



## GUIDANCE FOR FOSTER/ KINSHIP CAREGIVERS

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Counseling the caregivers of children in foster/kinship care presents unique challenges for the pediatric professional. Children and teens entering foster care have most likely already been impacted by multiple childhood adversities and toxic stress.

Early in placement, the issues caregivers need advice about concern helping children and teens deal with the stress of removal from their family and all that is familiar and the attendant grief and loss that accompany the transition into a new family setting. These changes are superimposed on the trauma history experienced by these children.

Visitation of children with their families usually begins within a week or 2 after removal and placement.

- Visitation can be healing for children and their parents when it goes well but may be a reminder of separation, loss, rejection, and trauma for children whose parents fail to show up for the visit, show up late, are distracted by anger at child welfare agencies, manifest symptoms of mental health problems, or exhibit rejecting or blaming behaviors toward their children.
- Nearly half of children return to their family of origin within the first 6 months of placement, but other children may remain in foster care for years. Helping families with visitation under a variety of circumstances is very important.

The guidance that pediatricians offer to foster/kinship caregivers, birth parents, and the young people in their care will vary depending on each child's circumstances. The following discussion focuses on some common themes.

### TRANSITION INTO FOSTER/KINSHIP CARE

The change that children experience when they enter foster/kinship care may be emotionally traumatizing for all but the youngest infants or those children who feel truly safe for the first time in their lives.

- Caregivers may need to be reminded that the child is grieving and frightened and may be very angry, especially if this is not the first disruption in caregiving. Many children are in a state of emotional shock the first few days to weeks after placement and may appear compliant and cooperative, when in fact they are in an acute phase of grief. Other children may present with or soon develop:

- ♥ Difficulty sleeping
- ♥ Food hoarding
- ♥ Overeating or food refusal
- ♥ Frequent prolonged tantrums or periods of inconsolable crying
- ♥ Aggressive behaviors toward children, animals, or adults.

- Foster/kinship caregivers may need to be reminded that:

- ♥ Children are grieving
- ♥ Challenging behaviors may emerge that have been adaptive in a previous environment
- ♥ Children who have been neglected or abused or exposed to domestic violence and chaotic caregiving may be very reactive emotionally to even small changes, let alone major ones like visitation or other children entering or leaving the home
- ♥ Older children and teens may be unable to sleep because of strange noises in the new home
- ♥ Nightmares related to loss or prior trauma are common
- ♥ Children are often worried and anxious about their parents or siblings.

Some children adapt readily to being in foster/kinship care, whereas others struggle for weeks or months through this transition.





- Caregivers may need support and advice in adjusting to the needs of each child.
- Children and teens may need frequent reassurance that:
  - ♥ They are safe
  - ♥ Someone will answer their cries or their questions or just be available to sit with them.

Taking time to help children and teens adjust to their new environment will help them ease into a predictable schedule over several weeks. Ideally, foster/kinship caregivers for infants and young children can be at home for the first few weeks, but this is rarely possible for caregivers employed outside the home. The vast majority of employers do not provide parental leave for foster/kinship caregivers, so infants and children have to immediately begin or resume child care at the time of placement. Maintaining children in their child care, preschool, and school settings during this transition time can be reassuring, especially if they are in a high-quality educational program.

Newborns may spend the first 6 to 8 weeks in one foster home with a stay-at-home foster/kinship caregiver, only to be moved to a different caregiver once they can attend child care. Foster care does not pay for multiple foster/kinship caregivers during the neonatal period, although this small monetary investment would promote healthy attachment by allowing a stay-at-home foster/kinship caregiver to provide child care and the long-term foster/kinship caregiver to pick the child up after work.

## ROUTINES AND PREDICTABILITY

Children benefit greatly from family routines and predictability. Established meal times when everyone eats together, engaging in child-directed play, reading with children, and bedtime routines foster a sense of security and safety.

Preparation for transitions, such as visitation with parents, and attendance at school or child care are very important in helping a child feel secure and cared for. Children entering a new environment need a lot of reassurance.

- They need to know their parents love them even if they cannot take care of them at the moment.
- They need to know when they will see their parents. Keeping a calendar with dates for scheduled parental visits that caregivers can point to can help even preschool children or toddlers.

Remaining calm in the face of a frantic, distressed child takes a great deal of self-control but is the best response, especially for a child who has experienced trauma. Children may parrot something their birth parents said at a visit that is hurtful to caregivers, so the pediatric professional may need to help the caregiver place the child's comments in context, while validating the caregiver's feelings.

Many foster care agencies conduct "icebreaker" sessions early in placement with a trained facilitator so that foster caregivers and birth parents can meet in a safe setting. Such meetings are an opportunity for foster caregivers to learn about a child from the parents and for the parents to become familiar with the person caring for their child.

Pediatricians who engage all of a child's caregivers can reinforce the importance of focusing on meeting the child's needs. Parents and caregivers do this by speaking respectfully about each other, sharing helpful information about the child, and maintaining routines and similar expectations in all environments. Many child welfare agencies have started using models such as Shared Parenting to build rapport between the child's birth parents and foster/kinship caregivers.

## VISITATION

Visitation is challenging for parents, children, and new caregivers because everyone's expectations and anxiety are high.

- Foster/kinship caregivers can be advised to provide a healthful snack and a transitional object for children to carry with them during the visit.
- If age appropriate, having the children make a small piece of art to give to their birth parents can be a nice way for children to share.
- Caregivers should reassure children that they look forward to seeing them after the visit with their parents.
- Ideally, caregivers transport children to visits. However, many children travel via Medical Motors because caregivers are working. In this case, assigning a particular driver to a specific child is recommended.
- Familiar adults should help children prepare for and transition into the visit and assist the parent and child in separating at the end of the visit, with reassurance that the next visit is scheduled.





- A reentry time once children return home or to child care is recommended. The caregiver or other familiar adult should welcome children back from their visits.
- Some children benefit from being engaged in child-directed play or a quiet activity, such as reading, as they adjust back to their daily routines after a visit. Other children need to run and play hard after returning from visits with their parents.

The foster/kinship caregiver or the child care provider may need to tailor activities after visits to meet the needs of individual children.

### IMPACT OF UNPREDICTABLE EVENTS

Many unpredictable events can occur during foster/kinship care and upend children's emotional well-being. Something seemingly simple like an upcoming court date can affect children's emotional and behavioral well-being because even young children quickly learn that important decisions about their lives are made by judges. Some changes

that can have a devastating impact on children's social and emotional health include:

- Other children entering or leaving a home
- A parent's failure to show up for visits
- Separation from siblings or sometimes reunification with them
- A parent receiving treatment for drug use or serving time in jail
- Resumption of visitation after a long lapse
- Being bullied at school
- Changes in school or child care placement
- Changes in foster/kinship homes.

Almost every health encounter in the medical home should be viewed as an opportunity to assess the social and emotional health of a child in foster/kinship care with appropriate guidance and/or referral when indicated.

### PERMANENCY PLANNING

A challenging aspect of parenting a child in foster/kinship care is the innate unpredictability of this living arrangement. More than 60% of children return to their family of origin, nearly 20% are ultimately adopted, and 9% age out of foster care.

At the beginning of a child's placement in foster care, caseworkers usually engage in dual planning; they develop simultaneous plans for reunification and adoption. This activity can be confusing for foster/kinship caregivers and for professional caseworkers. Ideally, foster/kinship caregivers treat children in their care as if they are their own. But this situation creates the potential for great loss for both the children and the foster/kinship caregivers when children leave the foster home.

#### REUNIFICATION

**ALTHOUGH FOSTER/KINSHIP CAREGIVERS RECEIVE** training on the transient nature of most foster care placements, the grief and loss they may feel when children return to their parents or extended families can be intense and enduring, especially if the foster/kinship caregivers feel that the children are being returned to situations that are less than appropriate.

Pediatricians can offer support to foster/kinship care-givers through both the anticipatory and the actual grief of children leaving their home. Usually, there is a period when visitation duration and frequency increase

and safety issues are closely monitored. Foster/kinship caregivers may start to emotionally disconnect during this time, which can be confusing to children.

Ideally, birth parents work with foster/kinship caregivers so that the child's relationship with the caregiver continues after reunification, but this happens infrequently. Likewise, children who are old enough to understand that they will be leaving a foster/kinship placement may engage in challenging behaviors as part of impending separation. They may also have anxiety about the change, have unrealistic expectations about returning to their parents, or be experiencing their own grief and loss issues.





## PERMANENCY PLANNING (CONTINUED)

### ENGAGING BIRTH FAMILIES

**PEDIATRICIANS CARING FOR CHILDREN IN TRANSITION** should be aware of the impact on both caregivers and children and counsel caregivers and older children accordingly. Sometimes the pediatrician will have a well-established relationship with the birth family and continue to provide the medical home care after removal to foster/kinship care. But many children in foster/kinship care have had spotty interaction with the health care system before their removal and access may not improve significantly afterward. Many children also change doctors as they move among caregivers. Because the birth parents or relative identified as a long-term resource for a child may not attend pediatric visits, the pediatrician is advised to engage

caseworkers, Court-Appointed Special Advocates, and the child's attorney in reaching out to birth parents. Often significant information is unavailable to pediatricians, so they rely only on the foster/kinship caregivers. Pediatrician can ask other professionals involved with the children to encourage birth parents or other relatives to attend pediatric visits.

Pediatricians need to realize that they may have little or no input in the ultimate permanency decision even though they may identify the foster/kinship caregivers as a more appropriate influence than the birth parents for a child or teen. This situation can be extremely frustrating for pediatricians who are experts in children's health and well-being.

### ADOPTION

**ADOPTION OF CHILDREN OUT OF FOSTER CARE PROVIDES** them with a forever family and can be "open" (some contact is maintained between the child and birth parents) or "closed" (no contact is legally provided for).

The Adoption and Safe Families Act of 1997 requires states to begin termination of parental rights proceedings once a child has been in foster care for 15 of the previous 22 months unless reunification is pending. Not all localities follow this standard closely, and foster/kinship caregivers have no legal standing in most states until a child has been in their care for at least a year.

Until children are freed for adoption, their birth parents remain their legal guardian. After children are freed, birth parents have no rights except possibly the right to a certain number of visits or phone calls in the case of open adoption. Adoption by foster/kinship caregivers with whom the child has a long-standing relationship is often a desirable outcome of foster care placement, but children may perceive being freed for adoption as the final loss of their family.

Behaviors may escalate at this time as children process the implications of permanent legal separation from their family of origin. Adoptive parents may be confused and hurt by a child's conflicted reactions. Family or individual mental health therapy may be indicated

and helpful during this period as the new and permanent family forms and the child deals with the final separation from the family of origin.

Birth parents may also need support during this period. Most birth parents lose their parental rights through a legal process called Termination of Parental Rights. Although birth parents may lack the ability to care for their children safely, they may still have a strong emotional connection to their children and feel as though their children are being stolen from them. Some parents deal with their grief by discontinuing visitation or expressing a great deal of anger toward the system and/or the potential adoptive parents or the children. Parents who voluntarily free their children for adoption have often moved through a long personal reflective process and recognize that their children are "better off" with the potential adoptive resources. However, the process of freeing their children for adoption is still often a painful one.

Pediatricians who engage the birth and adoptive parents can offer support during this difficult time by acknowledging everyone's feelings of guilt, anger, and sadness. Pediatricians can encourage all caregivers to focus on the children's needs and remind caregivers to minimize interpersonal conflict and negative comments about each other.





## PERMANENCY PLANNING (CONTINUED)

### AGING OUT OF FOSTER CARE

**ADOLESCENTS WHO CANNOT RETURN TO THEIR FAMILY** of origin or are not adopted out of foster care eventually age out of the system. In all but three states, the age of emancipation is 18; in three states, the age of emancipation is a more reasonable 21 years. Emancipation essentially disconnects the teen from all foster care supports and services, except Medicaid, for which the teen remains categorically eligible under the Affordable Care Act until age 26.

Emancipation is fraught with challenges for youth unless they have developed connections to caring adults such as foster/kinship caregivers, caseworkers, mentors, or members of their extended family who are committed to helping them navigate through life. Youth often leave foster care undereducated, poorly prepared for employment, and with minimal skills. Mental health, relationship, and substance abuse issues that result from unresolved or untreated childhood trauma lead to abysmal outcomes.

The preparation for independent living should include money management, employment skills, continuing

education, future planning, and life skills such as knowing how to shop for and prepare healthful meals, establish supportive relationships, and practice safe sex. Foster care agencies are supposed to begin this preparation when a child reaches age 14, but there are no studies indicating whether this occurs. The abysmal outcomes of youth who age out indicate that more work needs to be done to help children develop independent living skills.

Pediatricians can help youth in foster/kinship care navigate a path to successful independent living by providing guidance about acquiring the appropriate skills for their futures. Helping youth identify their skills and talents, encouraging them to complete high school or vocational training, and assisting them in obtaining job experience while in foster care are three important things to emphasize with youth. Pediatric providers can also encourage youth to identify and connect with adult role models and mentors who may continue to be a resource into adulthood even when foster care ends.

Visit the Healthy Foster Care America ([www.aap.org/fostercare](http://www.aap.org/fostercare)) for additional tools and resources for health care professionals to facilitate communication and collaboration with professionals, families, and children and teens in foster care.

