

Issues Related to Laboratory Screening for Children and Adolescents Entering Foster Care

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The article by Greiner et al¹ entitled “Laboratory Screening for Children Entering Foster Care” in the current issue is the first study in which researchers explore the application of the American Academy of Pediatrics (AAP) recommended laboratory screening guidelines for children entering foster care. Those guidelines, “Fostering Health: Health Care for Children and Adolescents in Foster Care,”² were first developed in the state of New York by a 20-person expert panel and were later endorsed by the AAP’s Task Force on Foster Care in 2005³ and reiterated in the latest AAP Policy Statement.⁴ Expert consensus was the only approach available in the absence of evidence about what constitutes quality health care for this population of underserved children with special health care needs. Given the absence of evidence to the contrary, the guidelines remain the standard today.

RATIONALE FOR SCREENING RECOMMENDATIONS

The “Fostering Health” guidelines were developed on the heels of the crack cocaine epidemic for those at high risk for vertically and horizontally transmitted infections but who mostly lack health records.² Children of all ages were considered to be at risk given the rates of disclosed and/or suspected sexual abuse, the high prevalence of adolescent at-risk sexual activity, and the lack of reasonable parental supervision related to substance abuse and/or mental health problems.

In addition to the high-risk nature of the population, several practical, scientific, and ethical issues require consideration with respect to laboratory screening when children enter foster care. First, the level of risk for infection may vary by locality and specific subpopulation. For example, certain subpopulations, such as unaccompanied refugee minors and commercially sexually exploited children, have a differentially higher risk for specific exposures; providers may wish to refer to the Centers for Disease Control and Prevention Web site for more specific guidance around such populations.⁵ Children also often enter foster care without complete health records, a problem that has only been partially solved by electronic records and immunization registries. Given that many children lack preventive health care before foster care,⁶ the children entering foster care are more likely to be underimmunized than their peers and to have missed other recommended screenings. Children spend variable amounts of time in foster care, ranging from days to years, and may experience several placements during that time. Thus, entry to care may be the only time providers can identify children with medical conditions and in need of treatment.⁴

At least 2 ethical issues also need consideration. First, avoiding further trauma to a child should be the primary goal of all those involved in the child’s care. This argues for the judicious use of laboratory screening or delaying it

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POTENTIAL CONFLICT OF INTEREST: Dr Szilagyi was the chairperson of the American Academy of Pediatrics (AAP) District II New York State committee that developed the initial health care guidelines for children in foster care (2001), the vice chair of the AAP Task Force on Foster Care that endorsed them (2005), and the author of the

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to allow time to prepare children for blood work and ensure they have appropriate emotional supports available when it is conducted. The costs to the child of retraumatization must be weighed against the benefits of screening in the context of what health history is available and the potential risk of undetected and untreated disease. Unfortunately, there is often no clear and easy answer.

A second ethical dilemma revolves around the disclosure of private health information about a child's biological mother that can occur when screening for vertically transmitted infections. A positive screen result for any of these infections requires further evaluation of the child and consideration of whether maternal disease has gone unrecognized, unreported, or untreated. The provider is under an obligation to reach out to the mother either directly or via child welfare to inform her about the results of testing and the implications for her own health and that of her child, to assist with access to needed care, and to engage her in health

decisions related to the child, when appropriate.

This issue is of increased concern with the recent influx of young children into foster care as a result of the opioid epidemic.

RECOMMENDATIONS MOVING FORWARD

A single study is insufficient to support the modification of national-level recommendations, but we concur with the authors that further studies are needed and that testing should be judiciously applied on the basis of a child's trauma history, health history, and risk factors. In the interim, child welfare, pediatric providers, and local public health officials will ideally collaborate on behalf of children entering foster care to develop protocols to achieve the following:

- Modify recommended laboratory screenings to reflect the prevalence of specific diseases in individual states and/or communities;
- Increase efforts to obtain and share birth and immunization records; and

- Develop protocols for screening adolescents for sexually transmitted infections and female adolescents for pregnancy while providing comprehensive reproductive health education and services.

Despite the complexity of the issues, laboratory screening is a relatively simple concern compared with the many complex issues related to caring for children in foster care.⁴ This special-needs population would benefit from the universal application of many of the other recommendations in "Fostering Health," including health, developmental, educational, dental, and mental health evaluations.³ We also suggest that "Fostering Health" become a living document that is revised annually on the basis of emerging evidence.

ABBREVIATION

AAP: American Academy of Pediatrics

AAP Policy Statement and Technical Report on foster care (2015) that let them stand; and Dr Schulte has indicated she has no potential conflicts of interest to disclose.

COMPANION PAPER: A companion to this article can be found online at www.pediatrics.org/cgi/doi/10.1542/peds.2016-3778.

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