Health Care Needs of Children in the Foster Care System

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Abstract. Nearly 750 000 children are currently in foster care in the United States. Recent trends in foster care include reliance on extended family members to care for children in kinship care placements, increased efforts to reduce the length of placement, acceleration of termination of parental rights proceedings, and emphasis on adoption. It is not clear what impact welfare reform may have on the number of children who may require foster care placement. Although most children enter foster care with medical, mental health, or developmental problems, many do not receive adequate or appropriate care while in placement. Psychological and emotional problems, in particular, may worsen rather than improve. Multiple barriers to adequate health care for this population exist. Health care practitioners can help to improve the health and well-being of children in foster care by performing timely and thorough admission evaluations, providing continuity of care, and playing an active advocacy role. Potential areas for health services research include study of the impact of different models of health care delivery, the role of a medical home in providing continuity of care, the perception of the foster care experience by the child, children’s adjustment to foster care, and foster parent education on health outcomes. Pediatrics 2000;106:909–918; foster care, child welfare, children with special health care needs.

ABBREVIATIONS. HIV, human immunodeficiency virus; ASFA, Adoption and Safe Families Act of 1997; AFDC, Aid to Families With Dependent Children; MCO, managed care organization; CATCH, Community Access to Child Health.

Despite efforts to prevent child abuse and neglect, decrease the rate of out-of-home placement of maltreated children through family preservation programs, and increase the number of adoptions of children out of foster care, nearly three-quarters of a million children are currently in foster care in the United States.¹ Over the past 2 decades, the greatest increase in placements has occurred among African-American children and infants and children <5 years old. Increasingly, there is a preference for placing children deemed in need of substitute care with kin. In some cities and states, in 1994 there were more children in kinship care than in regular foster care.² (In this article we use the generic term foster care to encompass care provided by both relatives, and nonrelatives, unless otherwise specified.) Nonetheless, in 1995 the Child Welfare League of America reported that out of a total of 483 000 children then living in out-of-home care, 49% were living in family foster care, 23% in kinship care, 15% in residential group care, 1.7% in therapeutic foster care, and 11.3% in other facilities such as emergency shelters and psychiatric hospitals.³

The vast majority of children are placed in foster care as a result of neglect, physical abuse, parental substance abuse or abandonment.⁴ Contrary to a prevailing misconception, only approximately 10% of children for whom abuse or neglect is substantiated (approximately one-third of those reported) are removed from parental care. Consequently, children in foster care are a very high-risk group of children and youth. Some children spend a substantial portion of childhood in foster care. For example, an analysis of national data on the characteristics of children in foster care revealed that approximately 37% had been in out-of-home care for 2 years or more, and approximately 12% had been in care for more than 5 years,⁵ while in some large urban centers (eg, Cook County, Illinois) the median duration of placement approached 5 years in 1994.⁶

Many children enter foster care with chronic health, developmental, and psychiatric disorders, reflecting the neglect and abuse experienced before placement in addition to the trauma from being separated from their parents. More disturbing, however, is evidence that their health care is often neglected while in foster care. In 1995, the US General Accounting Office found that young foster children do not receive adequate preventive health care while in placement, many significant problems go undetected, or, if diagnosed, are not evaluated and treated.⁷ Among other things, this neglect of children’s basic health care needs is a result of inadequacies in the foster care system, as well as inadequacies in the health care system.

Several efforts have been made to remedy this problem. More than a decade ago the Child Welfare League of America, in collaboration with the American Academy of Pediatrics, published guidelines for health care of foster children.⁸ Class action lawsuits in at least 21 states have challenged state agencies to ensure adequate care, including health care, for this very high-risk group.⁹ With a few notable exceptions, obstacles to delivering ade-
quately care to these children have persisted. The idealistic assumption that removing children from their parents obligates the state to provide exemplary care has seldom materialized. Thus, clinical and research challenges continue for health care providers and others involved in the lives of these children.

The purpose of this article is to review what is known about the health status and health care needs of children in the foster care system, offer practical guidelines for primary health care practitioners who care for children in foster care, and suggest areas for further medical, mental health, and developmental services research.

BRIEF HISTORY OF FOSTER CARE IN THE UNITED STATES

Until nearly 150 years ago, families who could not raise their own children relied for help on extended family members, charity from religious organizations, or orphanages. Many older children were apprenticed to tradesmen as a means of preparing them for adulthood.16 State-supported foster care in the United States arose in the 19th century from social welfare programs that sent children from Eastern cities to the Midwest, where they lived with farm families as an escape from the dangers of urban life. In 1863, the Massachusetts State Board of Charities approved funding for a system of state-supported foster homes, paying nonrelatives a weekly stipend of $2.00 to care for children in need of out-of-home placement. Federal support for foster care was established in 1933 under Title IV of the Social Security Act. In the 1960s the number of children placed in foster care rose dramatically in response to increased awareness of the problem of child abuse. However, by the late 1970s social service researchers had documented that many children remained adrift in the foster care system because little effort was made to either reunify them with their biological families or arrange for adoptions.11,12 In 1980, the Child Welfare Reform Act (PL 96-272) directed social service agencies to prevent out-of-home placements when possible, to make reasonable efforts to reunify them with their biological families when feasible, or to find adoptive placement when necessary. Although the number of children in foster care initially declined in the early 1980s, increases in the incidence of substance abuse, single-parent families, homelessness, child poverty and child abuse, as well as the emergence of human immunodeficiency virus (HIV) infection, resulted in even greater expansion of the foster care population.13 Current efforts to reduce the number of children in foster care include increased use of family preservation programs to prevent out-of-home placement, more attention to returning children home quickly from foster care, accelerating termination of parental rights proceedings, and greater efforts to adopt these children.

The Adoption and Safe Families Act (ASFA) of 1997 is the most significant recent legislation affecting children in foster care. The context for this law was the pervasive view that the pendulum had swung too far to the side of preserving families, and away from protecting children. ASFA establishes the health and safety of children in the child welfare system as clear priorities. Well-justified concern persists regarding the length of time children linger in care: ASFA requires states to begin terminating parental rights if a child has been in care for 15 of the prior 22 months. Under aggravated circumstances, such as when a parent has been convicted of a felony against a child or a parent’s rights to a sibling have been involuntarily terminated, AFSA enables (but does not require) the states to proceed with terminating parental rights without providing further justification for doing so. For all children in foster care, states must obtain a court order at least every 12 months and demonstrate that reasonable efforts have been made toward establishing a permanent plan for reunification, or toward legal guardianship or adoption. The legislation also offers fiscal incentives for states to increase the number of children adopted. Clearly, the intent is to limit foster care drift.

TRADITIONAL VERSUS KINSHIP FOSTER CARE

Nonrelative care was the norm in foster care until the early 1990s. However, as more women entered the labor force the number of nonrelative foster family homes declined from about 147,000 in 1984 to 100,000 in 1990.14 In response to this trend, public agencies sought assistance from the children’s relatives to provide kinship foster care homes. In current practice, the term kin includes any relative, by blood or marriage, or any person with close ties to the family.15

Kinship care may offer certain advantages. Children may find placement with known family members less traumatic than placement with strangers. Cultural and religious practices are more likely to be continued, and this has been a major factor for advocates of kinship care. Kin frequently have a special commitment to helping their own (blood is thicker than water). Contact with parents is often more frequent, and may facilitate eventual reunification. There may also be disadvantages to kinship care compared with regular foster care. Skeptics question whether the extended family members of these inadequate parents are appropriate surrogates to provide kinship care.

Although each situation should be individually weighed, it is crucial to ask how kinship care can be helped to succeed given the strong ideological preference for first seeking placement with kin. Potential kinship caregivers must be carefully screened, especially because they are often not required to meet the same standards used for licensed foster homes. Frequently, informal kinship placements (ie, no court involvement and no legal transfer of custody) are arranged by public or private social service agencies, and it is uncertain what services kinship families receive and what obligations the agencies impose under these circumstances. Moreover, we know little of how children fare in these informal arrangements. In most situa-
Health and Mental Health of Children in Foster Care

For nearly 3 decades, researchers have noted a high prevalence of health and mental health problems in foster children. In 1972 and 1973 Kavaler and Swire18 systematically studied the health status of 668 children 0 to 15 years old who had been in foster care in New York City for at least 1 year. Approximately half (45%) of the children had 1 or more chronic medical problems and more than a third (37%) required a referral to a specialist for further evaluation and treatment. Nearly one-third (29%) of the preschool children were suspected of having delayed development and more than half (55%) of the school-aged children were suspected of having borderline or retarded mental development. Moderate to severe mental health problems were noted in approximately 70% of the children. Since then, cross-sectional surveys of children living in different cities or regions of the country,11,19–25 statewide population-based studies26,27 and a multicity comparison study2 have confirmed Kavaler and Swire’s initial observations.

The findings of consistently high rates of physical, mental health, and development problems in this population raise several important questions. To what extent did children bring these problems with them into foster care? To what degree are these (or additional) problems attributable to the foster care experience? Does the foster care system attend to the special needs of these children and help to improve their health status and overall functioning? A review of existing data sheds some light on these questions.

HEALTH PROBLEMS AT THE TIME OF PLACEMENT

For the most part, children enter foster care in a poor state of health. In addition to abuse or neglect that commonly results in out-of-home placement, their poor health reflects exposure to poverty, poor prenatal care, prenatal infection, prenatal maternal substance abuse, family and neighborhood violence, and parental mental illness.33 Children entering foster care are also more likely to have received inadequate routine preventive health care before placement than their peers. Similarly, children entering foster care may be at especially high risk for HIV infection, given the association between child maltreatment and substance abuse. For example, Flaherty and Weiss28 reviewed the physical examination findings of 5181 children taken into protective custody in Chicago over a 22-month period. Nearly half (44%) had an identified health problem, including acute infections (otitis media, sexually transmitted diseases), anemia, and lead poisoning. In addition, approximately 5% of the children evaluated for physical abuse were found to have occult fractures not suspected by their case-workers. Chernoff et al21 reported that of 2419 children assessed shortly after placement in foster care in Baltimore, almost all (92%) had at least 1 abnormality on physical examination, including disorders of the upper respiratory tract (66%), skin (61%), genitals (10%), eyes (8%), abdomen (8%), lungs (7%), and extremities (6%). Nearly one-quarter (23%) of younger children failed a developmental screening and 22% of older children were already receiving special education services before placement. As a result of these evaluations, 53% of the children were referred for further medical services.

PSYCHOLOGICAL PROBLEMS AT THE TIME OF PLACEMENT

A child’s experience before placement plays a significant role in determining how he or she will fare emotionally in foster care. According to Bowlby,29,30 infants whose early needs are appropriately met form a secure attachment to their caregivers. This is the foundation for trust, important for forming relationships throughout life. Young children who have experienced chronic physical abuse or emotional neglect often show insecure, avoidant, or ambivalent attachment to their primary adult caretakers.31,32 Thus, if children enjoy a loving and supportive relationship with parents early in life, there may be a stronger likelihood of forming positive relationships with the foster family. Conversely, and more commonly in foster care, children who lack the experience of loving relationships with parents may be unable to establish healthy relationships with new caretakers.

Children in foster care experience psychological difficulties for many reasons.33 Placement in foster...
care is rarely a planned transition for children. Many children do not understand why a stranger has suddenly taken them to an unfamiliar setting. Some children may be unable or afraid to even ask where they are going, when they can go home, and where their siblings or parents are. They are often tired, hungry, dirty, and confused, and some may be in pain or distress from recent physical abuse or untreated medical conditions. Most children feel a combination of fear of the unknown, guilt in having somehow brought about separation from their family, and a sense of being punished. Removal from one’s family, even an abusive one, is generally traumatic for children.

CHILDREN’S ADAPTATION TO FOSTER CARE PLACEMENT

Although children’s patterns of adaptation to placement are quite individual and vary with age, several themes are common. For example, many children go through an initial period of appearing to adapt well to their new foster homes, although this is most likely a period of intense emotional turmoil during which they do not manifest overt behavioral disturbance. However, after a short period of time, often within 3 months, foster parents may notice a significant increase in negative behavior marked by provocative acting-out or limit-testing. These children behave as though they need proof that their foster parents really care for them before they can open themselves to a trusting relationship. Conversely, children may withdraw or be depressed, angry and aggressive, and resist the efforts of foster parents to comfort them. These children, initially cautious and wary of their new surroundings, are not willing to get too close to their foster parents. Both patterns may resolve favorably if foster parents respond with sensitivity and understanding. Many foster parents need support to manage the difficult psychological challenges of a foster child.

Less common are children with severe attachment disorders. Although they may at first seem to adapt well, these children have great difficulty developing relationships with their foster parents and remain emotionally detached. They often act in an indiscriminate fashion toward adults. Many exhibit extreme behavior problems, such as hiding or hoarding food, excessive eating (polyphagia) or drinking (polydipsia), rumination, self-stimulating and repetitive behaviors (masturbation, rocking or head banging), and sleep disturbance. Despite excessive appetites, these children may fail to gain weight or grow normally while in placement. Unfortunately, these children frequently experience a succession of foster homes because their extreme behaviors and lack of emotional reciprocity challenge the abilities of foster parents. Children with symptoms of attachment disorder and their foster parents clearly require the support and guidance of a mental health professional to interrupt this dysfunctional pattern of behavior.

Psychological and behavioral problems are more common among children in foster care than in normative or community-based samples, even when compared with children who have backgrounds of similar deprivation.\textsuperscript{34,35} Prevalence estimates of depression, conduct disorder, oppositional defiant disorder, attention deficit hyperactivity disorder, attachment, and anxiety disorders in this population range from 29% to 96%.\textsuperscript{18,20,23,36–40} In Chernoff et al’s study, the prevalence of extreme psychological problems was also quite elevated: 15% of children entering foster care reported suicidal ideation; 7% reported homicidal ideation.

Possible overuse of psychotropic medications in children in foster care has been raised as a significant problem,\textsuperscript{41} although the use of such medications in this population may actually be too low given the prevalence of mental health problems. For example, Zima et al\textsuperscript{42} conducted structured mental health evaluations on a sample of 6- to 12-year-old children living in foster care in Los Angeles and noted that only 16% had ever been treated with psychotropic medication; the most commonly prescribed agents were stimulants (62%), antidepressants (31%), and mood stabilizers (31%). However, less than half (48%) of the children with a psychiatric diagnosis for which treatment with medication was indicated had received any psychotropic medication in the previous year.

MAINTAINING FAMILY TIES DURING PLACEMENT: PARENTAL VISITS

Family reunification is a major objective of foster care placement for most children, and ongoing contact with parents during placement is an important factor with regard to determining if children eventually return home.\textsuperscript{43} Visits may also be a source of much emotional stress for children and their biological and foster parents.\textsuperscript{44} Most children respond to visits with parents with a combination of anticipation and anxiety and it is not uncommon for behavior problems to occur before and after visits. Children may feel anger at their parents, whom they feel have abandoned them. They may perceive the end of the visit as another abandonment when they cannot go home with their parents. Less commonly, they may be afraid of being subjected to further abuse or neglect during the visit. Where visits take place and how they are conducted may influence their impact on the children, but these factors have received scant research attention. Many agencies have specific programs to facilitate visits but some visits take place in the foster parents’ home, at a public site (eg, fast food restaurant) or in the biological parents’ home. The last is particularly problematic if not supervised, because behavioral problems, skin marks, or the child’s verbal account of the meeting after the visit may too readily be interpreted by foster parents or caseworkers as evidence of maltreatment by the biological parents.

Although visits with biological parents during placement are often stressful, such contact should reassure children that their parents still care about them. Visitation may help strengthen the biological family’s functioning and lead to more successful
outcomes once the child is returned home. Thus, child welfare agencies should carefully plan and implement visits, paying particular attention to the purpose of visits for the individual child and family. However, visits that subject the child to repeated neglect by the parent(s), exposure to violence, or conflict between the biological parents and the foster parents or child welfare agency may aggravate the child’s adjustment to placement and should be avoided until the situation can be improved.

HEALTH CARE UTILIZATION BY CHILDREN IN FOSTER CARE

As might be expected from the high prevalence of physical and mental health problems in this population, children in foster care are also heavy utilizers of health care services. In 1992, Halfon et al documented greater utilization and costs of medical care for children in foster care in California compared with other children receiving medical assistance coverage. The major health care expenses for children in foster care resulted from hospitalization for perinatal complications, infectious diseases, and mental health disorders. Length of stay was 36% greater for mental health conditions and 27% greater for perinatal problems for children in foster care. Most striking was this population’s use of outpatient mental health services. Although children in foster care comprised only 4% of all children enrolled in MediCal in 1988, they accounted for 55% of all visits to psychologists and 45% of visits to psychiatrists paid for by the program.

Takayama et al compared Washington State Medicaid claims data for children in foster care 0 to 7 years old with those receiving Aid to Families With Dependent Children (AFDC) benefits in 1990. The mean cost of health care for children in foster care was $3075 versus $543 for AFDC children. The greatest expenditures for children in foster care were for mental health, supportive care, hospitalization, and medical equipment. Mental health services were used by 25% of children in foster care, compared with only 3% of AFDC children; and supportive services of visiting nurses and physical therapists were used by 13% of children in foster care, compared with only 1% of AFDC children. More than twice as many children in foster care used medical equipment or specialist services or were hospitalized, compared with AFDC children. Most striking was the finding that a small group of children in foster care (8%), who suffered from psychiatric disorders, neurologic conditions, and other complex, chronic medical diseases, often of congenital origin, had health care expenses that exceeded $10,000 per year, and accounted for 63% of the total medical expenditures for children in foster care.

CHANGE IN HEALTH STATUS DURING PLACEMENT IN FOSTER CARE

The impact on children of removal from their parents and placement in a foster home is a critical issue for the child welfare field. However, only a few studies have examined how these children change over time while in out-of-home placement. Children who experience long-term, stable placement show significant improvements in health status, physical growth, and educational achievement. For example, Fanshel and Shinn followed approximately 600 children who remained in foster care in New York City for 5 years and found substantial improvements in their intellectual and academic performance. A study of children who entered foster care in Baltimore in different time periods found that better health status was positively associated with length of placement. A recent study of preschool children who entered foster care for the first time in Connecticut noted that nearly half the children, regardless of their height at the time of placement, experienced dramatic catch-up growth in height during the first year of placement. Nevertheless, a subset of children does not do well in foster care, and this raises several questions: Is this a particularly disadvantaged subset of children, or are these children whose foster families do not provide adequate nurturing? Can we identify and remediate the factors that contribute to their poor outcome? Alternatively, what can be learned from children who thrive in foster care?

THE IMPACT OF WELFARE REFORM ON FOSTER CARE

Recent changes in family policy, particularly in relation to federal and state programs that provide financial support to families with dependent children may have a dramatic impact on the number of children requiring placement in foster care and on their health status. The passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PL 104-193), known as welfare reform, has resulted in substantial changes in the structure of public assistance for poor families and children by ending benefits under the AFDC program, reducing the Food Stamps program and reducing eligibility for benefits under the Supplemental Security Income program. As a result, the number of families receiving public support has declined dramatically. However, the extent to which these families have been absorbed into the general workforce is not clear at present.

Although the impact of these changes on the health and welfare of children is uncertain, there is concern that without adequate support to escape poverty, many families’ ability to care adequately for their children will be compromised, increasing rates of maltreatment and the number of children who require out-of-home placement. Additionally, lack of affordable high-quality day care may further compromise these parents’ ability to remain in the workforce, or influence parents to place their children in inappropriate care settings. The current economic boom and large number of low-level jobs generated may also mask the true impact of welfare reform on this population. Once the economy returns to a more normal pace, the number of former
welfare recipients unable to find work may increase significantly.

THE IMPACT OF HEALTH CARE FINANCING REFORM ON FOSTER CARE

For nearly 40 years the Medicaid program has been the nation’s principal source of health care coverage for poor children. Yet, despite increased expenditures generally for this program, reimbursement to physicians, dentists, and mental health practitioners has not kept pace with inflation, and the number of physicians willing to care for these children has decreased.50 In an effort to control program costs and improve access to care, some state governments enroll Medicaid recipients in privately owned and operated managed health care organizations (MCOs). Because MCOs share some burden of financial risk for the health care of children in their program, they have an incentive to provide effective services in an efficient manner by offering access to primary health care providers and a network of specialty providers. In addition, MCO centralized data collection and tracking systems may permit child welfare agencies to monitor health utilization patterns of children in their care.51 Nonetheless, despite their potential for rectifying many problems of the fee-for-service reimbursement system, MCOs have come under criticism for restricting access to newer pharmacotherapeutic agents, pediatric subspecialty care, mental health, and other health services (eg, speech, occupational, and physical therapy). Again, the impact on the health of foster children enrolled in MCO programs is not yet clear.

BARRIERS TO HEALTH AND MENTAL HEALTH CARE FOR CHILDREN IN FOSTER CARE

Despite more than 30 years of concern by health care and social service professionals about the health and mental health of children in foster care, relatively little progress has been made in improving the delivery of needed services. The causes for this inertia are complex and widespread.

Among barriers to providing health and mental health care for this population are problems within the child welfare system itself. Anecdotally, children have become ill or died after placement because neither social workers nor the foster parents were aware of children’s immediate health care needs. Frequent moves among foster homes or out of and back into foster care also contribute to children receiving care from many different physicians with little or no continuity.

Many child welfare agencies lack specific policies regarding health care of children in foster care. For the most part, caseworkers rely on foster parents to exercise sound judgment to determine when children require health and mental health care, yet foster parents are not empowered to give legal consent for treatment. In some jurisdictions, biological parents must provide direct consent for health, developmental, and mental health care their children receive while in placement, introducing a potential obstacle or delay to necessary services. Although many parents sign consent for routine health care at the time of placement, caseworkers must locate and encourage parents to sign separate consents for other specific evaluations (eg, mental health, developmental, or educational) or treatments, including any psychotropic medications. Child welfare agencies are responsible for ensuring that children in their care and custody receive services necessary to optimize their health and development. However, most agencies have continued to struggle with significant resource shortages in the face of increasing case loads, and children’s health care has not been a priority for the child welfare system. Both the Child Welfare League of America56 and the American Academy of Pediatrics52 have provided general guidelines for health care to children in foster care, but these have not been widely implemented. State agency regulations are needed to specify how this should be accomplished.53 There is clearly a need for creative and collaborative initiatives between the child welfare and health care systems to improve the health care of foster children.

The continuing lack of comprehensive and coordinated health programs for children in foster care was apparent in a recent study conducted by the US General Accounting Office.7 Despite state and county regulations requiring comprehensive routine health care, nearly one-third of young children in foster care in Los Angeles, Philadelphia, and New York City had received no immunizations, one-third had identified health care needs that were not met, and an estimated 12% of children had received no routine health care services. Although 78% of the children were considered to be at high-risk of HIV infection resulting from parental drug abuse, only 9% had been tested for the virus. That children fail to receive even basic health care despite the presence of many adults and professionals who share responsibility for them, including biological parents, foster parents, caseworkers, guardians’ ad litem, judges, and health care providers, points to the need to clarify roles these individuals should play to ensure that children receive needed services.

Health care professionals share responsibility for poor care children receive in the foster care system. Although many physical, psychological, and developmental problems of these children are similar to those occurring in the general population, especially among low-income families, many health care providers and mental health professionals have had little training regarding issues specific to children in foster care and may not recognize problems or refer these children for appropriate care. In particular, community health care providers are more likely to identify and refer young children entering foster care for evaluation and treatment of physical health and educational concerns than for developmental and mental health problems.54

Addressing the health care needs of children in foster care has not attracted many pediatricians. The children’s complex social situations, the extra time required to provide care, and the modest reimbursement may explain why many health care
providers have been deterred from becoming involved. Lack of communication with professionals in the child welfare system and frustration with the limitations of that system may also discourage health care providers.

Nationally, the inflexibility of existing state-operated Medicaid health care funding structures, and the move to managed care contracting without appropriate consideration of the special needs of children in foster care, have made it difficult to develop new approaches to delivering health and mental health services to this population. Furthermore, private foundations have shown little interest in supporting this aspect of child welfare. A notable exception has been the American Academy of Pediatrics, in cooperation with Wyeth Lederle Vaccines, which has supported several grass-roots efforts to develop innovative clinical programs for children in foster care through its CATCH (Community Access to Child Health) initiative.

IMPROVING THE HEALTH CARE OF CHILDREN IN FOSTER CARE

Health care services for children in foster care should not only enhance the health of individual children, but also facilitate and reinforce permanency plans. To these ends, several broader goals must be met, including development of an individualized health care plan for each child in foster care, and integration of that health care plan into the child welfare plan. The latter requires good communication between child welfare and health professionals.

Although it can be very difficult to obtain information from distraught, often angry, and sometimes absent parents, caseworkers or agency health care management personnel should try to collect as much health information as possible about the child, including current medical conditions, use of medication, past health history, previous health care providers, past hospitalizations, allergies, and need for ongoing services. Parental consent should be obtained to release all of the child’s health care records to the child welfare agency, which should then make them available to new health care providers. Children in need of immediate medical care should be seen in an emergency care facility; an appointment for an initial health screening examination should be arranged with a primary care practitioner. Ideally, agencies should identify a medical home for each child in their care and custody. Whenever possible, foster parents should be encouraged to continue children in the care of their usual health care provider. However, if this is not possible, child welfare agencies should recommend a provider in the community who has a particular interest in the health care of children in foster care. Continuity of health care, at least while in the system, will decrease the fragmentation of care that has been a serious problem for these children.

Health care professionals can play valuable roles in the care of foster children. Because of the high rates of health, developmental, behavioral, and educational problems, foster children generally require more frequent visits and more time than most children. Many states require that children newly placed in foster care have a comprehensive health assessment within 30 to 60 days of placement. In addition to the usual health maintenance activities required at each age, young children entering foster care should be screened for anemia, elevated lead level, sickle cell disease (when appropriate) and tuberculosis exposure. Signs or symptoms of physical abuse, neglect, or sexually transmitted diseases should prompt referrals for more complete evaluation, if possible, to an interdisciplinary team specializing in these problems. Developmental and psychosocial screening should include direct examination with standardized measures because studies have shown that reliance on caseworker and foster parent history for developmental information identifies only about 30% of all children with developmental delays. Thus, initial comprehensive medical evaluation should include mental health and developmental assessments. A follow-up visit should be arranged within 1 to 2 months to monitor the child’s adjustment to the foster home and to evaluate his or her development and emotional well-being. After their health status has been fully assessed, children in foster care should be followed closely to monitor their progress.

Each child’s risk for HIV, hepatitis B and C, and congenitally acquired infection (in particular, syphilis) should be assessed and followed with appropriate laboratory tests to confirm the diagnosis and ensure prompt treatment. Identification of children who are HIV-positive is critical because pneumocystis pneumonia prophylaxis and early antiretroviral therapy should be implemented along with modifications of the immunization schedule. For example, varicella vaccine should be withheld until a child’s HIV status is known to be negative.

A health plan should be developed by the health care provider for each child, updated at each health care encounter, and communicated to the caseworker and the foster family. Child welfare agencies should also maintain a centralized medical file so that health information can be included in case-planning decisions. Foster parents should be encouraged and supported to accompany the child on visits. In some areas of the country, Foster Care Medical Passports have been created to share medical information among professionals involved in the child’s care. These abbreviated medical record forms are usually kept by foster parents and brought to each health care visit. When used consistently, medical passports contain essential health information (eg, immunization history, a list of known chronic medical problems, routine screening test results, etc). However, more effective solutions to the problems of collecting, maintaining, and disseminating information about the health and mental health status of children in the foster care system will require the development of state-of-the-art computerized databases.
that integrate data from a variety of sources and incorporate appropriate security and confidentiality safeguards.

Health care providers can be effective advocates for children in foster care in several key ways. Caseworkers may need assistance in obtaining appropriate records from previous health care providers and interpreting the information. Individuals responsible for the child’s care must have a thorough understanding of the child’s health problems and the reasons for treatment recommendations. Foster and biological families may also benefit from support and advice health care providers can offer about child development and parenting issues. The health care providers’ ability to coordinate medical referrals and recommend specific community resources can ensure that children receive appropriate care in a timely manner. Adherence to recommendations should be monitored at each visit and health care providers should alert caseworkers if the plan has not been followed. Efforts should be made to identify reasons why actions are not taken, as this may help determine if foster or biological families need additional support to care for their children. Finally, health care providers should document both concerns and positive developments, and offer written opinions and recommendations to courts when necessary.

**PREPARING ADOLESCENTS TO AGE OUT OF FOSTER CARE**

As adolescents turn 18 they are generally no longer eligible for services through the foster care system, and their foster families may no longer accept responsibility for them. Clearly, this can result in a very difficult transition to independent living. Many states provide assistance to adolescents in foster care, such as help with housing, college, and job training to ease this transition. The responsibility for preparing adolescents for this transition rests primarily with the child welfare system. However, studies have found that adolescents who age out of foster care are generally poorly prepared for employment and independent living. Recent federal legislation (Title IV-E Independent Living Program) has doubled support for these efforts, from $70 million to $140 million. States are allowed to use some of these funds for easing the transition to independent living for youth aged 19 to 21 by, for example, covering room and board or offering medical assistance. Advocates need to work with states to help ensure these funds will be well-used to serve these very high-risk youth during a difficult transition period.

Health care providers can help prepare these youth by discussing future plans and preparation. Ensuring continued medical coverage may be another important issue, and the health care practitioner may offer to continue being the primary care provider for some period. Alternatively, assistance with finding a new provider is needed. There may also be a need to guide the foster family on how to encourage and support autonomy, but also to maintain an important emotional connection. The transition to independent living can raise many complex emotional and practical issues. Although there are few easy answers, health care providers can play a valuable role by supporting the teen and foster family in preparing for the challenges ahead.

**RESEARCH ISSUES**

Many important questions about foster care involve health, developmental, and mental health issues. Health care professionals, working with colleagues in social work and mental health, can help advance knowledge in this field, improve policy and practice in child welfare, and improve the lives of many children. Potential areas for research include the following:

**Models of Health Care Delivery**

Systematic and coordinated approaches to meeting health and mental health needs of children in foster care are needed, but salient elements remain to be identified. Delivery models have included specialized health clinics, primary care practices, hospital outpatient clinics, and use of medical consultants by social service agencies. There have been no comparisons of the impact of these varied approaches on health service utilization patterns, health status indicators of children, or costs. Given the high prevalence of health, developmental, and mental health problems in this population, it should be possible to measure favorable outcomes by reduction in the overall burden of illness and increases in positive outcomes such as the rate of physical growth, improvement in achieving developmental milestones, and/or emotional functioning, measured by standardized instruments.

**Role of Primary Health Care Providers**

Although many children in foster care require the services of pediatric subspecialists and mental health providers, all children should have a medical home where preventive health services can be provided and both acute and chronic problems treated appropriately. The effectiveness of coordinated primary health care services may be reflected in reduced reliance on inappropriate emergency department visits, subspecialist consultations, and laboratory investigations.

Health care practitioners need to be sensitized to the many issues raised in this article, and such efforts should be evaluated. Indeed, pediatricians seem willing to be primary health care providers for these children, but ways to involve them and improve their communication with other professionals involved in the care of these children (eg, social workers, lawyers, judges, etc) need to be developed.

**How Foster Care Is Perceived by Children**

Another potentially valuable area to evaluate concerns the children’s thoughts, feelings, concerns, and wishes. Understanding childrens’ views of their foster homes, foster parents, and caseworkers, the health care system and health care provid-
ers, and what they would like to see changed, may help to improve their experiences in foster care.

Children’s Adjustment to Foster Care

Studies should be conducted of how children of different ages adjust to placement in foster care. Very little information currently exists about children’s adjustments to care over time, and the impact of such critical junctures as termination of parental rights, changes in placement, changes in visitation patterns, or separation from siblings. A better understanding of foster care’s impact over time may assist foster parents in supporting children in their care. This knowledge may also help to identify children who are not adapting well early in the placement process, and may avert breakdown of placements through appropriate interventions.

The Impact of Foster Parent Health Educational Programs

Foster parents are usually required to participate in an educational program as part of the initial licensing process. However, little attention has been paid to the relationship between foster parents’ knowledge and skill in the area of health, developmental and mental health care, and the subsequent health status, developmental achievement, and emotional adjustment of children in their care. Foster parents can be trained to provide specialized medical care for chronically ill children, to provide developmental stimulation through play and recreational activities, and to assist in the treatment of serious emotional and behavioral problems by implementing specific behavior management programs.

The Impact of Other Specific Interventions

Little is known about the impact of specific interventions on the well-being of children in foster care. For example, early childhood educational programs, peer support groups, and/or enrollment in normal childhood activities such as sports teams, and community centers with structured activities, might be particularly valuable interventions. Also, peer-mentoring programs that use experienced foster parents to assist new foster families may result in more stable placements, improved child outcomes, and higher rates of foster parent retention.

CONCLUSIONS

Unfortunately, the population of children in foster care has increased dramatically over the past 2 decades. As a result of the circumstances that lead to placement, children entering the foster care system often have serious health and mental health disorders. Many of the children spend a significant portion of their childhood in foster care and there is little evidence that they receive comprehensive health care while in placement. In many respects, foster care remains a poor system for poor children. However, placement in foster care provides an opportunity and a responsibility to address all of the health care needs of this very high-risk group of children. Health care practitioners can play a significant role in providing care and assisting foster parents and caseworkers to ensure that children receive appropriate services in a timely fashion. Researchers can examine promising strategies for achieving these goals.

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The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://pediatrics.aappublications.org/content/106/Supplement_3/909