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CHILD PROTECTIVE SERVICES
The Health Status and Care of Children in Out-of-Home Care

—by Christine Risley-Curtiss

Introduction

One intervention frequently used to protect children who are at risk for maltreatment is placement in out-of-home care. Nationally, approximately 75% of children placed in out-of-home care are there primarily because of abuse, neglect, or abandonment (U.S. Department of Health and Human Services, 1988). At the time of placement most of these children have experienced inadequate physical and psychosocial care (Hochstadt et al., 1987; Chernoff et al., 1994). Unfortunately, while placement in out-of-home care (i.e., removal from the home) is intended to be a therapeutic intervention, it may contribute to a child's poor health (Eisenberg, 1962; Fine, 1989; Schor, 1988). The placement experience itself means separation from significant adults, siblings, and familiar surroundings. Many children come into care from crisis situations and may soon experience changes in placement. Any ongoing health care they may have had is interrupted.

In light of these circumstances, children in out-of-home care represent one of the most vulnerable groups in the United States in terms of their emotional, mental, and physical health needs. Ensuring that such needs are met is recognized as a responsibility of the child welfare agency (National Commission on Foster Family Care, 1991; United Way, 1987). However, the probability is small that the comprehensive health needs of these children will be served, with medical and mental health services to children in out-of-home care often duplicated, inefficient, and fragmentary (e.g., Halfon & Klee, 1987; Moffat et al., 1985: Schor, 1982; Shah, 1974a).

The purpose of this article is to review what is currently known about the health status and care of children in out-of-home care, and to provide recommendations to help ensure that the health needs of these children are better met.

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NEWS
1997 Colloquium, APSAC Code of Ethics, Nearing Completion

—by Theresa Reid

APSAC's commitment to involving members in the planning of their annual Colloquium has paid off again. For the past several months, more than 40 members have worked in disciplinary and topical subcommittees (child protective services, law enforcement, mental health, law, medicine/nursing, cultural issues, and research) to develop a 1997 Colloquium — to be held June 18-21, 1997, in Miami Beach, Florida — that is rich and diverse enough to address all aspects of child maltreatment.

They have succeeded admirably. One hundred scheduled seminars address such issues as the importance of corroboration in child maltreatment investigations, supervision in child protective services, biomechanics of abusive head trauma, assessing and intervening in neglect, conducting psychotherapy with adult survivors and child victims of trauma, forensic interviewing of children, representation of children in court, coordinating responses to fatal maltreatment, and interventing with women and children involved in domestic violence. Intensive, empirically-based skills training seminars range from three hours to six hours in length. Dozens of high quality ninety-minute field-generated presentations on all aspects of child maltreatment add breadth and diversity to the program.

A special pre-Colloquium institute — *"Enfrentando el maltrato:* Facing child maltreatment in Latino communities" — is open to all Colloquium registrants, and cultural issues in child maltreatment will be addressed throughout the program. The latest research in child maltreatment will be presented in daily research breakfasts, poster presentations, and in a daylong research symposium. In Open Forums every evening, Colloquium participants will meet in less formal settings to participate in case consultations on various aspects of maltreatment, discuss ambiguous physical findings, explore ways of "helping the helper," and debate ethical and legal issues for professionals who work in this field.

A complete Colloquium program will be sent to APSAC members in early February.

APSAC's annual national Colloquium is the

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Health status of children in out-of-home care

Out-of-home care usually refers to three main types of substitute care: regular foster family care, group home care, and kinship care, or placement with relatives (Dubowitz et al., 1993a). A growing body of evidence indicates that many children, regardless of the type of out-of-home care they receive, are not in good health. Recent studies of children entering care have found that 87% to 95% have at least one physical health problem; 50% to 60% have multiple physical abnormalities (Hochstadt et al., 1987; Chernoff et al., 1994). Studies on the health status of children already in care provide additional evidence that these children continue to be at high risk for multiple health problems while in placement. Some kind of physical problem has been almost uniformly identified for 86% to 90% of the children (Dubowitz et al., 1992; Moffat et al., 1985). Abnormalities in growth, vision, and hearing are common (Chernoff et al., 1994; Hochstadt et al., 1987; Kavaler & Swire, 1983; Moffat et al., 1985; Simms, 1989; White & Benedict, 1985).

Studies on the health status of children already in care provide additional evidence that these children continue to be at high risk for multiple health problems while in placement.

Chronic health problems such as anemia, asthma, and short stature also are common. Kavaler and Swire (1983) reported that, of 688 children in out-of-home care for varying lengths of time, nearly half (45%) had at least one chronic problem, and 20% of these had multiple disabilities. Additional reports show similar results, with chronic health problems affecting 34% to 76% of foster children and 15% or more having multiple disabilities (Chernoff et al., 1994; Gruber, 1978; Hochstadt, et al., 1987; Moffat et al., 1985; Schor, 1982; Shah, 1971; Simms, 1989).

The most prevalent problems found in children in out-of-home care have been psychological and/or behavioral. Maas and Engler (1959) found that 40% to 60% of foster children in nine communities across the United States had symptoms of psychological disturbance, in contrast to an estimated 10% prevalence in the general school population. Shah (1972), Schor (1982), Moffat et al. (1985), and McIntyre and Keesler (1986) found psychological problems in 35% to 49% of children in out-of-home care, while Hochstadt et al. (1987) recommended that 56.9% of those children over three years of age receive psychological treatment. Reports by Eisenberg (1962), Shah (1974b), Swire and Kavaler (1983), and Frank (1980) documented that 30% to 80% of children examined for psychological problems were moderately to severely impaired. Finally, depending on the cut-off score used, Thompson & Fuhr (1992) found evidence of psychopathology in 60% to 80% of the children in their out-of-home-care sample. Stein et al. (1994) found evidence of one or more problems in 41% to 63% of their sample.

Behavioral and emotional problems have been reported in 30% to 50% of children in out-of-home care (Dubowitz et al., 1993b; Keane, 1983; Kendall, Dale & Plakitsis, 1995; Risley-Curtiss, 1990; Simms, 1989). Hulsey and White (1989) found that the mean behavior scores on the Achenbach Child Behavior Checklist for maltreated children in out-of-home care were significantly higher than those for a control group of children who had never been in care. Shah (1972) found a high incidence of drug use among the children in his sample (27.5% for marijuana and/or hashish).

Children in out-of-home care also appear to have elevated rates of developmental delay and educational problems. Evidence of developmental delay has been found in 25% to 61% of preschool children (Hochstadt, 1987; Kendall et al., 1995; Simms, 1989; Swire & Kavaler, 1983) while 45% to 75% of school-aged children have had school problems (Fanshel & Shinn, 1978; Hochstadt et al., 1987; Moffat et al., 1985). Thirty-five percent to 48% have failed at least one grade (Chernoff et al., 1994; Moffat et al., 1985; Sawyer & Dubowitz, 1994) and many are functioning academically and cognitively in the low average range (Chernoff et al., 1994; Dubowitz et al., 1990; Eisenberg, 1962; Fanshel & Shinn, 1978; Fox & Arcuri, 1980). Twenty percent of Shah's (1972) sample had dropped out of school.

Finally, the little research that exists on the sexual development needs of children in out-of-home care suggests that these children are at high risk for early sexual activity, sexually transmitted diseases (STD), and pregnancy. In one study of children entering out-of-home care, children as young as eight years old reported being sexually active (Risley-Curtiss, 1996). More than one third of the 846 children in that study (aged 8 to18) reported being sexually active, with more than a third of those not using any form of contraception. Over 12% had already had an STD.

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Another study of teen women in care found that 41.1% had had intercourse, with 56.8% having had sexual intercourse while in their current placement (Polit, White & Morton, 1987). Fifty percent of the sexually active teen women in care had never used condoms, and 73% had not used them at most recent intercourse

Health service use by children in out-of-home care

In light of their relatively poor health and increased vulnerability, one would hope that children in out-of-home care are getting the health care services that they so obviously need. Many of the studies cited here, however, suggest that they are not, and that the foster care system may not be adequately identifying and addressing their comprehensive health needs (Gruber, 1978, p. 89).

Kavaler and Swire (1983) reported that 14% of 668 foster children had no admission medical examination documented. Further, of those children who, upon study examination, had visual problems, almost half (47%) had not been evaluated by an optometrist or ophthalmologist during the five years preceding the study, and 56% of them had no recorded evidence of such a problem in their medical records. Over 40% of children assessed as needing dental care had not seen a dentist during those same five years. Only one quarter of the children identified as having emotional or developmental problems had received treatment, and nearly all (93%) of the children who failed the hearing test had no medical record of such a problem.

Data from some of these studies also indicate that even when problems are known or suspected by caseworkers, and recommendations for health services are made, these services often are not obtained.

Similarly, Schor (1982) found that, of a random sample of 387 foster children enrolled in a Health Maintenance Organization (HMO), 12% had not received any medical care since their enrollment and another 1% had received care for acute problems only; that is, they had received no health assessment. In addition, 70% of children were inadequately immunized, and 80% of the chronic health problems identified were newly recognized since enrollment in the HMO. Schor (1982) reported that nonusers tended to be male adolescents and that the foster children in general tended to be low users of health care services, with visits other than health assessments averaging barely more than one per year.

Moffat et al. (1985) reported from a sample of 257 foster children, 79% of whom had been in care more than one year, that 18% had no known source of health care and nearly half had not been examined in the past year. Immunizations were complete for only 48% of the children, and of 77 problems uncovered by the study examination, the agency was aware of only 40 of them. Finally, Simms (1989) reported that 60% of the children with developmental delays were not involved in any treatment program, although they had been in foster care an average of six months.

Mental health services seem especially neglected. Gruber (1978) found that almost 30% of children with behavioral or emotional problems had never seen a mental health professional (p. 89). Frank (1980) reported that 12% of a group of foster children with moderate to severe psychosocial problems had never seen a mental health professional during the five-year study period.

The situation does not seem to have improved with time. Moffat et al. (1985) concluded that the "diagnosis, monitoring, and treatment of behavioral problems seem to have been the most neglected areas ..." (p. 134). Even more recently, Dubowitz et al. (1990) reported that of 144 children diagnosed as depressed or having emotional problems, only 18 (12.5%) were receiving treatment. They concluded that:

> The frequency of mental health services currently received by these children is alarmingly low ... few children have received a mental health evaluation and even fewer are receiving mental health services. (p. 67)

Data from some of these same studies also indicate that even when problems are known or suspected by caseworkers, and recommendations for health services are made, these services often are not obtained. Gruber (1978) reported that the treatment process had not been started for approximately 9% to 50% (varied by the handicap) of children known by caseworkers to have specific handicaps (overall rate = 23.7%). Further, 10.1% to 76.6% of those who had been evaluated and recommended for a specific treatment program were not receiving treatment (overall 26.2%). Kavaler and Swire (1983) related that of 363 referrals made over a five-year period, only 59% (216) were accomplished, while Shah (1974b) reported that of 308 recommendations

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for mental health follow-up services, fewer than half (144) were followed.

Finally, Risley-Curtiss et al. (1996) reported on health care use by 291 children entering foster care. They found that despite the fact that the children were part of a new health project designed to improve their health care and in the custody of an agency under a federal consent decree specifically requiring the provision of adequate health care, fewer than 50% of referrals for physical, dental, and mental health care were completed.

In summary, research clearly documents that children in out-of-home care typically are unhealthy and that they often are not getting the care they need. This failure to ensure adequate preventive and primary health care for such children has long- and short-term costs for the children as well as for the foster care system itself. For example, children with behavioral and emotional problems are at high risk for re-placement (Cooper, Peterson, & Meier, 1987; Miller, Mackey, & Maginn, 1981; Pardeck, 1985), for remaining in care longer (Lawder, Poulin, & Andrews, 1986; Sauber, 1967), and for returning to out-of-home care after discharge (Block & Libowitz, 1983; Rzepnicki, 1987). In 1987, 72% of the increase in out-of-home care placements in New York was caused by children reentering the system (Ooms, 1990). Thus, failure to provide treatment for some types of problems can contribute to increases in workload, numbers of children in care, and subsequent financial costs to the system itself. Even more critically, failure to provide needed services can lead to untold human suffering.

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Implications for child welfare practitioners

While some health services have been routinely provided by many substitute care agencies, health care for children in out-of-home care has generally received low priority (Kavaler & Swire, 1983; Schor, 1988; Simms & Halfon, 1994). Standardized health care for children in care has been advocated by such professional organizations as the American Academy of Pediatrics (Committee on Early Childhood, Adoption and Dependent Care, 1994) and the Child Welfare League of America (1988). Nevertheless, uniform models, policies, and procedures defining services to be provided and ensuring that all children in care receive appropriate health care have been lacking (Combs-Orme, Chernoff, & Kager, 1991; Kendall et al., 1995).

The concept of parens patriae (i.e., the state as parent) obligates child welfare agencies to meet the basic needs of children in its care. Failure to do so constitutes institutional neglect and the risk of lawsuits. Administrators and direct practitioners need to intensify efforts to ensure that children in care get the services they require. One major bureaucratic obstacle to adequate health care for foster children is the absence, in many agencies, of an adequate tracking mechanism (Chernoff et al., 1994, Kavaler & Swire, 1983; Risley-Curtiss et al., 1996). Such a mechanism could help caregivers, caseworkers, supervisors, and health providers ensure ongoing and timely care. For interventions to succeed, however, consensus on the importance of health care for children in out-of-home care must be obtained within the child welfare agency and its affiliated organizations, and with the public at large. Such consensus has been lacking.

In addition, practitioners may have to take it upon themselves to access the health care services that children in their caseloads need. To start with, all children in out-of-home care should receive the following:

- A physical examination, preferably before placement, but if not, then as soon after placement as possible. Since children often enter care lacking an accessible documented health history, this initial exam should be followed by a comprehensive follow-up evaluation within a month or so after placement.
- A mental health evaluation, in light of the high rate of psychosocial problems in this population. While the validity of a mental health examination at the time of placement has not been determined, an initial screening for serious mental health problems (e.g., suicidal potential) should be done at the time of placement, to be followed within the next month by a more comprehensive evaluation.
- A dental screening, also at the time of entry into care, and routine preventive dental care.

In addition, practitioners need to consider recommendations in the following areas.

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Training

Those practitioners who lack knowledge of health issues need access to training that emphasizes the importance of health care and increases appreciation for the critical nature of some of the problems these children have (e.g., mental health problems, sexually transmitted disease risks). Sharing such information with coworkers and administrators can broaden the impact of such training.

For example, practitioners should understand the fact that the presence of one high-risk behavior (e.g., suicidal ideation, sexual activity) often is an indicator of the existence of others (Risley-Curtiss, 1996). Research also suggests that the needs of African-American children, older children, and girls, especially their mental health needs, frequently are not adequately addressed (Benedict et al., 1988; Eisenberg, 1962; Risley-Curtiss, 1993; Takayama, Bergman, & Connell, 1994). Training can equip workers and caretakers to better identify the needs of children in their care.

The roles of the primary substitute caretakers (e.g., foster parents) and of caseworkers also may need to be clarified, documented, and communicated to all relevant parties.

Other training needs for both practitioners and caretakers may include:

- The administration of family health histories
- Assessment for certain problems such as clinical depression, the potential for suicide and homicide, drug and alcohol addiction, and sexual activity
- Health needs of African-American children
- Health needs of older children
- Health needs of girls, especially regarding mental health

Role clarification

The roles of the primary substitute caretaker (e.g., foster parents) and of caseworkers also may need to be clarified, documented, and communicated to all relevant parties. Caseworkers, as representatives of the agency and state, usually have the ultimate responsibility for ensuring that the health needs of children in care are met. However, it is often unclear who—the caseworker or the foster parent—is supposed to actually acquire services. Thus the worker waits for the foster parent to take the child to the doctor, while the foster parent waits for the worker to do so; meanwhile, the child suffers. Once these responsibilities have been clearly delineated, the need for supports (e.g., transportation and lists of available providers) should be assessed and such services made available as necessary.

Education and advocacy

Practitioners outside of the standard child welfare agency system also may have a role to play. For example, medical practitioners may have a good grasp of the connections among the biological, psychological, and social needs of children. When they come into contact with children in out-of-home care, they have the opportunity to educate caretakers and caseworkers (and the children if age appropriate) about the general importance of health care as well as about specific problems (e.g., STDs).

In all out-of-home care settings, practitioners need to pay close attention to children's biological as well as psychosocial needs. When any of these individual needs are unmet, a practitioner can serve as an advocate for that child, to facilitate the child's access to care. While low use rates are prevalent for children of all ages and ethnic groups, practitioners particularly may need to advocate for African-American children, for older children, for female children with mental health needs, and for children with extensive mental health problems (Risley-Curtiss, 1993). In one study, children who had extensive recognized mental health problems were less likely to be referred for physical health services (medical and referrals), despite the fact that they did not have fewer medical problems than other children (Risley-Curtiss, 1993).

Research

More research is also needed, especially in the area of use relative to need. Practitioners can assist in this endeavor by keeping adequate and accurate records regarding the need for, and access to, health services. Documentation of barriers and gaps in services can be helpful in advocating for increased resources. Participation in the evaluation of service provision to children in care also is important.

Finally, practitioners need to keep current with what others are doing to help address the needs of these children. To this end, a future issue of the *Advisor* will include information about a model program's approach to meeting the health care needs of children in out-of-home care.

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