The Pediatrician and the Child in Foster Care
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The Pediatrician and the Child in Foster Care

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Most pediatricians will encounter children in foster care in their practices, and some, by virtue of location, will have many children in dependent care as patients. Children in foster care have multiple, complex health care issues. Familiarity with the structure, goals, and mandates of the foster care system and its impact on the daily lives of children in its care is essential to providing high-quality comprehensive health care services to this vulnerable population.

Introduction

About 500,000 children reside in foster care on any given day in the United States. They are primarily the children of the indigent, and their lives prior to placement were riddled by violence and neglect. Removed from or abandoned by their families, these children were placed into a system intended to nurture and repair them, while facilitating the rehabilitation of their families. In reality, foster care has become a system of last resort for the most vulnerable children and intransigent families.

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History of the Foster Care System

Destitute and abandoned children have always been part of the fabric of American life. The foster care system, rooted in England’s Elizabethan Poor Laws of 1601, evolved out of the dedicated efforts of many individuals to improve the lot of such children. Designed to protect children who previously were left to their own resources, the charity of the community, or warehousing in institutions, the dependent care system was based on the premises that society has a responsibility for such children and that children fare best when they are reared in nurturing, family-based settings. The current foster care system is a 20th century response to the almshouses and orphanages of the 19th century.

Government funding and regulation of the foster care system in the United States is relatively recent. As part of the Social Security Act of 1935, Aid to Families With Dependent Children (AFDC) provided economic support to widowed parents who had young children. Beginning in the 1960s, Title IV-A of the Social Security Act was amended, allowing states to use federal matching funds for AFDC-eligible children placed into foster care. Over the next several decades, the population of children in foster care expanded rapidly due to both increased admissions and longer placements. The burgeoning costs of the system, coupled with the recognition that separating children from their families is almost always traumatic, led to several attempts at reform. In 1980, the Adoption Assistance and Child Welfare Act (PL-96-272) mandated states to develop preventive and reunification programs. Preventive services (eg, counseling, housing, parenting education, drug rehabilitation, and intensive family preservation programs) were intended to avert the removal of children from their biological families. Increased reliance on relatives and family friends as resources for the child prevented or delayed some placements. In an effort to shorten placement duration, agencies were mandated to do diligent casework, conduct biannual case reviews, and develop permanency plans within 18 months of placement, even in the most difficult cases. Adoption subsidies were funded, so that marginal family income was no longer a barrier to the adoption of children out of foster care.

After enactment of PL-96-272, the size of the foster care population shrank. Unfortunately, in the last...
decade, there has been a dramatic increase in the number of children in dependent care, with the surge in parental substance abuse offsetting the impact of earlier reforms. Welfare reform, which includes curtailed funding for preventive services and public assistance, is predicted to increase admissions to foster care further. Such programs are sometimes the only barrier to the complete dissolution of a destitute family that has multiple problems. However, legislation enacted in November 1997 may reduce the number of children in foster care by shortening the time between placement and the development of a permanency plan from 18 to 12 months. This same legislation enables caseworkers to consider the child’s best interest as well as parental rights.

Epidemiology

FAMILY PROFILES

Generally, families whose children reside in foster care are impoverished and living on the fringes of society with few social supports.

Almost all children entering the foster care system are placed involuntarily by court order, either for child abuse or neglect (70%), or by the juvenile justice system.

Nearly all experience multiple social stressors, including single parenthood, lack of education, unemployment, substance abuse, mental or physical health issues, family violence, and involvement in the criminal justice system. Many biological parents of foster children suffer emotional disturbances, and a small percentage are mentally retarded (<10%). In the past decade, parental addiction to drugs or alcohol, especially crack cocaine, has become almost universal in this segment of the population. About one third of these biological parents admit to being abused or neglected as children, and most were raised by substance-abusing parents. About one third have physically or sexually abused their own children or failed to protect them from abuse by others. In about 70% of cases, the child is removed following prolonged involvement with social service agencies, including Child Protective Services, after preventive strategies have been exhausted and the child’s health and safety are at imminent risk.

REASONS FOR ADMISSION

Admission to foster care is and should be difficult. Almost all children entering the system are placed involuntarily by court order, either for reasons of child abuse and neglect (about 70%), or by the juvenile justice system as person in need of supervision (PINS) or juvenile delinquent (JD) placements (27%). Only 3% are placed voluntarily by families temporarily unable to care for them; these usually are children who have catastrophic medical illnesses or severe behavioral disturbances.

The immediate reasons for placement in foster care have changed in recent decades. In the past, economic hardship, child abandonment, and parental physical or mental illness were the primary reasons for placement. Although poverty remains the pervasive factor underlying foster care for them, a percentage will require out-of-home placement. HIV-infected children also sometimes are placed when their families no longer can care for them.

POPULATION STATISTICS

It is difficult to ascertain exact numbers of children in foster care. Approximately 500,000 children reside in foster care on any given day, but many more cycle through the system annually. According to government statistics, there was an 80% increase in the foster care population in the decade between 1981 and 1991, with most of the increase occurring from 1986 onward. The genders are represented fairly equally in foster care, but there is a dramatic preponderance of children of African-American and mixed racial heritage in out-of-home care, reflecting, in part, their preponderance in the poorer segments of our society. Recently, the average age of children in foster care has declined as more younger children are being admitted, largely because of neglect due to parental substance use. Indeed, between 1986 and 1991, the population of children younger than age 5 years placed in foster care mushroomed by 110% in large urban centers. Currently, about one third of those in care are adolescents and one third are younger than age 5. The number of unaccompanied refugee minors, especially from Cuba and Haiti, also has increased recently.

The Foster Care System

The foster care system, which was simple in its conception of providing needy children with nurturing families, has become a complex bureaucracy. Federal legislation determines patterns of funding and regulatory guidelines, but responsibility for the structure and implementation of programs resides with state social service agencies, which delegate daily management to county or private social service agencies.
CASEWORKERS

Each foster care program retains the responsibility for hiring and training caseworkers and foster families. Casework positions are entry level jobs in most social service departments, requiring no more than 2 years of college education, although the professional demands are more commensurate with the Masters degree level of social work skills. Foster care caseworkers are advocates for the biological family and must undertake a “diligent effort” to rehabilitate the parent(s), ensuring the accessibility of whatever educational or service resources are necessary (eg, housing, counseling, medical care, and drug and alcohol rehabilitation) for reunification. They also must coordinate educational, developmental, medical, and mental health services for the children. The caseworker’s legally mandated mission to reunite the child with the family of origin sometimes is in direct conflict with his or her best judgment of what constitutes the best interests of the child. Caseworkers then have the delicate task of supporting the biological parents through the process of developing an alternate permanency plan and enabling the child to develop secure attachments and a sense of belonging in a different family system. Caseworkers also recruit, train, monitor, annually recertify, and investigate minor complaints about foster homes.

Caseworkers must develop a working familiarity with the legal system, particularly the family court and juvenile justice system. Within 72 hours of removal of a child from his or her home, the caseworker must prepare a petition for the court documenting the reasons for removal. Many children are returned within this time frame if the social welfare agency lacks sufficient basis for the removal. Even well-documented petitions occasionally are denied by the court. Petitions often are prepared with the help of county attorneys, but in many states this responsibility falls primarily on the caseworker. Finally, caseworkers must be prepared to return to court regularly (usually at 3- to 6-month intervals) to provide ongoing documentation for the continuation of dependent care and to detail their own efforts on behalf of the family toward reunification.

OTHER PERSONNEL

In many states, when an individual child’s best interests appear to be in conflict with the goal of reunification, the court may appoint a law guardian for the child. This attorney, designated the child’s voice in court, often has limited contact with his or her young client. In some states, the court also may appoint a court-appointed special advocate worker to represent the child’s interests. These trained volunteers, who are not attorneys, devote many hours to investigating the child’s circumstances for presentation to the court.

GUARDIANSHIP

Legally, parents retain guardianship of their children residing in “the care and custody” of the county commissioner of social services. Guardianship can be terminated only as part of a separate legal process, in which the commissioner then becomes the child’s legal guardian until the child either reaches the age of majority or is adopted. Sometimes parents choose to free their children for adoption, but more commonly, termination of parental rights (TPR) occurs involuntarily, after a parent has continued to resist all efforts at reunification. The TPR process can take years, during which time dual, but conflicting, efforts at reunification and alternative permanency planning may occur.

The Child in Foster Care

Foster care for the child is a world fraught with uncertainty, upheaval, and losses. Children often are removed under urgent circumstances from all that is familiar to them. For children, the family, no matter how dysfunctional in society’s terms, is the center of their world. When separated from parents, a child is removed simultaneously from home, neighborhood, perhaps siblings, toys, clothes, familiar routines, school, and all else that has defined his or her world.

The system is literally thrust upon the child. Agencies may place children initially in a shelter or an emergency foster home until a traditional foster home becomes available. Most homes are kind and welcoming, but unfamiliar to the child. Within the first few days, the child meets a variety of strangers, from child protective and foster care caseworkers to police officers, physicians, and members of the foster home. There is little privacy, and most children, who are mourning the loss of their homes and families, are uncertain when they will see them again; are afraid to ask questions; and feel alone, isolated, and out of control. Not surprisingly, children are wary in the first several weeks, termed the “honeymoon period,” but as they adjust, they begin to act out their anger, frustration, and sadness.

LENGTH OF TIME IN CARE

Children removed from their families spend varying lengths of time in foster care. About 50% cycle through care in weeks to months, but about 10% remain in the system for years as their families repeatedly fail to meet the goals set by social services for reunification, yet resist other permanency options. The strongest determinant of length of stay (LOS) is the biological family’s level of cooperation with the individualized case plan for their child(ren), although it has been documented that minorities, older children, and children who have developmental disabilities are almost twice as likely to remain in care. The average LOS in the foster care system has declined from a high of slightly more than 5 years to about 2 years, a reduction attributed in part to increased efforts at reunifica-

The average length of stay in foster care has declined from about 5 years to 2 years, due in part to the 1980 Child Welfare Act that mandates permanency plans within 18 months of placement.
Foster Care

For the child who remains in foster care, even in a stable placement, there are major issues with which to contend. Although consistent visitation with the biological family is the best predictor of reunification, such encounters are laden with difficulty for the child. The tenor of the parent-child relationship varies. Children who have been abused or severely neglected by their parents may not feel safe, even during supervised visitation. Some parents attempt to sabotage the relationship of the child with the foster family. Parents may visit inconsistently, which is confusing and frightening for children. When the parent does come, the visit ends with the child reliving the initial separation. When the parent fails to appear, feelings of rejection and abandonment are reinforced. Visitation usually progresses through stages from visits supervised by caseworkers in a neutral setting to visits in the parent’s home for more extended periods and eventually unsupervised visits.

The life of the child in foster care is grounded in uncertainty, powerlessness, and guilt. Children in foster care will deny knowing the reason they were placed in care, and younger children may blame themselves for the disruption. Children do not know how long they will be in care, whether their parent will visit, or when their parent will get out of jail or the rehabilitation center. Biological parents may make promises they do not or cannot keep. Sometimes children are discharged from foster care or moved from one placement to another with the same abruptness with which they entered care. Other children tease them about being in foster care, contributing to their already poor self-regard and sense of alienation.

The process of terminating parental rights can create significant conflict. Termination of rights severs the child’s legal ties to the biological family, but not the emotional ties, and the child may be torn between conflicting loyalties to the biological family and the adoptive family. If the parent voluntarily frees the child, the child may view this as the ultimate rejection. Behavior problems often escalate around the time that parental rights are terminated and the adoption process is begun in earnest.

KINSHIP CARE

In the last decade, there has been a greater than 300% increase in children placed in “kinship care,” that is, foster care provided by a relative who has become certified as a foster parent with the intention of providing care for extended family members. For those whose income is marginal, certification includes eligibility for foster care stipends, which usually exceed the monies available through public assistance for the child’s care. Placement with a relative is believed to be advantageous for the child by maintaining a position within the larger family of origin and reducing the number of placement disruptions. In one study, children were half as likely to be abused or neglected when placed with a relative versus a nonrelative, although there are concerns that homes of relatives are monitored less rigorously than foster homes.

Foster Families

Foster families are the unsung heroes of the foster care system. Most are warm, caring, and dedicated individuals who open their homes to society’s most difficult and fragile children, taking them into their families and nurturing them through multiple crises. Foster parents vary in the education and skills they bring to caring for children, but they generally are motivated by religious conviction, altruism, or personal need. They tend to be “child-centered,” having raised children of their own and viewing foster care as a mission because of their love for children. They are usually married, of middle or lower middle income, from backgrounds rich in tradition, deeply religious, and have a relatively open definition of who constitutes family. About 5% of foster families have specialized training or skills and act as resources for severely emotionally disturbed or medically fragile children. Many states now have designated skilled homes that provide care for children who have HIV infection or other complex medical problems.

REIMBURSEMENT

Reimbursement rates for foster families vary widely. Families are paid a daily “board rate” for each child, which is set by individual states and determined by the child’s age, health needs, and complexity of required parenting tasks. Average monthly board rates for uncomplicated children are approximately $300 per month and are expected to cover food, shelter, personal needs, recreation, and most transportation and educational costs. Many agencies reimburse for some transportation (involving medical or mental health visits) and pay an additional stipend.
for clothing biannually. The highest foster family board rates are paid for children who have extremely complex medical issues or severe behavioral and emotional issues and may exceed $1,000 per month. About 30% of children in foster care, mostly adolescents, reside in residential or group homes, which is the most costly form of care. Residential placement costs may exceed $40,000 annually per child.

**TRAINING**

Recruitment and adequate training of suitable foster families are two of the most compelling tasks facing social welfare agencies. Caseworkers educate foster parents about child development, child abuse and neglect, behavior problems, discipline, safety issues, and their roles in relation to the agency and biological families, but the training is minimal. Agencies also lack the staff to scrutinize foster homes adequately, and annual recertification is less intense than the original certification process. As noted previously, approximately 10% of foster homes are closed annually for substandard care.

**ISSUES FOR THE FAMILY**

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 are accountable to caseworkers, the legal system, and the biological family for the child’s care. However, foster parents may feel excluded from planning on the child’s behalf because the biological parent retains legal custody, social service agencies generate permanency plans, and courts make placement decisions. Thus, foster families may be the individual child’s strongest advocate, but they are the second most powerless group in the foster care system, after the child.

Foster parents often receive only limited information about the children in their care. Placement in a foster home frequently still is regarded as the only necessary therapeutic intervention needed by a child, and agencies vary widely in the degree of guidance they provide to foster parents. Foster families may be overwhelmed, and placements may fail when foster families feel alone in handling complex behavioral and emotional problems. Because of shortages in foster homes in many areas, particularly large urban centers, most homes maintain the maximum number of children allowed under regulations, which can vary with the ages of the children in the home and ranges from four to six.

Foster families, like children in foster care, experience multiple separations and losses as children enter and leave their homes. They are in the unenviable position of preparing a child for return to a home situation that they usually deem unsuitable. Relationships with biological families can range from adversarial to mutually supportive. Foster parents often bear the brunt of a child’s anger over a failed visit or a parent’s phone call. They may feel scrutinized by the system, but simultaneously unsupported. They sometimes are accused falsely of child abuse or neglect by an angry child or parent.

It is the foster family that is approached for adoption when the biological family no longer is considered a permanency option for the child, and usually the foster family does adopt the child. Some families choose to retain a child as a long-term foster care placement either because the parent feels too old to adopt or the child is not freed by the biological family or chooses against adoption.

**Biological Parents**

Removal of a child is traumatic to the biological parent as well as to the child. For some, the shock of having a child removed is sufficient to precipitate improved parental behaviors, resulting in speedy reunification. About 50% of children in foster care are returned to their biological families within the first 6 months after removal. For other families, even the removal of a child does not alter ingrained patterns of substance abuse, violence, and child neglect.

In the process of battling addiction and poverty, parents often have to contend with feelings of guilt, powerlessness, inadequacy, anger, frustration, and resentment when children are removed. Although they retain legal custody, contact with their children usually is very limited, with only several hours of visitation per week at a neutral site supervised by a social worker. Parents may fail to appear for visitation, whether because of guilt, the pain of separation, fear of confronting their child(ren), or barriers such as illness and transportation.

Although the emphasis of the foster care system is on reunification and caseworkers are mandated to provide a range of services to birth families, some parents become locked in an adversarial relationship with the system, resentfully refusing all help offered. Some maintain only minimal contact with their children, sometimes just enough to prevent termination of their rights, effectively abandoning their children to the system. Some parents refuse to free their children for adoption, even when it is clear that an alternate permanency plan is in their child’s best interest and that reunification is not an option. In the 1990s, it has become possible for families to agree to “open adoptions,” which provide for several visits per year and are believed to benefit the child by providing ongoing contact with the family of origin.

**Outcomes for Children in Foster Care**

As already noted, about 50% of children are returned to a parent or relative within the first 6 months of placement. Of the remainder, 90% eventually are returned to the family of origin; unfortunately, there is about a 20% to 30% recidivism rate in the first year after reunification.

About 15% of children in foster care eventually are adopted, and more than 90% are adopted by their foster families. About 10% of adoptive foster families are relatives who became certified to care for the child. Almost all adoptions involve some subsidy, which reflects the board rate at the time of the adoption. Subsidy continues until the child reaches 18 years of age.

Approximately 5% of children grow up in the foster care system. Most are adolescents who have no
hope of reunification with their families and are tracked into independent living programs. Others are children considered difficult to adopt by virtue of their medical or behavioral problems, although many are older minority children awaiting adoptive placement, largely because there have been insufficient minority homes to accommodate the population.

A small percentage (3% of adolescents) are lost to care through elopement, and a similar number become involved with the criminal justice system or other long-term residential care. Children may remain in foster care until age 18 years in most states, although a few states allow placement to continue until age 21 years.

Transracial Adoption
The transracial adoption debate is multifaceted and complex. Professional social work and community standards long have supported a policy of placing children in ethnically similar homes, deeming it to be “in best interests of the child, which lie in having a stable family structure, preferably of similar cultural heritage, and the interests of the community in preserving minority families and culture. Ideally, these goals are not in conflict; in reality, they sometimes are.

International Foster Care and Adoption
The foster family care system that exists in the United States, Canada, Great Britain, and a few other countries, such as Korea, is an unusual solution to the problem of unwanted, abandoned, and destitute children throughout the world. Korea probably has the most stringent foster family care system, subsidized by adoption fees, in which families are well-screened, well-paid, and limited to one child per family. The United Kingdom calls its providers “foster-carers” to distinguish them as professionals who are expert in providing respite for children and families, but not substitutes for the family of origin. Some cultures, particularly Jewish and Islamic, have no formal dependent care system, relying instead on families within the community to assume the responsibility for needy children. Most countries rely on orphanages, run by the government or charitable organizations, to care for destitute children.

In recent years, the numbers of children adopted into families in the United States from international countries has soared, from about 7,000 in 1990 to more than 11,000 in 1996. Most adopted children now originate from China (3,000 annually), Russia (2,500 annually), and Korea (1,500 annually), along with several hundred per year from Romania, India, and Vietnam. International adoption is risky and complex because it is poorly regulated, little information is available about the children, available information is often suspect, and the family must comply simultaneously with adoption and immigration regulations, which vary from country to country. Families also must adopt the child in the country of origin and then complete a second adoption process in the United States.

Children available for adoption from foreign countries have much in common with children in the foster care system in our country. They are the children of the poor and disenfranchised in their own culture and often have been neglected or abused prior to placement in their country’s dependent care system. For many, the physical abuse and neglect continue after placement. Post-institutional syndromes, particularly resulting in sensory integration deficits, are common, especially among children adopted from Russia and Romania. Parental drug and/or alcohol abuse is a common issue internationally for children in out-of-home placement, and some children manifest the developmental and behavioral sequelae of prenatal exposure. Failure to thrive, developmental delay, psychosocial dwarfism, fetal alcohol syndrome, and infections are common, but may remain undiagnosed until the child arrives in the United States. International adoptees suffer not only the loss of their family of origin, especially if they are older, but also may experience cultural dissonance, especially if the adoption is transracial.

International placement with an adoptive family carries some risk for the child because there are limited safeguards. Agencies may serve simply as “facilitators” for the adoption, in which case they are not accountable for investigating an adoptive family to assess the appropriateness of the placement and may abrogate any responsibility toward the child once the adoption is complete. Some countries seek to provide some minimal assurance that children are adopted into safe and appropriate settings. For example, Korea forbids adoption except by married couples, and both Thailand and Romania require the adoptive parent to appear in court to complete the adoption. China has fairly restrictive criteria for adoptive families, but simultaneously provides minimal, often
inaccurate, information to prospective parents.

Child and family advocates involved in international adoptions strongly recommend that families work only with reputable licensed adoption organizations, preferably ones that perform home studies and remain a resource once the adoption is complete. Families should request any available written documentation and a videotape of the child. Although far from perfect, the latter aids in assessment of the developmental and physical well-being of the child. It also is strongly recommended that adoptive parents travel to the country of origin, both to familiarize themselves with the child’s background and culture and to obtain as much specific information about the child as possible.

There are many corollaries between children in foster care in the United States and those adopted from other cultures. Furthermore, if an adoption fails, as a small percentage do when families are overwhelmed by a child’s health or emotional issues, these children are placed into the foster care system in the United States. These, plus many issues specific to international adoption, are detailed in other reviews.

Health Care for Children in Foster Care

Children in foster care represent a highly vulnerable, medically complex population that suffers high rates of chronic medical illness; developmental disabilities; educational disorders; and behavioral, emotional, and mental health problems. In general, these conditions predate placement. Prenatal drug exposure, poor maternal nutrition, and poor prenatal care predispose to a higher incidence of preterm and small-for-gestational age infants. Postnatally, psychosocial deprivation, poor nutrition, and failure to attend to the child’s health care and developmental needs exacerbate problems. Limited use of preventive health services, fragmentation of care, and underimmunization are typical of children entering foster care. Unfortunately, foster care may potentiate rather than ameliorate such problems.

COMMON MEDICAL PROBLEMS

Studies of the health status of the foster care population have yielded fairly bleak results, although comparisons with a similar socioeconomic group not in foster care are difficult to attain. Approximately 80% of these children have at least one chronic medical condition, with about 25% of all children in care having three or more chronic problems. The diagnoses encountered most commonly are listed in Table 1. Respiratory problems affect about 35% of children in foster care, with asthma being the diagnosis encountered most commonly (18%); the high prevalence is attributed partially to a higher incidence of preterm birth and attendant lung disease and partially to the concentration of the foster care population in urban settings. About 20% of children in foster care are of short stature, with an additional 6% to 10% of infants and toddlers meeting criteria for failure to thrive. The overrepresentation of children of short stature is attributed to prenatal insults, poor nutrition, and emotional deprivation. At the other extreme, about 15% of children in foster care meet the criteria for obesity.

Hematologic disorders, mostly attributable to anemia, are present in about 20% of children. A variety of dermatologic diagnoses are reported, especially atopic dermatitis, acne, and seborrhea, although the prevalences vary among age groups. Burn scars or scars from physical abuse are encountered commonly (10% to 15% of children younger than 12 years). Visual and hearing impairment, recurrent otitis media, gastroesophageal reflux, neurologic disorders (varying from mild motor delay to seizures and cerebral palsy), and congenital anomalies are more prevalent than in the general pediatric population. Sexually transmitted and other infectious diseases also are encountered commonly. About 8% of children in foster care are “high-cost” patients because they are dependent on technology, have multiple handicaps, and/or are heavy users of ancillary services.

Children in foster care have a high prevalence of dental problems,
especially caries and malocclusion, which are reported in about 20% of the population. Changes in placement may result in a lapse in dental care, so continued monitoring of dentition and reminders to foster parents about the importance of routine dental care are important. Referral for dental care should begin at age 2 years.

**IMMUNIZATIONS**

Children in foster care tend to be underimmunized, even compared with other poor children, and every health care encounter should be viewed as an opportunity to immunize a child in foster care. It is our practice to administer inactivated polio vaccine (IPV) instead of oral poliovirus vaccine (OPV) and to withhold varicella vaccine until HIV status is known to be negative. Although the Centers for Disease Control and Prevention recommends universal hepatitis B immunization, state guidelines vary widely. In some states, immunization of children younger than 1 year of age and/adolescents is mandated, but other children are excluded. Children in foster care who have not been immunized against hepatitis B should be immunized regardless of age. The population is transient, the children are at high risk for vertically transmitted infection, and adolescents are at risk because of sexual practices. We perform a baseline hepatitis screen on all adolescents (children older than 11 years of age) before beginning the immunization series.

**ROUTINE SCREENING**

Underuse of routine preventive health care services implies poor screening for iron-deficiency anemia and lead and tuberculosis exposure. Many children in care reside or have resided in older housing, and pica is a commonly encountered behavioral issue, both factors that increase the risk for elevated plasma lead levels. Poor nutrition prior to foster care places children at risk for iron-deficiency anemia. Thus, clinicians should obtain plasma lead levels and screen all children younger than age 6 years for anemia at regular intervals. Universal tuberculosis screening of refugee minors and children of incarcerated or HIV-infected parents is recommended.

**INFECTIOUS DISEASES**

Maternal lifestyles during pregnancy, including substance abuse and promiscuity, place children in foster care at increased risk for a variety of vertically transmitted infectious diseases, including HIV, hepatitis B and C, congenital syphilis, and herpetic. Up to 80% of young children placed into foster care are at high risk for HIV infection, but fewer than 10% are screened because of the complexities of risk assessment, obtaining informed consent, and issues of confidentiality. Guidelines for testing children in foster care vary from state to state. Some agencies use risk assessment tools to determine a child’s risk for HIV infection, although the accuracy of such tools depends on the biological parent’s availability and veracity. In general, the biological parent retains the right to grant or withhold consent unless the child has been freed for adoption or parental rights have been terminated. Agencies vary in their policies regarding consent procedures when a parent declines screening but the child meets high-risk criteria. Identification of children who are HIV-positive is critical to appropriate medical management, including Pneumocystis pneumonia prophylaxis, modification of the immunization schedule, and early antiretroviral therapy.

Adolescents in foster care also represent a high-risk group for HIV infection, usually because of unprotected sex with multiple partners. In general, adolescents in care may consent to HIV testing unless they are cognitively impaired. Confidentiality laws vary, but in some states the adolescent has the right to designate who has access to HIV-related information, while in others, social service agencies and their representatives have access to such data on any child in their care and custody, including adolescents.

**DEVELOPMENTAL AND BEHAVIORAL PROBLEMS**

Approximately 60% of preschool children in foster care have a developmental disability, especially language disorders, poor social-adaptive skills, and delayed fine motor skills. Older children have higher rates of educational disorders, including learning disabilities, behavioral disorders, and limited cognitive ability; nearly 40% qualify for special education services. Many are placed in special education settings for emotional rather than for cognitive concerns because severe attentional difficulties, poor impulse control, and aggressive behavior often preclude placement in a regular classroom. Children younger than 5 years of age should undergo a formal development evaluation within 3 to 4 months of admission to foster care and receive developmental screening at each health supervision visit, with follow-up evaluations as indicated. The high prevalence of language disorders (50% to 60% of preschool children) implies that near universal hearing and speech evaluations of toddler and preschool children is beneficial in identifying those who would benefit from services. Older children who are not performing at grade level should be referred for an educational evaluation as soon as possible.

**MENTAL HEALTH DISORDERS**

Mental health disorders are rampant in the foster care population, with prevalences of severe disturbance ranging from 35% to 85%. Mental health care is the single overwhelming health care need of most children in care. These children use both inpatient and outpatient mental health services at rates 15 to 20 times greater than other children of similar backgrounds. Conduct disorder, oppositional defiant disorder, attention deficit hyperactivity disorder, and anxiety disorders are the mental health diagnoses cited most commonly for children in foster care (Table 2). Experienced professionals in foster care believe that the prevalence and severity of mental health disabilities have increased dramatically in the past decade and that more children are being diagnosed at younger ages. Preplacement issues, such as prenatal drug exposure, poor maternal nutrition, inappropriate parenting, and abuse and neglect during early childhood, all contribute to the poor emotional health of these children. Entry to
TABLE 2. Common Mental Health Diagnoses Among Children in Foster Care in Washington

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<td>Conduct disorder</td>
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<td>Oppositional defiant disorder</td>
<td>17 to 35</td>
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<td>Attention deficit disorder</td>
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<td>Anxiety disorders</td>
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<td>Depression</td>
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Foster care may exacerbate emotional disorders rather than remediate them because of the trauma of separation from families, the vagaries of the foster care system, and the emotional turmoil of living as a child in an uncertain world. Physicians should screen for emotional and behavioral issues at each health supervision visit. Almost every child in foster care older than 4 years of age should have regular encounters with a mental health therapist to help him or her deal with issues of ongoing separation and loss as well as feelings of anger, sadness, powerlessness, alienation, and guilt.

We use parent questionnaires to elicit some behavioral and emotional health information, but also have developed a clinician-administered short form that includes more specific questions about behaviors that are encountered frequently in this population. Some of the behaviors addressed in the latter form include fire-setting, animal cruelty, hyperphagia, hoarding, serious sleep disorders, and self-injurious behaviors.

Even children who apparently are thriving may have intermittent counseling needs. Inconsistent visitation, resumption of regular visits after a prolonged lapse, cessation of visitation, the process of being freed for adoption or of having parental rights terminated, and the final phases of the adoption process are particularly difficult times for children in foster care during which resumption of lapsed counseling or increased frequency of counseling visits are beneficial.

Many foster families have a wealth of child-rearing experience, but the clinician should not presume that knowledge about child development, behavior, discipline, and safety are adequate. Anticipatory guidance should be a routine part of well-child care and include issues specific to foster care, such as behavior problems related to visitation and the permanency planning process, significant sleep disorders, confused loyalties, issues of attachment, and issues related to violence and coercion.

PROVIDING CARE

Several characteristics of the foster care population render the provision of comprehensive, high-quality health care difficult, including the lack of medical information, lack of continuity of care, limited access, and complex issues of consent and confidentiality. Children usually enter care with a dearth of available medical information, and many leave their primary source of care. Identification of prior sources of care can be cumbersome and often is undertaken incompletely by case-workers. Responsibility for health care usually is delegated to foster families by caseworkers. The diffusion of responsibility underlies the pattern of inadequate, fragmented, times redundant health care. Foster families may use their physician as a resource for children placed with them, but because children move in and out of care and between foster homes and residential facilities, multiple providers may be involved, leading to fragmentation of care. Children who do not have obvious health care needs or clear-cut signs of significant child abuse or neglect are less likely to receive routine preventive health care, especially if they are in kinship care. However, many of those children will have unidentified or unmet health-related needs.

FINANCIAL ISSUES

When children enter foster care, they become eligible for Medicaid in most states, regardless of the biological family’s insurance coverage. Insufficient Medicaid reimbursement limits the number of providers willing to care for these children, especially when their health problems are multiple and complex. Currently, many states are “transitioning” children in foster care from Medicaid fee-for-service to Medicaid managed care. This may enhance access for preventive health care and subspecialty referrals because of better reimbursement, but mental health services probably will be rationed more tightly, making them less accessible.

Federal Medicaid regulations require all states to offer the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program to Medicaid-eligible children. Although states vary in their delivery of EPSDT services, it is useful for physicians to know that states are required to offer screening for medical, developmental, vision, hearing, dental, and mental health problems. Furthermore, states are mandated to provide for any diagnostic, treatment, and follow-up services for problems identified upon screening.

MONITORING CARE

Even though children in foster care use medical resources at a rate five or six times that of other poor children, they still have many unmet health needs. Many chronic medical conditions are untreated and sometimes undiagnosed. Despite the increased contact with medical providers, about one third of children in foster care fail to receive timely preventative health care. Our office employs a tracking system to recall children for health care visits and an enhanced preventive health care schedule that allows more timely identification of problems. Unfortunately, no studies have assessed health care outcome with the more intensive case management we recommend.
Standards for providing and monitoring the health care of children in out-of-home care were published by the Child Welfare League of America in cooperation with the American Academy of Pediatrics in 1988. In general, these guidelines are very similar to those outlined previously and in Table 3, although we recommend more frequent health supervision visits. Unfortunately, many states have only broad guidelines governing the provision of health care to children in foster care. Legal mandates may hold the social service agency responsible for the physical, emotional, and mental health of children in its care and custody, but there are multiple barriers to translating those mandates into actual health care management, including insufficient funding, inadequate caseworker and foster parent knowledge about the health care needs of children and health care systems, limited understanding of the foster care experience by health care workers, and blurred boundaries of responsibility for health care management for this complex population. Guidelines, although useful, have little impact on the availability, accessibility, and appropriateness of services for this population. The implication is that the pediatrician should assume responsibility for the management of health care for children in foster care to assure that regular comprehensive medical visits occur, that referrals are made quickly, that immunization status is updated, and that indicated ancillary services are in place.

### Recommendations for Clinicians

Children in foster care most often are accompanied by their foster parents for health care visits, although occasionally caseworkers and/or biological parents also may be present. It is essential for the physician, caseworker, and foster parent to communicate with each other concerning health care issues and for the caseworker to keep the biological parent, who remains the child’s legal guardian, informed. Physicians and caseworkers often have overlapping responsibilities, especially with respect to mental health referrals and referrals for developmental assessment. Reciprocal sharing of information concerning referrals and treatment plans should facilitate services and prevent duplication of effort (Table 3).

The following recommendations are based on our long experience with children in foster care:

1. Gather as much prior health history as possible. This may involve asking the caseworker to obtain the appropriate signed releases of information from biological families. Important information includes prenatal and birth history, developmental issues, growth curves, immunization history, results of screening for lead and anemia, and risk factors for HIV and other vertically transmitted infections. For older children, additional information should include any chronic illnesses, medications, allergies, surgeries, and educational history. Mental health history is very useful, but rarely available.

2. Become familiar with agency guidelines regarding consent and confidentiality for children in foster care. Whenever possible, obtain a signed consent to provide medical treatment, but do not withhold care pending signed consent; courts deem the provision of health care in the absence of consent less harmful than the withholding of care. Consent for HIV testing is governed by separate state guidelines in most instances and should be pursued for all children in foster care. Certain adolescent health care issues, such as pregnancy, sexu-

### TABLE 3. Guidelines for Managing Health Care of Children in Foster Care

| 1. Obtain signed releases of information for medical, developmental, educational, and mental health records. |
| 2. Become familiar with consent and confidentiality guidelines for children in foster care. |
| 3. Develop a tracking system to recall children at regular intervals for preventive health care. |
| 4. Develop an enhanced preventive health care schedule—biannual from 2 to 6 years of age, then annual: |
| • Maintain a well-documented health care record. |
| • Screen for developmental issues at each health care encounter; screen for hearing and vision annually for all children older than age 3 years; assess school placement issues. |
| • Screen for the following: child abuse and neglect, mental health issues, and behavioral problems at each encounter. |
| • Screen for risk for HIV, hepatitis B, and tuberculosis at each health supervision visit; screen children younger than 6 years for lead and anemia; assess growth parameters at each visit. |
| • Review issues of placement and visitation at each encounter. |
| • Conduct a complete physical examination of the disrobed child at each health supervision visit; screen for physical and sexual abuse and neglect at each encounter. |
| • Review immunization status at each encounter—universal hepatitis B immunization; use IPV until known to be HIV-negative; consider use of varicella vaccine in HIV-negative children if varicella status is unknown or the child is varicella-nonimmune. |
| • Refer when a problem is identified. |
| 5. Educate foster families, caseworkers, patients, legal representatives, and biological parents. |
| 6. Develop a system for communication with caseworkers, attorneys, and biological parents. |
ally transmitted diseases, birth control, and substance abuse, also usually are governed by separate laws concerning minors in each state.

3. Comprehensive preventive health care in the foster care population requires diligent effort on the part of the clinician. Because of the complex, multiproblem nature of issues in this group of children, longer appointment slots and a tracking system are suggested. Ideally, the agency should keep the physician informed about changes in placement and caseworker assignment and about any referrals made by the caseworker.

4. An initial health assessment should take place within 30 days of placement and should include the items listed in Table 3. Ideally, all children should be examined within 72 hours of placement to assess for signs of physical or sexual abuse or neglect and to manage any acute problems present at entry to care. Children older than age 2 years should receive preventive health care services biannually; children older than age 6 should have at least annual health supervision visits. This enhanced frequency, in our experience, allows more rapid identification and remediation of health problems, especially behavioral, developmental, and emotional difficulties. A detailed health care record should be maintained and available for use by caseworkers and attorneys, when necessary. In some areas, medical passports, which accompany the child through the foster care system and summarize all important medical information, have been used with varying degrees of success.

Given the high prevalence of developmental disorders in this population, every child younger than age 5 years should receive a formal developmental evaluation within 3 months of entry to care, unless already involved in a special program. Developmental screening should be a part of each health supervision visit, with repeat formal evaluation as indicated. Speech and language evaluation are particularly important because of the high prevalence of language delay in the foster care population.

Children who are not achieving up to their potential in school should have an educational assessment. Maintain regular contact with teachers, especially for children placed in special education programs. Request summaries of individualized educational plans and periodic evaluations.

Every child older than 3 years should be considered a candidate for a mental health assessment unless already involved in therapy. The child’s status should be reviewed by a mental health professional at admission, whenever the child’s level of function changes, or when there is a major life change, such as termination of parental rights, a change in foster care placement, or the illness or death of a parent or foster parent. Maintain regular contact with mental health providers and request periodic summaries from the therapist. Focus on visitation and the child’s progress through the foster care system, including legal status and adjustment to placement, at each health supervision visit or mental health encounter; these factors have important implications for mental and emotional health.

Annual screening for lead and hemoglobin should be undertaken in children younger than 6 years. Refugee minors or children whose parents are incarcerated or abuse drugs should have a tuberculin screen using the Mantoux test. We screen children once at entry; then at 3- to 5-year intervals. HIV risk should be ascertained at each health supervision visit, and consent for screening of high-risk children should be obtained if possible.

Screen for physical and sexual abuse and neglect at admission and each health supervision visit. Assess patterns of interaction in the foster home regularly. Mental health, behavior, development, and educational issues should be reassessed at each visit.

It is important to immunize children at each health care encounter to reduce missed opportunities in a population whose vaccination status is even worse than that of poor children in general. Universal hepatitis immunization is recommended. We use IPV rather than OPV until the HIV status is known. Varicella vaccine is now available for use in susceptible children. If no history is available, we immunize children according to guidelines once the children are known to be HIV-negative.

5. Educate foster families, patients, caseworkers, and legal personnel, especially about issues related to chronic illness, mental health, and behavior.

Summary
Caring for children in foster care, as for any child who has complex issues, is challenging and sometimes daunting. The pediatrician should become familiar with the intricacies of foster care agencies and the consent and confidentiality issues for children in dependent care. While maintaining communication with the social services agency, the physician should assume the responsibility for health care case management to promote regular comprehensive preventive health care; to ensure that children in foster care have access to all necessary services; and to optimize the physical, emotional, developmental, and mental health status of children placed into dependent care.

Acknowledgment
The author gratefully acknowledges Elizabeth McMahon, PNP, the members of her staff, and the foster families and caseworkers whose daily commitment to caring for children in foster care is a source of inspiration.

SUGGESTED READING
U.S. State Department, Office of Visa Processing. Significant Source Countries of Immigrant Orphans (FY85-FY96). 1996

PIR QUIZ

1. Which one of the following is the most common reason for placing a child in foster care?
A. Abandonment by parents.
B. Child abuse/neglect.
C. Economic hardship.
D. Parental physical/mental illness.
E. Parental substance abuse.

2. Which one of the following is the eventual goal of the foster care system for children?
A. Adoption by an appropriately screened couple.
B. Continued care by foster parents.
C. Placement in a residential or group home.
D. Reunification with biological family.
E. Transfer of care to capable relatives.

3. Which one of the following is a true statement regarding the foster care system for children?
A. Children often feel relieved and happy when removed from their abusive parents.
B. Financial support is a major incentive for foster parents to provide foster care.
C. Foster parents have legal guardianship rights while the child is in their care.
D. The long-term care plan is based primarily on the foster care caseworker’s assessment of the child’s best interest.
E. Most children placed in foster care are returned to a parent or a relative.

4. Which one of the following special health care needs of children in foster care requires the most vigilant screening, assessment, and intervention?
A. Dental caries.
B. Growth failure.
C. Inadequate immunization.
D. Lead poisoning.
E. Mental disorders.
## The Pediatrician and the Child in Foster Care

Moira Szilagyi

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