

Foster Children with Special Needs: The Children's Aid Society Experience

ANGELA DIAZ, M.D.¹, SHARON EDWARDS, M.D.¹, WENDY P. NEAL, M.D.¹, PAULA ELBIRT, M.D.^{1,2},
MANDY RAPPAPORT, M.D.¹, RUDD KIERSTEAD, M.B.A., M.P.P.³, AND BEVERLY COLON, P.A.³

Abstract

Children in foster care have many health needs. This article presents the model of the Children's Aid Society (CAS) of New York City in addressing these needs. In addition to their regular foster care program, CAS developed the Medical Foster Care (MFC) in response to the growing number of boarder babies (children with medical conditions who are abandoned at hospitals), and the Therapeutic Foster Care (TFC) for foster children with emotional and behavioral mental health problems. The MFC serves 145 children considered medically fragile, as evidenced by congenital diseases such as heart disease, renal agenesis, cerebral palsy, seizure disorders and mental retardation. The TFC serves 50 children with severe levels of emotional and behavioral symptomatology. As is indicated by the extensive services offered through CAS's regular foster care program, as well as MFC and TFC, these children require specialized treatment. In addition, systems of information maintenance and exchange surrounding the health care of foster children need to be improved. Often agencies are ill-equipped to do adequate background checks on these young people and as a result deliver them to foster care situations where their health needs are not revealed and therefore not addressed. Health care providers also need to stay informed on the overall subject of foster care, as their voices will probably be crucial in ensuring that the extensive needs of these children are adequately represented to government, medical and other service providers.

Key Words: Foster care children, foster care adolescent health, Children's Aid Society.

Introduction

SOME OF THE UNHEALTHIEST CHILDREN in the United States are those in foster care (1). Dr. Paula Jaudes of the University of Chicago states that foster care children are twice as likely to have chronic diseases and 4.5 times as likely to have psychological illnesses when compared with children involved with the Aid to Families with Dependent Children (AFDC) program (1). Studies from the General Accounting Office indicate that as many as 58% of foster care children have serious health problems and 62% have been subject to prenatal drug exposure (2). Further studies from the Child Welfare League of America suggest that 30% of children in foster care have severe emotional problems (3). Based on an inner-city study, newborns placed into foster care were 8 times more likely to be born to

HIV-infected mothers than newborns who went home with their mothers (4). Two factors that may precede placement in the foster care system, sexual abuse and risky behaviors such as drug use or sexual activity, also put young people at risk for acquiring HIV infection (5). In addition, the number of foster care children with handicaps and disabilities has been rising (6). As a direct consequence of many of these disorders, foster care children achieve lower educational levels and gain fewer vocational skills than children from AFDC families (7).

In a Washington State study comparing health care costs for children in foster care and for AFDC children of the same age, it was found that 25% of foster care children used mental health services vs. 5% of AFDC children (8). In addition, twice as many foster care children were hospitalized as were AFDC children. In terms of dollars, these statistics amount to \$3,000 per year in health care expenditures for each foster care child vs. only \$543 per child for children and their families who receive public assistance. Further analyses point to the fact that much of the health care used by foster care children is consumed by a small percentage (8%) who suffer from severe mental and neuro-

From the ¹Division of Adolescent Medicine/Mount Sinai Adolescent Health Center, Department of Pediatrics, Mount Sinai Medical Center, New York, NY and ³Children's Aid Society (CAS), New York, NY. ²Provide full-time services at CAS.

Address all correspondence to Angela Diaz, M.D., Director, Mount Sinai Adolescent Health Center, 320 East 94th Street, 2nd floor, New York, NY 10128; email: angela.diaz@msnyuhealth.org

Accepted for publication February 2004.

logical disorders, including post-traumatic stress syndrome, cerebral palsy, hydrocephalus, and seizure disorders. Thus, children residing in foster care homes have a higher degree of health care needs that require more intensive and comprehensive services.

Methods

Of the total number of foster care children in the United States, approximately 4% (21,476) live in New York City (9). The Children’s Aid Society (CAS) of New York City is a large provider of foster care and adoption services, which is independent of governmental services agencies. CAS developed the Medical Foster Care Program in response to the growing number of boarder babies (children with medical conditions abandoned at hospitals), and the Therapeutic Foster Care Program for children with mental health problems.

Data on 110 children entering CAS foster care were collected to analyze the health conditions affecting this population and the intensive service programs developed by the CAS to improve health outcomes. Each child in the study received a comprehensive medical assessment and history. As health records of foster care children are usually poorly maintained, additional information was gathered by talking with caseworkers at other agencies and with physicians. Medical findings, including data collected at follow-up medical visits, were corroborated throughout the six-month period. Age at time of placement was recorded as well as stated reasons for placement. The original 110 children in the study and an additional 26 received psychiatric evaluations.

Results

The CAS Medical Foster Boarding Home Program

Recognizing the high incidence of neglect, physical abuse and parental drug or alcohol abuse among foster care children in New York City, CAS started the Medical Foster Care (MFC) Program in 1988. The program currently serves 145 children, nearly 50% of whom are younger than 5 years old and 61% of whom are male. All of the children are considered medically fragile, as evidenced by congenital diseases such as heart disease, renal agenesis, cerebral palsy, seizure disorders and mental retardation. Many of the children in the program

spent the first several months to years of their lives as “boarder babies” in hospitals, where they had been abandoned at birth.

The eligibility requirements for children in the MFC Program are listed in Table 1. The program’s success stems almost entirely from the willingness of foster parents to step forward to care for these children. While medical foster parents receive stipends nearly three times higher than do regular foster parents, the requirements of their time and energy as caregivers suggest that their primary motivations are not monetary (Table 2).

The training of medical foster care parents consists of two parts. During the first or more traditional part, the CAS “home-finders” discuss issues such as prevention of child abuse, alternative methods of discipline, human development, emergency situations, separation, burn-out prevention, nutrition, safety, first aid, and common childhood illnesses. The second part is devoted to the unique medical caregiving that will be required of a foster parent based on a particular child’s conditions. Once the foster parents complete this training and officially agree to accept a medical foster child, more intensive training enables them to be certified by

TABLE 1
Eligibility Requirements for Children in CAS Medical Foster Care Program

Criteria
<ul style="list-style-type: none"> • Child must be hospitalized or require high level medical facility; • Child does not require lifetime institutional care; • Child possesses a chronic condition sufficiently severe that it requires specialized attention, though not so specialized that medical foster care could not handle it safely.

CAS = Children’s Aid Society

TABLE 2
Eligibility Requirements of Adults Seeking to Be Foster Parents in CAS Medical Foster Care Program

Criteria
<ul style="list-style-type: none"> • Participate in all orientation and training; • Complete home study evaluation; • Successfully complete a background check; • Have physical examination; • Identify one parent to stay at home; • Appoint a back-up person (respite provider) for emergency situations

CAS = Children’s Aid Society

a team of trainers that includes nurses and, if necessary, hospital staff.

The medical foster care child is placed with certified foster parents and is assigned both a CAS nurse and a social worker. The assigned nurse provides routine medical case management and advice for both the foster parents and the child throughout the period of care. In addition, the nurse helps parents arrange for specialty services and often serves as medical liaison, on behalf of the family, to health care providers. The nurse may also play a role as an informant for and trainer of the child's natural parent(s) should eventual reunification be possible. The social worker visits the foster home regularly in accordance with federal and state requirements. Once there, the social worker provides an assessment, counseling and support for the foster parents. Between visits, the social worker is also available for questions and advice, and can arrange for therapy and special care for the children. An important additional role for the social worker is making arrangements to provide for respite care, as well as assistance in maintaining the bonds and protocols between the foster parents, the child, and the natural parent(s) if reunification is still a possibility.

The CAS Therapeutic Foster Care Program

The Therapeutic Foster Care (TFC) program was started in 1990 to address the population of mostly older foster care children with severe levels of emotional and behavioral symptomatology. Nearly 80% of the 50 children in the program are between the ages of 5 and 11 years, with the other 20% between 12 and 18 years of age. Even compared with children in regular foster care, the conditions experienced by TFC children are more severe (Table 3), and consequently, TFC children experience a greater incidence of psychiatric disorders (Table 4).

Eligibility for TFC is restricted to those "who require individual intensive treatment but have the potential to function within a family unit in the community" (10). Most of the children referred to the program are either in a mental health facility or psychiatric hospital, or have had problems in several foster homes. The program provides traditional foster care services as well as services that are provided to children admitted into institutions and group facilities. It is based on the concept that children with severe emotional problems are likely to receive more stability through well-trained foster care parents than through a continuous path of

TABLE 3
Most Common Conditions Leading to CAS Therapeutic Foster Care and Regular Foster Care

	Therapeutic %	Regular %
Parental		
drug abuse	94%	45%
alcohol abuse	14%	14%
mental problems	44%	10%
Abuse		
neglect	50%	28%
physical	58%	23%
sexual	22%	7%

CAS = Children's Aid Society

TABLE 4
Psychiatric Diagnoses of CAS Therapeutic Foster Care Children and Regular Foster Care Children

Diagnosis	Therapeutic %	Regular %
Depression	42%	14%
Anxiety disorder	28%	19%
Adjustment disorder	20%	14%
Attention deficit/ oppositional disorder	64%	25%
Learning disability	20%	42%
Mental retardation	8%	19%
Psychosis	14%	0%

CAS = Children's Aid Society

institutionalization or relocation (as is often the case in other foster care agencies).

As with the Medical Foster Care Program, prospective TFC parents must be married and have a designated respite care provider. The Children's Aid Society trains TFC parents through an intensive "basic" foster care training followed by 28 additional hours of therapeutic approaches to care. Parents are then briefed as to the specific condition of the child with whom they will be matched.

The TFC parent is assisted by a team of providers that includes a social worker, a sociotherapist, an art therapist and a psychiatrist. The social worker coordinates all the components of the program and arranges for the child's education, therapy and tutoring, as well as ongoing evaluation with the foster parents. The social worker also visits the home regularly and is the main contact with the child's biological parent(s). The sociotherapist trains, supervises, and supports the foster parents on specific methodologies considered essential to the child's long-term recovery and functioning.

Methodologies include active listening, communication, negotiation and motivation. The sociotherapist also serves as an advisor to the foster parents. Based on the mental diagnoses of the psychiatric clinic from which the child is transferred, the psychiatrist and art therapist are responsible for the development and evaluation of medication and art therapy treatments. Art therapy is primarily used for children with weak verbal skills. The psychiatrist uses play therapy and/or verbal therapy for ongoing diagnostic and evaluative purposes.

The Therapeutic Foster Care Program has been successful in its primary goal, providing its target children an opportunity to recover in the warmth of a home atmosphere as opposed to that of an institution. Its successes are apparent, in that a greater percentage of children are recovering in TFC than in institutional care. However, the program is not always successful. Some TFC children have been returned to institutions; others have advanced in only very slight degrees toward emotional stability.

Discussion

These data provide a description of the needs of some children in the care of the Children's Aid Society. As is indicated by the extensive services offered, these children need specialized treatment. The issue before the government and the public is whether to pay for this treatment now or face the consequences and costs of having a dysfunctional and dependent adult population later on.

In addition, health care providers need to stay informed on the overall subject of foster care. Their voices will be crucial in ensuring that the needs of these children are adequately represented to government, medical and other service providers. Criticisms leveled at the foster care system could compromise the well-being of the approximately 588,000 children who are dependent on it nationally (11). Health

care providers can play an essential role in ensuring that this does not happen.

Finally, the systems of information maintenance and exchange surrounding the health care of foster children need to be improved. Despite information technology, some foster agencies are ill equipped to do adequate background checks on the youths involved and often deliver them to foster situations in which their major disorders either remain hidden or continue to go untreated. An adequately secured foster-link web page for agencies would help them document information and coordinate treatment plans more thoroughly and efficiently.

References

1. Bilaver LA, Taudes PK, Koepke D, Goerge R. The health of children in foster care. *Social Service Review* 1999; 73(3):401–417.
2. U.S. General Accounting Office. Health care needs of many young children are unknown and unmet. Washington (DC): U.S. Government Printing Office; 1995.
3. Schor E, Aptekar R, Scannell T. The health care of children in out-of-home care. Washington (DC): Child Welfare League of America; 1987.
4. Nicholas SW, Bateman DA, Ng SK, et al.. Maternal-newborn human immunodeficiency virus infection in Harlem. *Arch Pediatr Adolesc Med*. 1994; 148:813–819.
5. Committee on Pediatric AIDS. Identification and care of HIV-exposed and HIV-infected infants, children, and adolescents in foster care. *American Academy of Pediatrics*. *Pediatrics* 2000; 106 (1 pt 1):149–153.
6. Tartara T. Characteristics of children in substitute and adoptive care, fiscal year 1989. Washington (DC): American Public Welfare Association; 1993.
7. Festinger T. The foster children of California. Sacramento (CA): The Children's Services Foundation; 1994.
8. Takayama JI, Bergman AB, Connell FA. Children in foster care in the state of Washington: Health care utilization and expenditures. *JAMA* 1994; 271(23):1850–1855.
9. Administration for Children's Services (2003). Latest statistics: monthly update. Retrieved 2/13/04, from www.ci.nyc.ny.us/html/acs/html/whatwedo/opireport.html
10. Koerner E. A tough art: creating a new life for emotionally disturbed, behaviorally disordered foster children. New York: The Children's Aid Society; 1995.
11. Child Welfare League of America (2001). Foster care: facts and figures. Retrieved 2/13/04, from www.cwla.org/programs/fostercare/factsheet.html