Health and Mental Health Services for Children in Foster Care: The Central Role of Foster Parents

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It is well documented that children enter foster care with special health and mental health needs and, while in care, those conditions are often exacerbated. However, less attention has been given to foster parents who have the most contact with these children. Results are presented from a national study on the developmental, health and mental health care needs of children in foster care that included foster parents’ perspectives and observations. Their role in improving child well being is explained and recommendations for policy, practice and advocacy also are included.
Many children enter foster care suffering from insufficient prenatal and health care, poverty, homelessness, exposure to alcohol and other drugs, learning problems in school, and, of course, physical abuse, sexual abuse, and neglect (Blome, 1997; Downs, Moore, McFadden, & Costin, 2000; Halfon, Mendoca, & Berkowitz, 1995; Kortenkamp and Ehrle, 2002; National Commission on Children in Need of Parents, 1978; National Commission on Family Foster Care, 1991; Pecora, Whittaker, Maluccio, Barth, & Plotnick, 2000). Children with these risk factors need a stable and therapeutic living arrangement, in which the effects of these traumas can be ameliorated if not healed (Duncan & Brooks-Gunn, 2000; Fein & Maluccio, 1991). This article first summarizes key research findings over the past 20 years on the health and mental health needs of children in foster care. These previous studies document that foster parents—although they are trusted with the daily care of children with complex needs—largely have been overlooked from research efforts and recommendations in this area. This article then details interventions that could address foster parents’ concerns about accessing health and mental health services for children in their care. Advocacy for more inclusive research for the foster parents is the third objective of the article.

Background

More than two decades have gone by since the passage of P.L. 96-272, the Adoption Assistance and Child Welfare Act of 1980, which had the promise of significant reform for children and adolescents reported to be “drifting” in out-of-home care. But the 1980s saw the social safety net for many American families dismantled, the emergence of HIV/AIDS, increased reports of child abuse and neglect, caseworkers* overwhelmed by increasing caseloads and

* The authors believe that only professionals with degrees in social work (BSW, MSW, PhD, or DSW) should be labeled social workers. As most children in foster care are served by individuals without those degrees, the generic term “caseworker” is used here.
decreasing agency and community supports, and a dwindling supply of foster parents whose role in the delivery of foster care services continued to be ambiguous (National Commission on Family Foster Care, 1991; Pasztor & Wynne, 1995).

The need for developmental, health, dental, and mental health care for children in foster care was documented as early as 1982 (Schor), showing that while abused, neglected, and emotionally maltreated children had a range of health and mental health problems, the health care they subsequently received failed to address these issues. Although the role of caseworkers as part of the systems-wide problem was addressed, no specific recommendations were made for the role of foster parents.

Hochstadt, Jaudes, Zimo, and Schachte (1987) studied 200 children taken into care in Cook County, Illinois, during August 1984, finding that they were at “high risk for medical and psychosocial problems” (p. 53). As one of the first articles to specifically address the role of foster parents, the authors report that “foster parents are the critical element in the successful delivery of adequate health care services to foster children” (p. 61), recognizing many problems foster parents faced in obtaining adequate healthcare services.

In a study that included a potential role for foster parents relating to the mental health needs of children in care, the perspectives of foster parents were evaluated along with those of administrators, caseworkers, and healthcare providers in 14 counties in California (Halfon & Klee, 1987). The authors found that while children who were injured, abused, or ill could receive healthcare immediately, only one county provided routine mental health assessments, and less than a third of the children ever received such evaluations. In addition to recommending communication, coordination, and joint planning among relevant agencies to address these service gaps, Halfon and Klee recommend increased resources and training for both agency staff and foster parents.

In 1991, the National Commission on Family Foster Care (convened by Child Welfare League of America in collaboration with
the National Foster Parent Association) predicted that the number of children in care would continue to increase, and the nature of their needs would continue to be "complex, changing, and perplexing" (p. 21.) The commission found that children coming into foster care not only have special needs but, in many cases, "extraordinary" health, mental health, behavioral, and developmental needs. In its report, *A Blueprint for Fostering Infants, Children, and Youth in the 1990s*, the commission calls for legislative action to require each child’s case plan to document how health and mental health needs would be assessed and addressed periodically. Moreover, the commission specifically requests that child welfare agencies develop plans to recruit and retain foster parents and casework staff who could meet the protection, developmental, health and mental health, and permanency needs of an increasingly fragile population of children in their care and on their caseloads.

In 1992, another study in Illinois—which involved 500,000 children—compared how those receiving AFDC (now TANF) and who later came into foster care used health services versus those who received assistance but were not placed (Bilaver, Juardes, Koepke, & Goerge). Findings supported the researchers' hypothesis that "the population of abused and neglected children who go on to enter foster care may have significantly more health problems, and especially mental health problems, than other poor children" (p. 416). While the authors discuss a possible relationship between access to and use of healthcare and caseworker influence, they do not specifically mention of the role of the caregivers in the process.

In 1995, an analysis studied the health status of children in foster care seen in a multidisciplinary assessment center in Oakland, California. The 213 children in the study had high rates of chronic multiple medical and mental health problems (Halfon, Mendonca, & Berkowitz, 1995). The authors also note a possible relationship between emotional, developmental, and behavioral problems to the number, quality, and timing of children’s placements, with potential implications for foster parents.
Focusing specifically on the role of foster parents, a child welfare agency in Montreal, Canada, instituted a quarterly health newsletter for foster parents to help them address the “high prevalence of medical, emotional, developmental, and behavioral problems originating both with events leading up to placement and as a consequence of the placement itself” (Rich, 1996, p. 437). Noting that foster parents often are inadequately trained, the Parents at Heart newsletter addressed their attitudes and skills when confronting behavior problems. By the fourth issue, a positive effect of the newsletter was reported. The author states, “when victims of child abuse and neglect are placed in inadequately prepared foster homes, the state implicitly colludes in continuing their maltreatment” (p. 442).

Analyzing the “risk factors and high incidence of psychopathology among children in out of home placements” (Schneiderman, Connors, Fribourg, Gries, & Gonzales, 1998, p. 29), mental health practitioners and administrators in New York City recommended a framework and guiding principles for mental health services that did include direct work with foster parents based on the clinical needs of the children in their care.

A Connecticut study compared young children entering foster care and receiving customary, community-based services with another group newly entering care but participating in a comprehensive multidisciplinary program (Horwitz, Owens, & Simms, 2000). After studying 120 children, the authors reported that foster mothers’ “limited experience” in the assessment of children’s problems could not only affect children’s receiving appropriate services but placement stability as well.

Simms, Dubowitz, & Szilagyi (2000) restate the developmental, health, and mental health risks for children in foster care. They suggest that strategically improving the healthcare of children would require further research in the areas of delivery models, the appropriate roles of primary providers, children’s adjustment to care, and educational and peer mentoring programs for foster
parents on children’s developmental, health, and mental health challenges.

In 2001, a national study on healthcare policies for children in out-of-home care was reported in *Child Welfare* (Risley-Curtiss & Kronenfeld). Virtually all of the 46 participating state child welfare agencies acknowledged falling short of meeting the standards set by the Child Welfare League of America for the healthcare of children in out-of-home care. Approximately 37% of the states indicated that they provided or required no training on healthcare issues for their caregivers. More than 52% of the respondents did not have “identifiable, written” responsibilities for caseworkers and caregivers for accessing healthcare, contributing to a “lack of clarity” between their roles, so “the child suffers” (p. 344).

In San Diego, data was collected on 480 children in long-term foster care to examine factors influencing the use of outpatient mental health services. While the researchers reported that almost 1/2 of their population demonstrated a need for mental health services, indicating a troubled and troubling group of children, they specifically raised the need for more clarity in the “role that caregivers and social workers may have as de facto ‘gatekeepers’ into the mental health system” (Leslie, Landsverk, Ezzet-Loftstrom, Tschann, Slymen, & Garland, 2002, p. 473).

Most recently, The Urban Institute’s national study on the well-being of children in the child welfare system reported that children placed with foster parents and relatives were “more likely to have behaviors problems, to have been suspended or expelled from school, and to have received mental health services” (Kortekamp & Ehrle, 2002, p. 3). This study documents that approximately 25% of these children were in family arrangements in which the caregivers themselves were considered to be “aggravated” and provided minimal cognitive stimulation for the younger children (p. 3). The authors’ policy recommendations include “equipping” foster parents to care for children with “complex needs.”

Adding to these examples are specific populations of children in care who may be even more likely to have health and mental
health risks. These populations include children of color, whose numbers are disproportionate and expanding. And they are more likely to suffer poor outcomes than their white counterparts (Pecora, Whittaker, Maluccio, Barth, & Plotnick, 2000; Stehno, 1990). Public policy supports the placement of children across ethnicities and cultures, but their health and mental health needs may be less well understood and, therefore, the response to them may be less if their caregivers are not culturally competent (Chung, Vostanis, Cumella, Doran, Winchester, & Wu, 1999). Also, the unique needs of gay, lesbian, bisexual, transgender, and questioning youth have only started to be addressed in the past decade; how their health and mental health concerns can be best served in foster care needs more attention (DeCresenzo & Mallon, 2002; Mallon, 1997).

Method

An opportunity to learn from the observations and experiences of foster parents was provided through a strategic capacity assessment that began in 1997, when the U.S. Administration for Children and Families (ACF)/Maternal and Child Health Bureau (MCHB) Technical Advisory Group Subcommittee on the Health of Children in Foster Care established the Public-Private Partnership for the Health of Children in Foster and Other Out-of-Home Care.

In the first stage of a national study, the Center for Healthier Children, Families, and Communities at UCLA conducted a mail survey in 1999–2000 of child welfare, Medicaid, health, and mental health agencies in all 50 states plus the District of Columbia to assess the policy, administrative, and practice issues that influence the adequacy of health and mental health care services available to children in foster care (Halfon, Inkelas, Flint, Shoaf, Zepeda, & Franke, 2002). The five largest counties in each of the 11 states with county-administered child welfare agencies were selected. All remaining counties (from both states with state-administered child welfare and states with county-administered child welfare) were pooled, and the largest 10 counties were selected. The overall response rate for
state and county agencies combined was approximately 71%, including 80% of state agencies and 60% of sampled county agencies. The survey research team included two doctorate public health researchers and a pediatrician with nationally recognized child welfare and public health research expertise.

The mail surveys described service delivery arrangements, assessed the organization and delivery of services, and identified what states and localities were doing to improve capacity, collaboration, and performance. From the returned surveys, the research team sought to identify states and localities that had developed innovative approaches in some aspect of the delivery of health and mental health services, and through the second stage of the study, to understand how the local policy environment contributed to those innovations.

A series of site visits was incorporated in the study design to obtain more detailed information from nine state and county jurisdictions where returned surveys indicated policies or practices that were particularly innovative. The aim was to use indepth, qualitative site visits to explore contextual factors—such as local leadership, concentration of local expertise, legal advocacy, and consent decrees—that may contribute to better systems outcomes. The site visits were designed not only to identify obstacles to health and mental health services experienced by foster parents and other child welfare, health, and mental health professionals, but also to highlight policies, programs, and practices that might be working effectively.

Nine jurisdictions participated in the site visits from 2000 to 2002. The sites were selected based on organizational and geographic diversity. The nine sites included five county-administered child welfare agencies, one city and county agency, and three state-administered agencies serving urban, suburban, and rural populations. The locales were in the east, the mid-Atlantic, the south, the midwest, the mountain, and the southwest states.

The site visit teams included combinations of a doctoral level social worker with national child welfare expertise, a practitioner
with masters degrees in social work and public health, two doctorate public health researchers, and a pediatrician with nationally recognized child welfare and public health research expertise.

The teams met separately with the following individuals and groups: child welfare agency administrators, supervisors, and line casework staff; judges; staff from health and mental health agencies; child welfare advocacy groups; and foster parents. This analysis focuses on the findings from focus groups of foster parents. Focus groups were selected as the most effective way to obtain information from foster parents because the intent was to gather perspectives on system functioning rather than details of personal experiences, which would be best collected on an individual basis. Also, the child welfare field recognizes the use of focus groups for several reasons. Participatory research facilitates empowerment (Gold, 1998), so foster parents could be participants and not just subjects. A participatory approach is congruent with the need for a more clearly articulated and valued role for foster parents who may feel marginalized (Pasztor & Wynne, 1995). Focus groups are useful in obtaining “qualitative data on a specific subject” (Packard, Jones, Gross, Hohman, & Fong, p. 21).

Because of informed consent considerations that precluded the research team from directly soliciting participation, foster parents were recruited by their sponsoring jurisdictions. Agencies were asked to invite either by letter or phone call a diverse mix of foster parents, including those with less than two years or more than 20 years of fostering experience, diversity in ethnic and gender, and representation by a foster parent association. Focus groups intentionally were kept small so all participants could contribute. A total of 55 foster parents participated in the nine focus groups, ranging in foster care experience from less than five years to more than 20. Ethnic distribution included African American, Caucasian, and Latino participants, and the majority were foster mothers.

Focus groups were approximately 90 minutes long and held at the sponsoring agency. They followed a standardized protocol,
including welcome and introductions, purpose of the study, informed consent, inquiry about physical and mental health challenges of the children in their care, resources available to address those issues, agency policies on health and mental health screenings, assessment and ongoing treatment, information sharing including health passports, and overall impressions and recommendations. Content analysis was used to organize and interpret data from the focus groups to identify common patterns, themes, and examples.

Results

Four major concerns were identified by the foster parent participants: (1) the developmental, health, and mental health needs of the children placed in their care; (2) access to health and mental health services for the children, and continuity in service provision; (3) communication challenges with casework staff and other service providers; and (4) foster parents' role limitations.

Developmental, Health, and Mental Health Needs

Foster parents at all sites were consistent in identifying a range of developmental and health problems for the children in their care. These included low birth weight, exposure to alcohol and others drugs, otitis media, obesity, skin conditions like eczema, respiratory conditions like asthma, dental problems, enuresis, speech delays, failure to thrive, and developmental delays. The description the kinds of health problems that children experience was consistent with what has been reported in past studies.

Commonly encountered mental health and behavioral problems included eating disorders, depression, bipolar disorder, oppositional defiance, sleeping disorders, post-traumatic stress disorder, learning disabilities, aggression, attention deficit disorder, age-inappropriate sexualized behaviors, and general acting out such as lying, stealing, and cursing.
Access to Services and Continuity in Service Provision

Foster parents reported two major ways of accessing health and mental health services. Most typical was that the child welfare agency would expect foster parents to find their own medical providers in their communities. This private provider was to be used for initial health screening within the required number of days following placement and for subsequent preventive care, as well as treatment for illnesses and injuries. The other strategy was to use a multidisciplinary setting (or in one jurisdiction, a hospital emergency room) selected by the child welfare agency to provide initial health screening or assessment.

The most likely strategy to ensure timely access to services were those cases when foster parents had a preexisting relationship with a physician from their own parenting experiences, who they also used their fostering capacity. In other cases, when fostering was the first experience with parenting, parents reported searching for a pediatric provider who also was a Medicaid provider. Many foster parents, however, reported frustration in finding physicians who would accept Medicaid. Other physicians refused to treat children in care at all, because of these children’s complex health and related needs and the risk that the physician might have to testify in court. Some foster parents complained of delays in obtaining Medicaid cards, and that some physicians refused to serve children if the card could not be presented. These situations left foster parents scrambling to find some medical assistance. Some reported that their community had a strong foster parent association and relied heavily on this network for finding providers. Foster parents noted they more often relied on each other than their child welfare agencies for referrals.

While foster parents reported that accessing health care could be difficult but always doable, even if it meant going to an emergency room, mental health services were scarcer. Across sites, foster parents reported long waiting lists at community mental health centers. In one jurisdiction, all foster parents were assigned
a single facility, resulting in weeks of waiting for mental health appointments. Medication for children also was reported as troubling, not only because of problems in inconsistent applications, but because foster parents had to pay out of pocket for costly medications and wait months for reimbursement.

Lack of continuity in both medical and mental health care was consistently a concern. Foster parents in all jurisdictions reported that as children moved among foster families, group homes, birthfamilies, and back into care, commensurate disruptions in health and especially mental healthcare occurred. Developmental, health, and mental health information often did not follow the child, and this problem was especially true for medications. Foster parents raised grave concerns about the effect on children’s well-being when essential medication, including psychotropic drugs, was administered sporadically. They also were concerned about not understanding potential side effects of medications.

**Communication Challenges with the Casework Staff and Other Service Providers**

Without exception, foster parents recognized the need for more effective and efficient communication with caseworkers, as well as between themselves and health and mental health service providers. This need for communication focused on two areas: (1) the content and quality of information to be shared, and (2) the process for sharing it. Foster parents recognized that developmental, health, and mental health information should be a permanent part of a child’s record, spanning intake, placement, and termination. They expressed frustration that critical information sometimes seemed to get lost through the placement process.

Foster parents typically could not differentiate between information that was known by agency staff and not shared, and information that simply was not known. Particularly striking was the near universal report across sites that foster parents routinely received children with no available medical information. They gave
examples of health and mental health information being withheld from them for fear that they would not accept a child with special or extraordinary needs. One example came from a foster parent who agreed to take an infant on an emergency basis, with no shared medical information. Placed during a time of snow, the baby came in a snowsuit. The caseworker left quickly and, upon removing the outer clothing, the foster parent discovered that the baby was in a full body cast. Instances of not being told about histories of sexual abuse and destructive behavior also occurred.

Foster parents expressed strong concerns that agencies withheld health and especially mental health information because of "confidentiality." They asked a logical question: "If we can be trusted with the 24-hour protection and care of a child, why can't we be trusted with health and mental health information about that child?" They emphasized that confidentiality should not be a basis for withholding crucial information needed for appropriate care of the child.

In addition, the process of sharing information was also described as problematic. All of the site visit jurisdictions had some version of healthcare passports, developed for children in foster care so that information could be collected, coordinated, and centralized to make it more transportable. But some foster parents did not want to use them because they did not know how or they felt the passports were too large to manage, there was missing information, or there was information they did not understand. They also reported that some medical and behavioral health providers did not like the passports because of concerns about accuracy and additional work. Foster parents generally understood that the value of healthcare passports was linked to the willingness, ability, and resources of those responsible for entering and transferring information.

Foster parents also identified others other than casework staff with whom they interacted around children's developmental, health, and mental health issues, including parents and kin, adop-
tive parents, and health and mental health providers. They expressed special difficulty in talking with the parents of children in care, echoing caseworkers’ concerns that parents were sometimes resistant to learning about the special needs of their children, especially if they perceived some failure on their part as the cause of the children’s difficulties. Parents were more likely to believe that the children were healthy going into foster care; thus, they were the ones who created the problems. Foster parents also believed that prospective adoptive parents were more likely to receive the most comprehensive health and mental health information, creating an impression of a two-tiered system. Some foster parents identified special circumstances when sharing health and mental health information with youth transitioning out of foster care for independent living.

Communication with doctors and other health and mental health professionals also was described as a challenge, particularly understanding diagnoses and how to navigate the healthcare system. And most foster parents did not know the extent to which judges and courts could order assessments and access to healthcare, or how they used health and mental health information in determining case dispositions. When children received comprehensive multidisciplinary evaluations, however, those evaluations apparently were being used in the decisionmaking of caseworkers and judges. Yet, the role of foster parents in that process was less clear. Only one jurisdiction had a case review process that included health and mental health issues and systematically included foster parents as well as the parents of children in care.

Role Limitations

Whether foster parents should be viewed as professional colleagues, clients, or something in between has been the subject of debate for at least 60 years (Hanford, 1941; Pasztor & Wynne, 1995; Pecora, Whittaker, Maluccio, Barth, & Plotnik, 2000). Unsurprisingly, with the exception of the two jurisdictions where
there were strong foster parent associations, foster parents reported challenges in meeting the needs of children by virtue of their role. Conflicts played out in two categories: role clarity and skill.

As previously mentioned, foster parents sometimes felt they were treated as "glorified baby sitters"; casework staff perceived them as having no need for or right to information about children in their care. Foster parents had numerous stories about hardships when health and mental health information was not shared. For the most part, the foster parents participating in the focus groups considered themselves to be essential members of the care team, needing and expecting complete and accurate information. They did acknowledge that there are foster parents who may be less willing or able to manage health and mental health information about child well-being. They also strongly recommended that those who did not have that capacity should not be foster parents.

Foster parents reported a critical need for competency-based training to begin managing the health and mental health issues facing the children placed with them. They acknowledged being intimidated by physicians and mental health professionals and feeling uncomfortable asking for clarification, especially if they did not have a relationship with the doctor or psychologist. Asking casework staff for assistance often was problematic because either the child welfare staff were not accessible because of caseload size, or the caseworkers were not sufficiently well-informed to provide help.

Interestingly, caseworkers in focus groups conducted simultaneously across the site visits echoed the foster parents' concerns that they often have little clinical experience with health and mental health issues for children in foster care. Yet, caseworkers must develop and execute children's permanency plans, and thus, are expected to identify unmet health and mental health needs. They also are the decisionmakers for many of these important health issues. Both foster parents and caseworkers in several jurisdictions identified the need for a dedicated medical unit, or a centralized healthcare unit, for consultation and full-time availability
for mental health crises, as well as assistance with the management of chronic medical and mental health problems.

Two other logistical issues surfaced: childcare and transportation. As foster parents typically care for several children at one time, they reported difficulties obtaining childcare when one child had medical or counseling appointments. Transportation also became a problem when health and mental health appointments were located far away. While some foster parents could turn to extended family or other foster families for help, they rarely could turn to the case-workers and, in fact, were negatively "rated" when they did.

Finally, no foster parents reported experiencing any specific discrimination by health and mental health providers because of their role as foster parents or their ethnicity. However, some foster parents expressed concern in being able to access health and mental health providers who were of the same ethnicity or spoke the same primary language, especially when children or caregivers were speaking English as a second language.

Discussion

Although the sample size across the nine jurisdictions was effective for participatory research, it nonetheless was small, and thus, is a major limitation for this study. Foster parents were invited by their agencies to meet the general criteria previously described, and then the participants self-selected to be in the focus groups. While the findings cannot be generalized to all locales and foster parents nationwide, the diversity of participants by age, gender, ethnicity, years of experience, and foster parent association affiliation was valuable. Further, the foster parent observations and perceptions reported above substantiate what survey researchers have reported on specific health and mental health problems and services for children in care. The findings are consistent with anecdotal information about foster parent perspectives, and this study is one of the first to report the experiences and recommen-
dations for systems change from the perspective of foster parents, who "have the most interrupted contact with, and knowledge of the young persons in their care" (Maluccio, Krieger, & Pine, 1990, p. xiii). It is this recognition that provides the foundation for the following recommendations.

The goal of child welfare historically has been to protect children from abuse and neglect, rather than to proactively promote children's well-being. With the Adoption and Safe Families Act of 1997 (ASFA), child welfare agencies now must achieve the outcomes of child safety, permanency, and well-being. Attention to well-being, in concert with the other two, may help promote policies with greater focus on children's health, mental health, and development. But actively promoting children's well-being is a challenge to many community-based child welfare systems. Essential health, child development, and mental health services generally are not under the direct control of child welfare agencies. Thus, improving children's access to services requires not only strengthening internal assurance policies, but also paying more attention to services provided in the health and mental health sectors, which are often foreign territory to many foster parents and agency staff.

No matter what systems improvements may be put in place by child welfare agencies or their health and mental health counterparts, little can be done without a qualified workforce charged with the daily care of the children. Two important populations continue to be limited in size as well as skills: a severe shortage among child welfare casework staff (Alliance for Children and Families, American Public Human Services Association, and Child Welfare League of America, 2001; Beaucar, 1999; Pasztor, Saint-Germain, & DeCrescenzo, 2002; The Annie E. Casey Foundation, 2003; U.S. General Accounting Office, 2003.), and the dwindling population of foster parents (National Commission on Family Foster Care, 1991; Pasztor & Wynne, 1995). How can important performance outcomes be achieved without an appropriate number of adequately trained and high-quality foster parents in a central caregiving role?
One approach is the professionalization of foster parents, which has had considerable success but is limited by funding and a host of other complex factors (Pecora, Whittaker, Maluccio, Barth, & Plotnick, 2000). Pending the kind of large-scale institutional change that would enable foster parents to be trained and supported to provide therapeutic family environments, the following recommendations should be considered.

**Staff and Foster Parent Responsibilities and Relationships**

First, the role of foster parents as active, valued members of the service provider team must be established. This entails recruiting, selecting, and training foster parents for clearly defined roles and responsibilities regarding child safety, well-being, and permanency, with commensurate system and staff supports. Foster parents must have full disclosure of children’s developmental, health, and mental health needs to be able to act in an informed and responsible manner on behalf of the children in their care. Second, child welfare agency policy should require staff who have intake and investigation responsibilities to obtain as much medical, developmental, and family history as possible for future needs, and to collate, synthesize, and evaluate this information for case planning. Third, agencies using health and mental health passports must ensure accountability and consistency on the part of foster parents and casework and supervisory staff, which will no doubt require additional training and accountability, as well as a more user-friendly passport system. The possibility of an automated computer or PDA-based “passport” system of information transmission in the near future is not unreasonable.

**Interagency Relationships**

Foster parents must be able to rely on health and mental health care systems. They must have timely receipt of Medicaid cards for newly placed children. Foster parents need education about the health and mental health needs of children in their care. They
must have access to referral networks or specialized assessment and treatment centers. They need “on-call” medical experts to assist them with generic health systems issues, as well as specific questions regarding symptoms and medications. In many areas of the country, there are well-developed health information systems that are operated by the local children’s hospital or other health care systems. It should be possible to develop a set of telephone protocols that would allow the advisor nurses to provide informed health care information to foster parents 24 hours a day, seven days a week. Creating telephone-accessed information and advisor services for foster parents and care coordination services for healthcare providers could improve access to needed services dramatically, and reduce obstacles to needed information. Of course, casework staff, as foster parents’ role reciprocals, must have this information, as well.

The mental health needs of children in care are compelling. Children begin “acting out” with their foster families hours, days, weeks, or months after placement. Behavioral and emotional problems that are not understood by foster parents can result in multiple disruptions and a revolving door of multiple placements before children are referred for mental health assessments and interventions. Foster parents should not be responsible for calling attention to the mental health issues of children in their care. Rather, mental health assessments should be provided within an appropriate time frame after placement, especially when physical and sexual abuse is suspected or confirmed. As Dore (1999, p. 3) states, “the child welfare system can no longer afford to go it alone in its attempts to provide care to children who present with severe emotional and behavioral disorders as a result of abuse and neglect...collaboration between child welfare and mental health systems is imperative.” Finally, foster parents may need support in assessing their own willingness, ability, and resources to care for children with a range of developmental and behavioral diagnoses.
Kinship Care

While some jurisdictions count kinship care (the placement of children with relatives) as part of family foster care, none of the participants in the focus groups were kinship caregivers. However, while no kinship caregivers participated in these focus groups, previous research has evidenced that kinship families are equally challenged regarding health and mental health needs, not only of the children, but also of the caregivers (Altshuler, 1999; Berrick, 1997; Dubowitz, Feigelman, Harrington, Starr, Zuravin, & Sawyer, 1994; Fuller-Thomson & Minkler, 2000; Pasztor, Goodman, Potts, Insuasti, & Runnels, 2002). Relatives caring for younger family members under the auspices of the child welfare system have a separate set of challenges. Legislation, policies, and funding streams have required that they function as foster parents. The differences, however, in family dynamics between the acquired role of the foster parent and the inherited role of a grandparent, aunt, or sister caregiver are dramatic. All of the recommendations listed here should be considered from the unique perspective of kinship care.

Research

Just as parents of any child are expected to have the most influence on their well-being, foster parents logically have comparable influence on the well-being of challenged and challenging children placed with them. Yet, a comprehensive review of the literature exploring foster family characteristics and problems of children in foster care reveals that “surprisingly little” is known about how foster families affect the behavioral and emotional functioning of children placed with them (Orme, 2002). While foster parents are not responsible for the problems plaguing children when they enter care, their role in the health and mental health healing process must be recognized and supported (Fox, Frasch, & Berrick, 2000). New research is needed, so that policies and services for children in family foster care can improve the role of foster parents. Although research on the role and effect of therapeutic foster care on child
outcomes is significant, much less research exists on what it takes to support foster parents to provide an optimal caring environment.

**Advocacy**

Pediatricians, social service, and child welfare researchers have been writing about health and mental health concerns for children in foster care for more than two decades. The problems persist as the number of children in care continues to grow. This work should go one step further: Develop not only a “research to practice” agenda, but also promote a “research to policy” agenda. This could include, for example, sharing findings with elected officials and advocacy organizations, and disseminating the growing number of best practice models that are emerging across the country.

**Conclusion**

Qualitative research documenting the experience and needs of foster parents attempting to access health and mental health care for children placed with them reveals a number of common barriers and impediments to optimal care across the United States. From this limited but cross-jurisdictional study, the authors conclude that foster parents are not receiving the role clarity, training, information, and support they need to responsibly help address increasingly complex health and mental health challenges. With new demands for child welfare agencies to be accountable for demonstrating improved child safety, well-being, and permanency outcomes, the provision of better health and mental health services for children will become even more important. Given these mandates, bold steps must be taken to make sure foster parents can access the resources needed for children in their care, and that they are essential members of the caregiving team.

Because of their daily caregiving responsibilities, foster parents have only limited ability to improve the quality of health and mental health services. Of course, foster parent associations provide a critical voice. Impetus for change, however, also must come
from others in the social services and medical professions who may have more access to policymakers and administrators on behalf of foster parents and the vulnerable children in their care.

References


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