

# Special considerations for the health supervision of children and youth in foster care



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## INTRODUCTION

Over 76,000 children and youth are in foster care in Canada, and their numbers are increasing annually (1). Children and youth in foster care have higher than average medical, emotional, developmental and educational needs (2). These special needs are often chronic, under-recognized and neglected. There are many barriers to health care including lack of or inadequate medical records, lack of consistent care or follow-up due to temporary placements, and difficulty accessing services. There are no practice guidelines specifically designed to meet the health care needs of children and youth in foster care. Despite that, most paediatricians will encounter foster children within their practices.

The present statement highlights the health care issues specific to children and youth in foster care in Canada. The prevention, reporting or emergency management of child maltreatment is not discussed.

A PubMed search was performed for relevant articles using search terms such as foster, care and health, limited to title and abstract; children and adolescents zero to 18 years of age; and a time span of 10 years (1997 to 2007). References from retrieved articles were also searched. In addition, resource material was sought from the Child Welfare League of Canada, Centres of Excellence for Child Welfare, Health Canada, Statistics Canada, Government of Canada and First Nations Child & Family Caring Society of Canada.

## BACKGROUND

Foster care is the provision of care and supervision by a family other than a biological parent or guardian, and is approved and arranged by a child welfare authority (3). At times it is a temporary placement with the goal of family reunification after relevant support services such as parenting skills training, counselling, respite care, daycare, life skills training or specialized treatment programs have been accessed. Other times it is a transition to adoption or long-term fostering as part of permanency planning – a process offering continuity of nurturing and life-long relationships.

Children enter into the child welfare system for a variety of reasons and under differing placement agreements. In some cases, special needs children from remote, often Aboriginal, communities may be placed in foster care to facilitate access to services not available in their own communities. Children and youth may be in immediate need of protection from or may be at risk of abuse or neglect. Common risk factors include drug and alcohol addiction, extreme poverty,

homelessness, violence, previous involvement with the child welfare system, prenatal drug and/or alcohol exposure, family history of mental health disorders, severe behaviours or complex medical problems, and cognitive or functional impairment of parents with little resources or support.

Child welfare services operate under provincial and territorial jurisdictions. Each jurisdiction has its own legislation, definitions, policies and services. The exception to this is the federal responsibility for children with First Nations status. Approximately 40% of foster children are Aboriginal (up to 68% in Manitoba), and 6% of Aboriginal children are in care. In recognition of the over-representation of Aboriginal children in care, a growing number of Métis and First Nations child and family service agencies have been developed to provide culturally based services pursuant to provincial child protection laws (4). Jordan's Principle was a proposal to the federal government to resolve jurisdictional disputes affecting services to First Nations children. A motion of support of Jordan's Principle passed unanimously in the House of Commons on December 12, 2007. This is a child-first principle that ensures the needs of the child are met by the government of first contact until the jurisdictional dispute is resolved (5). More advocacy is needed to ensure this moral direction on government is in fact implemented at the federal and provincial/territorial levels.

Provincial laws govern issues of consent for treatment. Quebec is the only province that is not governed by the Criminal Code of Canada but by the Quebec Civil Code and the Youth Protection Act for matters of child maltreatment (1). For more information on the child welfare system in Canada refer to Table 1.

## HEALTH SUPERVISION

With first contact of a child or youth in care, the physician must collaborate with the child welfare staff; usually the child protection worker becomes the legal guardian while the child is in foster care. Foster and birth parents, as well as group home personnel may also be part of the initial contact. A complete medical history is often unavailable at the initial visit, and physicians must be prepared to provide service with little background knowledge of the child. It is the responsibility of the child welfare worker to provide consents for transfer of medical charts and obtain thorough documentation of past medical history including medications, allergies and immunization records.

**TABLE 1**  
**The Canadian welfare system**

Resource	Telephone	Web site
Centres of Excellence for Child Welfare	416-978-1386/3255 (Toronto), 514-343-6111/7735 (Montreal)	< <a href="http://www.cecw-cepb.ca">www.cecw-cepb.ca</a> >
Child Welfare League of Canada	613-235-4412	< <a href="http://www.cwlc.ca">www.cwlc.ca</a> >
First Nations Child & Family Caring Society of Canada	613-230-5885	< <a href="http://www.fnccaringociety.com">www.fnccaringociety.com</a> >
National Clearinghouse on Family Violence	1-800-267-1291	< <a href="http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence">http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence</a> >
Human Resources and Social Development Canada Foster Care Report – September 2006	613-957-9832	< <a href="http://www.hrsdc.gc.ca/en/publications_resources/social_policy/foster_care/page01.shtml">www.hrsdc.gc.ca/en/publications_resources/social_policy/foster_care/page01.shtml</a> >

The Child Welfare League of Canada calls for a redesign of services to better meet the needs of foster children and youth. They note the high incidence of children with developmental delays, children who are HIV-positive and those who have had substance abuse exposure (eg, fetal alcohol spectrum disorder).

The American Academy of Pediatrics (6) and the Child Welfare League of America (7) have published guidelines relevant to the health supervision of children in foster care. Among these are the recommendations for an initial medical visit within 24 h of placement, a comprehensive follow-up visit within 30 days of placement and routine screening for development, mental health, dental health and sexually transmitted infections (6,8,9).

### HEALTH CARE ISSUES

The health care needs of foster children are as vast and varied as in any general paediatric practice. However, children entering into foster care are often in poor health not only because of risk factors such as poverty, prenatal exposure to drugs or alcohol, or parental mental illness (10), but also due to inadequate medical supervision before coming into care. Some common issues that arise on admission to foster care include poor hygiene, underimmunization, dental neglect and contraceptive needs for adolescents. The 2003 Canadian incidence study of reported child abuse and neglect (11) found that in 34% of substantiated maltreatment investigations, there was at least one physical, emotional or cognitive health problem. Fifteen per cent of investigated children had a learning disability, 10% had developmental delays, 3% had a substance abuse-related birth defect and 2% had a physical disability. The study also reported that 40% of investigated children had at least one behavioural functioning issue, with 13% of cases having poor school attendance, attention-deficit hyperactivity disorder (ADHD) or negative peer involvement (11). This is compared with national ADHD rates of 8% to 10% in males and 3% to 4% in females younger than 18 years of age (12).

A study (13) of 334 foster children living in urban Canada reported respiratory disorders in 19.6%, dermatological disorders in 16.3% and ophthalmological disorders in 6.3%. The study also reported that 33.9% of foster

children had a chronic disorder such as asthma, cerebral palsy or congenital abnormality, possibly requiring multidisciplinary care and closer medical follow-up. Mental health problems including ADHD and behaviour problems were found in 55% of children 18 months to 12 years of age (13).

Another study (14) of 248 children in foster care found 70% to have had a lifetime history of treatment for emotional or behavioural problems, compared with 17% to 22% in community samples.

The 2004 Ontario Crown Ward Review (2) reported high rates of behaviour problems, aggression, ADHD, emotional problems and developmental delays. Overall, they reported that 82% of this population had special needs.

Dental neglect or failure to seek treatment for dental caries or periodontal disease is also a common finding among children entering into foster care. One-half of all victims of child maltreatment have had craniofacial, head and neck injuries (15).

Data from the United States (16,17) showed that 45% to 92% of children entering foster care have at least one identifiable health problem, with highest rates for respiratory, growth, dermatological and hematological disorders. Higher rates of educational problems are reported including learning disabilities, intellectual disabilities and academic failure (18,19).

### SUMMARY

Children and youth entering into foster care are a high-risk, special needs population with many barriers to optimum health care. Paediatricians are in a distinct position to champion for these children and provide comprehensive health care if aware of the issues. The present statement provides an overview of some of the issues and challenges within this paediatric population and offers the following recommendations for health supervision.

### RECOMMENDATIONS

- Physicians should recognize that children and youth in foster care have a higher incidence of special needs including chronic medical conditions, mental health disorders, and developmental and academic delays.

- Physicians should collaborate with child welfare professionals, foster parents, group home staff and, when appropriate, parents and family members to determine the urgency for assessment and to provide optimum health care to foster children and youth in Canada.
- On placement in foster care, children and youth should have an initial medical visit, including a physical examination, to screen for and treat health conditions requiring prompt medical attention such as acute illness, infection, pregnancy or chronic conditions requiring medication and significant developmental delays or mental health disorders. The need for vision, hearing and dental screening should be assessed.
- During the initial assessment, physicians should evaluate the infant, child or youth's need for screening tests such as complete blood count, ferritin, lead level, HIV, hepatitis B and C titres,  $\beta$ -hCG, cervical or urethral swabs for sexually transmitted infections, and Papanicolaou smear on a case-by-case basis. Routine ordering of tests is not recommended.
- A follow-up medical visit should be arranged to review the medical history including immunization status, perform a complete physical examination, complete or review referrals for developmental and mental health assessments as required, and ensure dental follow-up has been arranged. Laboratory investigations that were part of the initial screen should be reviewed.
- Physicians should be aware of and sensitive to the unique cultural, emotional, spiritual and physical needs of children and youth of all ethnic groups, including Aboriginals.
- Physicians should evaluate the need for referral for psychoeducational assessment and support on admission and throughout foster care placement. This could include liaising with teachers, principals, special educators and tutors.
- Physicians should partner with child welfare professionals to establish and maintain thorough medical records to provide consistent care and follow-up. Health care records should follow the child or youth throughout and beyond foster care placement.
- Children and youth who are either currently or have previously been placed in foster care should be monitored more frequently than the general paediatric population.
- Physicians should advocate for permanency planning including placement stability and personal intervention plans which establish a child or youth's long-term life goals.
- Physicians should be aware of community resources to assist the fostering caregivers in the care of these special needs children and youth (Table 1).

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**COMMUNITY PAEDIATRICS COMMITTEE**

**Members:** *Drs Minoli Amit, St Martha's Regional Hospital, Antigonish, Nova Scotia; Carl Cummings, Montreal, Quebec; Barbara Grueger, Whitehorse General Hospital, Whitehorse, Yukon; Mark Feldman, Toronto, Ontario (chair); Mia Lang, Royal Alexandra Hospital, Edmonton, Alberta; Michelle Ponti, London-Middlesex Children's Aid Society, London, Ontario (2002-2007); Janet Grabowski, Winnipeg, Manitoba (board representative)*

**Liaisons:** *Drs Raphael Folman, Mississauga, Ontario (Community Paediatrics Section, Canadian Paediatric Society) (2005-2007); David Wong, Summerside, PEI (Community Paediatrics Section, Canadian Paediatric Society)*

**Principal author:** *Dr Michelle Ponti, London-Middlesex Children's Aid Society, London, Ontario (2002-2007)*

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The recommendations in this statement do not indicate an exclusive course of treatment or procedure to be followed. Variations, taking into account individual circumstances, may be appropriate. *Internet addresses are current at time of publication*