Editorials

Caring for Children in Foster or Kinship Care

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Family physicians are likely to encounter patients who are involved in the foster or kinship care system. Kinship care is the care of a child by a relative or close family friend that is mediated by the child welfare system. The foster care system in the United States serves approximately 675,000 children annually.[1] Of those placed in foster or kinship care, 59% will spend at least one year in care.[1] Most of these placements are a result of neglect, physical or sexual abuse, housing inadequacy, or parental incarceration or illicit drug use, all factors that can cause toxic stress in children.[1]

The effects of toxic stress on the neuroendocrine-immune system may lead to childhood attention and attachment difficulties, poor emotional regulation, aggression, hyperactivity, and impulsivity. Toxic stress may increase the risk of adulthood cardiovascular disease, cancers, asthma, autoimmune disease, and depression.[2] As family physicians caring for all ages, we must consider how childhood trauma impacts health later in life by using trauma-informed care. Trauma-informed care is a whole-person approach to health care that acknowledges the impact of trauma on health and facilitates long-term engagement in care that is inherently patient-centered.[3] Children in foster or kinship care are likely to experience fractured and inadequate health care. However, with proper attention, planning, and education, family physicians are well suited to lead a multidisciplinary team that cares for these children into adulthood.

Children who enter the child welfare system often have educational difficulties, developmental delays, mental health problems, and oral health issues. Up to 80% of children enter the system with at least one medical problem, and one-third have a chronic medical condition.[2] It is the role of a family physician to ensure continuity of care and help foster families navigate the health care system. It is also our responsibility to familiarize ourselves with the general structure and regulation of our local child welfare systems and to use trauma-informed care. We must support caregivers, who may already be under our care as patients, through the added stressors that often come with caring for foster children.

To ensure adequate comprehensive and coordinated care for foster children, the American Academy of Pediatrics recommends that these children be seen early and often, starting 24 to 72 hours from the initial placement and continuing monthly for the first three months.[2] It is good practice to allow extra time for these appointments. Visits should ideally occur monthly for the first six months of life, then every three months until 24 months of age, and then at least every six months thereafter.[2] Each of these visits should include an evaluation of mental and physical health, development, adjustment to foster care, and psychosocial stressors. Although many elements of a typical visit overlap with those performed at wellness visits,[4-6] additional guidance is provided in *Table 1*.[2]

TABLE 1

Health Care Considerations for Children in Foster or Kinship Care

History
Review immunizations, hospitalizations, trauma history
Identify factors that require immediate attention or that may affect the child's placement in a foster home (e.g., pregnancy, suicidal or homicidal ideation, violent behavior, signs of abuse or neglect)
Establish who has authority to consent to health care for the child
Collect case workers' contact information
Review the child's school performance, and assess the need for special education services such as an IEP or 504 plan
Review developmental and mental health screenings to identify problems early that may require referral
Assess risk of HIV and other STIs
Assess for caregiver stress and whether the foster placement is a good fit, including checking for major religious or cultural differences that may cause friction in the relationship; share any concerns with the case worker
Examination
Pay particular attention to growth parameters, vital signs, skin, and external genitalia
Assess for signs of abuse (for more information see https://www.aafp.org/pubs/afp/issues/2022/0500/p521.html); any signs of abuse should be photographed for the child's chart
Perform hearing, vision, and dental screenings regularly

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IEP = individualized education program; SNAP = Supplemental Nutrition Assistance Program; STI = sexually transmitted infection; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children.

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TABLE 1 *(continued)*

Health Care Considerations for Children in Foster or Kinship Care

Assessment and plan

Refer child for dental care and mental health counseling

Schedule therapies for any developmental delays; children younger than three years should be referred to state early intervention programs

Update immunizations; consider starting human papillomavirus vaccination at nine years of age in this high-risk population

Test for pregnancy, HIV and other STIs, and nutritional deficiencies, as indicated by the patient's history and review of systems

Counsel adolescents on safe sex and healthy dating behaviors; provide access to contraception, preferably long-acting reversible contraception

Refer patients and caregivers to government assistance programs as needed; children younger than five years automatically qualify for SNAP and WIC benefits in most states

Anticipatory guidance

Counsel caregivers on parenting a child who has experienced trauma; the American Academy of Pediatrics Trauma Toolbox for Primary Care (https://www.aap.org/traumaguide) may be helpful

Discuss with children of all ages the concepts of good touch/bad touch, safe adults, and stranger danger because children in foster care may show indiscriminate friendliness toward adults

IEP = individualized education program; SNAP = Supplemental Nutrition Assistance Program; STI = sexually transmitted infection; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children.

Information from reference 2.

Providing medical care for children in foster or kinship care requires extra time and special attention to the specific needs of this vulnerable population. Family physicians are in a unique position to provide continuity of care to the child and the caregiver. *Table 2* provides resources for physicians and caregivers.

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TABLE 2

Resources for the Care of Children in Foster or Kinship Care

Physicians

American Academy of Pediatrics Trauma Toolbox for Primary Care

https://www.aap.org/traumaguide

Child Welfare Information Gateway

https://www.childwelfare.gov

Mason PW, Johnson DE, Albers Prock L, eds. *Medicine: Caring for Children and Families*. American Academy of Pediatrics; 2014

Caregivers

Child Welfare Information Gateway

https://www.childwelfare.gov

Keck G, Kupecky RM, Gianforte Mansfield L. *Parenting the Hurt Child: Helping Adoptive Families Heal and Grow*. Navpress; 2014

National Foster Parent Association

https://www.nfpaonline.org

Purvis K, Qualls L. *The Connected Parent: Real-Life Strategies for Building Trust and Attachment*. Harvest House; 2020

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2. Jones VF, Schulte EE, Waite D; Council on Foster Care, Adoption, and Kinship Care. Pediatrician guidance in supporting families of children who are adopted, fostered, or in kinship care. *Pediatrics*. 2020;146(6):e2020034629.
3. American Academy of Family Physicians. Trauma-informed care. December 2021. Accessed September 28, 2022. https://www.aafp.org/about/policies/all/trauma-informed-care.html
4. Turner K. Well-child visits for infants and young children. *Am Fam Physician*. 2018;98(6):347-353.
5. Riley M, Morrison L, McEvoy A. Health maintenance in school-aged children: part I. History, physical examination, screening, and immunizations. *Am Fam Physician*. 2019;100(4):213-218.
6. Locke A, Stoesser K, Pippitt K. Health maintenance in school-aged children: part II. Counseling recommendations. *Am Fam Physician*. 2019;100(4):219-226. ■