

# Influences on the Mental Health of Children Placed in Foster Care

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Qualitative research methods were used to explore stakeholder perceptions of various influences on foster children's health. Semistructured interviews were conducted with focus groups of foster children, foster parents, and foster care professionals. Interview data were analyzed using content analysis procedures. Themes emerging from this analysis focused primarily on the foster children's mental health, including difficulties associated with perceiving oneself as being different, the children's need for coping strategies, problems encountered with the foster care system, transitions between foster homes, and the need for medical homes. Stakeholder groups recognized the necessity of mutual support for one another and proposed potential solutions for addressing concerns.

**Key words:** *children, focus groups, foster care, mental health, transitions*

**C**HILDREN in the United States increasingly suffer from the consequences of poor parental decision making and from social and governmental policies that do not adequately protect them.<sup>1,2</sup> When children are identified by a state as unprotected, neglected, abused, or abandoned, they may be removed from the home and placed in care that is meant to be safe and supportive. More than 80% of the children entering foster care have some form of educational, developmental, emotional, physical, or mental health problem.<sup>3,4</sup> Moreover, significant mental health problems are common among

young foster children into adolescence.<sup>5</sup> Because children in foster care have more unique and complex healthcare needs than do other disadvantaged children,<sup>3,6</sup> states face a significant challenge to meet their healthcare needs.

The healthcare needs of foster children are complicated by preexisting health issues as well as issues specifically related to placement in foster care.<sup>7</sup> Once in foster care, ongoing health problems and risk for further complications are exacerbated by<sup>4</sup> (1) removal from the biological home and the trauma of parent separation,<sup>8,9</sup> (2) failure of medical providers to recognize and follow through with evaluation and treatment of developmental and mental healthcare needs,<sup>10</sup> and (3) failure to receive healthcare services when referred.<sup>11</sup> Inadequate treatment of healthcare deficiencies that existed prior to entering foster care are further compounded by the barriers to healthcare once in foster care.<sup>12</sup>

The assertion that foster children receive inadequate healthcare is supported by data from the 2003 *Hawaii Child and Family Services Review*.<sup>13</sup> The final report of this review indicates that 43% of the time Hawaiian foster children do not have their healthcare needs met. However, the report does not provide

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adequate information about specific health issues and about Hawaii's ability to address the needs of its foster children.

## PURPOSE

To address the deficiencies in the Hawaiian child and family services report, a qualitative research study was undertaken. The primary purpose of the study was to explore varying influences on Hawaiian foster children's health. The questions that guided the study were as follows: (1) what are the influences on the health of Hawaiian foster children? and (2) what support is needed for the foster children to better achieve optimal health?

## METHODS

Because literature is limited about the perspectives on healthcare held by those involved in foster care, a qualitative design comprising focus groups, semistructured questions, and content analysis was utilized. Krueger and Casey<sup>14</sup> have recommended procedures for conducting focus groups, which entail group size, questioning strategies, group participants, group moderating, and data analysis. These were closely followed. A multiple category design consisting of stakeholders from various foster care sectors (youth, parents, and professionals) was considered appropriate for the aim of this study.

## PARTICIPANTS

Adolescent focus group participants were recruited through the Hawaii Foster Youth Coalition. Current foster parents (relative and nonrelative) and professionals (representing various roles within the system, such as social workers, guardians ad litem, public health nurses, doctors, and managed home directors) were recruited by the Hawaii Foster Parent Association to represent their respective groups. To be eligible for the study, participants were required to (1) have participated in the state's foster care system for a minimum

of 1 year and (2) speak English. In addition, former foster children were required to be between 18 and 19 years old and to have left the foster care system within the year prior to the study. Study approval was granted by the Institutional Review Board of the University of Hawaii. Informed consent was obtained from all participants prior to the collection of data. All informants received a \$25.00 gift certificate as compensation for their time. A total of 7 focus groups were formed: 5 groups were former foster children (groups sizes ranged from 4 to 7 for a total of 32 former foster children), 1 group consisted of 6 foster parents, and 1 group consisted of 10 foster care professionals.

## PROCEDURE

A similar set of questions was generated for each stakeholder group by an advisory board. Adolescent members of the board recommended terminology appropriate to their age group. Each focus group began with a general question designed to address participant perceptions of how a child's mind and body were affected by being in foster care. Subsequent questions were designed to elicit participant views on positive and negative aspects of foster care, which may have impacted the foster child's physical and mental health. Each focus group discussion was moderated by the investigator and ended with clarification and confirmation of summary data. During each discussion, an assistant taperecorded the proceedings, took notes, and addressed group needs.

## ANALYSIS

The focus group interviews were transcribed verbatim and analyzed following Krippendorff's<sup>15</sup> recommended procedures for content analysis. Data were coded qualitatively following an inductive interpretive process that entailed utilizing constant comparison techniques, searching for recurring themes, clustering, developing mutually exclusive defined categories, and finally

interpreting the meaning of the data within a theoretically grounded framework. Data were analyzed by the investigator immediately after each focus group session using Atlas.ti software. Data categories were validated or modified during subsequent focus groups by participant checks. Interrater reliability was used to assess reliability. The Cronbach's  $\alpha$  agreement coefficient of all data categories was .92. The methods of purposive sampling, theory presentation, and confirmation with stakeholders suggested by Krippendorff were used to assess the validity of the interpretive framework that was developed. Trends in stakeholder responses were then compared to identify the key factors that participants believe affect foster children's health in Hawaii.

**RESULTS**

The former foster children (*foster children*), foster care parents (*parents*), and foster care professionals (*professionals*) groups indicated during the focus group interviews that the physical healthcare needs of foster children were met over time. Although the discussion questions were designed to encompass both physical and mental health, all participants focused on the pressing need for mental and emotional support of children in the foster care system. The issues identified as key differed slightly by stakeholder group and are reflected in the data on themes and subthemes shown in Table 1. The themes identi-

fied during the coding process are organized according to stakeholder group and detailed in the following sections. The relative priority of issues was not a focus of the study; therefore, presentation of the themes in Table 1 is not meant to indicate any rank ordering by participants.

**Foster children**

One major theme, *mental health*, and 6 subthemes—*being different*, *transitions*, *coping strategies*, *normalcy wanted*, *autonomy wanted*, and *connections wanted*—were derived from the focus group interviews with foster children.

**Mental health**

The concept of mental health is defined as a foster child's psychological and emotional well-being, comprising the ability to function appropriately in individual, family, and societal relationships. The foster children interviews focused on concerns related to mental health caused by ongoing stress from the multiple life situations that they regularly encountered. Frequent changes in patterns of living, caused by changes in foster home assignments, were cited as having the most influence on mental health. One youth compared being in foster care to "being tossed around like a little ball." The foster children indicated that frequent movement between homes and schools decreased their level of trust of others and adversely affected their

**Table 1.** Themes and subthemes identified by stakeholder group

	Foster children	Parents	Professionals
Mental health	×		
Being different	×	×	
Transitions	×	×	×
Coping strategies	×		
Normalcy wanted	×		
Autonomy wanted	×		
Connections wanted	×		
System problems		×	×
Medical home			×

desire to build new relationships. Foster children were further confused by (1) inconsistent directives for problem solving within the system, (2) restrictive rules that did not allow maintenance of prior relationships, and (3) varying communication patterns used in foster homes and by their assigned professionals. Foster children consistently reported feeling overwhelmed by the foster care system; one youth summarized this feeling as a "struggle to maintain sanity." Another youth indicated that depression resulted from the confusion and stress of "trying to figure out how life is supposed to be."

Statements about mental health issues and the complexity of emotional responses resulting from living in foster care were common. One participant's statement is representative of the responses:

It takes time to trust because you don't know who is going to go away tomorrow. Let's just say like you are beaten up, thrown in a corner, telling you we do not love you or want you . . . Then you get put in a family and they are hugging you, and I feel like "What the heck is this? You are touching me. It is like go away! Hey, let me stay in the corner." You start reacting like, "Oh my God, she is touching me. Should I hit her? Or push away? Or do something?" You feel like totally weird because you have never had someone touch you and say "I love you, I care about you. I want good things for you." What does that mean? I don't understand it.

Mental health was variously described by participants with 6 subthemes identified. The first 3 subthemes relate to the foster children's self-perception, including their experiences and reactions to living in foster care. The last 3 themes are linked to the foster children's perceived solutions to their mental health issues and their desire for normalcy, autonomy, and connections. Although the 6 subthemes are closely intertwined, the informants perceived each one as having a distinct influence on their mental health.

### *Being different*

The feeling of *being different* was identified by both the foster children and parents as

an influence on mental health. It was consistently defined as the experience of living life as a foster child in comparison to what is commonly seen as "living as a normal child."

The foster children recognized thoughts of being different from other children based on what they termed "their life experiences." One youth described how foster children perceive themselves as different: "You feel different . . . some people pity you when you come in all the time with bruises . . . then people know you're foster kids . . . everyone treats you different." A stigma related to being a foster child was perceived. The next statement helps clarify the children's feeling of being stigmatized, "... when they learn [you are a foster child], they look at you different, they treat you different . . . they don't want to be friends with you because you are considered different . . . they think you are in foster care because you probably went runaway . . . like you probably did something . . . people think you are the bad kid." The foster children wanted their differences to be acknowledged, but they did not want to be judged negatively for life experiences and living situations that were beyond their control.

### *Transitions*

The concept of *transitions* was identified by all 3 participant groups as a primary influence on mental health and was consistently defined as experiences and feelings occurring as a direct result of a foster child's move from foster home to foster home.

Moving between foster homes was influential for all informants. One foster child explained a common problem related to transitions: "If we knew some little information about what the family is about, it would be easier on us to let go and to be okay with being at the new house. But, what the family gives to us we will give back to them." Another youth went on to describe the transition process in detail:

It's scary being put into . . . a complete strangers' home and they don't even talk to you, they don't even acknowledge you, it's scary knowing you're

there, but you're really not there, you're there but they don't make you feel like you're wanted. All we do is get put into a car and drove to their house and then dropped off. And we are told this is where you are staying. . . . As soon as the foster parents know there is a kid coming, the social worker gives the foster parents a file about us. So there are no excuses for them to say they don't know what we get or need or what's the problems.

Foster children wanted to be treated with respect and be informed and involved with decisions before, during, and immediately after their moves between homes. Additional suggestions included being given time to organize the move to prevent the loss of belongings, being greeted at the door by the foster family, being introduced to other family members and their roles, being informed of the house rules, and receiving an orientation to the new home environment. The desire for courtesy and for information that would facilitate their integration into the new home was consistently expressed.

### ***Coping strategies***

Foster children cited a variety of strategies for coping with foster care. *Coping strategies* as a subtheme was defined as a foster child's engagement in self-protective measures to deal with feelings of uncertainty and being devalued. The following statement is a common example of how foster children reported coping: "That is just how I cope . . . I call the social worker and report everything, cuz I not know what she [the foster mom] gonna to do crazy next. Then I get in trouble with my foster mom and she stop me from telling social worker. I had to find another way to get out of there, so I get in trouble." Deliberate misbehavior was motivated by the desire to be sent to another foster home or back to the biological home. Reported strategies were frequently ineffective or self-destructive.

The foster children often described situations in which they felt powerless, unsupported, and uninformed. Examples of such situations included (1) denial of requests to move from homes where they perceived unequal treatment with biological children;

(2) withholding of state provided spending money by the foster parents; (3) feelings of being "treated like a maid"; (4) inappropriate disclosure of the foster child's personal information; (5) lack of access to safe food; (food locked or outdated); (6) physical, mental, or sexual abuse by the foster parent; (7) confinement of the foster child; (8) isolation from siblings; and (9) severance of school activities when moving.

### ***Normalcy wanted***

The foster children interviewed consistently cited the need for a predictable routine and security. The subtheme *normalcy wanted* was defined as a foster child's need for life stability. One youth described the concept of normalcy as "where you are not confused by what is happening." The foster children reported feeling traumatized by their home placement experiences. Specifically, their need for normalcy related to feelings of lack of control and their confusion as a result of constant life changes. These feelings affected the informants' self-esteem, security, and identity. The foster children described the desire for foster care professionals to allow them to participate in decisions about home placements.

### ***Autonomy wanted***

Informants valued having control over their current and future life situations. *Autonomy wanted* was defined as foster children's desire for involvement in decisions influencing their lives and well-being. One informant discussed the difficulty of having no personal power: "You always have other people telling you what to do and making your decisions. It is just not right. You can't even learn how to make decisions." They indicated that making decisions about where to live was a potential area in which they might learn about decision making.

The foster children repeatedly emphasized the need to actively participate in mental health therapy decisions. Although many of these children faced significant mental health issues, most felt therapy was a "waste" of their

time and that it was "unproductive." They verbalized resentment in being forced to receive therapy before they were ready. Informants were distressed by frequent changes in therapists and by having to repeat life stories and personal information multiple times to strangers. Therapeutic relationships were terminated when foster children moved to a new home or when the therapist decided to discontinue working with foster children.

Autonomy in the future was defined as being prepared to live independently after foster care. To facilitate this transition, foster children requested training in life skills, which might include financial management, decision making, job seeking, driving, and establishing their own home.

### *Connections wanted*

The foster children provided multiple examples indicating the importance of feeling connected to their mental health. *Connections wanted* was defined as a foster child's desire for relationships that helped them to develop normal bonds, security, and trust. One foster child explained that "... normal kids know their history and feel connected to something." Another informant expressed the need for foster parents to "step up to the plate and do their job of creating bonds and trust" and felt that "if the [foster] parents were trying to also take care of emotions, they would feel more connected."

Based on the informants' responses, a lack of continuity and instable foster care home placement contributed to their feelings of disconnection. The foster children verbalized feelings of significant personal loss caused by interrupted biological family connections, particularly when it involved their siblings. One strategy, suggested by a participant, for connecting foster children with their "huge, confusing history" was to create a scrapbook with pictures, descriptions of schools, and foster parents' comments.

### **Foster care parents**

As in interviews with foster children, *mental health* was the major theme derived

from discussions with foster care parents. *Being different* and *transitions* were identified as subthemes. An additional theme, *system problems*, also emerged from these interviews.

### *Being different*

Foster parents described foster children as markedly different in personal and social skills, when compared with children who had not been in foster care. The following two quotes clarify what foster parents view as challenges. One parent said, "These kids are different... they come without even knowing the basics—how to brush their teeth, take a bath, comb their hair, eat with all the silverware—and that might even be when they are in third grade." Another parent supported this view: "These children are a specialized group. They have a lot more needs than the average child walking around." Parents went on to report that traditional parenting skills often seemed inadequate when working with many of the foster children. Parents reported that they regularly dealt with unique and complex needs for each new child coming into their homes.

### *Transitions*

Mental health problems related to *transitions* were seen as equally important to parents and foster children and were conceptually similar. Although transitions from one foster home to another are a common part of a well-functioning foster system, because of its importance in the lives of foster parents and children, the topic was considered independent of system problems. Factors related to home-to-home transitions were (1) receiving adequate and accurate information and (2) how the child was treated before and during the move. One parent statement contradicted the foster children's belief that parents are informed about each child in their care: "I just get information from the hard knocks of life... not hardly any information is given. So you just mostly get information from what the kids disclose." Foster parents often felt their

parenting was uninformed and would benefit from more information provided by the foster care system.

In another statement, a parent seemed conflicted about the foster care professionals' involvement with transitions: "Sometimes the workers truly don't know. . . . But sometime the knowledge is there and you are not given it because they know you will say 'no' to the kid." Often the foster parent had similar concerns as the foster children about the inadequate information they were provided.

### ***System problems***

The concept of *system problems* was consistent between both the foster care parent and foster care professional groups. The "system" refers to the policies and procedures that foster parents, foster care professionals, and the state must follow when caring for foster children.

Incomplete or unavailable health records were seen as a system problem that negatively impacted foster children's healthcare. Multiple foster parents reported that a lack of current medical records resulted in repeated vaccinations for foster children. One parent spoke of difficulties that occur when accurate health records were not available: ". . . when I get them [foster children] and am trying to prepare them for school or Head Start, I am the one who unfortunately has to torture these poor kids again since no one seems to know. It doesn't help me have a good relationship with them right way."

The state's application of federal privacy regulations, intended to maintain an individual's confidentiality, has created problems for foster parents. Consistently, foster parents reported experiencing problems with obtaining children's medical histories because a systematic procedure for providing records does not exist. Professionals were required to go through the court system to obtain individual medical records, placing an additional burden on their time. The foster parents repeatedly reported feeling uninformed. One exception was children with special healthcare needs,

such as speech or physical therapy; health records for these children were automatically available.

The second system issue was related to foster parents' performance regulations. Common concerns were the limited enforcement of regulations and the minimal system accountability. For example, several parents reported cases that when they received children from another long-term foster home placement, the child was infested with head lice and/or scabies. The common feeling among participants was that procedures needed to be instituted that would make foster parents accountable for each child's healthcare.

### **Foster care professionals**

Three key themes were derived from the focus group discussions with foster care professionals: *transitions*, *system problems*, and *medical home*.

#### ***Transitions***

There was a consensus among focus group participants that home-to-home transitions are problematic. A foster care professional stated:

Every time a kid gets moved it is a big trauma. One big problem is that foster parents are really not trained to deal with transitions. I don't think we talk enough to the kids about it, and I don't think we give them services to deal with it. Just even moving into a new foster home, everything is different. So they may be really happy to be moved, but it is still difficult.

Both foster parents and foster care professionals discussed the need for mutual support of their respective roles when foster children are moved from one home to another. That is, foster parents desired greater support from foster care professionals, while foster care professionals desired greater understanding from foster parents. Several individuals within each focus group seemed to understand how to accomplish this and to continue support for the foster child. However, many foster parents and foster care

professionals reported feeling disconnected from each other.

### **System problems**

The foster care professionals interviewed for this study recognized similar system problems as the parents, as well as additional problems. Professionals expressed personal concerns about how the system affected their interactions with foster children. The following is a common example: "... a huge system problem is now I get to tell these three boys they are going someplace else. No one has told them they are going to be moved. Now, today, three kids are splitting up because there is no place to put them together. Kids just get moved and the siblings get separated." Professionals also reported frustrations with heavy caseloads that decreased the amount of time available to address problems and with a lack of appropriate foster homes.

### **Medical home**

According to responses provided by the foster care professionals, having a "medical home" could enhance foster children's health. The term *medical home* refers to continuity in coordinated primary healthcare for every foster child. One professional explained:

There is a lack of consistency in the attending doctor and the records aren't available like they should be. So, pertinent or subtle information that could lead to an early diagnosis, like a chronic condition, does not get picked up and followed. The kid gets to be an adult and something is discovered that could have been diagnosed and dealt with long before it is. The lack of consistency for medical care must have a bearing on children's health.

Foster care professionals also recognized the complexity of maintaining a medical home when children frequently move locations and when parents have varying schedules and responsibilities. Having a medical home would improve parent and provider access to health records; however, because of the potential inconvenience for parents in obtaining the healthcare this solution might decrease how often foster parents utilize healthcare.

## **DISCUSSION**

Each of the participant groups provided both unique perspectives and common insights into the factors affecting the health of foster children. During the focus group discussions, the informants directed the focus to mental health issues. The generally held belief was that physical needs are addressed more readily than mental health needs. Mental health issues are a well-documented problem within the foster care system and are discussed throughout the literature.<sup>16-19</sup> It is common for foster children to experience anxiety, depression, negative self-esteem, and feelings of mistrust. Many of the foster children's mental health issues are associated with the common practice of having foster children make multiple home-to-home moves.<sup>19,20</sup> The stress resulting from this instability is often overwhelming for foster children, who may be already mentally fragile. Frequent moves exacerbate a foster child's emotional problems, which in turn, increases the need for mental health services.<sup>20-22</sup> Stability in home placement is necessary to enhance a foster child's mental health status, which may result in greater positive adjustments to independence and adulthood.<sup>23</sup> Developing and implementing procedures that lead to positive transitional periods could enable these psychologically vulnerable children to adopt more effective coping strategies. The recommendations presented by the foster children in this study suggest that developing a training program to assist foster children and parents during transition periods would be beneficial.

The notion that foster children differ from those children not in foster care is not novel.<sup>10,17</sup> However, the new information suggested in this study is that the foster children recognize qualitative differences when comparing themselves to nonfoster children. During the focus group interviews, when the foster children were engaged in personal reflection, recognizing their differences appeared to contribute to self-realization and created some comfort for participants.



The foster parents interviewed in this study equally recognized that foster children were different. The need to tailor parenting skills to fit the needs of individual foster children is consistent with information about parenting foster children in the literature.<sup>4,22</sup>

Foster children's participation in decisions is also an important factor in enhancing mental health and is discussed in the literature. Increased involvement in home placement and healthcare is recognized as contributing to greater mental health.<sup>5,24-26</sup> The mean age for children in foster care in the United States in 2004 was 10.1 years of age.<sup>27</sup> At this age, some foster children may be developmentally ready to contribute to decision making affecting their lives within the foster care system. Promoting autonomy in children contributes to their feelings of security.<sup>19</sup> However, the common belief held by foster children in this study—that they are able to determine the appropriate time to initiate mental health therapy—is contradicted in the literature where researchers have demonstrated that early intervention services optimize mental health outcomes.<sup>6</sup>

The idea that all children would benefit from a medical home has long been promoted

by the American Academy of Pediatrics<sup>28</sup> and has been particularly important for foster children.<sup>29</sup> Having a medical home would resolve the common health issue of inconsistent care and unavailable medical records. However, if medical homes are not established, the foster care system needs to develop procedures that would centralize healthcare and allow foster care providers to obtain accurate health records.

In conclusion, the complex issues of the foster care system in one state, Hawaii, were explored. The numerous mental health problems experienced by children, from program entry throughout their time in foster care, warrant a coordinated effort to facilitate higher quality care. Interdisciplinary care is an approach that could positively impact foster children's healthcare by supporting collaboration among stakeholders.<sup>30</sup> Further research is needed to clarify this preliminary investigation into the factors affecting foster children's mental health in the foster care system. Health professionals can become promoters of positive change within the foster care system by adopting leadership roles within their unique positions of community involvement.

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