MEDICINE

THE HEALTH AND CARE OF FOSTER CHILDREN

—by David L. Chadwick

Introduction

The purpose of this article is to summarize current knowledge about the health of children in foster care, and to present some approaches to improving foster children's health. The care of foster children is clearly a child abuse issue. For at least ten years, most children in foster care have been there for protection from very serious abuse or neglect. Infants of drug addicted mothers are making up a larger and larger proportion of children entering foster care. Few states place these infants just because of perinatal maternal drug use, however. Most also require that they be neglected or abused to a degree which would require out-of-home care in the absence of maternal addiction.

The care of foster children has received insufficient attention in the child abuse literature. For many years, health professionals in child abuse work have concentrated their efforts on assessment, diagnosis, and verification. More recently, mental health professionals have concentrated efforts on care of the problems of sexually abused children. It is time that child abuse professionals turned greater attention to children in foster care, who are among the country's neediest.

The Health Status of Foster Children

The physical and mental health status of foster children have been the subject of a number of studies during the last decade. Schor (1982) compared the health status of foster children in the Baltimore area with that reported in other surveys of foster children and with general pediatric populations. Psychological, behavioral, and chronic physical health problems were much more frequently found in foster children than would be expected in general pediatric populations. Schor concluded that foster children have "a high rate of chronic medical problems, educational handicaps and severe emotional impairment." Hochstadt, et al. (1987) directly examined 149 abused and neglected children entering foster care in Chicago and found problems strikingly similar to those revealed by Schor's chart reviews. Foster children are shorter, lighter, and much more likely to have chronic physical conditions and emotional and developmental problems than are their peers. Moffat, et al. (1985) reviewed 257 random records of 900 foster children in Montreal and concluded that, although serious handicapping conditions were often well cared for, growth problems, less serious chronic problems, and behavioral problems were generally unaddressed. Moffat et al. pointed out that this neglect persisted despite the enactment of universal health insurance in Canada, and they pointed to the absence of a planned, systematic approach to health care for this population.

Schor (1982) pointed out the changes in the foster care population during recent decades, indicating that in the 1970's abuse and neglect replaced loss of parents as the chief reason for out-of-home care and that, as a result, emotional problems in foster children have become more common. In addition, during the last decade, the passage and implementation of Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980, placed great pressure on social service agencies to keep abused and neglected children out of foster care. A dramatic increase in child abuse reports may have canceled out the reduction in the numbers of foster children in care intended by that law, but as more children were seen by social services, and a smaller percentage placed or kept out of their homes, the severity of the problems of the children in care increased.

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Another and even more marked worsening in the health status of foster children is now being seen as large numbers of infants affected by perinatal drug use enter care. This trend has not yet seen its peak. These infants seem even less likely than children of past years to leave foster care by return to their natural parents or by adoption.

It is now probably safe to say that foster children are the unhealthiest subset of U.S. children. The visibility of this problem is reduced by geographic and custodial transience and miserable health record-keeping.

The Health Care of Foster Children

Foster children enter care with health problems of many kinds. Moreover, foster children still have significant problems after some period in care. Foster care does not appear to cause the problems, but neither does it ameliorate them. In this connection it is interesting to note that the study by Wald, et al. (1988) showed that the problems of school performance and emotional adjustment seen in a population of foster children were only slightly less severe than in a population of comparably abused and neglected children who were kept in their homes with intensive family services.

Chadwick (1985) argued that foster care should be a therapeutic experience. Although foster care interrupts gross abuse and neglect in most cases, and allows some resilient children to heal themselves, systematic diagnosis and treatment are generally not provided to foster children.

Many dependent children in out-of-home care are moved frequently from one home to another. In many jurisdictions, "emergency homes" are available to take new children at all times, then move them quickly to other settings. Reabuse and replacement after reunification with natural parents accounts for mobility as well, as do failed placements, in which foster parents eventually turn a child away. Goldstein, Freud, and Solnit (1973) called attention to the profoundly disturbing developmental consequences of transience and absence of attachment in the lives of young children, and proposed a policy of legal decision-making which would take children's attachment needs into account. Unfortunately, however, policymakers in child welfare and social services have generally been unable to provide for the developmental imperatives of children.

The American Academy of Pediatrics (AAP) (1987) has noted that "the foster care system has not been successful in addressing the health needs of children." Halfon and Klee (1987) surveyed foster parents and social workers in 14 California counties by telephone, and found—for the most part—poorly organized and limited health care services being provided to foster children. Foster parents and social workers frequently pointed out that few private physicians now accept Medicaid-supported patients, and that public clinics are increasingly difficult to access.

The transience of placement exacerbates the problem. Medicine has traditionally regarded the patient's personal history as the most important component of knowledge for understanding health or disease. Even the most technologically sophisticated tests reflect the patient's status at a single point in time; change in many of these measurements is the rule. These measurements are best recorded and made a part of the person's health history, along with all of the information which the person knows from his or her own experience. Yet in most cases, persons providing health services to foster children are expected to do so without a complete personal health history, because of difficulties in obtaining such histories and in insuring that they follow the children across placement changes.

Mental health care is very limited for foster children, and when it is provided, it is usually because the child's behavior presents serious problems to the foster parent, rather than because the child's history or an assessment suggests the need for mental health care. Some foster parents "doctor-shop" for physicians who will prescribe psychoactive drugs for foster children as a means of behavior control. Although some medication of this sort may be justified, the general disarray in the foster care system means that medications are being used without clear indications and careful medical control.

continued on next page

Legal and Policy Implications

The problems in the health of foster children have not gone unnoticed. The articles cited above themselves cite others that address the issue, and the Child Welfare League of America (CWLA, 1989) has reviewed the problem and published standards for the health care of children in out-of-home care. The standards call for excellent health assessments, case planning, therapy, and continuous case management for all foster children. Few if any foster children currently receive care at a level of quality approaching that recommended by the CWLA.

In the early 1980's the American Civil Liberties Union (ACLU) (Lowry, 1989) began to instigate litigation aimed at forcing responsible states and counties to provide adequate health services for foster children. Weinstein and LaFleur (1990) have written a detailed review of the status of legislation and case law as they affect the responsibilities of governmental entities with respect to foster children's health. States and counties are increasingly being held responsible for the provision of good care to foster children, and the risks to both the governmental entities and to individuals who fail to insure this care are rising. Nevertheless, and despite universal agreement that good care should be provided, no state that has been carefully examined has been found to provide good health care to its foster children.

Insuring Health for Foster Children

A project based at the Center for Child Protection at the Children's Hospital in San Diego, and the Children's Services Bureau of the San Diego County Department of Social Services, and funded by the David and Lucile Packard Foundation, has begun to address the problem of foster children's health. The project is intended to create a complete and accessible health care record for every child in out-of-home care, and an accompanying health care plan for each child. To keep costs within reach of the government that must pay them, the San Diego model creates new functions and educates providers and administrators within existing systems. The model has a number of elements which may be essential for reliably improving foster children's health.

1. A consortium has been developed of public agencies and private practitioners knowledgable about and determined to provide good health care for children in out-of-home care. This consortium now includes the San Diego County Department of Social Services, the Department of Health Services, the Children's Hospital, private physicians, private and public mental health specialists, and a growing set of foster parents.

2. A health history for each child going into medium or long-term foster care is developed.

3. The health history is recorded both in an electronic data base and in portable paper form (The Health Passport).

4. Physical and mental health care is provided within the community by private physicians, community clinics, hospitals and hospital clinics, and public and private providers of mental health services.

5. New health information from all encounters is recorded in the centralized data base.

6. Record maintenance, record review, and quality assurance are centralized. The standards for the quality assurance program are those established by CWLA for the health care of foster children.

7. The health record is continuously available to foster parents, supervising social workers, and all health providers during the period of dependency.

8. The health record is provided and explained to natural parents or other guardians whenever these individuals become either the physical or legal custodians of the child.

9. The health record is provided and explained to children who are attaining majority and preparing to exit dependency.

Five years after the project's inception, a number of these elements are more or less in place; but almost all require further developmental work. In practice, each of the listed components is a project unto itself, requiring the investment of considerable time and energy and the continuing support of the entire coalition of interested persons. Acceptance of the goals by top management, middle management, and service delivery personnel is essential, but by no means automatic or instantaneous.

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We have yet to determine that the health of children is being improved as a result of their being in care; the next major step in the project is to examine this question in a sample of children entering care during the next three years.

Summary and Conclusions

Foster children arguably constitute the least healthy subset of children in the U.S. Despite obvious need, they do not receive adequate health care. As awareness of this situation grows, legislation and litigation put increasing pressure on the governmental entities which have custody of foster children to provide them with the treatments which will benefit them.

The obstacles to provision of good care for foster children are daunting. The children have major needs which would be hard to meet if they were in capable natural families. The absence of the natural parent (who is the health advocate and health case manager for children in most homes), and the division of parental responsibility between an agency social worker and a foster parent, neither of whom is likely to have a long term relationship to the child, weakens efforts to provide good care. Frequent moves and an absence of health records increase the odds that providers who see foster children are limited to dealing with acute issues, and that the chronic, debilitating mental and physical health problems will go unaddressed.

A health system which intends to provide good care for foster children must deal with all of these issues. In addition, if persons abused during childhood are prone to repeat the maltreatment they experienced, then foster children represent a population which should receive whatever interventions may help interrupt the intergenerational transmission of abuse.

Despite the difficulties, providing good health care to foster children is a critical responsibility. For one thing, as the lawsuits have shown, if the State removes children from the natural parents because of abuse or neglect, and then continues to neglect them, the State is guilty of the worst kind of hypocrisy, and the courts will not tolerate the situation. For another, if the long-term detrimental effects of abuse and neglect are to be overcome by children, they must have the help from adults that allows them to accomplish that task. If we fail to provide that help, we are not only guilty of a gross moral failure, we may ensure that society has to continue to care for them as adults, in the penal system, the mental health system, or both.

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David Chadwick, MD, is Director of the Center for Child Protection at Children's Hospital of San Diego, and a member of APSAC's Advisory Board.