SPECIAL ARTICLE

Foster Care: An Update

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ABSTRACT

Objective: To inform child and adolescent psychiatrists about the almost 500,000 children now residing in the American foster care system. This overview surveys the pediatric, developmental, and psychiatric needs of these children. **Method:** Child and adolescent psychiatrists, pediatricians, a child welfare researcher, a social worker, and a psychologist developed a consensus paper from their experience with child welfare and a review of the literature in their respective fields. **Results:** Being in foster care is a defining experience in these children's lives. They are at risk in myriad ways: for instance, being poor, having chronic health deficits, experiencing the trauma of abuse and neglect, and suffering from a garnut of emotional challenges. Evolutionary developments in foster care such as therapeutic foster homes, kinship care, and changes in Medicaid funding will continue to alter the system. **Conclusions:** Foster children are a huge reservoir of unmet pediatric and psychiatric needs; research on them is spotty at best. It is hoped that child and adolescent psychiatrists will meet the challenges these youngsters present and will advocate for them. *J. Am. Acad. Child Adolesc. Psychiatry*, 1997, 36(4):448–457. **Key Words:** foster care, adoption, child abuse, sexual abuse, permanency planning.

In attempts to balance the budget and reform welfare, the federal government will change American social policy. In particular, transferring federal programs to state block grants and decreasing Medicaid spending may dramatically reduce funds available to serve poor children and adolescents, including those in foster care. Furthermore, limiting Aid For Dependent Children to a 5-year lifetime eligibility would force indigent children into a foster care system that is overburdened; increasing numbers of disturbed children already have been diverted into foster care from the mental health and criminal justice systems. This article, developed by a group of child and adolescent psychiatrists, pediatricians, a social worker, a psychologist, and a child welfare researcher, will discuss health, social policy, and treatment developments in child welfare in order to inform child and adolescent psychiatrists about the great unmet needs of the almost 500,000 children in family foster care.

An Overview of Foster Care

Societies have always had to deal with orphaned children or those whose parents could not care for them. In this country, the first White House Conference on the Care of Dependent Children in 1909 recommended that carefully selected local foster families be used rather than orphanages or the railroad trains taking orphans west that were then popular (Hacsi, 1995; Simms, 1991). Conference participants also concluded that

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poverty alone was no reason to take a child from parents. Indeed, during the Great Depression, federal legislation created social policy that helped families keep their children. The 1935 Social Security Act provided support to indigent children; other federal programs gave financial aid and WPA jobs to poor families so that youngsters would not need placement.

With these family supports, and with the prosperity that followed World War II, the number of children placed out of their homes remained stable at approximately 250,000 a year. However, after the "Battered Child Syndrome" was published in 1962 (Kempe et al., 1962), reports of child abuse multiplied dramatically. Increasing numbers of abused and neglected children were placed in foster homes against their parents' wishes, changing foster care from a largely voluntary to an often involuntary system (Rosenfeld et al., 1994).

As the foster care population grew, critics argued that placement might not help children. They showed that despite the system's lofty goals, actual practice was grossly deficient. Rather than care being temporary, *average* stays were approximately 5 years (Fanshel, 1981). It was clear that separating children from their parents could result in emotional difficulties. Worse, many foster children drifted from home to home without permanency.

In 1980, the federal government passed Public Law 96–272 to "end the drift of children in foster care; encourage planning for permanency for each child within a hierarchy of desirable options, ranging from returning the child to his or her biological parents, through adoption, to long-term foster care; provide for oversight to move cases through the child welfare system; and develop preventative services to avert the family breakdown that removal of children from the home entails" (Fein, 1991a, p. 576). Agencies were mandated to develop "permanency plans" quickly and to enforce them within 18 to 24 months of placement.

The hope was that with Public Law 96–272 and more comprehensive services for families in crisis—remedial education, dental care, visiting nurses, and special pediatric and psychiatric care—fewer children would enter care. Those who did would stay briefly, either because families would be reunited or children would be adopted quickly. From 1977 to 1982, the foster care population halved, decreasing from 502,000 to 243,000; the average time in care also declined dramatically (Fein et al., 1990).

Although permanency planning was apparently working, the trend did not last. By the mid-1980s, poverty, homelessness, substance abuse, and human immunodeficiency virus (HIV) infection had placed many families and children at society's margins. By 1993, the foster care population had almost doubled (Tatara, 1994). The average stay had lengthened. Permanency was not being achieved, perhaps because family reunification often was impossible and adoptive homes were not available in sufficient numbers. Foster homes are supposed to promote growth, but not all approved homes were adequate.

The types of children entering care also changed. Low family income is still the best predictor of a child's removal from home (Lindsey, 1991). But other conditions, including substance abuse, HIV infection, and homelessness, were increasingly associated with poverty. Poor children often come from violent environments, witnessing drug sale, drug use, prostitution, domestic violence, and homicide. Racial and ethnic concerns also became evident. Although nonwhites make up 19% of the general population, by 1990, 61% of foster children were African-American, Native American, and Latino (Tatara, 1993). Despite this childhood disproportion, minority-group adolescents are underrepresented in foster care but are overrepresented in jails and psychiatric facilities (Fein and Maluccio, 1992).

Many children's situations are exacerbated by the system they encounter. Most children now entering foster care have been severely traumatized and have special medical, psychiatric, educational, and social needs that traditional child welfare and foster care services were not designed to address (Child Welfare League of America, 1991). Despite these needs, there are too few foster care workers, resources are scarce, and sensitive permanency plans tailored to each child's needs are infrequent. Very young children are particularly at risk. Separating 6- to 36-month-olds from their primary caregivers, when the emotional scaffolding of a personality is being formed, is probably especially harmful (Halfon et al., 1995). The foster care system pays too little attention to true permanency, which would avoid multiple placements, particularly of children with chronic behavioral or health problems (Child Welfare League of America, 1988); would ensure that good relationships form with foster parents when placement cannot be avoided; and would even minimize

the number of changes of the child's social worker. Although at times multiple placements may be necessary, the child can experience each one as a rejection that may interfere with the child's later capacity to form intimate relationships.

Physical Health Needs

Over the past 20 years, several surveys have found that foster children have three to seven times as many acute and chronic health conditions, developmental delays, and emotional adjustment problems as other poor children. In a survey of preschool foster children, Simms (1989) found that 60% suffered from developmental delays, 35% had a chronic medical problem, 15% had a birth defect, and 15% were of short stature. More recent studies report similar findings (Chernoff et al., 1994; Halfon et al., 1995). Increasingly, children in foster care have lost parents or primary caregivers to acquired immunodeficiency syndrome (Halperin, 1993); their numbers are likely to increase (Michaels and Levine, 1992). Some are themselves infected with HIV and are likely to eventually require sophisticated pediatric care.

Many foster children receive inadequate health care prior to placement; regrettably, many get insufficient health services after entering care (Halfon and Klee, 1992). A study of young foster children in three urban centers noted that 12% had received no routine health care, 34% were not properly immunized, and 32% continued to have unmet health needs after placement (U.S. General Accounting Office, 1995).

The Child Welfare League of America and the American Academy of Pediatrics (1994) stressed that all foster children should have prompt physical examinations; comprehensive developmental, educational, and mental health assessments; routine health care; and a health "passport" that follows them wherever they are placed. Sometimes these guidelines have been implemented only after litigation, but most agencies still have not fully complied with the recommendations (Halfon and Klee, 1992).

Evidence suggests that many foster children who receive needed interventions improve their health, developmental, and emotional status. For instance, White and Benedict (1986) examined the health and health care utilization patterns of foster children. Approximately half were in placement for at least 18 months and received initial and follow-up health examinations. In general, children whose conditions were amenable to treatment improved during placement. A recently completed prospective study demonstrated significant "catch-up" in height and weight in preschool foster children followed for up to 1 year after placement (Simms and Horwitz, 1996).

Mental Health Needs

Research Findings on Needs and Outcomes. Mental health, particularly of infants and toddlers, is not as simple to measure as height and weight, so research has often focused on cognitive, language, and growth delays, not on underlying emotional disorders and attachment difficulties. Halfon et al. (1995) found that 84% of their foster care sample had developmental and emotional problems: "Younger children were more likely to have gross and fine motor problems. Language abnormalities were most frequently observed in children aged one to five. . . . Cognitive problems affected approximately one third of the population under age five years and were detected in 52% of school-age children. Emotional, self-regulatory (coping and self-help), relational, and behavioral abnormalities were most prevalent in school-age children" (p. 389).

Most studies of foster children's emotional health are methodologically flawed: they had small samples, did not use standardized instruments, or had no criteria for psychopathology. Furthermore, few standardized instruments have established norms for children in foster care, who have unique attributes and, in many cases, intertwined emotional, developmental, cognitive, and physical difficulties. Instruments such as the Child Behavior Checklist (CBCL) may not be entirely accurate for foster children. Parent, social worker, or self-reports can also underreport problems; in one study, 33% of foster parents or social workers reported that the foster children they cared for had emotional, developmental, or behavioral difficulties, although a careful assessment found that 84% did (Halfon et al., 1995).

When available studies are viewed in aggregate, they suggest that foster children have extensive mental health needs. For example, McIntyre and Keesler (1986), using the CBCL with a random sample of 158 foster children, found some psychological disorder in nearly half. Hulsey and White (1989) found that the overall CBCL score for foster children was higher than a comparison group's, indicating more behavior problems.

Studies have linked foster care to conduct disorder. For instance, Fanshel et al. (1990) found that 44% of young adults who had been foster children reported being involved in delinquent activities that led to court charges. In another study, children with multiple foster care placements more often displayed criminal behavior (Berridge and Cleaver, 1987). Is the relationship cause and effect? After all, many older children enter care *because* their behavior has become problematic. Widom's (1989) seminal study found that adult criminal activity was correlated with child abuse and neglect, not with living in a foster home.

The popular press often reports that foster care harms children. This conclusion seems unfounded. Although outcome studies of foster care can be confusing because they lack appropriate comparison groups or baseline assessments before, or at entry into, out-of-home placement, several studies show that foster care placement can have *positive* outcomes. For example, Fanshel and Shinn (1978) noted that children who remained in foster care over a 5-year period showed significant improvement in academic achievement and moved out of special class placements. The effects were most dramatic for children from the most deprived backgrounds and for those who remained in foster care.

Wald et al. (1988) compared three groups of 5- to 10-year-old children: one abused group in foster care for a year, one similarly abused that stayed continuously in their birth homes while they and their families were given intensive social interventions, and a matched comparison group that had not been abused. While nonabused children made steady progress in all spheres, most abused children changed little. Over the study's 5 years, 57% of abused children who stayed with their parents were abused again. However, the children in foster care received better medical care, their school attendance improved significantly, more performed adequately at school, and they did marginally better in their social development and social competence. While Wald et al. found little change in the two abused groups, changes in well-being that did occur favored foster care. Fein et al. (1990) also reported positive functioning in most areas for foster children in care 2 years or more.

Methodological weaknesses of existing research and numerous confounding variables make it hard to reach a single, definitive conclusion on foster care's impact. Folman's (1996) innovative study of foster children concluded that the discrepancies among the ratings of social workers, biological parents, and foster parents; the danger of labeling transient behaviors as pathological; and the difficulty of assessing foster children with instruments developed for other populations require transactional and ecological perspectives that take into account the complexity of variables and that militate against simplistic answers. For the most part, children who entered foster care decades ago fared adequately in care. We cannot predict whether that finding will remain true now that more abused and severely traumatized children are entering foster care.

Risk Factors for Developmental Psychopathology. Most poor children do not have severe psychopathology. Biology, temperament, and experience play important roles. But abused children from poor, disorganized families seem far more likely to end up troubled. Abuse increases children's aggressiveness and creates a milieu of violence that affects socialization with peers (Lamphear, 1985). Garmezy (1993) proposed that severely deprived children are exposed to "cumulative stressors," which put them at risk for psychiatric disorders and adult criminality. Growing up economically deprived leads to poor access to, and/or underutilization of, prenatal care, increased risk of teenage pregnancy, and limited educational opportunities (Kliegman, 1992). Furthermore, the social and economic deficiencies that accompany lower class status make everyone in the family more vulnerable to the impact of any biological or environmental stressors (Hertzman, 1994).

Research on risk and protective factors helps explain why some foster children avoid negative outcomes while others do not. Werner and Smith (1992) conducted an ongoing, 32-year prospective, multidisciplinary study of 505 infants born in 1955 on Kauai, Hawaii. They found that two thirds of children with four risk factors by age 2 (risk defined as, for example, poverty, moderate to severe perinatal stress, mothers with little education, family discord or divorce, parental alcoholism, parental mental illness) developed learning disabilities, behavioral problems, teenage pregnancy, and/or mental illness (Werner, 1989). On average, foster children have more than 14 risk factors (Thorpe and Swart, 1992). Other investigators have found that abuse (Egeland and Brunnquell, 1979) combined with severe poverty and parental mental illness or addiction, alleviated by few protective factors, puts foster children at significant risk for adverse psychological outcomes.

What leads to resiliency? The resilient third of Werner and Smith's (1992) cohort had three clusters of protective factors: (1) at least average intelligence and a disposition that elicited positive responses from family members and strangers; (2) emotional ties with parent substitutes that encouraged trust, autonomy, and initiative; and (3) an external support system (in church, youth groups, or school) that rewarded competence and provided them with a sense of coherence.

Vailliant (1993) found that the single best predictor of good long-term outcome was a child's ability to form one good relationship with someone, not necessarily a parent or relative. This principle lies at the heart of the concept of foster families for dependent children. Indeed, encouraging children to form or maintain a good, supportive relationship may be the most positive force in these children's lives.

The Emotional Plight of Foster Children. When a foster child is discussed at a psychiatric conference, the child's care status may be mentioned as if it were incidental. Yet parent–child separation, the breaking and remaking of attachments, makes the care experience central in a foster child's emotional life.

Many foster children say their biological parents were right to abuse or neglect them. Wanting desperately to be back in familiar surroundings, they view their parents as "good" and themselves as "bad." While this dynamic can be seen at any age, it is more common among preschool and early school-age children. These children's egocentric and magical thinking contributes to their blaming themselves, as does their need to keep the external object "good," both to sustain the their budding self-esteem (i.e., they come from good "stock") and to retain a sense that the external world is coherent.

Abused children often believe—sometimes, unfortunately, assessing their situations realistically—that they are "throwaways" about whom no one cares. Entering foster care compounds this difficulty because they must contend with why they were given away by, or taken from, their biological parents. This would diminish any child's self-esteem; it makes those foster children who internalize their feelings depressed and/or suicidal. Other adolescents in care may not blame themselves, but blame "the system" against which they then act out. These adolescents who externalize may hate everyone and everything and see the world as persecuting them. Paranoid, lacking inner reserves, they are like hair triggers that will fire with minimal pressure (Rosenfeld and Wasserman, 1990). Because they expect past injustices and indignities to dominate the present and future, these irritable children can be impulsive, violent, and explosive. They may act out by running away, being promiscuous, becoming truant, or being aggressive against people and property.

Children whose biological parents neglected or abused them often see adults as unavailable, unreliable, perhaps even punitive. They enter care expecting their foster parents to reveal, sooner or later, how uncaring or abusive they are. Thus, some children provoke a negative response from foster parents just to prove that their vision of the world, forged in their relationship with their abusive or neglectful parents, is accurate. Better to be smart than surprised.

Biological and Foster Parents. Biological and foster parents experience contradictory demands which create tension between them and among social workers, psychiatrists, and other professionals. Biological parents are expected to participate in designing a "service plan" in partnership with the child welfare agency. Rarely is it a partnership; usually, birth parents are told what they must do to get their children back. The plan may include drug and/or psychiatric treatment, parent training, and securing a residence for the family. Since birth parents usually get fewer remedial services once their children are placed out of their home, they often are unable to comply with the service plan (Lindsey, 1991). For instance, adequate treatment for drug abusers often is unavailable.

If biological parents are to be reunited with their children, the relationship must be strengthened, dysfunctional interactions between parents and children must be improved, and abuse and neglect must be ended. Infrequent supervised visits, often in awkward settings like agency offices or restaurants, afford too little opportunity to make such improvements. The worker offering help in "partnership" with the biological family is also acting on behalf of a state that has taken the children away. This creates an ongoing tension between assuring the children's safety and wanting to "empower" biological families by returning children home as soon as possible. Balancing these perspectives can be difficult. How much risk is acceptable? A misjudgment can lead to a family broken unnecessarily or a dead child who might have been kept alive.

Foster parents also face multiple, seemingly incompatible, expectations. They are encouraged to make major emotional investments in rearing and nurturing a child who may be difficult to live with. Simultaneously, they are expected to support the child's eventual reunion with birth parents and to separate easily and gracefully when that time comes (Edelstein, 1981). Should foster parents become attached to children they care for? Might this attachment impede family reunification? If they remain detached, can they provide an environment that facilitates a child's emotional growth?

Visitation is the single best predictor of family reunification (Fanshel and Shinn, 1978) and is a mandatory component of foster care. However important visits are, they can be extremely stressful. Foster children, who often become anxious before and after visits, may act appropriately as long as the visit lasts. When it ends, some have temper tantrums or become aggressive to their foster parents ("I don't have to listen to you. I'm going back to my real mother anyway."). Sometimes biological parents fail to act wisely at, or even keep, visitation appointments; their children often find the stress and disappointment unbearable. Again, the foster parents are left to deal with the child's reactions and are expected to support the biological parents (even those who act inappropriately during a visit) and then to gracefully prepare the child for the next visit. No wonder some foster parents dread visitation. At times, foster children become pawns in a struggle between the two sets of parents; unbearable stress, suicide gestures, and aggressive behavior may then precipitate a crisis that brings the child to psychiatric attention (Pilowsky and Kates, 1996). It is not surprising that most foster parents cannot fulfill their role to everyone's satisfaction.

Mental Health Assessment and Treatment

Foster children have extensive mental health needs. For instance, in California, foster children make up 4% of the Medicaid population. They use between 40% and 50% of Medicaid child mental health dollars (Halfon et al., 1992). So it comes as no surprise that foster parents and foster care agencies often need psychiatric evaluations and psychotherapy and educational remediation for the children. But workers are overloaded; school systems, especially in inner cities, are overburdened; and courts often delay decisions. So foster parents and mental health professionals must advocate with child welfare agencies, schools, and courts.

A detailed discussion of clinical assessment and psychotherapy with children in care is addressed in a number of pertinent publications (Fine, 1993; Gallagher et al., 1995; Kates et al., 1991; Pilowsky, 1992; Rosenfeld and Wasserman, 1990; Steinhauer, 1991). But several points deserve mention.

Clinical Assessment. Targeted history-gathering may help identify children who are likely to adjust poorly to family foster care, even when they do not demonstrate overt behavioral disturbances. A history of severe physical or sexual abuse, extreme neglect, multiple disrupted attachments to primary attachment figures, or multiple removals from a biological parent's care are likely to be associated with poor adaptation to foster care. Alerted to the possibility of poor adjustment, clinicians and the foster family can plan better for the child's life in care.

Assessing biological and foster parents is a vital prelude to treatment planning. The parents, as well as child welfare agency workers, may all have concerns they will not discuss openly with the clinician. For example, foster parents may have a need to demonstrate how superior they are to the child's biological parents. Biological parents may want to minimize their problems, hoping to get their children back sooner. Foster parents who wish to adopt a child may unwittingly try to alienate the youngster from the biological parents. Rarely will they tell the clinician about what they are doing, if they are even aware of it. Biological parents may warn the child not to tell anyone, including the clinician, anything negative about what happened at home if "you want to be back with us someday." In such a case, a guarded, laconic, seemingly paranoid child simply may be complying with parental wishes. Because so much may be hidden at first glance, several interviews, conducted by someone who is alert to the particular psychodynamic elements out-of-home placement implies and who has an understanding of the conflicting interests of the parties involved, may be needed to clarify an otherwise confusing history.

Treatment. Psychotherapy may be unnecessary in situations in which the foster parents are sensitive and knowledgeable, the children resilient, and the biological parents caring and eager to participate in their children's lives. Many foster children need psychotherapy, but

treatment probably will become less likely as Medicaid becomes fully managed care. Not all foster children who need therapy are ready for it; a child's external world must be stable and safe; caretakers must be predictable. Sometimes, when this cannot be achieved quickly, psychotherapy is mistakenly recommended as if it were a panacea. Psychotherapy cannot create a situation in which a child can grow or make an inadequate level of care acceptable; it can only help disturbed and disturbing children take advantage of good situations (Bettelheim and Rosenfeld, 1993).

In some ways, the foster care system has become an open air mental hospital serving many very disturbed children, placing them in the "least restrictive" environment. It expects foster parents with little specialized training to deal with severely abused, disturbed children. Remarkably, these homes often are up to the task. However, some behavior is too much even for very good foster parents. Although the underlying rationale for placing children in the least restrictive environments flows from good intentions, it can have unfortunate results. "A bit of anxiety spurs learning. When anxiety exceeds a certain threshold, it makes learning impossible. What the foster care system often mandates is that children endure the maximal anxiety they can tolerate without decompensating entirely. Only when the child is sufficiently disturbing does the state decide that psychotherapy or a more restrictive—and more richly staffed—facility is needed" (Rosenfeld et al., 1994, p. 885).

A psychiatrist consulting about a foster child should not automatically recommend mental health treatment, however difficult the youngster. For instance, a consultant can help the agency choose a family that can best meet a particular child's needs and can help foster parents deal with disruptive or puzzling behavior so the child does not need to be placed elsewhere (e.g., by educating them about a child's loyalty conflicts and tendency to stay attached to severely abusive parents while expecting abusive behavior to be repeated). The consultant may also make certain that the child is placed at an appropriate level of care. Another complication of psychotherapy occurs when foster parents are ambivalent about the process and find it inconvenient to bring the child consistently to therapy sessions.

When psychotherapy is indicated, it should address the consequences of maltreatment and help the child cope with the loss of birth parents, neighborhoods, and friends. Because of these losses and painfully disrupted attachments, foster children may be reluctant or unable to attach to substitute caregivers, resulting in unfortunate consequences for personality formation. Most foster children carry a permanent emotional scar from their separations. The uncertainty intrinsic to foster care also aggravates a loyalty conflict for children between their biological and foster parents. It is unclear whether this conflict can be resolved with the help of psychotherapy before children know whether they will live with their birth parents again (Fine and Pape, 1990).

Another aspect of consultation faces child and adolescent psychiatrists who see foster children in community mental health settings. Under managed care they are asked primarily to provide medication; psychotherapy and planning may be delegated to less trained people or may not be provided. In these situations, psychiatrists must struggle, sometimes unsuccessfully, to use their consultative positions to assure that comprehensive, well-thought-out treatment plans are designed and implemented.

An important part of treatment is the training professionals can offer foster parents. Many foster children have lived with arbitrary punishment, uncontrolled rage, and unpredictability. To them, the parental consistency that most parents practice intuitively is a new experience. Foster parents need to be trained and supported in offering a consistent and nurturing environment, advocating for services, and understanding the child's special emotional needs. Professionals training foster parents need to convey sensitivity to these emotional dilemmas and help foster parents learn how to manage the behaviors they evoke.

Focusing on the foster child's emotional situation may lead a staff to unwittingly neglect essential educational, speech, and language remediation. Typically, foster children have attended school sporadically before entering care; often, even while in care, they move from school to school. Emotional trauma combined with poor school attendance keeps some from learning and contributes to their oppositional behavior at and about school.

New Developments in Foster Care

Kinship Foster Care. Traditionally, foster parents were not related to their foster children. In the 1980s, relative care increased dramatically. Today, almost 50%

of foster homes in some localities are kinship homes. Advocates of kinship care maintain that it confers significant advantages: Children placed with relatives remain connected to their birth families and cultural milieus. But children in kinship homes also have longer placements and are less likely to receive needed health services (U.S. General Accounting Office, 1995). Licensing standards for kin generally are less rigorous; kinship homes are less carefully supervised so children have more unsupervised contact with abusive and neglectful birth parents. Some states reimburse kinship homes at a lower rate, which may be another reason they prefer kinship care. Whatever the realities may be, without kinship homes, the system could not accommodate the large numbers of children who need placement.

Alternative Placements. Variations on group and family care are now being experimented with. For example, innovative programs have introduced "graduated therapeutic visitation," which uses visits as vehicles for therapeutic and psychoeducational interventions aimed at improving interactions (Irwin and Saletsky, unpublished). A pilot program in Syracuse, New York, initially places almost all children removed from home in a small group residence for 2 to 3 weeks; children are not expected to become part of a new family, which diminishes loyalty conflicts. Large sibling groups are accommodated: parents are encouraged to visit at least daily. Through work with the child and family and a therapeutic milieu, placement is sometimes avoided, and when it is inevitable, adjustment to foster care placement is better (Irwin, personal communication, 1996).

Treatment (or Therapeutic) Foster Care. To deal with the rising number of emotionally disturbed foster children, many child welfare agencies have created treatment foster care programs that provide intensive services to the most demanding and disturbed children. Such programs often are connected with broader networks of community-based mental health and child welfare services (Stroul, 1989). Similar programs interest managed care companies as cost-effective alternatives to hospitals and residential treatment centers (Rosenfeld et al., 1997).

Fine (1993) described in detail how such a program, organized on developmental and network principles, operated over a 10-year period. Careful follow-up indicated that (1) relationship therapy took place within foster homes and was generally helpful; (2) the program was most helpful to children with learning, developmental, and neuropsychiatric disorders; (3) foster parents who were most successful were typically mature, experienced, skillful, well-socialized, and independent; and (4) enduring attachments to foster families usually increased the foster children's sense of affiliation with their biological families, enhanced positive morale, and fostered a child's willingness to accept support during later years.

In contrast to current treatment foster care programs in which psychiatrists serve as consultants, in the program Fine (1993) described a child and adolescent psychiatrist was integral. Many of that program's homes cared for several children at one time, maintained relationships with birth families, and followed the children over time, often into adult life.

Managed Care. Managed care systems now being planned or implemented for Medicaid will likely have a profound effect on the clinical services foster children receive. To some, they promise new opportunities to provide cost-effective, well-thought-out care. Others predict that abused and/or neglected children will simply get fewer services (Flint et al., 1995; Hughes et al., 1995).

Under current managed care pressures, some child psychiatric inpatients are being discharged prematurely to a foster care system that is expected, but is unprepared, to care for barely stabilized patients. To respond to these challenges, the foster care system will need to develop and fund new, transitional modalities for children who cannot live at home but who need intensive mental health services, not hospitalization. Private managed care companies and public foster care systems need precise agreement about where one's obligations end and the other's begin. If they are to serve these children well, managed care companies need to provide high levels of pediatric, neurological, psychiatric, and remedial services. Alternatively, they may conclude that foster children are a population they cannot serve profitably (Rosenfeld, 1995).

Conclusion

Protecting children is an inexact art; treating damaged ones is an exquisite challenge. Our knowledge is spotty. Research has not delineated all the emotional concerns foster children face, characterized the best clinical and environmental techniques, or identified

which practitioners can best treat this population. Finally, the law has no definitive procedures. Overall, the systems affecting children (child welfare, education, health, mental health, and juvenile justice) often do not work together. The greatest concern is that our society sets a low priority on children's well-being. Growing numbers of children live in poverty. Substance abuse and domestic violence create havoc with parent–child relationships, and homelessness is the inevitable outcome of a defunct housing policy (Fein, 1991b).

Our current political system is committed to decreasing child welfare expenses. This will test an already overburdened foster care system and challenge providers. Ultimately society must decide what resources our most vulnerable children deserve. If we do not pay now, a far higher price will be exacted later.

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