

Healthcare for children in foster and residential care

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It is a sad fact that child health and child welfare services tend to run in parallel tracks in many European societies. As a consequence, we know surprisingly little about the health situation and health needs of children in foster and residential care in Europe. This is in stark contrast to the USA where paediatricians within the American Academy of Pediatrics have been deeply involved with health issues of foster care for several decades (1). The study on runaway children in Spain by Gonzalvo Oliván in this issue of *Acta Pædiatrica* (2) demonstrates that child health professionals are needed in foster and residential care in Europe as well, a fact that is further underlined by the high mortality rates found in recent studies of children in foster care in Scandinavia (3, 4).

In many countries in Europe as many as 3–4% of all children under the age of 18 y spend some time in the care of child welfare services (5). Children and youths entering care need individual health assessments (6), as described by Oliván (2). These children have often experienced family violence, physical abuse, sexual exploitation, parental addiction and/or long-term neglect in their birth home and need an assessment that takes into account different kinds of health hazards related to these circumstances (7, 8). It is also important to document any chronic health condition that the foster parents and caseworker should know about, since information of this kind is often lacking in the child welfare investigation. American studies have demonstrated that one medical condition is present in 60% of foster children and at least three in 20% (5, 6). The status of all known chronic illnesses should be discussed directly with the caseworker and foster parents so that appropriate medication and treatments are made available.

Weight and length measurements are important to reveal poor nutrition and enable identification of subsequent catch-up growth. All body surfaces need to be examined for bruises and deformities, and X-rays may be warranted to document old fractures. Tests for sexually transmitted diseases and hepatitis B should always be considered when there is a family history that includes abuse of illicit drugs or sexual exploitation (5, 6).

Studies in the UK and the USA have demonstrated a prevalence of psychiatric disorders in populations of foster children (7, 9, 10) as high as the 54% described in runaways in Spain by Oliván (2). Behavioural disorders

are usually diagnosed, but affective disorders, anxiety and attention deficit hyperactivity disorder (ADHD) are also common. The aetiology of this high morbidity is to be found in a complex web of risk factors related to family dysfunction, traumas, separations, foetal exposure to substance abuse and hereditary vulnerabilities. A child psychiatric evaluation is therefore an important part of the foster care, so that treatment can be initiated when needed and foster parents appropriately guided, especially when caring for adolescents (11). A careful developmental assessment is also an important part of the initial evaluation, and has particular relevance for the dire educational needs of foster children, consistently demonstrated in many studies (12).

Children entering foster and residential care often lack immunizations as well as other preventive child health measures owing to parental neglect or an unstable housing situation. Dental health is often poor and earlier contacts with dentists unsatisfactory. A plan to fill in these gaps should be made for each child that enters foster care (9).

Removal from parents and subsequent placement in foster care is a stressful experience for most children (13). Psychological and emotional problems may therefore worsen rather than improve during the first year in care. Some children entering care have severe attachment difficulties that often create dysfunctional interaction patterns with the foster family. Guidance by a mental health professional is often helpful for the foster parents in these cases and serves to prevent multiple changes of foster homes, which is otherwise a common outcome, again especially so for adolescents (9, 11).

Evaluations in the USA have demonstrated that children in foster care often do not receive the health and medical care they need and are entitled to (1, 9). Information about health conditions is often difficult to obtain when the children come into care. Many child welfare agencies do not have specific policies regarding the healthcare of children in foster care and lack medical and psychiatric expertise within their staff. Changes of foster homes are not uncommon for foster children with mental health problems and tend to disrupt ambitious psychiatric treatments (11). Health professionals may also contribute to this institutional "neglect" because of poor training regarding the health problems of foster children. Community paediatricians have an important role in collaborating with child welfare agencies to break down these barriers. An

important step is the creation of an information system that allows medical and psychiatric information to follow the child in an effective manner (9).

The American Academy of Pediatrics outlines three different kinds of healthcare settings for foster children; a physician within the child welfare system, community-based care, or specialized foster care clinics (1). Specialized foster care clinics have been described as being particularly valuable for foster children with mental health problems and developmental delays where assessment is often difficult and time consuming (7).

In conclusion, it should be emphasized that children in foster care in Europe have not only been the victims of parental neglect, but also, to a certain degree, of a societal neglect when it comes to health issues. Perhaps the paper by Oliván in this issue is a sign that better days are coming for these vulnerable children and youths in Europe.

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