CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

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Pediatrician Guidance in Supporting Families of Children Who Are Adopted, Fostered, or in Kinship Care

Veronnie F. Jones, MD, MSPH, FAAP,[a] Elaine E. Schulte, MD, MPH, FAAP,[b] Douglas Waite, MD, FAAP,[c] COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE

The child welfare system strives to provide children and adolescents in foster care with a safe, nurturing environment through kinship and nonkinship foster care placement with the goal of either reunification with birth parents or adoption. Pediatricians can support families who care for children and adolescents who are fostered and adopted while attending to children's medical needs and helping each child attain their developmental potential. Although this report primarily focuses on children in the US child welfare system, private and internationally adopted children often have similar needs.

THE FACES OF CHILD WELFARE IN THE UNITED STATES

The child welfare system strives to protect the safety of children while supporting families whose children are placed in foster care. In this document, the term "child" includes infants, children, adolescents, and young adults. The child welfare system also serves as a bridge to the primary goal of permanency through reunification or adoption. On September 30, 2018, the Adoption and Foster Care Analysis and Reporting System reported that 437 283 children and adolescents were in foster care.[1] Of these children, 262 956 entered foster care during the fiscal year of 2018, with 250 103 exiting foster care. The number of children served in the foster care system during 2018 was 687 345. There were 125 422 children waiting to be adopted, with 71 254 having parental rights terminated and 63 123 subsequently being adopted from care. Primary reasons for entering foster care include neglect (62%), parental substance use (36%), poor coping skills of the caregiver (14%), physical abuse (13%), and inadequate housing (10%). Other reasons that account for less than 10% in each category include child behavior problems, parental incarceration, parental alcoholism, abandonment, sexual abuse, child disability, relinquishment, parental death, and child alcohol and other substance use.[1] A growing number of children, estimated to be 5% to 10%

abstract

[a]Department of Pediatrics, School of Medicine, University of Louisville, Louisville, Kentucky; [b]The Children's Hospital at Montefiore, Bronx, New York; and [c]Department of Pediatrics, Icahn School of Medicine at Mount Sinai, New York, New York

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Address correspondence to V. Faye Jones, MD, PhD. E-mail: vfjone01@louisville.edu

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of the total foster care population, are specifically placed because of complex medical needs.[2] In many cases, a combination of these factors leads to foster care placement.

The 2018 Adoption and Foster Care Analysis and Reporting System reports the mean age of children in foster care is 8.3 years of age, with 42% of children 5 years or younger. Of note, adolescents 13 to 20 years of age account for 21% of the population in foster care.[1] Black or African American children account for 23% of the foster care population, and Hispanic and Latino children make up 21%. Children who identify as ≥2 races account for 8% of the foster care population, and children of American Indian or Alaskan native, Asian American, and Native Hawaiian or other Pacific or unknown ethnicity represent 4% of the population.[1] Forty-six percent of children are placed in nonrelative foster care, with another 32% placed in a relative or kinship foster home. Other placement categories include institutional (6%), group home (4%), trial home discharge (5%), preadoptive home placement (4%), supervised independent living (2%), and runaways (1%). Fifty-nine percent of children exiting foster care in 2018 returned to a parent or primary caregiver, and 25% were adopted, 7% were emancipated, 7% were living with other relatives, 11% were placed in guardianship care, and 1% transferred to another agency.[1] In 2017, a report by the National Council of Juvenile and Family Court Judges revealed Black and African American and American Indian and Alaska Native children constitute 27.5% and 2% of the population in care, respectively, although African American and American Indian and Alaska Native children represent approximately 14% and 1%, respectively, of the general population.[3] Although the data during the time period did not reveal overrepresentation for Hispanic and Latino children nationally, they did reveal disproportionate representations in several states.[3] These disproportionate rates of children in the child welfare system may result from social factors related to poverty, race, and class bias in initial reporting and subsequent processing of children in the child welfare system.[3–6] The effects of structural racism in the child welfare system also should be acknowledged and addressed in the disproportionate rates of minority children in the system.[7,8]

LEGISLATION SUPPORTING THE CARE OF CHILDREN IN FOSTER CARE AND ADOPTION

In 2018, the Family First Prevention Services Act was signed into law.[9–11] This law evolved in response to an increase in child welfare placements as a result of the opioid epidemic. The current increase in placements is similar to increases observed in 1999 at the height of the crack cocaine epidemic, when 567 000 children were in foster care.[12] The Family First Act allows reallocation of annual foster care funding to states, territories, and tribes to be redirected toward evidence-based preventive programs for mental health services, substance use treatment, and in-home parenting skill training with the goal of keeping children with their families, focusing especially on families affected by substance use and psychiatric illness.[9–11] The Family First Act also seeks to improve the well-being of children in foster care by placing children in the least restrictive environment within the child welfare system while setting standards of care for children with special needs placed in residential treatment programs, including timely assessments and periodic reviews to ensure continued need for a high level of care.[9–11,13] Summaries of the Family First Prevention Services Act and other significant federal legislation passed to protect children in foster care are highlighted in Table 1.[13–15]

KINSHIP CARE

Approximately 4% of all children in the general population are cared for by extended family members. Although the vast majority of these more than 2.7 million children in the United States live in extended family homes without involvement of the child welfare system, approximately 104 000 of these children have been formally placed in kinship care as part of the state-supervised foster care system.[23] One-quarter of all children who have been removed from their homes by the child welfare system are subsequently placed in a kinship home. Over the past decade, the number of children in kinship care has grown 6 times faster than the number of children in the general population (18% vs 3%, respectively). It is estimated that 1 in 11 children live in kinship care for at least 3 consecutive months at some point before the age of 18 years. The likelihood that African American children will experience kinship care is more than double that of the overall population, with 1 in 5 African American children spending time in kinship care at some point during their childhood.[23] The passage of the Adoption and Safe Families Act in 1997 promoted placement in kinship care as a means of shortening length of child placement in foster care while continuing a child's relationship with his or her birth parent.[20] Kinship care is relatively cost-effective and may keep children more connected with their families, communities, and cultures compared with nonkinship care.[24,25]

Multiple studies suggest specific advantages when children are placed with members of their birth family.[26–32] In a systematic review, authors found that children placed in kinship foster care experienced fewer behavioral problems, mental health

TABLE 1 Federal Mandates for Adopted and Foster Children

	Description
Family First Prevention Services Act of 2018 (Pub L No. 115-123)[13]	This act reforms the federal child welfare financing streams Title IV-E and Title IV-B of the Social Security Act to provide prevention services, including mental health services, substance use treatment, and in-home parenting training. Allows IV-E funds to support inpatient substance use disorder treatment settings that allow the placement of children with their parents when those settings can treat the needs of both the parent and child. Reauthorizes the Regional Partnership Grant program, which supports multidisciplinary approaches to addressing the effects of parental substance use on child welfare. Mandates that services be trauma informed and evidence based. Seeks to improve the well-being of children already in foster care by incentivizing states to reduce placement of children in congregate care while raising standards for residential treatment programs.
Fostering Connections to Success and Increasing Adoptions Act of 2008 (Pub L No. 110-351)[16–18]	States must make reasonable efforts to place siblings in the same foster home unless doing so would be contrary to the safety or well-being of any of the siblings. If siblings are not placed together, the state must make reasonable efforts to provide frequent visitation or other ongoing interaction between siblings unless this interaction would be contrary to a sibling's safety or well-being. Ensure that children have permanency goals to improve the well-being of children served by public child welfare agencies. Child welfare agencies are required to notify relatives of the child's removal from the custody of the parent. Promote permanent placement with relatives. Maintain connections with siblings and family. Increase the number of adoptions for waiting children. Improve outcomes and transition for older youth. Improve outcomes for American Indian and Alaska Native children. Improve competencies of individuals working with children involved in the child welfare system. Improve education stability and coordination of medical needs.
Child and Family Services Improvement and Innovation Act of 2011 (Pub L No. 112-34)[19]	Requires states to monitor children removed from the home for emotional trauma States must track and enact protocols for appropriate use of psychotropic medications States must report on steps taken to ensure developmental health for young children in state care
Adoption and Safe Families Act of 1997 (Pub L No. 105-89)[20]	Provides a fundamental change in child welfare philosophy from a primary focus of reunification with the biological parents as the principal goal without regard to parental history, to a process of considering child well-being related to the child's health and safety in permanency planning. Improves the safety and promotes permanency for fostered children through adoption or the establishment of other permanent homes. Gives preference to the placement of abused and neglected children with relatives. Provides provisions to ensure family support. Places an emphasis on timeliness to permanency.
Indian Child Welfare Act of 1978 (Pub L No. 95–608).[21,22]	Enacted "to protect the best interests of Indian children and to promote the stability and security of Indian tribes and families by the establishment of minimum federal standards for the removal of Indian children from their families and the placement of such children in foster or adoptive homes which will reflect the unique values of Indian culture, and by providing for assistance to Indian tribes in the operation of child and family service programs." Gives greater authority to tribal governments to collaborate in decision-making in child custody proceedings. When a child lives on a reservation or is a ward of the tribe, tribal leadership can assert exclusive decision-making power.

disorders, and placement disruptions compared with their counterparts in nonkinship care.[26] Thirty-two percent of children placed in early kinship care showed behavioral problems 36 months after placement, compared with 46% of children placed in nonkinship homes when controlling for baseline behavior before placement.[27] Children also experienced less stigma and trauma from the separation from parents and were more likely to remain connected to siblings and maintain family cultural traditions.[28–32] Researchers have consistently shown that relative caregivers are more likely to be single, poorer, and older; to have less formal education than nonkin foster parents; to care for large sibling groups; and to have chronic health conditions or disabilities because of their age.[33,34] Children who come to the attention of child protection and

are placed with a relative but are not taken into state custody (voluntary kinship care) are more likely to be cared for by a grandparent (87%) than children placed in kinship foster care after being taken into state custody (43%). Conversely, children in kinship foster care are more likely to be in the care of an aunt or uncle (37%) than those in voluntary kinship care (10%).[33] Children in kinship care are more likely to be removed from the birth parent's home because of parental substance use and neglect than children in nonkinship care.[34] For kinship families, unexpected placement of children with relatives may exacerbate financial and daily life stress. A report by the Annie E. Casey Foundation revealed 38% of children living in kinship care live below the federal poverty threshold, and 63% live below 200% of the poverty level.[23] A recent report by Generations United revealed that of the 2 572 146 grandparents responsible for their grandchildren, 57% were in the workforce, with 20% living below the poverty line.[35]

Despite these challenges, voluntary and kinship foster caregivers are less likely to be aware of financial benefits and other support services available to children in nonkinship foster care.[23,36,37] The Annie E. Casey Foundation reports that fewer than 12% of kin caregivers receive help from Temporary Assistance for Needy Families program, although the majority of families are eligible to receive benefits.[23,37] Fifty-eight percent of low-income kinship families do not receive Supplemental Nutritional Assistance Program benefits (food stamps) or Medicaid health coverage.[23,37] Only 17% of families receive child care assistance, with a mere 15% seeking housing cost support.[23] These statistics highlight how little our current child welfare system and communities support kinship families, especially those outside of the child welfare system, and why pediatricians, through referral to benefit resources and simple acknowledgment of the dedication of kinship parents, can be an important part of a support network to kinship families who care for children who would otherwise be placed in a nonkinship home.

The Families First Act has several provisions to support kinship families by extending Title IV-E eligibility requirements at the end of 12 months while ensuring that programs provided to children are not counted against a kinship caregiver's eligibility for other programs.[9–11,13] The Family First Act funds the development of an electronic interstate database to help facilitate placement of children with relatives who live in states other than the child's state of origin. Additionally, the Family First Act allows states to receive funding for up to 50% of the state's expenditures on kinship navigator programs that work to help locate potential kinship placements for children in the child welfare system.[9–11,13]

In addition to placement in kinship care, placement of siblings in the same foster home helps maintain ties to a child's family of origin. Approximately two-thirds of children in the child welfare system have a sibling in care.[38,39] The Fostering Connections to Success and Increasing Adoptions Act of 2008 was the first federal law to address the placement and welfare of siblings and promote ongoing relationships with siblings, requiring:

[S]tates to make reasonable efforts to place siblings in the same foster care, kinship guardianship, or adoptive placement, unless doing so would be contrary to the safety or well-being of any of the siblings. If siblings are not placed together, the state must make reasonable efforts to provide frequent visitation or other ongoing interaction between the siblings, unless this interaction would be contrary to a sibling's safety or well-being.[16–18]

Efforts to maintain sibling placement can be complicated because of inaccurate contact information after sibling separation.[40] Furthermore, specialized medical and psychiatric needs of a child may require an exceptional foster home placement, which further complicates attempts to keep siblings together.[41] Maintaining contact with siblings and other members of a kinship family in such cases helps ameliorate the strains such separations put on ties to a child's birth family.

An often-forgotten venue of kinship care and placement of siblings is the adult sibling caregiver, which is the third largest relative caregiver group behind grandparents and aunts and uncles.[42] In their study, Denby and Ayala[42] reported adult sibling caregivers have the same unmet service needs as other kinship caregivers, and the emotional toll may be even greater because of their unique sibling relationship to the child's birth parents. Although sibling caregivers who express a relatively high degree of parenting ability report strong support systems, others with low levels of family involvement and social support report a dissatisfaction with available services.[42] Additionally, when younger siblings have special health care needs, the adult sibling caregiver is more likely to commit to adopt their siblings.[42] Pediatricians can help adult sibling caregivers connect with peer-aged parents and caregivers to support parenting skills. By educating sibling caregivers on the developmental abilities of their younger siblings, pediatricians can ease unrealistic caregiver expectations while encouraging activities to promote child development.[42]

Kinship caregivers report significantly fewer support services than other foster caregivers, such as parent training, peer support, and respite care.[43] Grandparents who become adoptive parents may have

the additional burden of grieving lost expectations of their own children becoming parents while coping with the stresses of raising another generation of children and managing the ongoing challenges that led to their grandchild's placement in care.[35] In some cases, the stress of taking in a grandchild may cause problems within a marriage, exacerbate preexisting health issues, and increase financial strain within the family. Kinship parents may experience guilt or resentment over the birth parents' inability to be primary caregivers for their children.[35] At the same time, kinship parents may face challenges from birth parents who may express anger over the circumstances that led to their children being placed in foster care and feel the kinship parent conspired against them to obtain custody.[35,44] In addition, children may not understand or may resent the kinship parent, blaming them for their inability to live with their birth parents.[28] Boundaries must be set regarding the type of contact, timing, and granting of parental responsibility to the birth parents. All family members may need to be reminded that the guardian or adoptive parent is the responsible parent.

ADOPTION AND PERMANENCY

Approximately 2.4% of the child population in the United States is adopted, accounting for 2.1 million children.[45] In 2014, there were a total of 110 373 adoptions, with 41 023 (37%) adoptions with at least 1 adoptive parent related to the child by blood or marriage, and 69 350 (63%) family-unrelated adoptions.[46] The number of children who are adopted in the United States has steadily declined, primarily because of a decrease in international adoptions. In 2004, 22 989 children were adopted internationally. In 2013, 7092 international adoptions occurred, dropping to 4714 in 2017.[47] Although this clinical report is focused on children who are served through the child welfare system, awareness of other venues for adoption is important, because many of the same issues exist for both groups.

Additional demographic data collected by the Children's Bureau at the Department of Health and Human Services Administration for Children and Families provide a broader picture of adoptive families.[48] Data reveal that the predominant family structures are married couples (68.8%) and female-headed households (26.5%). Previous families of fostered youth account for almost half of adoptions, with relatives making up 31% of adoptive families. Eighty-one percent of children adopted from the foster care system are classified as having special needs. Ninety-one percent of families receive an adoption subsidy. White children account for most adoptees (49%), whereas African American and Hispanic children represent 19% and 22%, respectively.[48] Younger children are more likely to be adopted than teenagers. According to a report from the Children's Bureau through a partnership with the Ad Council, AdoptUSKids, youth in the foster care system between the ages of 15 and 18 years represent 43% of all children with active photograph listings on AdoptUSKids.org, but only 5% of all children adopted in 2015 were in that age range.[49]

Two different forms of adoption influence a child's subsequent relationship to his or her family of origin. Closed adoption allows no sharing of identifying parental information with the adoptive parent, leaving large amounts of information and details of an adopted child's family of origin and birth unknown to the adoptive parent. In contrast to closed adoptions, open adoption allows a continuum of communication between birth families, adoptive parents, and the adopted child.[50] Open adoption may be restricted to birth parents' participation in the selection of the adoptive parents or may extend to regular communication between, or face-to-face meetings with, the adoptive parents, adopted child, or both.[51,52] Open adoption is a dynamic and fluid process with the goal of child-centered integration of a child's family of origin with the adoptive family that ensures the child's awareness of his or her origins and culture. Open adoption may be particularly important to an older child or adolescent with long-standing bonds to members of his or her birth family. Postadoption contact between families is typically unregulated; in rare cases, a judge may order postadoption contact with birth family relatives, even over the adoptive parents' objection. Although these statutes are present in most states, their implementation is varied.[53]

As children age into adolescence and adulthood, they often wish to seek out more information about their biological families.[54] In attempting to gain information about their birth parents, adopted individuals who joined their families through intercountry adoption may choose to make a trip to their country of birth. Others seek information about their birth parents through commercially available DNA testing that matches an individual with those who share a similar DNA inheritance.[55] Advancements through social media have also made it much easier to locate relatives of their family of origin.[56] Other available routes include exploration of reunion registries, reestablishment of ties in a lapsed open adoption, or restoration of other ties that have connections to the child's family.

Although some adoptive parents may view their child's searching for his or her birth family as a sign of rejection, this transition is a normal sign of healthy emotional growth and

establishment of identity. The experience of a reunion with the biological family may be rewarding but may also cause the child to re-experience his or her loss. In preparing for contact and reunion, those who have been adopted or experienced foster care may need to anticipate a whole range of realities, including rejection by the birth parent(s) and family members.[57,58] Pediatricians need to be aware of the feelings children may have after meeting a sibling, either one who is older or who remained with the birth parent(s) or one who was born after the child was placed. Adoptive parents may fear birth parents will interfere in the adoptive family's life or affect the child's bond with the adoptive family. All members of this triad may need the help of mental health professionals to work through these situations. An adoption-competent social worker and/or counselor can discuss the extent of communication between the adoptive family and birth family and provide needed support by identifying benefits and drawbacks to the relationship. Pediatricians are encouraged to become aware of local community resources, support groups, conferences, services, and mental health professionals to which families confronting these difficult issues can be referred. Some available resources are included later in the article.

MEDICAL ISSUES

Children, adolescents, and young adults involved in the child welfare system often have multiple health care needs.[59–66] Because children who have been in foster care may move through multiple placements, the resulting fracture of medical care places children at risk for having medical, developmental, and psychiatric needs that remain either unaddressed and/or untreated. In addition to developmental delays and behavioral issues that can occur because of neglect and early environmental deprivation, physical and sexual abuse can lead to marked behavioral challenges at any age. The effects of toxic stress in early childhood on the neuroendocrine–immune system not only leads to psychological and psychiatric morbidity but also can result in higher risks for later medical morbidity. Additional information on the effects of early life adversity on brain development and both physical and mental health can be found in the 2012 American Academy of Pediatrics (AAP) policy statement and technical report on early childhood adversity and toxic stress in addition to the AAP Trauma Toolkit (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Training-Toolkit.aspx).[67,68]

Among the multiple factors associated with removal of a child from a parent's home, parental substance use is one of the most common. Although 36% of children in the child welfare system are referred because of documented parental substance use, children referred for neglect (62% of child welfare referrals) often have parental substance use that has not been documented at the time of intake.[1] Although parental substance use is often reported on foster care intake, the co-occurrence of alcohol use by the parents is often overlooked. This is especially important in caring for children born with neonatal abstinence syndrome. The prevalence of fetal alcohol spectrum disorders (FASDs) among children in foster care has been estimated to be 16.9%.[63] A recent study of children in foster care referred for developmental evaluation provides further evidence of the prevalence of FASD in foster care and lack of diagnosis of this disorder. Eighty percent of children subsequently diagnosed with an FASD had not been previously diagnosed with this disorder.[64] Given this prevalence, all children entering foster care should be screened for prenatal alcohol exposure. The AAP has created an implementation guide for pediatric primary care providers to increase screening for prenatal alcohol exposure (https://www.aap.org/en-us/Documents/FASD_PAE_Implementation_Guide_FINAL.pdf). In addition, a comprehensive medical evaluation, including behavioral health assessment by using validated tools to identify needs, is most effective when completed soon after placement.[61,62,66] An early evaluation allows the pediatrician to identify and address existing medical diagnoses, uncover issues unaddressed before placement, discuss developmental and behavioral concerns with parents, and make appropriate referrals when appropriate.[61,62,66] Other issues for exploration, particularly in the adolescent and young adult population, include a history of their own substance use, mental health history, and the potential of the adolescent or young adult to be involved in sex trafficking.

Review of past medical records allows successful coordination of the child's medical, developmental, and mental health needs. Children in foster care may arrive at the office or hospital with little or no documented medical history. Despite reasonable efforts to obtain past records, information may be incomplete or uncomprehensive in scope. Barriers to obtaining consent from birth parents can make these efforts frustrating. Determining who has legal authority to give consent to care and allow access to past medical records is critical. Access to a child's medical history is particularly important for children with complex health care needs. At the time of admission to the child welfare system, the person with legal custody of the child signs consent for general and emergency medical care. Consent for further medical intervention beyond routine care must be obtained from the legal guardian. Foster parents

may not be authorized to sign consent for medical care. Many states have passed medical consent laws that allow kinship caregivers to make health decisions on the child's behalf with parental consent and without having to obtain legal custody.[69] In cases in which, despite diligent efforts, obtaining consent is not possible or in cases of parent refusal to sign consent, local child welfare authorities or the family court system can override custody rights in acting toward the best interests of the child.[70] Such situations may include the need for surgery, medical tests, psychotropic medication, and developmental evaluation and intervention. These legal issues often require pediatricians to act as advocates for the child while working with the foster care agency and family court system. After adoption, adoptive parents gain the right to be legal guardians and make decisions separate from the birth parent. The AAP Council on Foster Care, Adoption, and Kinship Care has provided further guidance related to consent in "Health Care Issues for Children and Adolescents in Foster Care and Kinship Care"[61] and at the AAP Fostering Health Web site: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Fostering-Health.aspx.

Particularly relevant parts of the health care record include past medical history; complications of pregnancy; late recognition of pregnancy; lack of prenatal care; prenatal exposures to maternal alcohol, substances, and/or tobacco; poor maternal nutrition; preterm birth; maternal and paternal psychiatric illness; and genetic diseases within the family. Important history also includes the number of previous placements, significant past relationships, developmental delays, abnormalities in growth, behavioral challenges, mental health history, substance abuse, and any traumatic events such as physical and sexual abuse, including sex trafficking.[61,62,65,66] Pediatricians can use the time a child is in foster care to integrate the medical, developmental, and psychiatric history within an electronic health record that can be easily forwarded to new placements while working with their state child welfare system to advocate for centralized or portable records that can travel with the child across foster care placements. Examples of categories within such records may include birth and developmental history, prenatal drug and/or alcohol exposure risk factors, immunization records, past psychiatric treatment, and ongoing diseases and medications. When reviewing medical records, informed interpretation of the Health Insurance Portability and Accountability Act allows proper sharing of information to improve continuity and coordination of medical care. The Health Insurance Portability and Accountability Act contains several provisions that encourage information sharing regarding children in foster care.[71]

In collaboration with members of child welfare services, pediatricians can develop treatment recommendations that support caregivers in planning to best meet their child's physical and mental health needs while anticipating future challenges. Pediatricians without expertise in this area may seek resources through the AAP Council on Foster Care, Adoption, and Kinship Care to assist in this effort.[72] For internationally adopted children, this evaluation includes, but is not limited to, infectious disease and developmental screening tests and assessment of immunization status, as recommended in the AAP *Red Book*[73] and the Centers for Disease Control and Prevention *Yellow Book*.[74] The following AAP resources are also available to guide pediatricians: *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit*,[75] *Developmental and Behavioral Pediatrics*,[76] and *Adoption Medicine: Caring for Children and Families*.[77]

Finally, identification and documentation of a child's medical diagnoses may be necessary in establishing eligibility for financial subsidies to support the child's needs. Although the type and amount of assistance vary by state and typically are negotiated before the adoption is finalized, financial subsidy may specifically support medical and/or psychiatric care, counseling or therapy, special equipment, tutoring programs, or other support services that may help children who have special needs.[78–80] Community services, such as early child intervention programs, quality early childhood learning centers, parent support groups, financial assistance, respite care, trauma-informed care, and community organizations, including local child welfare agencies, can also help support families. Organizations such as the Child Welfare League of America[81] and Generations United[82] may be valuable resources for pediatricians and families.

COMMUNICATING WITH CHILDREN AND ADOLESCENTS ABOUT PLACEMENT AND PERMANENCY

Even before a child understands the words "adoption," "adopted," "foster care," "kinship care," "guardianship," and "biological family" or "birth family," these words should become a part of a family's natural conversation, whether the adoption is open or confidential, kinship, or foster-adoptive placement.[83,84] Positive language lays a foundation for a child's later understanding of the abstract concepts of foster care, adoption, and separation from birth parents. It is generally not advisable for families to wait until "just the right minute" to talk to children about their permanency status, because this

may leave children feeling betrayed and wondering what else their parents may have hidden from them. Early communication that shares these sensitive histories, starting with placement or early childhood, helps maintain trust between the parent and child. Encouraging an honest, nonjudgmental discussion of a child's birth family and the placement or permanency process will give a child permission to ask questions and express thoughts and feelings that not only serve to develop trust and a feeling of security but also help ameliorate the shame and the stigma associated with being in the child welfare system.[85–87]

Some information in a child's past may be difficult to discuss, such as previous sexual or physical abuse or having been conceived in the context of rape or incest, and should be discussed on the basis of the child's questions and developmental ability to understand these difficult thoughts, feelings, and memories. Furthermore, for older youth and adolescents, discussion of parental psychiatric history, substance use disorder, and life challenges that might have hindered a parent from being a greater part of the child's life can help open future questions and dialogue. Pediatricians, potentially with the collaboration of a mental health specialist, may help the family decide how and when to disclose this information. Open discussion with a child is essential in building bridges of trust and security within a family, but it is also important that the discussion be framed with developmentally appropriate language.[87] Effective communication nurtures a child's self-esteem as he or she grows in the understanding of what it means to join a family and integrate disparate parts of their lives. A child's understanding of the meaning of permanency changes with his or her cognitive development. The pediatrician can counsel parents about the need to understand the child's specific questions surrounding placement and permanency in the context of the child's current development and answer questions in a way that supports a child's sense of self and self-efficacy (Table 2).

Children placed in families at a young age may not understand that they have another family besides the family with whom they live. For many children and adolescents, separation anxiety and other internalizing and externalizing disorders may be pronounced, especially with children who remember the loss of birth or foster parents, siblings, or other relatives. Children may fear that their current family will abandon them in the same way once their "hidden flaws" are discovered. Some children may express yearnings to have been "in the belly" of their mother with whom they are presently living.[86] By kindergarten, many children realize that most of their peers are not in foster care, kinship care, or adopted, which may lead children to feel responsible for their birth parents' inability to raise them as well as for the repeated losses through moves in and out of foster care. This feeling of responsibility is especially true when a foster placement does not advance to adoption of the child.[89–93]

Pediatricians are encouraged to model positive adoption language for all families. Adoptive, foster care, and kinship care families are "real" families; siblings who joined a family through any of these channels are "real siblings." Birth parents do not "give up a child for adoption," which might imply to the child that he or she was of less worth and was given away. Rather, they "make an adoption plan for a child." Furthermore, in modeling positive language, pediatricians can use vocabulary that reflects respect and permanency about children and their families.[84] A "life book," that compiles both happy and difficult periods of a child's life experiences can be an effective tool for parents in helping a child process their thoughts and feelings.[94] Some families choose to develop rituals with their child to honor the child's birth parents on birthdays or holidays or as a special prayer to commemorate the birth family. Rituals like these allow children to acknowledge and remember their past but also to honor their present status.[84]

LOSS, GRIEF, AND TRAUMA ASSOCIATED WITH FOSTER CARE PLACEMENT

Although birth parents may anticipate the loss of their parental rights or loss of their child through adoption, the surrendering of their child often precipitates grief and a sense of loss manifested as denial, sorrow, depression, anger, and guilt. Birth parents may grieve the loss of their role as a parent and of playing a significant part in their child's life. The later birth of other children may be a reminder of the loss of the child that they did not raise.[95] In cases in which change of custody is kept secret, friends and family may not even be aware of this loss or not understand the extent of the birth parent's loss.

Foster parents can experience loss and grief with each child for whom they care. In many instances, foster parents interact with birth families to support reunification of the family. Although reunification may be the mutually desired goal, the resulting separation can be traumatic to both the foster parent and child.[96] Moreover, other children in the home may experience loss and undergo their own grieving process. Birth children of foster parents report feelings of guilt, sadness, and blame at the departure of a child who had been fostered in their childhood home.[97] Anniversary reactions often occur for children with each passing year. Anniversaries may trigger thoughts of the birth family, and children may wonder whether their birth parents still love them or even

TABLE 2 Developmental Tasks and Issues Specific to Adopted and Foster Children

Age and Developmental Stage	Erikson's Psychosocial Stages of Development[88]	Issues That May Be Intensified for Adopted and Foster Children	Strategies for Families and Pediatricians
Birth to 16 mo	Trust versus mistrust	Difficulty or failure to develop a trusting, reliable attachment to caregivers Children may present with feeding problems, anxiety, depression, aggression, sleep disorders, and lack of trust[56]	Educate caregivers of the need to provide a consistent, sensitive, and responsive environment Caregivers should be vigilant for behavioral dysregulation that can be a sign of previous trauma and toxic stress[36]
18 mo to 3 y	Autonomy versus shame and doubt	A child's emerging self-centered perception of the world can become fragmented from experiences of multiple caregivers, previous neglect, and physical or sexual abuse	Caregivers should be aware of the manifestations of early childhood adversity and toxic stress[56,57] Create a highly structured, calm environment that provides a feeling of safety and security Address a child's questions and fears with acknowledgment tempered with reassurance of the child's current safety Be vigilant for developmental delays and behavioral problems, especially in cases of known or suspected prenatal alcohol or drug exposure and in such cases facilitate referral for evaluation for fetal alcohol spectrum disorders Refer to early intervention for developmental delays and behavioral concerns
3–5 y	Initiative versus guilt Problem-solving; attempts to understand permanency and past and current living arrangements	Children who have experienced trauma or been placed with multiple caregivers may exhibit anger, withdrawal, aggression, or sadness because of feelings of insecurity about their environment or caregivers Children who come into families by foster care or adoption experience loss in multiple areas of their life; loss should be viewed as a form of trauma and may manifest in variety of ways depending on the child's developmental level, the type of placement (temporary versus permanent), familiarity of surroundings and support systems[82–85]	Keep a daily, consistent routine Understand a child's current concerns and behaviors in the context of their past experiences and meet these challenges with acknowledgment and reassurance Validate a child's feelings while setting limits on problematic behavior Refer to mental health services when appropriate Refer for speech and other developmental or behavioral problems Consider referral to developmental-behavioral pediatrician and/or referral for evaluation for fetal alcohol spectrum disorders in cases of developmental or behavioral challenges Provide opportunities to nurture intellectual curiosity by allowing preschoolers to explore their environment through imaginative play and social engagement Encourage preschoolers to plan and participate in new activities of their own choosing within the bounds of a safe environment
Middle childhood	Industry versus inferiority Peer groups have increased influence over a child's self-esteem	Fostered or adopted children may experience low self-esteem and feelings of inferiority or rejection as they become aware of their differences from their peers. Such issues may be especially difficult for children placed in homes of a different racial or cultural background In addition to loss of their family of origin, fostered children may experience the loss of friends, surroundings, culture, and disruption of past routines	Caregivers can help their child integrate past experiences into their current life Caregivers can help a child begin to understand how current feelings and thoughts may be related to past experiences while grounding the child to their present life circumstances Refer to mental health services when appropriate Refer for educational support services if indicated Consider referral to developmental-behavioral pediatrician and/or referral for evaluation

TABLE 2 Continued

Age and Developmental Stage	Erikson's Psychosocial Stages of Development[88]	Issues That May Be Intensified for Adopted and Foster Children	Strategies for Families and Pediatricians
			for fetal alcohol spectrum disorders in cases of learning and/or behavioral challenges Caregivers can be encouraged to educate their child about their cultural history while being sensitive to nonverbal clues that they communicate about race and cultural differences
Adolescence	Identity versus role confusion Autonomy Abstract thought; concepts like adoption and permanency may be internalized and adolescents might go through an intense period of self-reflection in an attempt to define their identities. As adolescents develop and begin the task of separation and individuation, permanency issues commonly become important, changing relationships between the adolescent and family	Early life trauma and toxic stress can worsen as a child moves from childhood to adolescence, especially when compared with peers who have had more stable childhoods Adopted adolescents or adolescents in foster care often struggle to integrate their past life into their current life and their future Adolescents may challenge authority within and outside the family, which may result in conflict; Youth may "test" caregivers by challenging their commitment to their relationship Risk-taking or unhealthy peer relationships can place adolescents at high risk for substance use, chronic truancy, and/or involvement in the juvenile justice system; such behaviors are sometimes precipitated by contact with or identification with birth parents who may have had similar difficulties	Caregivers should be aware of the manifestations of past traumatic events and losses and meet challenging behaviors with understanding but age-appropriate limit setting Encourage diary and creative writing or other art forms as a path for integrating past and present experiences into a life story Ensure appropriate support services are provided in school Refer for mental health or substance use treatment services when indicated Consider referral for evaluation for fetal alcohol spectrum disorders Pediatricians can screen for and directly address risks for substance use, depression, suicidality, and criminal behavior in one-on-one conversations with the adolescent In cases in which adolescent risk-taking behavior becomes a risk to an adolescent's future or placement stability, caregivers can consider pursuing a person-in-need-of-supervision petition in family court
Young adulthood[86]	Experiment and exploration: love, work, and worldviews	Housing instability Educational dropout Unemployment Lack of trust, expectation of failure in life trials, and social acceptance Engagement in criminal activities	Support transition with extension of foster care to age 21 y Supportive housing Job placement Funding for college opportunities Social networks and mentoring

think about them. The Child Welfare Information Gateway provides useful resources for families on separation and grief.

FAMILY DIFFERENCES

Although all children, especially in adolescence, face the normal developmental task of clarifying their identity, adopted children and children living in foster care with parents of a different race, ethnicity, or cultural background face the additional challenges of assimilating disparate parts of their lives. Children as young as 3 or 4 years are aware of differences between themselves and members of other racial groups.[98–102] When children live in communities where they are members of an ethnic minority, the differences in racial identity will be easily apparent to classmates, other parents, and strangers. These differences may provoke a child's sense of confusion about their racial, ethnic, or cultural origins.[102]

Children may encounter racist remarks for the first time, particularly in situations in which they are not physically or emotionally safeguarded by their parents. Role-playing with children with respect to stereotypes and racist statements may help them to feel in control when they encounter comments from strangers, friends, or extended family members.[103,104] Parents who have not experienced racism personally may need to pay extra attention to teaching their children effective ways to respond to racism. Families should openly acknowledge racial differences while providing the child with relationships with others of the same race or ethnic group, including adults and children.[104] The child should also be given the opportunity to learn more about the heritage of

his or her racial and ethnic group and country of origin.

An estimated 220 000 children are being raised by more than 111 000 same-sex couples, with approximately 12% of children identified as adopted or in the foster care system.[105,106] Gates et al[107] reported that same-sex couples are 4 times more likely to adopt and are 6 times more likely to foster children than their different-sex counterparts. Additionally, approximately 25% of same-sex couples raising children are involved in kinship care arrangements. In the past, same-sex couples raising adopted children were typically older, more educated, and had more economic resources compared with other adoptive parents.[107] More recently, however, this trend may be changing secondary to the evolving societal acceptance and legal climate within the United States.[108,109] Between 2014 and 2016, 16.2% of all same-sex couples were raising children.[109] The majority (68%) of the couples were raising biological children; however, same-sex couples were more likely to have a child who was adopted (21% vs 3.0%) and/or a child in foster care (2.9% vs 0.4%) compared with male-female couples.[109]

In 2002, the AAP published a policy statement and technical report supporting coparent or second-parent adoption and reaffirmed the policy statement in May 2009.[110,111] Regardless of the sexual identity of the parent, children thrive best when raised in a home that provides a caring, supportive, and secure home environment. Children who grow up with gay or lesbian parents show the same emotional, cognitive, social, and sexual development as children who grow up with heterosexual parents.[112] Authors of a recent study exploring the perspectives of youth who were adopted by gay and lesbian parents reported that although many children experienced more bullying and teasing than their counterparts, children of gay or lesbian parents were more accepting, had greater understanding, and were more compassionate toward people and individual differences than their counterparts raised by heterosexual parents.[113] This growing literature supports pediatricians in their advocacy for all capable individuals to have the opportunity to become foster and adoptive parents.

EDUCATIONAL CHALLENGES

Information from a 2018 multistate study reveals that 65% of foster youth had had more than 1 foster care placement, 34% had experienced 5 or more school placements; up to 47% had been placed in special education, and 65% completed high school by age 21.[114] Additionally, 17- to 18-year-old youth in the child welfare system are 2 times more likely to be suspended and 3 times more likely to be expelled from school.[114] Researchers in the 2005 Midwest study of 736 foster care alumni found that although 57.8% of former foster youth earned a high school diploma and 5% completed a general equivalency diploma (GED), 37% had attained neither a high school diploma nor GED.[115] Youth who earn a high school diploma are 1.7 times more likely to complete an associate's degree and 3.9 times more likely to complete a bachelor's degree and have higher incomes than those with a GED credential.[115] A 2018 multistate study found that although 70% to 84% of high school graduates wished to pursue further college education, only 32% to 45% actually enrolled in college, and only 3% to 11% attained a bachelor's degree.[114]

Researchers have shown that a higher incidence of exposure to one or more traumatic adverse childhood experiences affects educational achievement.[116–118] Maltreatment experienced before kindergarten was associated with negative academic and behavioral outcomes by second grade.[117,118] Kovan et al[119] report children involved with the child welfare system had poorer outcomes than their peers with no involvement with the child welfare systems on measures of receptive vocabulary, math reasoning, and teacher ratings of anger or aggression and anxiety or withdrawal. These findings support previous studies with similar conclusions of poor outcomes of children who have experienced neglect in early childhood.[117] Similarly, poor science outcomes have also been reported for children who experience neglect before kindergarten compared with their peers.[117] Thus, disproportionate representation of children from minority populations in the child welfare system helps maintain disparities in academic outcomes.[3–6] Quality early child care and early education programs, such as Head Start and prekindergarten programs, can partially mitigate the effects of maltreatment on school readiness and child development.[118–121] For children younger than 3 years, referral to a federally funded early intervention program may be warranted. For children older than 3 years, Individualized Education Program and 504 plans under the Individual with Disabilities Act can be mechanisms to obtain services and resources to help meet the special needs of children in foster care or those who have been adopted.[122] In addition, the Uninterrupted Scholars Act (Pub L No. 112-278), passed in 2013, allows information sharing between schools, child welfare agencies, and tribal organizations without parental consent.[123]

TRANSITION CARE TO ADULTHOOD: BARRIERS AND OPPORTUNITIES

Most young adults not in foster care continue to receive ongoing financial and social support from their parents beyond age 18.[124] In 2018, approximately 19 000 young adults aged out of foster care, potentially

losing the financial, educational, and social support services of state foster care overnight when they turned 18 to 21 years old, depending on the state in which they resided.[1,125] Adolescents in foster care enter the world of adulthood all too often ill prepared, their prospects compounded by mental health problems, substance use, and underemployment.[126,127] The Midwest outcome study revealed that fewer than half of young adults leaving foster care were currently employed at age 26, approximately half of the young adults who had worked during the past year reported annual earnings of $9000 or less, and more than one-quarter had no earnings at all.[127] Researchers in a study of aged-out youth found that 20% were chronically homeless, with housing instability associated with emotional and behavioral problems, physical and sexual victimization, criminal conviction, and high school dropout.[128]

Title IV-E of the Social Security Act was amended in 1986 to create the Independent Living Program, allowing states to receive funds to provide independent living services.[129] State child welfare agencies are required to develop a transition plan in collaboration with the youth aging out of foster care that includes housing, health insurance, education, local opportunities for mentors and continuing support services, workforce supports, and employment services.[16–18,129,130] The age limit for foster care varies by state, with some states extending care to 21 years of age. The Fostering Connections to Success and Increasing Adoptions Act of 2008 amended Title IV-E to extend the age of Title IV-E eligibility from 18 to 21 years.[16–18,129] In one study, youth living in a state that extended the age of foster care to 21 years were nearly twice as likely to complete at least 1 year of college education.[126] Awareness of state-specific age limits on foster care placement allows early transition planning for all adolescents in the medical home.[131] Youth who remain in care past age 18 attain higher educational credentials, which translate into better employment outcomes.[126,127,132,133] Furthermore, even when the level of educational achievement is controlled for, the number of years in care after the age of 18 positively affects employment and higher wages of the youth.[134] This study suggests a window of opportunity within transition planning for obtaining employment before discharge from foster care. It also supports the extension of foster care from age 18 to age 21.[134]

Youth transitioning out of foster care report that the most important support for working toward their educational and employment goals are job preparation skills, transportation, child care, educational services, and overall life skills.[135] Yet, former fostered youth who currently live independently overwhelmingly describe a lack of resources in the areas of employment, education, finances, housing, access to independent living classes, personal care, and networking.[135] Although parents outside the foster care system often contribute to the development of young adult independence by advancing important skill-building activities early in life, empowering youth to make decisions for their own lives, and reinforcing the youth's ability to learn and cope with the consequences of those decisions in a supportive environment, this support often fails to be included in the transition care of children in foster care.[136]

Mental health challenges further complicate transition planning from foster care. More than half of young adults leaving care (54.4%) have current mental health problems, compared with less than one-quarter of the general population (22.1%).[137] The prevalence of posttraumatic stress disorder within the previous 12 months is higher among young adults in foster care (25.2%) than among the general US population (4.0%) and nearly twice the rate of that experienced by American war veterans (Vietnam: 15%; Afghanistan: 6%; and Iraq: 12–13%).[137] The prevalence of major depression within the previous 12 months is significantly higher among foster alumni (20.1%) than among the general population (10.2%).[137] Although mental health challenges might be thought to be solely linked to foster care placement, researchers of studies among US adoptees suggest otherwise. Among 96% of the adopted children placed before 1 year of age and all children adopted before their second birthday, adoptees were 4 times more likely to attempt suicide than nonadoptees.[138] Potential contributing factors for the increased risk of suicide attempt include early trauma before adoption, prenatal substance and alcohol exposure, and genetic predisposition to psychiatric illness.[138]

In the face of these adversities lie barriers to medical and psychiatric care. In a study of foster care alumni, only 47% of young adults had health insurance as they prepared to leave foster care.[139] Young adults in foster care are more likely to have health conditions that limit their daily activities, report more emergency department visits and hospitalizations during the previous 5 years than their peers, and suffer medical problems that are left untreated because of lack of health insurance.[61,140] Pediatricians can help youth prepare to transition their health care needs by identifying medical issues that require regular follow-up and educating youth on how to use health insurance benefits and nonemergent medical care.[133] Information on billing for the delivery of health care transition services can be found in the 2017 Transition Coding and Reimbursement Tip

Sheet, as well as other resources, on the Got Transition Web site.[141]

Finally, children placed in foster care are at risk for "crossing over" to the juvenile justice system, and inversely, many juvenile justice–involved youth later become involved in the child welfare system. These youth are commonly referred to as crossover youth, whereas youth with concurrent involvement in both the child welfare and juvenile justice system are described as dually involved or dually adjudicated youth.[142,143] Children who have experienced maltreatment average a 47% greater risk for future delinquency relative to children who have not experienced abuse or neglect.[144] An estimated 56% of crossover youth have mental health problems. A growing body of research indicates that running away from foster care increases the probability of subsequent involvement in the juvenile and/or adult justice system, especially for male individuals, with 42% of youth with runaway histories in one study having at least 1 juvenile and/or adult conviction.[145] Approximately 16% of children placed into foster care experience at least 1 delinquency court involvement compared with 7% of all maltreatment victims who are not removed from their family.[144] Other characteristics related to delinquency include age at first child welfare placement, years in placement, number of placements, total length of time in residential care, and sex, race, and recurrence of maltreatment.[144,146] African American youth involved in the child welfare system are up to 13 times more likely than white fostered youth to become involved in the juvenile justice system.[147] Reasons for this disparity are complex; however, structural racism should be considered.[7,8,147] Structural racism refers to the policies and practices that reinforce racial group inequity by allowing privilege associated with race, in this case white-colored skin, while withholding those same privileges from communities of color. Structural racism is insidious and embedded within historical, cultural, and ideological norms of organizations and systems.[8] Norms around language, behavior, and practices, such as policing and court judgments, are typically based on white middle class expectations and contribute to the disproportionate involvement of youth of color in both the child welfare and juvenile justice systems.[147] Recognition of structural racism in current systems allows for education and interventions to be put in place to mitigate its effects.

One of several promising approaches to juvenile court involvement is multisystemic therapy.[148] Multisystemic therapy interventions target problems identified by the child, family, and worker within and between the multiple systems of the home, school, and neighborhood to problem-solve challenges and support success.[146,148] Pediatricians can affect the outcomes of these youth by participating in a multidisciplinary team that includes members from the juvenile justice system, child welfare organizations, and the family. This coordinated approach provides opportunities to change the trajectory of children with judicial involvement and affect the long-term outcome of their lives.[149]

THE LAST WORD: RESILIENCE

Resilience is the developmental process by which an individual can use internal and external resources to negotiate and adapt to current challenges while developing skills to aid future challenges. Resilience implies the presence of adaptive capacities to negotiate life challenges effectively.[150] In a study of 164 young adults emancipated from foster care, nearly half (47%) managed challenges in education, employment, civic engagement, relationships, self-esteem, and mental health, and 16.5% had low educational and low occupational competence, low civic engagement, problematic interpersonal relationships, low self-esteem, and high depressive symptoms. Yet among those youth having difficulties in their external life, 30% exhibited internal resilience, characterized by psychological well-being, despite having difficulties in external circumstances such as education, employment, homelessness, early parenthood, drug use, and criminal activity. In contrast, 6.5% of youth showed significant emotional difficulties despite the appearance of external competence.[151] Thus, young adults can demonstrate resilience in one area of their lives even as they struggle in others. The greatest association with improvement in resilience is having more than one strong network (biological family, peers, foster care), with multiple strong social networks ameliorating the psychological stress of life struggles.[152] In addition to biological family, foster parents, extended family, and peers, support can come from child welfare case workers, therapists, teachers, mentors, coaches, and pediatricians, many of whom often continue to be a resource after the formal placement has ended.[149] For this reason alone, pediatricians can never underestimate the effect of the day-to-day interactions they share with fostered youth. Conversations for even a simple medical concern can affect a child or foster parent in ways we can never foresee.

Further information on the care of children in foster care and children who have been adopted can be found on the AAP Council on Foster Care, Adoption, and Kinship Care Web site.

KEY POINTS AND RECOMMENDATIONS OF CLINICAL REPORT

- Children and adolescents involved in the child welfare system,

whether formally or informally, often have multiple health care needs that require an interdisciplinary team to maximize their well-being. See the AAP Fostering Health Web site for further information: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Fostering-Health.aspx.

- Children and adolescents in foster care and those who have been adopted are at far greater risk than the general population for neurodevelopmental disorders, such as fetal alcohol spectrum disorders. Pediatricians can provide surveillance and screening of socioemotional well-being using validated tools and being aware of developmental and mental health issues common among children and adolescents in foster care. See the AAP Fetal Alcohol Spectrum Disorders Toolkit for further information: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/fetal-alcohol-spectrum-disorders-toolkit/.
- Many children and adolescents experience social and emotional issues during periods of transition. It is important for pediatricians to counsel and provide information to parents in the recognition and management of current and future medical, developmental, and behavioral problems.
- Pediatricians can advocate for the development of a standardized process for consent and transfer of health information with their local Department of Social Services.
- Pediatricians can address the effects of adverse childhood experiences, early childhood adversity, and trauma on early brain development and life course trajectory for both physical and mental health, as recommended by AAP policy.[39] See the AAP Trauma Toolkit for further information: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Training-Toolkit.aspx.
- Pediatricians can encourage parents to have developmentally appropriate discussions using developmentally appropriate language with their child or adolescent. Words such as "adoption," "adopted," "foster care," "kinship care," "guardianship," and "biological family" or "birth family" should become a part of a family's natural conversation, whether the adoption is open or confidential, kinship, or foster-adoptive placement.[84,85] Positive language lays a foundation for a child's later understanding of the abstract concepts of foster care, adoption, and separation from birth parents and facilitates the formation of an integrated identity.
- Pediatricians can help parents acknowledge racial and cultural differences and support children and adolescents in coming to an understanding of these differences. See HealthyChildren.org for further information for pediatricians Talking to children about racial bias https://www.healthychildren.org/English/healthy-living/emotional-wellness/Building-Resilience/Pages/Talking-to-Children-About-Racial-Bias.aspx Teaching children cultural and racial pride https://www.healthychildren.org/English/family-life/family-dynamics/Pages/Teaching-Children-Cultural-and-Racial-Pride.aspx
- Pediatricians can be aware of the complexity of losses experienced by children and adolescents in foster care or kinship care or adopted, in addition to losses experienced by foster, adoptive, and birth parents, while facilitating mental health referral as needed.
- Pediatricians can advocate for young adults who are transitioning out of care and/or involved in the juvenile justice system, because they are at risk for poor physical and mental health outcomes, low socioeconomic status, and lower educational attainment.

RESOURCES

Available resources include the following:

AAP, Council of Foster Care, Adoption, and Kinship Care (https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Council-on-Foster-Care-Adoption-Kinship/Pages/Foster-Care-Adoption-Kinship.aspx);

AAP, Healthy Children (https://www.healthychildren.org/English/Pages/default.aspx);

National Council for Adoption (http://www.adoptioncouncil.org/);

Child Welfare Information Gateway (https://www.childwelfare.gov/):

- Legal Issues in Adoption (https://www.childwelfare.gov/topics/systemwide/courts/processes/legal-issues-in-adoption/);
- Working With American Indian Children and Families in Adoption (https://www.childwelfare.gov/topics/systemwide/cultural/adoption/american-indian-families/);
- Helping Children and Families with Separation and Grief (https://www.childwelfare.gov/topics/outofhome/casework/helping/); and
- Helping Youth Transition to Adulthood: Guidance for Foster Parents (https://www.childwelfare.gov/pubPDFs/youth_transition.pdf);

Grandparents Raising Grandchildren (http://www.raisingyourgrandchildren.com/Index.htm);

AdoptUsKids: Families for Native American Children: Consideration When Fostering and Adopting

(https://www.adoptuskids.org/adoption-and-foster-care/overview/who-can-adopt-foster/families-for-native-children);

Jones BJ, Tilden M, Gaines-Stoner K. *The Indian Child Welfare Act Handbook: A Legal Guide to the Custody and Adoption of Native American Children.* Chicago, IL: American Bar Association; 2008;

National Center for Mental Health and Juvenile Justice. Family Involvement in the Juvenile Justice System (https://www.ncmhjj.com/wp-content/uploads/2016/09/Family-Involvement-in-the-Juvenile-Justice-System-for-WEBSITE.pdf); and

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LEAD AUTHORS

Veronnie F. Jones, MD, MSPH, FAAP
Elaine E. Schulte, MD, MPH, FAAP
Douglas Waite, MD, FAAP

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STAFF

Mary Crane, PhD, LSW
Tammy Piazza Hurley, BS

ABBREVIATIONS

AAP: American Academy of Pediatrics
GED: general equivalency diploma
FASD: fetal alcohol spectrum disorder

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