Fostering Health: Health Care for Children and Youth in Foster Care

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Children and adolescents placed into the foster care system have special health care needs. The physical and psychological consequences of abuse and neglect, as well as the trauma from being removed from their homes lead to physical, emotional and developmental problems. In addition, other risk factors associated with poor physical and mental health such as lack of medical care, poverty, homelessness, violence in the home, parental substance abuse, parental mental illness and premature birth, are often present and compound the child's health risk.[1]

In 2010 in Rhode Island, there were 2,223 indicated investigations of child abuse and neglect involving 3,414 children. Among victims of child abuse and neglect in Rhode Island in 2010, 36% were age three and younger, 12% were ages four to five, 30% were ages six to 11, 15% were ages 12 to 15, and 7% were ages 16 and older. The vast majority (79%) of child maltreatment cases involved neglect. The greatest contributors to neglect are poverty, parental substance abuse and/or mental illness.[2]

As of December 31, 2010, there were 2,293 children under age 21 in the care of Rhode Island Department of Children, Youth and Families (DCYF) who were in out-of-home placement**.** Types of placements for these children varied, including 31% in non-relative/private agency foster care homes, 23% in relative foster homes, 13% in group homes, 12% in residential facilities, and approximately 2-5% in each of the following six settings: at the Rhode Island Training School, with relatives caring for children, in independent living/supervised apartment, in DCYF shelter care, in psychiatric/medical hospital/substance abuse treatment facility, or in other settings.[2]

Placement stability is a significant concern for children in foster care in Rhode Island and nationally. Changes in foster care placement jeopardize continuity of medical care and nurturing relationships. Placement instability has been associated with negative behavioral and mental health outcomes.[3] In **Federal Fiscal Year (FFY) 2010**, 14.1% of the 1,694 children who had been in out-of-home care for less than one year in Rhode Island had experienced three or more placements. Three or more placements were experienced by 35.4% of the 731 children who were in care between 12 and 24 months. Almost two-thirds (65.6%) of the 1,022 children who had been in care for two years or more experienced three or more placements. The percentage of children in the Rhode Island child welfare system who were reunified with their family of origin in less than 12 months from the time of removal from the home increased from 68% in FFY 2009 to 71% of children in FFY 2010 compared with the national standard of 76%.[2]

Medical Needs

The health and emotional needs of children in foster care are complex. The prevalence of chronic conditions among foster children has been estimated at between 30 and 80%.[4, 5] An estimated 25% of foster children have 3 or more chronic conditions.[6] A disproportionate number of foster children are below the 5th percentile for height, weight and head circumference.[4, 6, 8] Common medical problems for children in foster care include: respiratory problems (asthma and upper respiratory infections), allergic and infectious skin conditions, dental caries, pediculosis, anemia, delayed immunizations, and impaired vision and hearing.[4, 6, 7-10]

At the time of placement children should be examined for signs of abuse and acute illness. The child's medical record should be obtained and the stability of chronic illnesses should be evaluated. Screening for developmental and mental health problems including suicidal ideation should be completed.[8] Risk factors for vertically or **sexually transmitted infections (STIs)** also must be assessed. Routine testing for STIs should be completed because adolescents in foster care are more likely to engage in high-risk sexual behaviors when compared to adolescents not in care.[11]

Cognitive Development

Developmental delay is exceedingly common among foster children.[12, 13] A varied and complex interplay of environmental and biological risk factors place foster children at high risk for developmental problems. Physical and emotional trauma associated with abuse, neglect, exposure to violence and lack of both a stable, nurturing caregiver and appropriate stimulation often characterize the foster child's environment of origin. Perinatal drug exposure, prematurity and nutritional deficiencies during the early critical period of brain growth adds to the biological fragility of this already high risk context.

Social-Emotional Development

Children in foster care are at particularly high risk for mental health problems as a result of the stresses placed upon them by their home environment. Depression, reactive attachment disorders, acute stress responses, and post traumatic stress disorders are some of the common mental health diagnoses of children in foster care. Unmet emotional needs while living in abusive and/or neglectful home environments are then compounded by the trauma of removal from the only home that child has known. Addressing the multiple layers of emotional trauma for children in foster care is critical. Studies have shown that long term supportive and therapeutic relationships are essential for the emotional wellbeing of children in foster care and improve psychological outcomes. Children in foster care however, are often prescribed multiple psychotropic medicines in an attempt to alleviate symptoms often without an in depth assessment of the etiology of these symptoms.[14]

Barriers to Care

Multiple barriers interfere with meeting foster children's health care needs. Despite their high need for quality coordinated and comprehensive services, foster children remain underserved. A

1995 review of health services for children 36 months-of-age and younger in foster placement in New York, California and Pennsylvania found that less than half had all of their health care needs met and 19% and 32% had none or only some of the health care needs met respectively.[15] Some of the factors that negatively impact a child receiving services include: young age, African American race, and placement instability. Placement instability, in particular for children in foster care, has also been shown to contribute to behavioral problems.[10]

Another barrier to optimal health care is a lack of information regarding foster children's medical histories[6,8,16] including immunizations and screening.[3,15] Barriers around sharing of health information between social services, physicians, foster parents, biological parents and children represent an additional challenge and can lead to miscommunication.[8,9]

In summary, children and adolescents in foster care have more intensive service needs as compared to the general pediatric population or even other children who are poor. As children with special health care needs, children in foster care suffer from significant difficulties in getting the care that they need.

Fostering Connections to Success and Increasing Adoptions Act of 2008

The Fostering Connections Law of 2008 is the most comprehensive federal legislation passed regarding the care of children and adolescents in foster care for more than a decade. This law recognizes that the health of children in foster care is a priority and that there must be up to date health records for children in care. The new law strengthens requirements that Rhode Island provide a plan to coordinate health services for children in foster care.

The law requires that Rhode Island develop a system for the ongoing oversight and coordination of heath care services for children in foster care. Rhode Island must ensure the identification and response to these children's health care needs, including behavioral, mental and oral health and the coordination of those services. In addition, the plan, developed in consultation with medical experts, is to outline a schedule for initial and follow up health screenings, address how health needs identified through screenings will be monitored and treated, describe how medical information will be updated and appropriately shared, discuss how health care will be continuously and collaboratively provided and address the monitoring of prescription medications.[17,18] The mandate is unfunded, but its inclusion and specificity in the Fostering Connections Act underscores the importance of health care for children in foster care.

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Practice Parameters for Primary Health Care

The **American Academy of Pediatrics** (AAP) Task Force on Health Care of Children in Foster Care has defined standards of health care delivery and management to promote quality health care for children and adolescents in foster care since they require a more significant level of care by providers.[8]

The AAP Task Force on Health Care of Children in Foster Care has also defined national standards regarding the number of medical encounters and screenings that children and adolescents should receive while in foster care.[8]

- Health information gathering at the time of removal is an essential first step. This information should identify medical, developmental, and mental health conditions that will require ongoing therapy and identify health conditions that will affect the selection of foster placement.
- The first medical screen should occur within days by a medical provider experienced in the health care of foster children. This screen should occur within the first few days or at least within two weeks of removal. The purpose of this evaluation is to identify medical, developmental and health problems that need immediate attention and that might affect placement decisions.
- Health information gathering needs to continue. The collection of this health information should be more comprehensive and build on information already known about the child or adolescent. At a minimum, this information should include:
  - Names and contact information for caseworker and foster parents
  - Number, type and timeframe of out of home placements and any other previous Child Protection Program evaluations.
  - Immunizations
  - Allergies
  - Current medications
  - Prior hospitalizations, injuries and operations
  - Family medical history
  - Contact information of current and previous health care providers including sub-specialty care providers, Early Intervention, mental, behavioral health and oral health providers.
  - Medical problem list
  - Special educational needs
  - Name of schools attended
  - Individualized Educational Plan
  - Mental health history including past treatment plan and recommendations
  - Behavioral evaluations and treatment plans
  - Developmental assessments.
- Comprehensive Health Assessment at 30 days. This evaluation should be performed by a medical provider experienced in caring for

children and adolescents in foster care. This purpose of this evaluation is to evaluate in more depth the health, developmental and mental health needs of the child after the child has been in care. Gathered health information should be reviewed at this visit.

- Follow-up assessment at 60 days conducted by the same medical provider, is utilized to review results of treatment plans, assessments and review of coordination of services.

- Periodic preventive health care is recommended monthly for children in the first six months of life, every three months for children in the first two years of life and every six months for children over two. These visits are needed to ensure that all health needs are addressed and care is coordinated and communicated to the appropriate care providers.

Healthy Foster Care America is an organization initiated by the AAP and other partners to provide a resource for up-to-date recommendations and tools. This website is a highly recommended and useful tool for any provider caring for children and adolescents in foster care: http://www.aap.org/fostercare/.

Rhode Island Recommendations

Based on the well-established needs of children and youth in foster care, the requirements of the Fostering Connections Act of 2008, and AAP guidance, providers caring for children and adolescents in foster care in Rhode Island should:

- Be prepared to work closely with Rhode Island's child welfare agency, RI Department of Children Youth and Families, which is responsible for children in foster care, as well as children with behavioral health needs and those in the juvenile justice system.
- Communicate effectively to provide health information and education with child welfare and social service staff, consulting staff, foster parents, birth parents and the children and adolescents that are in care.
- Be prepared to devote significantly more time during encounters with children in foster care given their myriad of health issues and the importance of sharing this health information to designated parties.
- Be aware of the specific and special health care needs of children in foster care and be prepared to adequately assess issues of abuse and neglect, identify and screen for mental and development health issues and be familiar with DCYF policies and procedures.
- Be prepared to coordinate services and develop care plans with specialists, social services and primary care physicians.
- Be prepared to provide a Medical Home for foster children that is comprehensive, coordinated, compassionate and continuous.

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