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Caring for Our Children: An Examination of Health Care Services for Foster Children

JANET WEINSTEIN* and
JOLIE LA FLEUR**

> Children are any culture's greatest natural resource. The future of the world depends on our children's conceptions of themselves. All their choices depend on their view of themselves.[1]

INTRODUCTION

Children have a right not to suffer at the hands of the system while in foster care.[2] Omissions which constitute nothing less than abuse and neglect, however, occur at levels far exceeding what a reasonably-run foster care program should produce.[3] The poor health service provided to children in foster care is symptomatic of this abuse and neglect.

Many children enter the foster care system with a history of mistreatment that is continued or exacerbated when the system itself fails to provide for the children's physical and mental health needs. This type of mistreatment has been termed "program abuse."[4] When initially placed, children show consistently high rates of chronic health problems.[5] After having been in care, these

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1. J. BRADSHAW, JOHN BRADSHAW ON: THE FAMILY 1 (1988).
2. *See* Mushlin, *Unsafe Havens*, 23 HARV. C.R.-C.L. L. REV. 199(1988) [hereinafter Mushlin].
3. *Id.*
4. *Id.* at 200.
5. Schor, Edward L., M.D., A Summary of a White Paper of Health Care of the Children in Foster Care: Report of Colloquium on Health Care for Children in Foster Homes. [hereinafter Schor], at 17, citing: A. GRUBER, CHILDREN IN FOSTER CARE (1978); Kavaler & Swire, *Services for Foster Children: An Approach to Evaluation*, CHILD WELFARE 51, 9 (Nov. 1972) 574-584 [hereinafter Kavaler & Swire (1972)]; Hochstadt & Jaudes, The MAPS Project: Medical and Psychosocial Screening. Report to the Illinois

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children have much higher rates of physical and emotional illness, as well as developmental and educational deficiencies, than those found in normal populations.[6] As a society we have failed to meet our obligations to these deprived and most needy of our children. In allowing this failure to occur, we have compromised our integrity and our society's future.[7]

In the last twenty-five years, the number of children in foster care has increased fivefold.[8] Despite the welfare system's well-intended efforts over the years to help children and families, it continues to be among the most destructive human services in this country. The children who come within the orbit of child welfare

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Dept. of Children and Family Services: LaRobida Childrens Hospital and Research Center, Chicago, Ill. (Dec. 1984).

6. *Id.* at 1, 6, citing Kavaler & Swire (1972); Schor, *The Foster Care System and Health Status of Foster Children*, 69 PEDIATRICS 521-28 (1982).

7. *Id.* at 17. *See also* Ammerman, Cassisi, Hersen & Van Hasselt, *Consequences of Physical Abuse and Neglect in Children*, 6 CLINICAL PSYCHOLOGY REV. 291-310 (1986).

> There is considerable empirical support for greater prevalence of intellectual deficits and academic underachievement in maltreated as contrasted to nonmaltreated children. [*Id.* at 295.]
>
> A robust finding in the literature is the prevalence of externalizing behavior problems in maltreated children. Externalizing disorders encompass hyperaggressiveness, acting out, conduct problems, hyperactivity, and delinquency. Indeed, increased incidence of aggressiveness and conduct problems in abused children and adolescents has been widely reported. [*Id.* at 300.]
>
> When contrasted to nonabused subjects, abused children were found to have more behavior problems and to be less socially competent. [*Id.* at 301.]
>
> In addition to delinquent and future criminal behavior, child abuse and neglect have been implicated in other adolescent and adult disorders. [*Id.* at 302.]
>
> Results consistently indicate that maltreated children exhibit a variety of deficits in social functioning. [*Id.* at 305]

There is also a problem of the kind of modeling these children receive for parenting when they have their own children. There is no consensus, but there are many who believe that abused children will be more likely to abuse their own children than will adults who were not abused as children. *See* Kaufman & Zigler, *Do Abused Children Become Abusive Parents?* 57 AM. J. OF ORTHOPSYCHIATRICS 186-92 (Apr. 1987); LaRose & Wolfe, *Psychological Characteristics of Parents Who Abuse or Neglect Their Children*, 10 ADVANCES IN CLINICAL CHILD PSYCHOLOGY at 55-97.

8. In 1984, there were an estimated four hundred thousand children in foster placement in the United States (Child Welfare League of America, *Child Welfare Planning Notes: Characteristics of Children in Substitute and Adoptive Care* (1984)), with the population growing 1% per month by one California estimate (Halfon & Klee, *Health Services for California's Foster Children: Current Practices and Policy Recommendations*, 80 PEDIATRICS at 183-91 (1987)) [hereinafter Halfon & Klee].

> Nearly 500,000 children are estimated to be currently in out-of-home placement, a figure expected to reach more than 840,000 by 1995 if current trends continue, according to a study released by the House Select Committee on Children, Youth and Families. Recent census figures put the number of children under 18 in the nation at about 63 million.
>
> . . . .
>
> The report attributed the growing out-of-home placements to child abuse, new conditions resulting from crack cocaine, alcohol abuse and abuse of other drugs, and homelessness.

Minors in Foster Care, Custody Put at 500,000, L.A. Times, Dec. 12, 1989 at A4, col. 1.

are extremely vulnerable to damage: almost all are poor;[9] many come from families racked by substance abuse and domestic violence;[10] and a disproportionate number are racial and ethnic minorities.[11] In many instances, the system intended to help these children only completes what poverty and discrimination have begun, producing yet another generation of the economically dependent and socially and psychologically unstable citizens. Grown-up former foster children fill our mental hospitals, our jails and our welfare rolls.[12] As many as fifty percent of the homeless youth on our streets are young people who were raised in foster care.[13]

As a society, we are very short-sighted when, through our elected officials, we cut funding for dependency programs. The amount of money ultimately spent on these children when they reach adulthood and fill our mental hospitals, jails, and welfare rolls is by far greater than the cost of providing appropriate care to children. However, the adequate funding of social services programs under existing law would not solve the problem entirely. Fundamental rethinking of the entire system is necessary.[14]

The foster care system[15] has so uniformly failed to help these children that the 1990s may be a decade of unprecedented litigation aimed at helping these children via the courts. Litigation has become the most foreseeable recourse because these children do not have the access or influence to move the executive or legislative branches of government to increase the awareness and concern needed to bring about change.[16]

This article discusses the lack of adequate care and treatment of children in the foster care system, with a particular focus on deficiencies in the provision of mental health services. It discusses

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9. Study of National Incidence and Prevalence of Child Abuse and Neglect: 1988, Study Findings, Executive Summary [hereinafter NIS-2].

> Low income was a significant risk factor for child maltreatment under both sets of definitions. Children from families whose 1986 income was less than $15,000 experienced substantially more maltreatment in all categories compared to those from families earning $15,000 or more. There were also more frequent injury/impairments at every level among the lower income children.

Id. at xxiii.

10. M. LOWRY, THE CHILDREN'S RIGHTS PROJECT OF THE ACLU FOUNDATION ANNUAL REPORT OF PROJECT ACCOMPLISHMENTS (1989) [hereinafter M. LOWRY].

11. *Id. See also* Garbarino & Ebata, *The Significance of Ethnic and Cultural Differences in Child Maltreatment*, J. OF MARRIAGE AND THE FAMILY, Nov. 1983, at 773-83.

12. M. LOWRY, *supra* note 10, at 31.

13. *Id.*

14. Wald, *State Intervention on Behalf of Neglected Children*, 28 STAN. L. REV. 626 (1976).

15. For an historical overview of the foster care system, *see* A HANDBOOK OF CHILD WELFARE: CONTEXT, KNOWLEDGE AND PRACTICE ch. 21 (Laird & Hartmann eds. (1985)); K. WILTSE, FOSTER CARE: AN OVERVIEW.

16. Mushlin, *supra* note 2, at 280.

the two traditional approaches to rectifying the problem, legislation and litigation, and why these remedial measures are inadequate. Part I describes how children come into the foster care system and provides a more detailed look at the problems they encounter. Part II discusses the standards that should be imposed on the system to ensure the healthy growth of children. Part III sets forth existing legislation aimed at protecting foster children, and analyzes its efficacy in achieving this goal. Part IV examines the litigation process as a means for bringing about required change. Part V discusses other approaches that might be taken to fulfill our societal duty to our children.

I. THE STATUS OF HEALTH CARE FOR FOSTER CARE CHILDREN

Children enter the foster care system when their natural parents and extended families are unable or unwilling to care for them. As if this circumstance would not be emotionally destablizing enough, most of these children have also been the victims of abuse and neglect as members of dysfunctional families. Coming into the world and growing up in such an environment creates substantial psychological stress and damage to these youngsters. Whether the parental behavior was overtly abusive in a physical or sexual manner, whether it was neglectful (as is often the case in families suffering from drug and alcohol addictions), or whether it was explicit psychological abuse, the damage is done. Children who do not know when they will receive their next meal, their next beating, or their next sexual assault, adapt to their worlds in ways which may allow for their survival, but do not allow for healthy functioning and growing into maturity outside of that environment.[17]

Although removing children from such environments might seem the most beneficent act on the part of society, the trauma of separation from family, and of being shuffled through a bureaucratic and impersonal system, often adds to the original damage.[18]

17.

> That foster children frequently need mental health services has been long known. Schor found in a study that almost all the foster children evaluated suffered adjustment problems and more than half were at least moderately impaired. . . . These findings are in keeping with the nature of the reasons for foster care, most commonly that a child has not been protected from abuse or neglect; the child is almost by definition one placed at risk for emotional and behavioral disturbances. (Citations omitted.)

Molin, *Treatment of Children in Foster Care: Issues of Collaboration*, 12 CHILD ABUSE AND NEGLECT, 241-50, at 241 (1988) [hereinafter Molin].

18.

> The process of placement itself, even if necessary to protect the child, forms an additional source of distress. Moss and Moss reported the verbal threat to place a

Children may drift from foster home to foster home, never staying long enough to develop meaningful relationships with foster families or schoolmates. They may be subjected to further abuse in a foster home placement.

If this were the story of just a few, we should be concerned. The large number of children who must endure this kind of childhood should make the problem even more disturbing. In 1985, 1.9 million reports of child abuse or neglect were made in the U.S.[19] Generally these reports do not result in removing children from the home,[20] but they did for the 275,000 who were placed in foster care.[21]

The current medical care system for foster children is inadequate even to deal effectively with simple and common child health problems.[22] An early study revealed that nearly forty per-

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> child interfered with the child's sense of stability and connection to "home." During placement children experience the loss of a familiar environment and the rupture of relationships in the family and community. Along with the challenge to the child's identity as a member of its original family, the child may also feel anxiety about other family members still at home and sometimes guilt at being in a more nurturant environment than other family members. In the new home, there are additional issues and stresses, ranging from adapting to a new context, to sometimes having a poor match of personalities, resources, and needs between foster families and children, to, in the worst cases, a retraumatization due to abuse or neglect in the foster home. The demand for rapid adjustment during a period of separation and loss may exacerbate existing problems for the child or contribute to the development of new emotional and behavioral problems.

Id. at 241-42 (citations omitted).

To make matters worse, many of the children in the foster care system come into the system more than one time. In the 1988-1989 fiscal year, the county of San Diego removed 2,050 children from their homes. In one study 20-30% of children who were finally returned to their biological families were again removed to foster care. E. SCHOR, PEDIATRIC MEDICINE vol.7(7) (1989).

19. YOUTH L. NEWS, March 1988, cited in Bross, *Medical Diagnosis as a Gateway to the Child Welfare System: A Legal Review for Physicians, Lawyers and Social Workers*, 65 DEN. U.L. REV. 213 [hereinafter Bross].

20. *Id.* at 24.

21. *Id.*, citing 9 YOUTH L. NEWS, March 1988, at 5. In 1984, 89 children ages 12 and under out of every 10,000 were confirmed victims of some type of child abuse or neglect.

The Study of National Incidence and Prevalence of Child Abuse and Neglect (NIS-2) provides the following information:

> In 1986, an estimated 16.3 children per 1,000 or a total of more than one million children nationwide experienced abuse or neglect in 1986 which met the original standardized study definitions of maltreatment.
>
> Under the revised definitions, an estimated 25.2 children per 1,000 or a total of more than one and one-half million children nationwide experienced abuse or neglect in 1986.
>
> Countable cases of maltreatment increased significantly (by 66%) over their 1980 incidence rate.
>
> The increase in countable cases primarily reflected a significant increase (of 74%) in the incidence of abuse.

NIS-2, *supra* note 9, Executive Summary.

22. F. KAVALER & M. SWIRE, FOSTER CHILD HEALTH CARE 1 (1983).

cent of these children had no immunization records.[23] A comprehensive study of the medical status of foster children in New York found that many of the pre-school age foster children studied had not received vaccinations for the prevention of childhood diseases.[24] Fourteen percent had received no medical examination upon admission to foster care, and the average physical exam was incomplete.[25] Forty-seven percent of the children had visual problems that had not been evaluated by an optometrist.[26] Over forty percent needed dental care but had not been to a dentist.[27] Only one-fourth of the children who had identifiable emotional or developmental problems had received treatment.[28] Similarly, when children had received medical attention, it often was inadequate. For example, sixty-one percent of the children who received glasses were given inadequate prescriptions.[29] Clearly, the system for providing health care to foster children is not working.[30]

This failure to care for the well-being of foster children is exaggerated in the area of mental health care. The implications of foster care placement in this regard have been the subject of many studies, yet they are complex and not completely understood.

> Consideration of the emotional needs of foster children have focused on the issues arising as immediate consequences of place-

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23. Schor, *The Foster Care System and Health Status of Foster Children*, 69 PEDIATRICS 521-28 (1982).

24. These findings have been confirmed. Caplovitz & Genevie, *Foster Children in Jackson County, Missouri: A Statistical Analysis of Files Maintained by The Division of Family Services* 86-87, cited in Mushlin, *supra* note 2, at 208.

25. Kavaler & Swire, cited in Mushlin, *supra* note 2, at 208.

26. *Id.* at 209.

27. *Id.*

28. *Id.* "There are several possible reasons for the lack of clinical services for foster children. . . . Traditionally, the CPS caseworker has been expected to be the agent for meeting the child's emotional needs around placement without reference to adjunct professional services." *Id.* at 242 (citations omitted).

Molin provides further information about the problems of delivering effective mental health care to foster children.

1. Foster parents might have different opinions about the needs of the children under their care. This is exacerbated by the fact that the foster parents do not select the therapist.
2. Concerns regarding confidentiality and worries about the effect of disclosing personal problems may keep the foster parents from participating. In situations where the child is "acting out," "[a] collusive relationship may be formed, protecting the family and the agency." Molin, *supra* note 17, at 244.
3. "Many children are only able to make good use of therapy after they are provided a stable and adequate placement." *Id.* at 245.
4. Foster care is decentralized, with little collaboration and communication among biological parents, foster parents, social workers, teachers and health care professionals. Apparently no responsible person ever has the whole picture of the child's needs. The decision-making authority is also fragmented. *Id.* at 247.

29. Kavaler & Swire, cited in Mushlin, *supra* note 2, at 242.

30. Kavaler & Swire (1972), *supra* note 5. *See also* Schor, *Health Care Supervision of Foster Children*, CHILD WELFARE 60(5), at 313-19 (1981).

> ment, blame, and loss. Children in foster care often blame themselves for their separation from their parents; self-blame may be an internalization of blaming of children by their natural parents. Foster children may also need to grieve their losses but may be inhibited from doing so out of their fear that the expression of their grief and anger may alienate the foster family. They also may not feel the support and security necessary to open themselves to expression of loss. They may instead go through a "honeymoon" period with underlying autonomic distress before becoming able to grieve.
>
> At the end of the initial adjustment, however, foster care continues to present difficulties for the child. Children are aware that foster care is a temporary and unstable situation by its nature. Gries considers the ambivalence of biological parents, the social isolation of foster children, and the continuing sense of rejection and abandonment to be chronic stressors for children in foster care. . . . Several other studies identify issues of children continuing in foster care, including irrational beliefs about the reasons for placement, resentment of adults who negotiate their lives, and concerns about the relationships between foster and biological parents.[31]

Foster children are almost always emotionally disturbed to some degree.[32] Although the direct relationship between emotional impairment and the experience of being a foster child has no doubt always existed, there is evidence for growing concern. Agency respondents to a study performed by Children's Research Institute of California cumulatively indicated that one in every seven children currently in group care in California entered the system directly from a psychiatric hospital and in February of 1985 more that fifty percent of children placed in Northern California foster care came directly from a psychiatric unit, compared to less than one percent from 1964-1979.[33] Not only are the children more disturbed, but they are younger than ever before. Many attribute this degenerative trend to the increase of drug and alcohol addiction and abuse and greater reported incidence and severity of physical abuse, sexual abuse and neglect.[34]

Professionals responding to a study on mental health services for foster children in California cited four primary barriers to the provision of these services: (1) Medi-Cal, the low cost state insur-

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31. Molin, *supra* note 17, at 242. *See also* Howing, Wodarski, Gaudin, Jr. & Kurtz, *Effective Interventions to Ameliorate the Incidence of Child Maltreatment: The Empirical Base*, 34 SOC. WORK 330-37 (1989).

32. J. ROWE, H. CAIN, M. HUNDLEBY & A. KEANE, LONG-TERM FOSTER CARE (1984).

33. CHILDREN'S RESEARCH INSTITUTE OF CALIFORNIA, CALIFORNIA FOSTER CARE NETWORK SHELTER CASE STUDY: HEALTH, MENTAL HEALTH EDUCATIONAL ASSESSMENTS (1985).

34. Helfon & Klee, *supra* note 8, at 184.

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ance plan to which foster children are automatically subscribed, offers policies and procedures which too greatly limit the number of private providers; (2) Specific providers are often not trained in foster-child-specific issues such as sexual abuse and physical abuse, and are usually not bilingual; (3) Organizational and bureaucratic entropy, as evidenced by lack of coordination, lack of centralized services, lack of transportation, and lack of training guidelines for foster parents, prevents the effective delivery of services; and (4) An inadequate number of sub-population-specific programs are available for treating special children such as the severely mentally handicapped, sexually abused, and delinquent.[35]

II. Standards For Health Care Services for Children in Out-of-Home Care

The Child Welfare League of America has developed standards intended to serve as goals for the continuing improvement of services to children.[36] These standards are statements designed to be used as ideals or goals for practice in the field of child welfare service. The basic premises are as follows:

- The right to any immediately needed medical or health service, including a health screening prior to placement;
- the right to a timely comprehensive assessment of health needs upon entry into out-of-home care;
- the right to a health plan designed to meet individual health needs and integrated with the case plan;
- the right of parents or guardians and the child to participate to the fullest extent possible in the development and implementation of the health plan;
- the right to receive specialized health care required by the health plan provided by qualified professionals, in a comprehensive, continual, and coordinated manner; and
- the right to an adequate referral and follow-up system upon discharge from the child welfare system, to assure proper continuity of care.[37]

Children in foster care have the same basic needs for physical, social and emotional health services, and for supervision as do children in their own homes. The varied and distinctive aspects of their problems, however, warrant the establishment of specific agency procedures to assure that children in placement receive

35. *Id.*

36. These Standards were generated in collaboration with the American Academy of Pediatrics in 1988.

37. Child Welfare League of America, Standards For Health Care Services for Children in Out-of-Home Care, at xvii (1988).

health care that is comprehensive, coordinated and continual.[38]

L.J. v. *Massinga*,[39] the leading case in foster care reform, was brought by the American Civil Liberties Union on behalf of foster children against the Baltimore City Department of Social Services. The order set forth significant areas or standards with which a foster care system must comply. These standards are very similar to those set forth by the Child Welfare League.[40]

These two sets of standards, set forth by the League and in *Massinga*, articulate a common sense approach to caring for our children.[41] For example, health information regarding foster children is frequently lost and treatment plans disrupted as the care of the foster child is transferred from caseworker to caseworker and from one health care provider to another. The Medical Passport, required by the order in *Massinga* (and required in concept by the League's standards), is designed to alleviate this problem. It is tragic to think that these standards needed to be articulated; it is even more tragic to realize how far society is from meeting them.[42]

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38. *Id.*

39. L.J. v. Massinga, No JH-84-4409 (D. Md. July 27, 1987) (order granting preliminary injunction) [hereinafter *Massinga*].

40.

1. *Comprehensive 60-day Assessment.* Within 60 days of entering foster care, a child must receive a comprehensive physical, developmental and emotional evaluation.
2. *Initial Health Care Screening.* Within 24 hours of placement, the child must be examined for determinations of abuse and neglect and be treated for immediate medical problems.
3. *Medical Passport.* Every child shall have a Medical Passport that will accompany the child throughout his or her foster care placement.
4. *Comprehensive Health Care System.* The responsible agency is required to develop an integrated, computerized and quality system of health care.

41. An international standard, The Convention on the Rights of the Child, was adopted by the General Assembly of the United Nations on November 20, 1989. The Convention expresses the basic right of all children to grow up in a safe and healthy environment. In defining the specifics of what this means, the Convention sets forth requirements very similar to those of P.L. 96-272, including an emphasis on family reunification and regular provision of services and contact by the responsible social agency. This consideration of the rights of children was not a new concept in international law. On November 20, 1959, the Declaration of the Rights of the Child was proclaimed by the General Assembly of the United Nations (Resolution 1386 (XIV)), expressing the same concepts in less specific terms.

42.

> The health passport, initial screening, and 60 day assessment emphasize the health needs of children "entering" the foster care system. As a result, children already placed in care prior to implementation of the Decree must negotiate a fractured system of health care delivery with little overall supervision or monitoring of care. One child within the system has still not received sexual abuse therapy even though he remains depressed, has had episodes of sexual acting out, and has been court-ordered to receive an immediate referral for this therapy. Directives from the juvenile court have been in place for sexual abuse treatment since October 1987.

Massinga Compliance Report, Civil Action No. JH-84-4409 at 30.

III. Existing Laws Aimed at Protecting the Health of Foster Children

A. Federal Legislation

The most significant federal legislation dealing with foster children is the Adoption Assistance and Child Welfare Act of 1980, P.L. 96-272[43] (hereinafter P.L. 96-272 or "the Act"). The Act was designed to reverse federal financial incentives which had encouraged the excessive use of foster care, rather than the provision of services to keep biological families intact or an attention to efforts to find permanent families for children in foster care.[44] As a result of the Act, states now receive federal matching funds only when children are removed pursuant to a judicial determination that foster care (rather than returning children to their homes) is in the children's best interest. This legislation gave states increased fiscal incentives to prevent the need for foster care placement of children and to reunify children placed in foster care with their families.[45] Although the Act allows for considerable local variations in how it may be implemented, it required profound changes in many state child welfare systems.

The basic areas of reform identified by the drafters[46] include the following:

• Improvement in preventive services to avoid unnecessary removal of children from their homes;

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43. 42 U.S.C. §§ 620-628, 670-675.

44. Hardin, *The Adoption Assistance and Child Welfare Act of 1980: An Introduction for Juvenile Court Judges*, at 2 [hereinafter Hardin].

45.

> The federal law encourages states to prevent the unnecessary removal of children from their homes and to reunify foster children with their families by making state eligibility for funds under the Title IV-B Child Welfare Services Program, 42 U.S.C. §§ 620-628, and the Title IV-F foster care maintenance program contingent upon the implementation of certain services and protections for children and their families. These include the following: (1) limiting the use of Title IV-B funds for foster care, 42 U.S.C. § 623(c)(1); 2) making additional IV-B funds contingent on the implementation of preventive and reunification service programs and other protections, 42 U.S.C. § 627; (3) mandating forfeiture of IV-B funds if protections and services are not implemented by the deadline date, 42 U.S.C. § 627(b); (4) making Title IV-E eligibility dependent upon the development of a case review system and reasonable efforts to prevent removal and to reunify families, 42 U.S.C. §§ 471, 472; and (5) extending funding for foster care for voluntarily placed children if certain protections are provided to the family, 42 U.S.C § 472.

Golubuck, *Cash Assistance to Families: An Essential Component of Reasonable Efforts to Prevent and Eliminate Foster Care Placement of Their Children*, CLEARINGHOUSE REV. 1392 (Apr. 1986).

46. Numerous studies which had documented that these areas of reform were both necessary and possible had been presented to the Congress during the four years of legislative deliberation leading to the passage of the Act. *Id.* at 2.

• more careful placement of children to take into account children's special needs and to facilitate visitation and communication between parent and child;
• more efficient case planning and efforts to reunify families; and
• more decisive and timely action to secure permanent homes for foster children, including reunification when possible, or placement in another permanent and legally secure home.[47]

Health care for foster children was not the focus of this Act, but improved health care should be a natural by-product of the reform, which was primarily intended to overcome the pervasive pattern of "foster care drift," the haphazard and unplanned use of foster care by child welfare agencies.[48] Eliminating the "drift" problem should assist foster children in developing a sense of stability and should make it easier to keep track of these children and to stay abreast of their individual needs. This, in turn, should result in better health care, particularly better mental health care, for foster care children. However, because the child welfare system directly bears the brunt of other failures in our society, most children and families still fail to benefit from the federal protections.

Since 1980, escalating rates of child poverty, growing numbers of births to unmarried teenagers, increased substance abuse, a ninety percent rise in reports of abuse and neglect, and now the deadly threat of AIDS—all interrelated problems—have placed increasing stresses on families and new demands on the system, jeopardizing its ability to serve children in need.[49] Over a decade ago, we were not even considering the impact of such problems on the child welfare system.[50] Workers, supervisors, foster parents, and other caretakers do not have the training, support, or resources necessary for them to serve appropriately the children in their care. Additionally, the flow of dollars still favors out-of-home care.[51]

Legislators should look to the future of child welfare needs and not simply attempt to fix the current system. The onslaught of unforeseen societal problems will continue to burden the system. In 1980, Congress did not anticipate the phenomenon of "Boarder

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47. Hardin, *supra* note 44, at 2.
48. Hardin, *supra* note 44.
49. Allen, Testimony of the Children's Defense Fund Before the Subcommittee on Public Assistance and Unemployment Compensation Committee on Ways and Means and the Select Committee on Children, Youth, and Families, U.S. House of Representatives, May 1988 [hereinafter Allen].
50. *Id.* at 1.
51. *Id.* at 2. Out-of-home care refers to the placement of a child away from his/her biological family.

Babies." This term is used to describe babies who are born to drug-addicted mothers and who remain in the hospital, often for years, although they are medically ready for discharge.[52] In Washington, D.C., the child welfare system is in a state of crisis due to the number of children of crack cocaine addicts entering the system. Washington, D.C. is not in compliance with the federal statutes, or its own system, which mandates a prompt determination of whether a child is in danger or not. Recently, it was reported that cases involving 771 children remain uninvestigated.[53] Lawyers representing children in the D.C. Superior Court have complained angrily that some children who were voluntarily placed on a 90-day emergency basis have been kept in foster care for years, without a judge's approval or representation by a lawyer.[54] It is estimated that in 1989 the city's foster care program may have lost up to $18 million a year in federal payments because of poor record-keeping.[55]

It is evident the system is failing, and current laws are inadequate. Children have had to turn to the courts for protection. The dimensions of the problem suggest that nothing short of a total restructuring of the foster care system will do.[56]

Reform on the federal level is not imminent. Even if it were, the problems of foster care would not vanish with new federal legislation, as the federal government cannot mandate state compliance. It can only serve to offer economic incentives with which states may participate.

B. State Legislation

A survey of each state's relevant legislation regarding its foster care system is beyond the scope of this paper. An analysis of California provides an overview of problems and the current status of possible legislative solutions.

In 1982, California passed Senate Bill 14 to bring the state into compliance with P.L. 96-272.[57] Senate Bill 14 did not specifically

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52. *Id.* at 3.

53. Greene, *Sitting on a Time Bomb Waiting for Kids to Die*, Washington Post, Sept. 10, 1989, at A14.

54. *Id.* at 2.

55. *Id.* at 2.

56. Musewicz, *The Failure of Foster Care: Federal Statutory Reform and the Child's Right to Permanence*, 54 S. CAL. L. REV. 751 (1981).

57. S.B. 14 made the following changes in state law:

1. Imposed stricter legal standards governing removal of children from their homes. The Department of Children's Services has the burden of proof on whether removal of the child from the home is justified.

2. Required the Department of Children's Services to attempt to maintain the natural family setting through provision of services such as counseling, babysitting, homemaking clas-

address health care issues, but its focus on planning and contact held out some hope for better health care for foster children in the same way that P.L. 96-272 did, by emphasizing the need for stability.[58]

California has a statewide system of foster care for eligible children, operated in each county and funded in part by the state. As is true in the rest of the country, California's foster care system is experiencing difficulty because of the number of children entering foster care. Consequently, numerous studies are currently underway to help provide insight and resolutions to the problems.[59] Also in 1989, the Los Angeles Grand Jury requested Coopers & Lybrand, a well-respected accounting firm, to review and investigate the County Foster Care Program System. The Grand Jury expressed particular concern over child abuse prevention and mental health support. In this connection, the Grand Jury identified the following problem areas:

1. The Foster Care system may not be adequate to meet present needs for tracking and monitoring the placement of children within homes. This may result in children not receiving appropriate support services.
2. Children may be turned away from the Foster Care system because of insufficient housing and/or foster care homes.
3. Case loads of social workers may be excessive, preventing ad-

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ses and, where necessary, in-home caretakers.
3. Limited family reunification services to 18 months and required the court to conduct formal case reviews every six months to evaluate whether the child could be returned to the natural parents, should remain in family reunification the full 18 months, or should be transferred to permanency placement if reunification was not possible.
4. Required courts to adopt a permanent placement plan for any child remaining in foster care for 18 months or more.
5. Required the Department of Children's Services to maintain written case plans for every child in their care and to have social worker/child contacts at least once a month.

Coopers & Lybrand, Los Angeles County Grand Jury, A Report on the Los Angeles County Foster Care Program System (1988-1989) [hereinafter Grand Jury].

58. In January 1989, Senate Bill 243 became effective. This Bill revised the definitions of abuse and neglect contained in the Welfare & Institutions Code, specifying the conditions under which a child will be brought under court jurisdiction. The law provided clearer guidance to social workers and judges regarding the types of situations which the Legislature considers abusive or neglectful. But, again, health care was not an issue.

59. In 1989, the Research and Education Institute, Inc. Harbor/University of California at Los Angeles Medical Center, sponsored by the Community Issues Council, developed a plan to implement the following:
1. Increase the number of physicians and dentists willing and able to treat foster children,
2. Improve the collection, coordination, and evaluation of health related information,
3. Provide training for key members of the foster care system,
4. Develop a timely and comprehensive health examination and treatment process,
5. Assure the continuing appropriateness of the Department of Children's Services and Department of Health Services health care policies and procedures,
6. Improve the infrastructure available to coordinate the health system for children in the child protective services system.

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equate monitoring of potential physical and mental (emotional) abuse.

4. Although procedures and guidelines may be established and in place to support appropriate levels of foster child care, compliance may be inadequate.[60]

In California, each foster child is eligible for free medical services through the Medi-Cal program and the Child Health and Disability Prevention Program. As previously noted, children entering foster care have increased needs for specialized medical services as well as an increased need for "normal" children's health services such as preventive care, immunizations and treatments for common childhood problems.[61] The studies reveal that while children frequently enter our foster care system through a health facility during an investigation of possible abuse or neglect, paradoxically, the services they receive have little to do with "health care."

Perhaps a ray of hope in the midst of this rather gloomy picture is that the subject of health care for foster children seems to be receiving some attention. In 1989, Assemblyman Charles M. Calderon submitted a fact finding sheet on California's Child Welfare Services, in which he specifically addressed health services for children.[62]

Assemblyman Calderon was denied his request for a Joint Legislative Audit Committee to direct the Auditor General to investigate compliance with state foster care laws, despite his statement that his information revealed that state laws were not being followed, and as a result the health and safety of foster children is in serious jeopardy. Calderon will be introducing a package of Bills to improve California's foster care network. The legislation addresses the two most glaring deficiencies—lack of a standardized, comprehensive medical program and the inadequacy of the social service network. The legislation sets forth Standards for Health Care which include: Physical and Mental Health Care, Medical Records, Training to Foster Parents, Social Workers, and Policy and Fiscal Audit.[63]

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60. Grand Jury, *supra* note 57, at 17.

61. *Id.* at 3.

62. Calderon, Assemblyman Charles M., Fact Finding on Child Welfare Services. Assemblyman Calderon's findings were:
1. Physical and mental health assessments are incomplete and not conducted in a timely manner.
2. There is a shortage of physicians to treat foster children.
3. Health records of children are not adequately kept.
4. Monitoring of health services is inadequate.
5. The system cannot adequately care for the increasing number of drug and AIDS babies.

63. Letter from Assemblyman Charles M. Calderon (Aug. 3, 1989).

This legislation must be introduced by May 2, 1990, and would require approval by both Houses. The outlook for passage in 1990 is doubtful, despite Calderon's plea to his fellow legislators: "For the sake of the many children who have died and those who currently suffer from abuse and neglect, we must make every effort to improve the system."[64]

IV. Litigation

Judicial involvement in foster care reform offers the promise of benefitting foster children by materially improving a system that thus far has resisted reform. Without judicial scrutiny, the abuse and neglect that many children suffered in their original homes will continue after the state places them in foster care. "For these children, the temporary, substitute care by the state will not be a haven, but a hell."[65]

As noted by the American Civil Liberties Union:

> We have found that reform through litigation is one of the only methods available to insure that services to these children are improved. While these lawsuits take a great deal of time, resources and persistence, it is only through such lawsuits that the state agencies can be required to divulge detailed information about how the child welfare system is actually malfunctioning, and to confront the reality that its mismanagement is hurting family and children.[66]

Children who are in the custody of state child welfare agencies rarely walk in for appointments with legal services attorneys or call for legal advice,[67] yet there has been a heightened awareness of children's issues in the past several years.[68] Historically, children have been considered the property of their parents, particularly their fathers.[69] Succeeding shifts in the official view of Americans toward children coincided with shifting economic and social

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64. Letter from Assemblyman Charles M. Calderon (Aug. 4, 1989) referencing California Legislator 1989-1990 Regular Session, Preprint Assembly Bill No. 3, 4, 5, and 6.

65. Mushlin, *supra* note 2, at 204.

66. M. Lowry, *supra* note 10, at 32.

67. Redleaf, *Legal Services Outreach to Foster Children*, Clearinghouse Rev. 1497 (Apr. 1987). Children are reluctant to seek legal assistance for the following reasons: (1) Fear of lawyers and legal system; (2) Children do not understand what lawyers do or how the legal system operates; (3) Children who are raised in foster care and placed in multiple homes may not realize that there is anything wrong with this treatment; and (4) Children are dependents and need others to act to meet their needs. (Schall v. Martin, 467 U.S. 265 (1984)). The younger the children, the more they lack the skill of asserting or helping themselves. *Id.* at 1499.

68. Youth Law, at 1073 (Jan. 1986).

69. Blackstone reported that while parents owned a duty to maintain, educate, and protect their children, it was a duty void of legal persuasion. Bross, *supra* note 19, at 214.

contingencies,[70] and have culminated with the recognition of "rights" for children in the decision of *In re Gault*.[71]

Two legal principles, that children do have rights including a right to safety, and that the state as parens patriae[72] assumes the obligation to provide these rights, leave the state vulnerable to lawsuits by children who are under the state's protection and denied their rights. As a substitute parent, the state's child welfare program assumes responsibility for the child's physical and mental health care.[73] Those who may be named as defendants vary from suit to suit, depending upon the structure of the Foster Care System within each state. Possible defendants include state and county agencies, individual case workers, and government officials up to and including the governor of the state.

The available causes of action arise from both the Constitution and the common law, in addition to specific remedies which may be provided in specialized legislation by the states.[74] The Constitutional actions rely upon the fourteenth amendment and its enforcement through the Civil Rights Act.[75] The common law action

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70. *Id.* at 214.

71. 387 U.S. 1 (1967). In this case, the parents of a 15-year-old boy brought a writ of habeas corpus action in Arizona to challenge the constitutionality of the Arizona Juvenile Code. The boy had been taken into custody as the result of a complaint that he had made lewd telephone calls. After hearings before a juvenile court judge, the boy was committed to a state institution until he reached the age of 21. The U.S. Supreme Court held that the Arizona Juvenile Code did not provide juveniles with their due process rights guaranteed by the fourteenth amendment, including: (1) adequate notice of the charge and the hearing; (2) notice of rights including the right to counsel and to confrontation, and the privilege against self-incrimination; and (3) a record of the proceeding.

72. The concept of parens patriae developed when English Kings intervened in the familial relationship on behalf of the child because children were considered helpless. When Justice Cardozo was on the New York Court of Appeals, he described the concept of parens patriae as the responsibility to do what is best for the interest of the child. The judge is to put himself in the position of a "wise, affectionate, and careful parent" and make provisions for the child accordingly. The concept today is used to refer to the state's obligation and right to protect the young, the helpless, and the incompetent. Bross, *supra* note 19, at 216.

73. Child Welfare League of America, Standards for Foster Family Services 8 (1975), at § 3.10.

74. Where a state legislates a course of action, this may be enforced by an action in mandamus. In a pending California case (Timothy J. v Robert Chaffee, Los Angeles Superior Court, CA001128), a class action on behalf of all foster children in Los Angeles County, the plaintiffs are asking for a writ of mandate pursuant to the Code of Civil Procedure § 1085 commanding defendants to adopt a County Plan For Child Welfare Services in accordance with California Welfare and Institutions Code §§ 16501 and 16502. Plaintiffs are also asking for a writ of mandate to compel defendants to meet the minimum contact requirements of the Department of Social Services Manual of Policies and Procedures §§ 30-100 through 30-499. These regulations establish mandatory case management standards for child Welfare Services programs.

75. 42 U.S.C.A. § 1983. Section 1983 provides:

Every person who, under color of any statute, ordinance, regulation, custom or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdic-

arises in tort law, specifically in negligence. The issues involved in these actions are discussed below.

A. Constitutional Issues

1. Substantive Due Process—The Right to Safety

A substantive due process right is a right listed in the Bill of Rights, and is held to be so fundamental that a state may not interfere with its enjoyment, except according to strict limitations. In 1982, a unanimous court in *Youngberg. v. Romeo*[76] held that the state owes an "unquestioned duty" to provide reasonable safety for all residents of a state institution for the mentally retarded.[77] "The right to personal security consists of . . . uninterrupted enjoyment of . . . life . . . limbs . . . body . . . health, and . . . reputation."[78] The right to safety is a liberty interest under the fourteenth amendment.[79]

B. Enforcement Under Section 1983

> The foster children have suffered unspeakable injuries to body and spirit. They have suffered, it is true, because of circumstances beyond the reach of the most benign and effective protection any government has ever afforded. But, as well, children have suffered because state officials charged with protecting them have fallen short of what they undertook to do.[80]

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tion thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

76. 457 U.S. 307 (1982). The Court held that a plaintiff involuntarily committed to an institution for the mentally retarded had a constitutionally protected interest in conditions of reasonable care and safety.

77. As obvious as this right may seem, recognition of its existence developed quite slowly and it continues to lack clear standards defining its scope. As late as 1944, the hands-off doctrine effectively precluded litigation to enforce this right. The hands-off doctrine was a judicially created concept that commanded federal courts to abstain from examining prison matters. In 1974, Justice White sounded the Supreme Court's death knell to the "hand-off" doctrine in a single line: " There is no Iron Curtain between the Constitution and the prisons of this country." Wolff v. McDonnell, 418 U.S. 539, 555-56 (1973). In Estelle v. Gamble, 429 U.S. 97 (1976), prison officials who showed deliberate indifference to a prisoner's serious illness or injury were held to violate the eighth amendment's prohibition against cruel and unusual punishment. The Court declared that prison authorities have a Constitutional duty to provide prisoners with medical care.

78. 1 BLACKSTONE, COMMENTARIES 129. This concept of the centrality of the right of protection has not changed in modern times. In 1918, Justice Oliver Wendell Holmes authored an article identifying four conditions that make up the "necessary elements in any society." Holmes, *Natural Law*, in COLLECTED LEGAL PAPERS 310, 312 (1920), *cited in* Mushlin, *supra* note 2, at 218 & 219.

79. *See* Taylor v Ledbetter, 818 F.2d 719 (11th Cir. 1987). In this case, plaintiff was a child who was rendered comatose because of abuse by her foster mother. *See infra* note 83 and accompanying text.

80. Lynch v. King, 550 F. Supp. 325 (1982).

Foster children with inadequate health care present a situation ripe for a Section 1983 claim. Section 1983 of Title 42 provides a cause of action for individuals who, because of the actions of state officials, have been deprived of rights, immunities, or privileges protected by the United States Constitution or federal laws. As the Supreme Court has reiterated quite frequently, Section 1983 is not itself a source of substantive right, but merely provides a method for vindicating a federal right elsewhere conferred. The requisite elements for stating a cause of action under Section 1983 are: (1) that the conduct complained of was committed by a person acting under color of state law; and (2) that the conduct deprived the plaintiff of a federal Constitutional or statutory right.

1. *Historical Perspective.* The enactment of Section 1983 was the reaction of Congress to inaction on the part of certain states regarding lawless conditions within their borders, specifically, the lack of response to outrageous conduct by the Ku Klux Klan against southern blacks.[81] The remedy created was not a remedy against the Klan, however, but against those who represented a state in some capacity but were unable or unwilling to enforce a state law prohibiting such conduct.[82] Consequently, it is applicable to the situation of children in foster care because the state officials charged with the care of these children are apparently unable or unwilling to provide the Constitutional right to safety that these children have.

In *Taylor v. Ledbetter,*[83] the eleventh circuit gave foster children protection under the fourteenth amendment. The court, sitting en banc, held that allegations that state and county officials acted with gross negligence and deliberate indifference in placing the child in a foster home were actionable under Section 1983.[84] The court analogized a child in foster care to a child confined to a state mental health facility or to a prisoner, as in *Youngberg* and *Estelle.*[85] The court followed the reasoning of the second circuit in another important case, *Doe v. New York City Department of Social Services.*[86] In *Doe*, the court held a foster child had a pro-

81. Monroe v. Pape, 365 U.S. 167, at 171-83.

82. *Id.* at 175-76.

83. 818 F.2d 791 (11th Cir. 1987). In this case, plaintiff sued the Guinett County, Georgia Department of Family and Children's Services on behalf of a two-year-old girl for injuries that occurred while the child was in foster care. Allegedly, the child was beaten by the foster mother and given an overdose of unnecessary medication, causing her to become permanently comatose. The suit claimed defendants had violated the child's constitutional right to safety by failing to investigate adequately the foster home and by failing to provide complete information to the child's physicians.

84. *Id.*

85. *Youngberg, supra* note 76; *Estelle, supra* note 77.

86. 649 F.2d 134 (2d Cir. 1981). The court held that the agency that placed child in

tected liberty interest and that state officials had a responsibility to ensure the child's safety in foster care.

Access to a Section 1983 claim was recently limited by the Supreme Court in *DeShaney v. Winnebago County DDS*.[87] The Court held that a child is not constitutionally entitled to state protection unless the state has imposed a specific limitation on that child's freedom to act on his own behalf.[88] Chief Justice Rehnquist, writing for the Court, held that the State had no constitutional duty to protect a child from beatings by his father, even after receiving reports of possible abuse.[89] While this decision is a setback in the overall scheme of protecting children's civil rights, it can be distinguished on its facts from the claims by foster children, because of the three prong test enunciated in *Jensen v. Conrad* and discussed in the next section.[90]

2. *Special Relationship Test.* The Court, in *DeShaney*, adopted guidelines which had been set forth in *Jensen v. Conrad*.[91] In that case, the fourth circuit provided factors for consideration in determining whether a "special relationship" exists between the state and the individual, giving rise to a constitutional duty of protection. Specifically, the Court enumerated three factors:

> 1. Whether a victim or the perpetrator was in legal custody at the time of the incident, or had been in legal custody prior to the incident . . .
> 2. Whether the state has expressly stated its desire to provide affirmative protection to a particular class or specific individuals . . . [and]
> 3. Whether the State knew of the claimants' plight . . .[92]

Applying these considerations to foster children: (1) foster children are under the legal custody of the state, (2) the state has affirmatively stated its desire to provide affirmative protection to foster children as a class, and (3) through the enrollment in the system and observation by case workers, the state knows or should

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foster care could be liable for child's sexual abuse by foster parent because agency failed to supervise the placement adequately.

87. 109 S. Ct. 998 (1989).

88. *Id.* at 1003.

89. *Id.* at 998.

90. Jensen v. Conrad, 747 F.2d 185 (4th Cir. 1984) *cert. denied,* 470 U.S. 1052 (1985). The fourth circuit held that the state owes a constitutional duty to protect a child whose abuse has been reported to the state. The decision in *DeShaney* marks a substantial deviation from the notion that all children are entitled to protection. The concept that a child is free to act to protect itself unless that freedom has been curtailed by the state is mere fantasy. The fact that the agency responsible for protecting children had received ample notice of the abuse of Joshua DeShaney and failed to protect him was insufficient to give rise to the state's duty to protect, according to the Court.

91. *Id.*

92. *Id.* at 194-95 n.11.

know the plight of foster children, thus establishing the requisite "special relationship" required to create a duty of protection by the state.

Although the "right to safety" has recently been expanded beyond institutional walls,[93] foster children have received little benefit from the right.[94] *G. L. v. Zumwalt*[95] was the first class action which provided relief for a class of foster children predicated on a constitutional "right-to-safety" theory. Its value as precedent is limited, however, because it was a consent decree issued prior to trial.

In *Massinga*,[96] the leading foster children health care case, the Federal District Court for the District of Maryland, when applying the three factors from *Jensen,* held that plaintiffs had demonstrated the existence of a "special relationship" with defendants, such that plaintiffs were owed an affirmative duty of protection by defendants. "Here defendants undertook to provide plaintiffs with proper care and defendants have known, or had reason to know, of systemic deficiencies since the Task Force Report. Most importantly, plaintiffs are vulnerable children in custody of defendants."[97]

3. *Deliberate Indifference.* Once a "special relationship" between the plaintiff and defendant is established, an affirmative duty to protect exists and the defendant may not act with "deliberate indifference" to the plaintiff's protected right. For example, "deliberate indifference" was found in *Massinga* when the court held defendants were aware of the serious deficiencies in the child protection system and their tragic consequences. The defendants' duty to protect, as previously noted, and the systemic nature of the BCDSS failure to perform that duty, created a clear likelihood of plaintiffs' success on the merits.[98]

4. *Right to Safety Extended to Health Care.* The decision in *Massinga*[99] linked the right to safety with the state's provision of adequate medical care for foster children. *Massinga* involved the mistreatment of children in foster care placements and the court specifically found health care provision to be falling so short of the standard that the children's right to safety was being violated. The federal district court granted plaintiff's motion for a preliminary injunction, sanctions, and a default judgment, while denying de-

93. *Id.*
94. Mushlin, *supra* note 2, at 227.
95. 564 F. Supp 1030 (W.D. Mo. 1983).
96. *See supra* note 39.
97. *Massinga, supra* note 39, at 30.
98. *Id.*
99. *Id.*

fendants' motion for summary judgment. The outcome of the case was a consent decree between the parties that sets forth specific directives with which the defendant must comply. A large portion of the decree establishes requirements for health care.[100]

If the Baltimore Department of Social Services could come into full compliance, it would achieve the standards set forth by the Children's Welfare League of America.[101] This would be a giant step forward for foster children. A demonstration of the feasibility and success in providing these services could help to minimize compliance problems in other jurisdictions.

C. *Compliance Problems*

In *G.L. v. Zumwalt*,[102] the consent decree approved by all parties was published[103] at the request of plaintiff's counsel and because of the assistance it may render to other courts considering similar questions. This case, originally filed in 1979 and stipulated

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100. *Id.*

A. Defendants shall develop and maintain a medical care system reasonably calculated to provide comprehensive health care services to foster care children in a continual and coordinating manner in accordance with their needs.

B. All foster children shall have an initial health care screening if possible before placement in an out-of home care setting, but in any event, no later than 24 hours following placement.

C. All foster children shall be referred for a comprehensive health assessment within 30 days of entering placement. The assessment shall be completed within 60 days of entering placement. This assessment shall address the child's medical, emotional and developmental needs. The results of this assessment will be made available to the child's health care provider(s). The provider(s) selected by DSS to provide health care for the child shall be reasonably calculated to meet the child's specific needs identified by the assessment.

D. All foster children shall have periodic medical, dental and developmental examinations. If needs are identified at the periodic examinations that were not identified previously, the provider(s) selected by the Department of Social Service shall be reasonably calculated to meet these additional needs.

E. For each child in foster care the defendants shall develop and use an abbreviated health care record (e.g. medical passport), which shall accompany the child through the out-of home care system and upon his or her return home, adoption or emancipation. An abbreviated health care record shall require the following information: the medical facilities where the child usually receives care, the child's condition at placement as documented by his or her physician, and the child's immunization record, allergies/adverse reactions, chronic health problems and present medications. The foster parents of the child shall be provided with the health passport completed to the extent possible at the time of a child's replacement or if an initial placement within 5 days of placement. Copies of the forms contained in the passport shall be included in the child's case record and shall be reviewed by a supervisor at least every 6 months.

F. Within two years of entry of this Decree, defendants shall establish and maintain a health services management unit within the Department of Social Services. This unit shall be staffed by one or more health professionals who are trained and experienced in child health care.

101. *See supra* note 37 and accompanying text.

102. 564 F. Supp. 1030 (W.D. Mo. 1983).

103. *Id.* at 1031.

to in 1983, was still in a non-compliance status as of August 1989, ten years after filing. Compliance has been a major problem with all the foster children class actions.[104] As noted in the ACLU Annual Report,[105] the *Zumwalt* decree has 17 categories with which the defendant, the Department of Family Services (DFS) agreed to comply. Medical care is included as one of the 17 categories. Both defendant and plaintiff became aware that DFS was failing to comply, and a supplemental consent decree was issued that provided for a monitoring panel (the committee). Unfortunately, when faced with the first compliance audit, DFS again conceded difficulties with compliance, particularly with respect to implementing reforms regarding medical, dental and psychological services for children in need. By November 1988, for the third time, a consistent pattern of noncompliance was revealed, and DFS's own computers showed significant downward trends in compliance.

> There is a lack of a comprehensive plan to assure continuity of medical care for foster children as well as a lack of standardization in the evaluation process for children in care. Recommendations by the committee concluded a comprehensive evaluation and assessment system must be developed and applied to all children as they come into care.[106]

Massinga established the foundation for class action suits in at least five states and the District of Columbia.[107] It is apparent

104. *See infra* note 107.
105. M. LOWRY, *supra* note 10, at 25.
106. *Id.*
107. *Id.*

1. District of Columbia (Lashawn A. v. Barry, 89 Civ. 754, June 20, 1989): This is the newest of the ACLU's challenges to child welfare systems. The District of Columbia is considered one of the nation's worst systems. Approximately one-third of the caseworker positions are vacant while caseloads are 4 to 5 times the national standard, and children who enter foster care are likely to spend their entire childhood in government custody. (*Id.* at 4.) *See also supra* notes 53-55 and accompanying text.
2. Louisiana (Del A. v. Edwards, 855 F.2d 1148 (5th Cir. 1988)): The trial in this case began in 1989. The ACLU is optimistic that it will result in significant reforms in Louisiana. The ACLU expects this case to set important legal precedents that will make it easier to obtain similar results elsewhere. (*Id.* at 7.)
3. New York City (Martin A. v. Gross, 138 Misc. 2d 212 (N.Y. Sup. 1987)): The City is clearly failing to proceed adequately with the reform agreed to in the existing consent decree. (*Id.* at 11.)
4. Louisville, Kentucky (*In re* Michele and Michael P., 78J04583, 78J04584 Jefferson Cty. Dist. Ct., Kentucky (Sept. 14, 1981)): After some delay, the state hired a new staff person to enforce the consent decree. This has resulted in many improvements. (*Id.* at 19.)
5. New Mexico (Joseph and Josephine A. v. New Mexico Department of Human Services, 575 F. Supp. 346): By 1989, no concrete reforms were being implemented and the ACLU was forced to file a non-compliance report in June of 1989. (*Id.* at 22.)
6. Kansas City, Missouri (G. L. v. Zumwalt, 564 F. Supp. 1030 (1983)): The optimism of 1988 has been reversed. In March, 1989 no concrete reforms were being implemented according to the consent decree. The ACLU was forced to file a non-compliance report.

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that even court victories do not necessarily bring the desired changes. Actual implementation is a very long process.[108] Eventually, however, armed with court orders and a commitment to their enforcement, changes do occur as states become aware of the impact of the litigation.[109]

D. Tort Actions In Negligence

Cases alleging professional malpractice against workers, supervisors, and agencies in the child protective system, reflect an attempt to use the common law to right wrongs inflicted on children.[110] The Supreme Court's decision in *DeShaney* may lead to greater reliance on these actions. Local and state governments may be joined as defendants in these actions, under the doctrine of respondeat superior.[111]

The cause of action for professional malpractice is basically an action in negligence. To succeed, the plaintiff must prove that: (1) the defendant owed a duty to the plaintiff or to the class of people of which plaintiff is a member; (2) the defendant breached this duty; (3) the defendant's breach was an actual cause of the damage suffered by the plaintiff; (4) the defendant's breach was the proximate cause of the damage suffered by the plaintiff;[112] and (5) the plaintiff suffered damages.[113] In some situations, government entities may avoid liability under the doctrine of sovereign immunity.[114] The foster child has a strong possibility of success of over-

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(*Id.* at 25.)

108. M. Lowry, *supra* note 10, at 25.

109. *Id.* at 4.

110. *See, e.g.*, Bradford v. Davis, 290 Or. 855, 629 P.2d 1376 (1981), a case in which a foster child received $90,000 in settlement from the state of Oregon after alleging that the Children's Services Department negligently failed to supervise, screen and monitor his foster placement.

111. *Social Workers and Liability: Who Should Pay When Negligence Occurs?*, 4 Children's Legal Right Journal No. 4 (1989) [hereinafter *Social Workers and Liability*], at 6. Besharov, *Child Welfare Malpractice*, Trial 56-64 (Mar. 1984).

112. It is necessary to show that the defendant's negligence contributed in some way to the plaintiff's injury. The "but for" rule has traditionally been applied to determine "actual cause;" Johnson v. Union Furniture Co., 31 Cal. App. 2d 234 (1939); Prosser, *Proximate Cause in California*, 38 Cal. L. Rev. 375 (1950). The "proximate cause" element limits liability. Rules of proximate cause operate to relieve the defendant whose conduct is the actual cause, but, where, because of the nature of the events leading to the injury, it would be considered unjust to hold him legally responsibie, *See* W. Prosser & W. Keeton, The Law of Torts 237, 244 (5th ed. 1984); Restatement (Second) of Torts §§ 431, 440-441 (5th ed. 1984); Burke, *Rules of Legal Cause in Negligence Cases*, 15 Cal. L. Rev. 1 (1926); Arthur v. Santa Monica Dairy Co., 183 Cal. App. 2d 483 (1960).

113. Johnson v. Panama Pacific I.E. Co., 187 Cal. 323 (1921); United States Liability Insurance Co. v. Haidinger-Hayes, 1 Cal. 3d 586 and 594, 463 P.2d 770; Restatement (Second) of Torts, at §§ 281, 497 & 499.

114.

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coming the sovereign immunity obstacle if the child can accomplish the following: (1) demonstrate that the placement agency owed him a duty of care or had an affirmative duty imposed by statute or regulation; (2) show that the abuse while in the foster care system was related directly to the agency's negligence and that the agency's negligence was the proximate cause of the child's injuries; and (3) characterize the agency's actions as ministerial activities and not protected by sovereign immunity.[115]

In *Koepf v. County of York,*[116] the Nebraska Supreme Court stated:

> The placement in foster homes of defenseless children, and the supervision of their *health and care* once committed to the custody of the welfare department must be accomplished with the reasonable care commensurate with the circumstances. We hold that the political subdivision of this state can be held liable for a breach of that duty.[117]

While a negligence claim has not been used in a reported case to recover damages for inadequate health care, the *Koepf* court stated that the Welfare Department will be held liable for the health care of foster children.

In *Elton v. County of Orange,*[118] the court reversing the order that dismissed the complaint held that causes of action were stated by a dependent child against a county,[119] a county department of social welfare, and a county probation officer. The complaint alleged that the county was negligent in placing the child in a home where she was beaten, and alleged that the county failed

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> The theory of sovereign immunity originated in the fiction that the king can do no wrong. The doctrine arose from the practical necessity of enabling the state to exercise its functions unhampered by the demands on the exchequer resulting from the carelessness or mistakes of its officer. The doctrine has had widespread acceptance as a part of the American common law, and has been deemed to prevail except where it had been departed from by constitutional and statutory law as interpreted and applied by the courts.

People v. Superior Court, 29 Cal. 2d 754, 756, 178 P.2d 1, *cited in* 4 WITKIN, SUMMARY OF CALIFORNIA LAW 2358.

Despite important variations, all states retain immunity from suits that result from discretionary governmental activities. In most jurisdictions immunity has been waived by statutes for nondiscretionary actions which cause injury. W. PROSSER & W. KEETON, *supra* note 112, at 1048. The immunity doctrine has been under fire by progressive courts and law writers for many years. It has been urged that immunity should be abolished and full tort liability should be assumed by American state and local governments. (*See* Madison v. San Francisco, 106 Cal. App. 2d 232; Waterman v. Los Angeles County General Hospital, 123 Cal. App. 143, cited in 4 WITKIN, *supra*, at 2359).

115. Kieffer, *Child Abuse in Foster Homes*, 28 SAINT LOUIS U.L.J. 982 (1984).

116. 251 N.W.2d 869 (1977) (construing the Political Subdivisions Tort Claims Act, Neb. Rev. Stat. §§ 23-2401 to 23-2420 [1943]).

117. *Id.* at 871 (emphasis added).

118. 3 Cal. App. 3d 1053, 84 Cal. Rptr. 27 (1970).

119. The child sued the county and the two involved departments, but the court discussed the legal issues as though they were but one entity, the county.

to enforce and comply with certain state regulations governing dependent children and foster homes, which failure resulted in injury to the child.[120] The court held that the state law granting immunity for discretionary acts could not furnish immunity to the county because immunity was granted only for those acts and omissions which involved basic policy decisions.[121] The court stated that decisions made with respect to the care, supervision, or placement of a dependent child did not achieve the level of basic policy decisions.[122]

In *Vonner v State,*[123] the court held the state department of public welfare liable based on its negligent non-compliance with its own regulations regarding medical care and caseworker visitation of foster children.[124] The court stated that the causal relationship between the child's death and the department's breach of its visitation and medical examination regulations was adequately proved. In addition, the court held the state vicariously liable in place of the foster parents. The court pointed out that under state law, the department had legal custody and therefore the responsibility to provide for the physical, mental, moral and emotional well-being of the child, which responsibility could not be delegated to others.[125]

The usual remedy in an action for negligence is compensation for damage which has been done—only after the system has failed the child. Clearly, this is not the most expeditious means to achieve the goal of adequate health care for foster children. At the same time, success in these lawsuits should make officials and caseworkers expand their efforts to provide adequate care, as the risks not only involve administrative reprimands, firings, and downgradings, but also sizeable monetary damages.[126]

The equitable remedy of injunctive relief is also available to children in cases where a tortious act is threatened. The plaintiff, or petitioner seeking injunctive relief, must be able to demonstrate to the court that a tort is being, or is about to be, committed. In

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120. Elton v. County of Orange, 3 Cal. App. 3d 1053, 84 Cal. Rptr. 27 (1970). (*See* Annotation, Negligence in Placement of Children, 90 A.L.R. 3d 1219.)

121. *Id.*

122. *Id. See also* Vosburg v. Dept. of Social Services, 884 F.2d 133 (4th Cir. 1989), Babcock v. Tyler, 884 F.2d 497 (9th Cir. 1989) (Placement of children as judicial function entitled to sovereign immunity).

123. 273 So. 2d 252 (1973) (an action for manslaughter by the mother of a child against foster parents when her 5-year-old child had been beaten to death by the foster mother).

124. *Id.*

125. *Id. See also* Coleman v. Cooper, 366 S.E.2d 2 (N.C. App. 1988); Department of Health and Rehabilitative Services v. Yamuni, 529 So. 2d 258 (Fla. 1988); Turner v. District of Columbia, 532 A.2d 662 (1987).

126. *Social Workers and Liability, supra* note 111, at 6.

theory, this may prove difficult in these cases, as there is some logical inconsistency in predicting negligence. However, given the pattern of behavior engaged in by child protective systems which neglect the health care of foster children, it is conceivable that an action could be framed as one for past damages and to prevent future harm through injunctive relief. In a class action on behalf of foster children, the effect could be to prevent harm to a significant number in the class.[127]

In addition to proving the existence of a tort, the plaintiff must prove that the legal remedy of monetary damages would be inadequate. In these cases, the injury suffered by failure to provide health care would meet this requirement because these damages can never be compensated for with a reward of money and because the injury is threatened, rather than past. The injunctive remedy is particularly appropriate in cases where there is a repeated pattern of behavior which might lead to a multiplicity of lawsuits and/or recurring problems.

One possible problem in obtaining injunctive relief for foster children who are being denied adequate mental health care is that the desired relief necessarily involves taking action by the authorities responsible for child welfare. This translates into the need for a mandatory injunction, possibly creating a supervisory burden on the court. Although courts do not like to undertake these huge supervisory tasks, the desegregation cases proved their willingness to do so when there were no other alternatives.[128]

V. Other Approaches to Protecting the Mental Health Care Needs of Foster Children

The orientation of this paper has been toward the legal system, examining the instruments available to children, through their legal representatives, to bring about changes in the foster care sys-

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127. In Timothy J., et al. v. Chaffee et al., *supra* note 74, the plaintiffs are requesting declaratory and injunctive relief as well as a writ of mandate. In this class action, the plaintiffs set forth provisions of the California Welfare and Institutions Code and regulations adopted by the State Department of Social Services which allegedly are being violated and in danger of continuing violation. These provisions call for case management and provision of services which are intended to provide safety, including, specifically, physical and mental health care. The plaintiffs request injunctive relief requiring the enforcement of these laws, a writ of mandate against their violation, and declaratory relief regarding the duties and rights of the parties.

128. Brown v. Board of Education, 349 U.S. 294, 75 S. Ct. 753, 99 L. Ed 1083 (1955). After the court's promulgation of general guidelines for integration, implementation was largely left to the lower courts. In Cooper v. Aaron, 358 U.S. 1, the court held it had the power to enforce integration, and in Alexander v. Holmes County Board of Education, 369 U.S. 19 (1969) the court called for an immediate end to dual school systems. *Massinga*, *supra* note 39, has set a precedent for courts to implement and supervise specific court orders in the area of foster care reform.

tem. As has been demonstrated, new laws and court orders do not necessarily achieve these changes. Something more is needed. The allocation of sufficient monetary resources would be a significant step in the right direction. However, our very failure to do this to date is a reflection of the much larger problem underlying the difficulties presented by our foster children. The well-being of our children has not received the attention or commitment needed to insure the fulfillment of our promises. Inextricably related to this failure is our history of neglect for the family as a whole. Children cannot be removed from their families without suffering from that separation. We cannot expect to protect and treat these children outside of the context of their families.

The legal system is the driving force behind the child protective system, including foster care. The laws and regulations which were initially adopted to safeguard children who became dependents of the court have become part of the problem, as well as the solution. Social workers, who carry burdensome caseloads, find themselves buried in paperwork. The many forms and reports which they must prepare actually prevent them from making contacts with the children, biological parents, foster parents and other professionals involved in each case. Regardless of how well-intentioned any individual actor in the system may be (and there are many deeply committed people in this field), the realities of practice result in a system which churns out human beings as if they were widgets. The drama of the life of any individual child brought into the system is eclipsed by a tone of bureaucratic processing.

What is required, if we hope to produce any meaningful change within the system, is a shift away from our traditional adversarial approach to child protection. Although the existing system is, in theory, not supposed to be an adversarial one, in fact, it is. Perhaps the mere presence of lawyers has created this effect. This is not to say that lawyers are incapable of working in a collaborative way; they simply have not been trained to do so. Nor have they been trained to be sensitive to the affective realm in general. They are most often untrained in the social sciences, including the areas of human behavior and child development. Even assuming that the attorneys and the judges who work in this arena receive special training in these subjects, their approach to their work is not necessarily affected. Too many lawyers are geared to win and to think of problems in win/lose terms.

It may seem strange to cast the blame for inadequate mental health care for foster children upon the lawyers. Certainly that would be a most narrow view. We must, however, take responsibility for the fact that it is the laws we have drafted and enforced

which drive the system. Each time we have zealously advocated for a client in the system according to our professional mandate, we may have added to that adversarial nature which is fundamentally inappropriate for dealing with family and children issues. In general, each new form and report the social worker must complete may be the result of a lesson learned in an adversarial context. The need to cover oneself in the context of making decisions which will affect others is one such lesson. All of these legal challenges are not, in themselves, necessarily evil; it is the approach (the way we, as lawyers, see our work and our relationship to the system) that is problematic.

What needs to happen is a reaffirmation that child welfare is not an adversarial process and that our work, and the work of all professionals involved, is to collaborate in the interests of the children and their families. Interdisciplinary teamwork provides a powerful medium for this collaboration. Teams of physicians, mental health care professionals, lawyers, and social workers can work together to study the larger picture of a child's needs. This study, however, cannot be done outside the context of the family. Thus, the biological parents, the foster parents, teachers and other caretakers must be involved in a dialogue with the professional team, to the extent this is possible.[129] Each case, each child, must receive individual attention, rather than the boiler-plate approach which appears to be the norm in prescribing services and treatment.[130]

In addition to this collaborative approach, we need to do whatever we can to put an end to foster care drift. Both P.L. 96-272 and implementing state legislation shared this goal, but it has not been reached. Perhaps we should be taking another look at the concept of group homes. For children beyond the infant and toddler stages, a group home might offer more hope for stability and opportunity to develop social skills and self esteem than is currently available in an insecure foster home placement. These homes should not be large institutions, reminiscent of the orphanages of long ago, but instead should be homes for eight to ten children, supervised by caring professionals. We must find some way to provide stability to these children whose family lives have been so severely disrupted. Without this stability, it is often impossible to provide meaningful psychological therapy.

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129. *See* Molin, *supra* note 17.

130. We cannot and should not expect social workers to be experts in mental health and to be able to prescribe appropriate treatment for each child. A team approach would allow assessment by a mental health expert and discussion with the expanded "team" to ensure cooperation and support. This assessment should be done even before placement to assure the best match between foster child and foster parents.

Another idea we should explore is the professionalization of foster parenting. This is not to say that the receipt of a particular academic degree would entitle a person to be a foster parent. It has much more to do with our attitude toward the people who dedicate themselves to these children. Foster parents need to be trained to provide such services, have their work monitored by peers and be included in the decision making process for their foster children. They should receive the recognition and the compensation that we expect to give those who are working in other "respectable" service professions such as medicine or law.[131] The professionalization of foster care could help to create a cadre of "parents" who would provide the caring and the modeling needed by children who must be separated from their families.[132] As a society, we have not been forthcoming in our recognition of the similar contribution made by our school teachers, so such a goal seems unrealistic for the near future.

A combination of collaboration and professional foster parenting should effect a maximization of matching between foster parents and foster children. Incorrect matches currently contribute to foster drift as the child is moved from one home to another. In addition, these mismatches cause disruption within foster homes, making it difficult for even the best of foster families.

We need to recognize foster parenting as a therapeutic venture.[133] The first step in accomplishing therapeutic goals would be

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131. Foster parenting must not be used as a means to bolster income.

> Charles Loring Brace is credited with originating modern foster family care. His avowed motive was to rescue children from the exigencies of destitution and vagrancy. The street vagrants and the children's institutions of New York City were his first and primary sources of destitute and dependent children. . . . Committees of local citizens prepared the way with appeals to Christian charity spiced with an appeal to people's self-interest in that the farmers and tradesmen who took a destitute child would obtain free labor for farm or shop. In substance, appeals by present day foster home recruiters are much the same except that the appeal to charity is more subtle and the appeal to self-interest expressed in cash rather than in kind - that is, board payments rather than free labor.

Wiltse, *Foster Care An Overview*, A HANDBOOK OF CHILD WELFARE: CONTEXT, KNOWLEDGE AND PRACTICE 568-69 (1985).

132. The manual of policies and procedures for the San Diego Foster Family Homes holds that training be required for potential foster parents (Section 87017). This 12 hours of training is given without a final evaluation of learning. Training, beyond basic three hour classes in discipline, self-esteem, child abuse, and fostering's impact on the family, could be developed for participants. Further, current state-of-the-art education techniques such as integrated programmed learning/response and interactive roleplaying could be utilized to test whether the potential foster parents really learn something.

133. A five-year longitudinal study performed by Fanshel and Shinn, (D. FANSHEL & E.B. SHINN, CHILDREN IN FOSTER CARE: A LONGITUDINAL INVESTIGATION (1978)) showed that fostering can be therapeutic. Twenty-five percent of foster children in this New York study moved from "abnormal" or "suspect" classification to "normal" by the third year of testing. On the other hand, another 12% did not improve, while another 12% moved from "normal" to the "abnormal" or "suspect" categories. Realizing that there is a

to ensure that mental health screenings are performed at intake.[134] A thorough psychological evaluation for each child upon entry to the system, as well as a more rigorous appraisal of each foster parent's ability to supply an emotionally healing environment, would move us closer to success in this venture. Based on initial psychological evaluation, caution could be taken to see that children with specific emotional needs are not placed where additional abuse would be inadvertently precipitated.[135] Perhaps the most effective thing that could be done to provide required mental health care services to foster children would be to keep them out of the foster care system altogether. In-home treatment of abusive families has been the subject of study in California and the initial results are promising.[136] A substantial obstacle to the provision of effective mental health care to children is the instability they face in the foster care system. Allowing the children to remain at home with their families, while providing the intensive services required to help the family learn to cope, may be a good alternative for most of the children who come through the system. Naturally, it would not be an appropriate course of action, nor would it be considered, in a case where the child would be placed in danger by remaining in the home, or where the child was afraid to remain in the home. However, most cases of abuse and neglect do not involve the degree of severity which would require removal if these in-home services could be provided.[137]

CONCLUSION

Essentially, the underlying need in all of these suggestions is a reordering of societal values. Unless and until we choose to place children and families at least near the top of our list of priorities, we can expect the same old bureaucratic shuffling. This article has examined two law-based approaches to the problem of providing

potential for good as well as harm, we need to consider ways to maximize the former and minimize the latter. Strategic foster child-parent-matching could eliminate much of this chance improvement.

134. Halfon & Klee, *supra* note 8, studied 14 California counties and found that fewer than 10% of the children received mental health screening at intake into the foster care system.

135. For example, the manual of policies and procedures for the San Diego Foster Family Homes (section 87040) holds that application for licensure shall not be denied because a parent uses corporal punishment on his/her own children. Even though such punishment may never be used to discipline a foster child, the psychological effect of witnessing such punishment on the already anxious and hypervigilant child-victim of physical abuse is unquestionably abusive in itself.

136. *See* Wood & Barton, *In-Home Treatment of Abusive Families: Cost and Placement at One Year*, 25 PSYCHOTHERAPY 409-14 (1988).

137. NIS-2, *supra* note 9.

foster children adequate health care. Because the resolution to the problem is complex, there is no simple answer. Resolution through legislation does not appear to be imminent. Federal legislation only offers economic incentives to states, and individual states have not been prepared to cope with the increase of children entering the system both in terms of numbers and the unanticipated nature of the social problems attached to addiction and abuse and neglect.

On the other hand, litigation as a solution appears, at first glance, to have been more successful. Although it rarely answers the problems for an individual child hurt by the system, it may serve the more global purpose of warning states that providing foster children adequate services, including health care, is more economically prudent than losing a costly lawsuit. However, compliance problems severely limit the overall effectiveness of litigation.

Litigation and legislation alone will not build the kind of foster care system which our children deserve. A commitment of monetary resources would go a long way in improving the present provision of services, but would not be the final answer. Viewing foster parenting as the primary therapeutic process for these children is a workable and economically feasible approach. Better education and selection of foster parents will further serve to encourage program self-administration and reduce the burdens of overworked social workers. Adjustments in the Medi-Cal system, which would prioritize rather than inhibit psychological services, would facilitate prompt and thorough evaluation of each child. It would also encourage the involvement of enough quality professional help to the most needy among this population, both in initial group care and throughout foster placement.

Ultimately, the kind of commitment needed to make a significant change in the lives of foster children is one of heart, demonstrated by a genuine concern for the well-being of each child (and his or her family) that enters the system. Attitudes of collaboration and teamwork, rather than adversarialness, need to be adopted by all the professionals involved.