting in placement; and the impact of untreated childhood adversities on health. Neurologic and developmental conditions are particularly prevalent and may be the direct result of trauma, the sequelae of psychosocial deprivation and childhood trauma, or the result of substance exposures.

Multiple studies report that the major ongoing health problems of children in foster care are mental health and developmental problems. Sixty percent of children under age 6 years enter foster care with developmental delays in at least one domain, and up to 70% of children over age 5 years have a mental health or behavioral problem. These problems are rooted in the adversities and trauma children have experienced before foster care. Behaviors that may have been adaptive in a neglectful or abusive environment become maladaptive in a more normative setting. Evidence indicates that significant behavioral problems (aggression, stealing, defiance, prolonged tantrums, destruction of property, substance abuse), especially if accompanied by developmental problems, lead to placement disruptions that, in turn, exacerbate emotional and mental health problems.

Barriers to Health-Care

Once children enter foster care, their overall health does not appear to improve significantly. The transient nature of the population dramatically increases the likelihood that they will continue to have poor access to health-care. Health information on admission into foster care is almost universally lacking. Neither caseworkers nor foster parents have the level of knowledge necessary to serve as the health-care manager, yet the foster system relies on them to perform this complex task.

Although most children in foster care have health insurance in the form of Medicaid, this circumstance also limits access to health-care because of inadequate reimbursement, delays in payment, and limited numbers of medical subspecialists willing to participate in Medicaid. Medicaid-managed care may increase access to medical subspecialty care, but it reduces significantly mental health access for children in foster care. Failure to support and educate foster parents about a child's medical, developmental, and mental health needs and failure to secure appropriate treatment can lead to disruptions in placement when foster parents become overwhelmed.

Complex consent and confidentiality requirements may delay evaluations and treatment and confound communication among professionals. Emergency care can be provided even if consent is not available. However, each state has specific regulations about who can consent for health-care on behalf of a child in foster care. Many states, for example, require written consent of the legal guardian, who is usually the birth parent, for any procedure requiring informed consent, including administration of psychotropic medication. In general, child welfare agencies have protocols in place for obtaining consent, and health-care providers should address consent issues with their local child welfare agency.

Although the health clause of the Fostering Connections legislation now requires states to develop health systems for children in foster care, enactment is in its infancy in most states. Health systems with intensive care coordination are essential because inadequate health-care management underlies the pattern of inadequate, fragmented, and, occasionally, redundant care children receive.

Health-Care Recommendations

The Medical Home

Ideally, children in foster care will receive their health-care as children who have special health-care needs in the context of a pediatric medical home. The AAP has a number of resources (<http://www.aap.org/fostercare>) to assist pediatric professionals, but the major guiding principles of the medical home for the child in foster care are as follows:

- Pediatric care is accessible and continuous over the child's time in foster care, regardless of placement.
- Health-care coordination exists that ensures that all of a child's health-care needs, including mental health, dental, and developmental/educational needs, are identified and addressed.
- Compassionate care is given that includes an understanding of the impact of childhood trauma and loss on children and families.
- Care is culturally competent and includes an understanding of the microculture of foster care and its impact on children and families.
- Communication exists that includes the willingness to collaborate with child welfare and includes all of a child's caregivers, when appropriate and safe, in planning for a child's health needs.
- Comprehensive high-quality pediatric care is provided in accordance with AAP health-care standards for children in foster care.

Health-Care Standards

The medical home should follow the health-care standards for children and teenagers in foster care defined by the AAP Task Force on Foster Care adapted from AAP District II: New York State, *Fostering Health: Health-Care Standards for Children and Adolescents in Foster Care*. The standards are now available on the AAP’s Healthy Foster Care America website (www.aap.org/fostercare).

This website was designed for use by interdisciplinary professionals (legal, child welfare, judicial, mental health, and health), caregivers, and youth in foster care. These resources and detailed standards may also be helpful to pediatricians in advocating with states and foster care agencies for improved health services. A brief summary of the AAP health-care standards for children in foster care are listed in Table 2 and further described here.

ADMISSION HEALTH SERIES. Pediatric professionals should see children “early and often” after entry to foster/kinship care, because serial encounters often reveal

more health needs than one isolated evaluation, and they nurture a trusting relationship between the professional and patient. The recommended admission series includes:

- An initial health screen ideally performed within 72 hours of removal and placement to document growth parameters, signs and symptoms of abuse or neglect, and details of acute or chronic conditions, including mental health problems, in need of acute care or foster/kinship caregiver education.
- A comprehensive health evaluation within 30 days of placement, including a review of available health records, developmental and mental health assessments and referrals, assessment of adjustment to the foster care placement, appropriate screening, and continued caregiver education and support.
- A follow-up health visit within 60 to 90 days of placement to ensure that recommended evaluations are in process or complete, to continue monitoring the

Table 2. Foster Care–Specific Health Visits

Age of Child	Timing or Frequency	Rationale for Visit
Admission health screen	Ideally within 72 h of placement	Obtain growth parameters; document signs of abuse/neglect; diagnose and treat acute/chronic medical and mental health problems; ensure child has necessary medications and equipment; support and educate caregivers and youth through transition period
Comprehensive health assessment	Within 30 d of entry to foster care	Review all available health information. Monitor growth, adjustment to placement, and for signs of maltreatment; comprehensive physical examination; conduct recommended screening; mental health and developmental assessment and referral; caregiver and youth health education and foster care–specific anticipatory guidance
Follow-up health visit	60–90 d after entry to foster care	Review health, mental health, and developmental assessments. Review any new health information; monitor growth and development and care in foster home; monitor for signs of abuse and neglect; ensure all needs being met; ongoing anticipatory guidance and education
Infants to 6 mo	Monthly (between preventive health-care visits)	Monitoring of growth and development, especially if premature, substance-exposed in utero, or having complex health issues; support and education of caregivers
21 mo	Extra visit at age 21 mo	Monitor development and behavior closely; support and education for caregivers
2 to 21 y	Semiannual (between annual preventive health-care visits)	Monitor growth and development; assess adjustment to placement; monitor for emerging behavioral, emotional, and developmental problems and make appropriate referrals; support and education of caregivers and youth

adjustment to foster care, and to reassess the “goodness of fit” in the placement.

- Health information gathering is a process that starts at entry to foster care and may continue throughout the child’s time in foster care depending upon the complexity of issues.
- Communication with child welfare personnel around the child’s health, which should occur after every health encounter and include a health-care plan.

FOSTER CARE HEALTH VISITS AND PREVENTIVE HEALTH-CARE.

Periodicity underlies quality health-care for all children, but especially for those with special health-care needs. Children in foster care should have health-care visits over and above those recommended for all children to monitor all aspects of their health (medical, developmental, educational, emotional and behavioral, and dental; see <http://brightfutures.aap.org/>). Every health-care encounter should include monitoring for child abuse and neglect in the current placement. Foster care-specific visits (Table 2) that should be considered in addition to the AAP’s Periodic Preventive Health-Care Schedule include:

- Monthly health visits for infants from birth to age 6 months, especially in the case of infants who were premature, or who have a developmental or growth problem, difficult sleep or other behaviors, or a chronic illness.
- An additional health visit at age 21 months to monitor development and behavior through a critical period for toddlers in care.
- Semiannual visits from age 2 to 21 years in this highly mobile population to monitor developmental, educational, emotional, and physical health and to provide ongoing anticipatory guidance.

For children who have complex medical, developmental, or mental health problems, the pediatrician may consider even more frequent health visits if indicated.

MENTAL HEALTH-CARE. Mental health is the single most important health-care need of children in foster care. Children need early screening and assessment of mental health status and timely referral to pediatric mental health professionals. Components of mental health-care include:

- Mental Health Screening in the Pediatric Office. Ideally, all children in foster care would receive a full mental health evaluation, but, in communities with limited resources, the periodic administration of a validated mental health assessment (beginning in infancy) can help the clinician determine which children need referral.
- The Medical Home and Positive Parenting Strategies. The medical home can be a source of support and education for foster parents and children through a focus on children’s strengths and reinforcement of positive parenting strategies.
- Evidence-based Mental Health Services. Children in foster care have significant trauma histories and universal experience with family disruption. Over the past decade, a number of mental health interventions have demonstrated efficacy in improving outcomes in this population. Unfortunately, these evidence-based services are not available in every community. A list of evidence-based and promising mental health services appropriate for children involved with child welfare is available through the California Evidence-Based Clearinghouse for Child Welfare Practice (www.cebc4cw.org).
- Psychotropic Medication. Studies show that children and teenagers in foster care are more likely to be on psychotropic medications than peers not in foster care; they are also more likely to be on multiple medications, sometimes from the same class of drugs. In addition, the psychotropic medications prescribed may not match the major symptom or diagnosis of concern. Although some adolescents and children undoubtedly benefit from psychotropic medications, there is concern that medications are overused. Several states have developed comprehensive guidelines regarding the prescription and management of psychotropic medications in the foster care population. The reader is directed to guidelines available on the Healthy Foster Care America website (<http://www.aap.org/fostercare>) for further information. In general, psychotropic medications should be prescribed when needed as part of a comprehensive mental health treatment plan by a qualified pediatric mental health professional. A detailed health history, including mental health, behavior, development, trauma, medication use, social and family history, and a full mental health evaluation should be obtained before beginning medication.

Several basic principles should be kept in mind when using psychotropic medication:

- Therapy should be initiated with a single agent at the lowest dose.
- Dosage increases should be gradual and the patient closely monitored for efficacy and adverse effects.
- Single-agent therapy should be the goal, whenever possible.
- Pediatric professionals should be aware that not every child in foster care who presents with concerns of

hyperactivity and inattention has a true attentional disorder, because such behaviors may be a manifestation of early childhood trauma experiences, depression, or anxiety. Caution should be exercised before instituting any psychotropic medication.

- Referral to mental health professionals for evidence-based, mental health evaluation and services is the ideal initial assessment for the child or teenager in foster care.

DEVELOPMENTAL AND EDUCATIONAL HEALTH NEEDS.

Developmental and educational problems are two other major health needs of children in foster care. Trauma experiences and losses may result in learning difficulties and impaired development across multiple domains. Cognition, communication, and personal/social development are the most likely areas to be affected. If full developmental evaluation for all children in foster care is not possible, the pediatric clinician should at least use a validated developmental assessment tool to identify children in need of a full evaluation. Although some children show improved developmental skills and school achievement in foster care, any child who has behavioral or learning problems in school should receive an educational evaluation. It is recommended that the pediatrician work closely with the child's school to ensure that educational needs are identified and addressed.

DENTAL HEALTH. Foster parents in most communities report that children in foster care have limited access to dental care, despite a high prevalence of significant dental disease. Pediatric clinicians are encouraged to collaborate with their local health department and dental organizations to address access issues for children in foster care.

ANTICIPATORY GUIDANCE. Anticipatory guidance is a time-consuming and challenging process in foster care. Many foster families have a wealth of child-rearing experience, but the clinician should not presume that they have expertise in parenting children and teenagers who have attachment issues, past trauma, and ongoing bereavement around losses. In addition to the usual advice, anticipatory guidance should address issues specific to foster care, such as focusing on the child's strengths; positive parenting strategies; the impact of trauma on child behavior; supporting children through transitions (visitation, permanency planning, changes in placement, etc); significant sleep disorders; confused loyalties; attachment issues; the need for normalizing activities; and working with birth parents to reduce conflict and coercion.

Adolescents and school-age children should be counseled about safe behaviors, healthy activities, planning for

Table 3. Health-Care Management

Health-care management is the ultimate responsibility of the foster care agency, but requires health expertise, as well. These are several key components.

1. Consent and confidentiality. Child welfare should obtain appropriate medical consents and releases of information from the birth family, provide copies to the pediatrician, and educate health providers about the foster care agency's guidelines regarding consent and confidentiality. Psychotropic medication administration and adolescent health issues, such as pregnancy, sexually transmitted infections, birth control, and substance abuse, are governed by separate confidentiality laws in most states.
2. Obtaining health information. The gathering of health information often is a time-consuming, difficult task that occurs over time. Both the child welfare agency and the pediatric professional have a role in attempting to access health records from previous health-care providers, schools, child care settings, and immunization registries.
3. Health-care standards. Health providers and child welfare should attempt to provide health-care services in accordance with health-care standards set forth by the American Academy of Pediatrics for this special needs population.
4. Care in the context of a medical home. The primary care pediatric professional may serve as the point of access to mental health, dental, developmental, and subspecialty care. Timely referrals and care coordination, including communication with child welfare agencies, are crucial to ensuring that children in foster care receive adequate health-care. The pediatric professional should have some knowledge about child abuse and neglect and the impact of trauma, losses, transitions, and foster care on the child and caregivers.
5. Education of caregivers, youth, and child welfare personnel. Pediatric professionals are in a unique position to counsel foster, kin, and birth parents; other professionals; and youth about the child's health needs and the impact of early trauma on child behavior and development.
6. Health-care plan. Health information should be shared with child welfare personnel in language that ensures that the health-care plan for the child is incorporated into the child welfare permanency plan.

their futures, and developing relationships with adult mentors. Many teenagers in foster care, fearing yet another disappointment, have exhausted their capacity to attach to a parental figure; pediatric professionals can help foster parents understand the teenager's emotional world

while supporting an authoritative parenting style. Support for foster families and youth in foster care around transitions and other stressors can stabilize a foster care placement for a child. Ideally, the pediatrician also engages the birth parent and the child's caseworker in these discussions.

Health-Care Management

Health-care management ultimately is the responsibility of the foster care agency, with the caseworker as the ultimate case manager. However, the pediatric medical home has an important role to play in ensuring that a child in foster care receives all necessary health-care in a timely manner, and that caseworkers, caregivers, and youth in care all understand and participate in the health-care plan. This coordination requires that health professionals partner closely with child welfare to ensure adequate communication and information exchange. Specific health-care management tasks are outlined in Table 3.

The Pediatrician as Child Advocate

Pediatricians are in a unique position to advocate for changes in systems of care for children in foster care, especially in light of the health clause in the Fostering Connections legislation. Pediatric professionals can collaborate with their local AAP chapter to:

- Work with states to ensure that child welfare agencies are aware of and promote health-care standards for children in foster care.
- Partner with state and local child welfare agencies, departments of public health, and mental health organizations to develop evidence-based mental health-care resources in their community.
- Partner with state and local child welfare agencies, departments of public health, and dental organizations to increase access to dental care for children in foster care.
- Partner with state and local early intervention and school/preschool special education programs to develop strategies to assess the needs of children in foster care and to ensure access to needed services.

Summary

- There is compelling research evidence that children and adolescents placed in foster care for reasons of safety enter foster or kinship care after experiencing multiple, synergistic adversities that affect their health and well-being negatively.
- Consequently, children and adolescents in foster care are children who have special health-care needs because they have a high prevalence of medical, mental health, developmental, educational, and dental health problems.
- Evidence also indicates strongly that behavioral problems are associated with placement instability, and that instability, in turn, exacerbates behavioral and developmental problems.
- Foster care should be considered a window of opportunity in which the child or teenager can heal from past trauma.
- Expert consensus contends that child health, mental health, and developmental outcomes will be improved by child-centered medical home care while the child or teenager is in foster care.
- In addition, it is recommended that the pediatrician be proactive in engaging child welfare agencies to ensure that the health plan is an integral part of the child's permanency plan.
- Pediatric professionals also have a role in educating child welfare professionals, foster and kinship parents, birth parents, and youth about health and foster care-specific issues, and in advocating for appropriate health-care for this vulnerable population.

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To view the Suggested Reading list, other suggested resources, and a glossary, visit <http://pedsinreview.aappublications.org> and click on "The Pediatric Role in the Care of Children in Foster and Kinship Care" link.

PIR Quiz

This quiz is available online at <http://www.pedsinreview.aappublications.org>. NOTE: Since January 2012, learners can take *Pediatrics in Review* quizzes and claim credit online *only*. No paper answer form will be printed in the journal.

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You are the pediatrician in your community who contracts with the local Department of Social Services to provide health-care to the approximately 200 children in the Foster Care and Kinship Care Program, age birth to 18 years. Your program follows the AAP standards for children in foster care.

1. A 14-month-old child is being placed in a foster care home this afternoon. You ask the caseworker to arrange for you to do an admission health screen on the child within the next
 - A. 24 hours.
 - B. 48 hours.
 - C. 72 hours.
 - D. 96 hours.
 - E. 7 days.
2. You ask the caseworker also to arrange for you to perform a comprehensive health assessment on the child within the next
 - A. 10 days.
 - B. 15 days.
 - C. 30 days.
 - D. 45 days.
 - E. 60 days.
3. The child has been neglected and a court hearing will be held about where she should be placed. You understand that every child is represented in court by a
 - A. Caseworker.
 - B. Court-appointed attorney.
 - C. Court-appointed special advocate.
 - D. Family court prosecutor.
 - E. Law guardian who may or may not be an attorney.
4. You recognize that the primary goal of the foster care program is
 - A. Foster care for 1 to 3 years.
 - B. Out-of-family adoption.
 - C. Placement with a family member.
 - D. Termination of parental rights.
 - E. Timely permanency, ideally with the birth family when that is a safe option.
5. Your admission screen reveals a malnourished 14-month-old white girl who has an extensive candidal rash. You also learn that she has 2- and 3-year-old brothers who were found abandoned in another apartment in the house. They had been whimpering her name. The factor most likely to be problematic in finding a placement for this child is her
 - A. Age.
 - B. Gender.
 - C. Medical problems.
 - D. Race.
 - E. Sibling group size.

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Moira Szilagyi

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