Placement disruption of children with disabilities in foster care

Christine Platt, FNP-c, MSN *, Sheila M. Gephart, PhD, RN, FWAN, FAAN

The University of Arizona, College of Nursing, PO Box 210203, Tucson, AZ 85721, United States of America

ABSTRACT

Purpose: To investigate and describe available data on children with disabilities in the United States foster care system and examine placement disruptions.

Design: This quantitative descriptive study was a secondary data analysis of the Adoption and Foster Care Analysis and Reporting System (AFCARS) and included 680,611 children.

Methods: Descriptive and regression analyses were conducted.

Findings: Of 680,611 children in the U.S. foster care system in 2017, 22% had a medical or disability diagnosis, requiring additional or specialized care. Children with disabilities in foster care (CDFC) had a mean of 4.0 disruptions—significantly higher than the mean 2.37 disruptions among those without a disability ($p < .001$, $d = 0.51$). CDFC spent an average of 915 days in foster care compared to 514 days for children without a disability ($p < .001$, $d = 0.59$). Predictive risk factors for disruptions were increased child age, race (American Indian or Black), and increased foster parent age. Protective factors against disruptions included married foster parents and a child being placed outside of the child's initial state of residence.

Conclusions: CDFC have significantly more disruptions and longer stays in foster care. While risk and protective factors affect all foster children similarly, they have significantly greater effect on foster children with disabilities.

Practice implications: Increased disruptions compound the vulnerability of CDFC as relationships and support systems are broken. Understanding the extent to which childhood disabilities play a role allows school nurses, healthcare providers, and child advocates to better design interventions to improve lifelong health outcomes.

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Introduction

Disability status may have implications for children entering foster care, including the type of setting in which they are likely to be served, the stability of the setting, and length of time before permanency. Many times, foster families are tasked with providing for the complex physical and emotional needs of children with disabilities, but little is known about the extent to which those disabilities affect the long-term stability and outcomes for such vulnerable children (Bruskas, 2008; Gypen et al., 2017; Slayter, 2016). Foster families are culturally diverse by nature, often combining parents and children from different races, socioeconomic backgrounds, religions, and gender/orientation identities (Austin et al., 2021; Zinn, 2009). Parents, siblings, and new foster children must adapt to new traditions, expectations, and communication styles. The traumatic experiences and disabilities that accompany many children as they enter the foster care system compound the complex dynamics of such diverse family units. Without adequate

experience, training, and resources required to care for the unique medical and educational needs of a child with disabilities, a foster family may feel unprepared for and stressed by unexpected challenges, such as medication management, healthcare navigation, and participation in special education programs (Brown & Rodger, 2009). These events could result in a placement disruption, moving the child to another foster home and further compounding the child's vulnerability.

When a child is deemed to be in an unsafe situation requiring agency intervention, they may be removed from their current living situation and, by court order, placed in a licensed home. These homes are typically called foster care homes or foster families. Ability (licensing requirements by state and federal regulations), willingness, and vacancy are all required to be an eligible foster family. Geographical location plays a role in the agency's ability to place a child in a foster home close enough to facilitate reunification services and visitation with biological parents. Initial placement into a foster home does not guarantee a stable environment. Several types of and causes for placement disruptions exist. Current literature compared three types of disruptions (placement mismatch, substandard care, and child initiated), noting age and race as associated factors, as well as an increased risk of substandard care and disruptions in kinship care compared to non-relative care (Font, 2015; Font et al., 2018; Koh et al., 2014; Sattler

* Corresponding author.
E-mail addresses: crplatt@email.arizaon.edu (C. Platt), gepharts@arizona.edu (S.M. Gephart).

et al., 2018). Across these studies, disability status was not investigated, yet it could be an influence in placement disruption decisions due to the increased level of care required for a child with special needs, particularly in disruptions labeled as placement mismatch.

Children in the United States foster care system frequently experience health disparities (Blakeslee et al., 2013), some of which may stem from higher prevalence of disabilities and their associated risk factors. Children in foster care have poorer mental and physical health compared to children in the general population, even when compared to family type (such as single parents) and children in economically disadvantaged families (Turney & Wildeman, 2016). They are more likely to have been exposed to alcohol and drugs in-utero, leading to worse outcomes in several areas such as academic success, behavior, cognition, and hospitalizations (Arter et al., 2021).

Far less is known about the experiences of children with disabilities in the foster care system compared to those without a disability. However, children who are in foster care with learning disabilities have what researchers call "synergistic factors" compounding health disparities and leading to greater vulnerability (Grabovschi et al., 2013). Researchers documented concerns of foster parents and their challenges in caring for children with disabilities such as obtaining specialized professional services, incurring higher costs due to fostering a child with a disability, arranging appropriate educational services, addressing behavioral challenges, and navigating the healthcare system (Brown & Rodger, 2009).

When a foster family is unable to adequately care for a child, the child may be moved to a different home. These disruptions create greater barriers and significant health care challenges for an already vulnerable population. For example, a child's support at school can be greatly affected when disruptions lead to poor communication between parents and teachers and a lack of historical knowledge by teachers when a child must transfer schools. This is especially notable when the child also has a disability (Mires et al., 2018). A change in geographical location due to a placement disruption can create a need for a new healthcare provider. This transition may lead to the loss of valuable information and specific knowledge regarding the child's needs. Furthermore, disruptions and changes in healthcare providers can sever caring connections, and these lost connections are associated with higher levels of unmet healthcare needs during and after foster care (Collins, 2016). The more disruptions, the higher the cost to the child's wellbeing (educational, physical, and mental) and the higher the cost to the system (Vanderfaeillie et al., 2018). Strong associations exist between externalizing behavioral problems and the number of placements a child experiences (Jedwab et al., 2019; Vreeland et al., 2020). However, developmental needs secondary to a disability may be perceived as behavioral problems if not cared for by families or caregivers with specialized training.

Theoretical background for study

Two theories (Schlossberg's Transition Theory and Meleis' Transition Theory) were used to inform this research. Both theories were needed as neither theory alone encompassed all the concepts unique to fostering and placement stability. Schlossberg's Transition Theory has been used extensively within health disparities research and research pertaining to foster children, whereas Meleis' transition theory addresses family transitions and parenthood (Meleis et al., 2000; Schlossberg, 1981; Winter, 2014). Concepts from both theories aided in the operationalization of the variables and the analysis. For example, Schlossberg's concepts — such as situation (type of placement), self (type of disability), and social support (caregiver characteristics) — guided the investigation. A transition is any event that changes relationships, routines, assumptions, and roles. For children in foster care, such an event can also include a "non-event" where they expected a transition to occur (e.g., to biological parent's home) but it did not and they must adjust to it not happening as planned. Meleis et al. (2000) noted

that people in transition tend to be more vulnerable and have greater risks that may affect their health. This is particularly true for children in foster care (Bruskas, 2008). An individual's ability to cope and move through the transition depends upon assets and liabilities, which this study attempts to examine. By using both transition theories to guide the search for potential concept relationships, we examined placement disruption or transitions in the context of disability and fostering.

Purpose and aims

The purpose of the study was to investigate and describe available data on children with disabilities in the United States foster care system and examine placement disruptions. Understanding the extent to which disability status may play a role in increased vulnerability allows healthcare workers and child advocates to better understand and design interventions to improve lifelong outcomes. Within the data set, disability was defined as being clinically diagnosed with a disability including mental retardation (sic; i.e., more appropriately referred to as a person having a cognitive, developmental, or learning disability), visual or hearing impairment, physical disability, emotionally disability, and/or another medical diagnosis requiring special care. The aims of the study were to: 1) determine how many children in foster care during 2017 had at least one disability; 2) ascertain the number of disruptions in placements to foster homes for children with a disability; 3) compare the average duration that a child is in foster care between children with a disability versus children in foster care without a disability; 4) investigate type of placement settings for CDFC; and 5) identify risk and protective factors associated with disruptions.

Methods

Design

A cross-sectional descriptive secondary analysis of the Adoption and Foster Care Analysis and Reporting System (AFCARS) 2017 dataset, obtained through the National Data Archive on Child Abuse and Neglect, was conducted. Institutional Review Board approval was received through the University of Arizona's Human Subject's Protection Program. The protocol, using de-identified data, was determined to not be human subject research. The investigators retrieved the AFCARS data set, which is publicly available, and downloaded it into STATA to address variables in the aims. AFCARS was chosen because it includes all 50 states and contains the most accurate/large scale statistical data on foster care in the United States. However, data from the state of Colorado was excluded from this study because they did not report on disability status. We examined all children in the United States foster care system for any part of 2017, providing a snapshot of children in care.

Sample

The sample included 680,508 children in the United States foster care system during 2017, of which 51.58% were male. Race of foster children was predominantly white (68.5%), followed by black (30.8%). Also, 22.2% reported an Hispanic origin. Among CDFC, there was a slightly higher percentage of black children (33.8%). The average child's age at the time of removal was 6.5 years, though this average is higher (8.0 years) among CDFC. This United States sample included children and families from all U.S. states except Colorado, in addition to the District of Columbia and Puerto Rico. The District of Columbia had the fewest active foster care cases at $n = 1131$ (0.16%), followed by Delaware with $n = 1190$ (0.17%). California had the highest number of foster care cases with $n = 80,408$ (11.81%), followed by Texas at $n = 50,333$ (7.40%). See Table 1 for demographics of children and Supplemental Table B for foster family structure based on disability status.

Table 1
Demographic characteristics of foster children.

	Foster child disability			
	Without		With	
	N	(%)	N	(%)
Mean age at first removal (SD)	6.1	(5.6)	8.0	(5.6)
Sex				
Male	265,996	(50)	84,352	(56)
Female	262,846	(50)	67,314	(44)
Race				
White	356,083	(69)	97,537	(67)
Black	154,447	(30)	49,571	(34)
Hispanic Origin	108,002	(22)	34,162	(24)
Native American	26,926	(5)	6769	(5)

Variable selection and analysis

The data report the number of placement settings in which the child lived during their current foster care episode. Temporary living conditions, such as hospitalization or respite care from another foster family, are not counted as additional placements, nor are placements back in the original home, such as a home visit or a trial home placement. This was particularly important, because children with disabilities may experience more temporary out-of-home care than the general foster care population, and the study focus was on actual caregiver and long-term setting changes. The number of placements is used to represent disruptions; effectively, the first placement after initial removal from the biological home is counted as a disruption.

A child with a disability was defined as a child with one or more of the following diagnoses using the data set definitions: vision impairments, hearing impairments, mental disabilities, emotional disabilities, physical disabilities, or mental retardation [sic] (Children's Bureau, 2020). Other medical diagnoses factored into the definition of disability included epilepsy, fetal alcohol syndrome, shaken infant syndrome, and encephalopathy. Care was taken to only count a child once and to group their multiple diagnoses as one "disability." Many disabilities are found in conjunction with other medical and developmental abnormalities, particularly in children who had experienced abuse, neglect, or substance exposure. For example, a child with cerebral palsy who had vision impairments, hearing impairments, physical disabilities (bone developmental abnormalities), and developmental delays was only counted once. Inclusion of specific diagnoses was determined based on the disability typically requiring substantially more care and level of expertise by the foster family. Children in the process of receiving a diagnosis were excluded from the analysis, but the separate medical, mental, and physical diagnosis variables were aggregated into a single dummy variable. This was done using STATA software. Descriptive statistics were calculated to characterize the population, and t-tests were employed to compare mean foster care experiences across disability status. A probability model of regression was used to examine relationships between the child's disability status and various causes for initial removal from their parents' home.

Results

Question 1: How many children in the United States foster care system had at least one diagnosed disability during 2017?

There were 151,666 foster children with a medical diagnosis or disability in 2017, in contrast to 528,842 without a diagnosis in the U.S. foster care system. This equates to 22% of children in foster care with a medical or disability diagnosis that requires additional or specialized care.

A probability model of regression was used to examine relationships between the child's disability status and various causes for initial removal from their parents' home (see Table 2). If removal was partly

Table 2
Predictors of removal reasons on disability status (n = 687,406).

	b	[95% CI]		t
Child Behavior	0.415	[0.404,	0.426]	74.4***
Parental Substance Abuse	−0.297	[−0.304,	−0.290]	78.87***
Physical/Sexual Abuse	0.031	[0.021,	0.040]	6.36***
Neglect	−0.022	[−0.031,	−0.013]	−5.25***
Parental Absence	−0.009	[−0.019,	0.001]	−1.79
Child Disability	1.074	[1.051,	1.096]	91.78***
R^2				0.038

*** $p < .001$.

motivated by the child's own problematic behaviors, they were 42% more likely to have a diagnosed disability ($p < .001$). A child removed due to parental substance abuse was 30% less likely to have a disability ($p < .001$). Among children without a diagnosed disability, 4583 (or 0.9%) had disability listed as the initial removal reason.

Question 2: Do children in foster care with a disability have a greater number of disruptions than those without a disability?

Children with a disability in foster care (CDFC) have a mean of 4.00 disruptions whereas children in foster care without a disability have a mean of 2.37 disruptions (see Table 3). Children with a disability are more likely to be moved from home to home. A 2-sample t-test was conducted to determine significance. The analysis revealed significantly more disrupted placements for children in the foster care system with disabilities than for those without disability, with a moderate effect size ($p < .001$, Cohen's $d = 0.51$).

Question 3: Does the average length of time that a child is in foster care differ between children with disabilities vs. children without?

CDFC spent an average of 915 days in foster care compared to children without a disability who spent an average of 514 days in foster care. This is a significant difference with a somewhat stronger effect size ($p < .001$, Cohen's $d = 0.59$). Results of this analysis are shown in Table 3.

Question 4: Are children with disabilities more likely to be placed in more restrictive settings?

Placement categories included: pre-adoptive home, kinship (relative) foster home, non-relative foster home, group home, institution, supervised independence, trial home, runaway, and reported missing. The category with the highest percentage caring for CDFC was non-relative foster home (37.76%) followed by a foster home of a relative (19.55%). CDFC are less likely to be placed with a relative compared to children without a disability (31.96%); CDFC are more likely to be found in pre-adoptive homes, group homes, or institutions (Supplemental Table C).

Question 5: What are the predictive risk or protective factors affecting the number of disruptions for children with disabilities vs. children without?

Predictive risk factors were defined as the characteristics of foster children associated with more disruptions and included foster child age (older) and race (American Indian or Black), as computed in a linear regression reported in Table 4. The regression includes interaction effects of disability with age and race, and in each case, the interaction effect significantly amplified the direct effect. For example, a foster child who is Black had 0.332 more disruptions than one who is white, and a foster child with disabilities had 1.247 more disruptions than one who

Table 3
Placement disruptions and days in care by disability status.

	Mean	Std. Dev.	[95% Conf. Interval]	
Placement disruptions				
No disability	2.37	2.55	[2.36	2.37]
With disability	4.00	4.85	[3.98	4.03]
Days Spent in Foster Care				
No disability	514	578	[513	516]
With disability	915	947	[910	919]

Table 4
Predictors of child characteristics on number of placement disruptions (n = 670,097).

	b	[95% CI]		t
Constant	1.850	[1.836,	1.864]	252.47***
Foster Child with Disability	1.247	[1.212,	1.282]	69.97***
Age at Removal	0.069	[0.068,	0.071]	86.31***
Age at Removal × Disability	0.022	[0.018,	0.025]	12.54***
Black	0.332	[0.313,	0.352]	34.18***
Black × Disability	0.270	[0.230,	0.310]	13.31***
Am. Indian	0.248	[0.209,	0.288]	12.37***
Am. Indian × Disability	0.317	[0.229,	0.404]	7.06***
Asian	−0.179	[−0.256,	−0.101]	−4.50***
Asian × Disability	−0.666	[−0.835,	−0.496]	−7.69***
R^2				0.0628

*** $p < .001$.

does not. But a foster child who is Black and with a disability has an additional 0.270 disruptions—1.849 more than a foster child who is white without disabilities. Similar analysis on foster parent characteristics is reported in Table 5, showing that foster parent age is also a risk factor, while foster parents who are married or live in a different state than the biological family are protective factors. Again, these direct effects are significantly amplified when interacting with foster child disability. Of note, the R-squared value in both regressions is low, indicating considerable variance and modest explanation for the cause of disruptions among CDFC.

Discussion

This study adds to scientific knowledge by illustrating that CDFC do indeed have significantly higher placement disruptions. Placement stability appears to be one of the most important factors to improve outcomes for children in foster care, as it establishes a foothold in education and provides a consistent support figure (Gypen et al., 2017). As a CDFC is moved from home to home, or to a more restrictive and less ideal environments, such as group homes or institutions, they fall further behind as medical and educational services are fragmented. Each year, over 400,000 children find themselves in the United States foster care system (Children's Bureau, 2020). Expenses to care for these children is estimated to be roughly $15 billion annually (Font & Gershoff, 2020).

According to our findings, during 2017, 22% of children in foster care had diagnosed disabilities. In the broader United States population in 2017, only 0.4% of those under 5 years old and 7.3% of those ages 5–17 had *disabilities* (Kraus et al., 2018). These findings illustrate a disparity between the number of children in foster care who have disabilities compared to the general pediatric population. Disabilities may be a key driver in poor outcomes and the high costs to children and the system, particularly if these diagnoses are poorly understood and families are ill prepared. For example, negative externalizing behaviors exhibited by CDFC could be misinterpreted by caregivers as choices, when they are more directly a product of the underlying disability experienced by CDFC. This is problematic, because behavioral problems are a

Table 5
Predictors of foster parent characteristics on number of placement disruptions (n = 662,748).

	b	[95% CI]		t
Constant	3.056	[2.944,	3.167]	53.94***
Foster Child with Disability	0.994	[0.777,	1.210]	9.00***
Married Foster Parents	−0.296	[−0.313,	−0.278]	−33.02***
Married × Disability	−0.687	[−0.726,	−0.648]	−34.85***
Foster Parent Age	0.037	[0.036,	0.038]	84.66***
Age × Disability	0.030	[0.028,	0.032]	34.01***
Out-of-State	−0.931	[−0.985,	−0.878]	−34.06***
Out-of-State × Disability	−0.208	[−0.311,	−0.104]	−3.94***
R^2				0.0761

*** $p < .001$

strong predictor of poor placement stability (Konijn et al., 2019), and behavioral problems negatively affect integration into a foster family and adoption (permanency) (Leathers et al., 2012).

Predictive risk factors that increased the number of disruptions were similar for children without disabilities. However, these risk factors (such as child age, race, and foster parent age) had an even stronger effect on children with disabilities. Protective factors that might decrease the number of disruptions for CDFC are consistent with Meleis' and Schlossberg's theoretical concepts (such as resources and supports) which support healthy transitions (Winter, 2014). For example, a foster family with a married couple increases the potential for partner support. If a child has increased medical and emotional needs, the dual parenting and support they give to one another can act as a cushion protecting against parental burden. Designation as an out-of-state placement was a positive predictive factor for placement stability. The theoretical concept of network logically connects to why this factor is protective. A child is not typically moved out of state unless kinship (family) or an adoptive home is located (Sankaran, 2006). Moving out of state indicates the potential for permanency before the child is placed into the home.

Untangling the multifaceted correlations versus causes of health disparities in this population can be challenging. Health disparities are avoidable differences in health outcomes (higher burden of disease) experienced by socially disadvantaged populations (Centers for Disease Control and Prevention, 2013). CDFC have several factors which are associated an inequitable burden of disease that follows them into adulthood (Gypen et al., 2017). Children who require high levels of care, such as those with disabilities, might be more likely to enter the foster care system, but it is also possible that conditions such as drug abuse and neglect impacted development and caused higher levels of disability. Further investigation is warranted to determine these links and associations. These subtle interactions may also contribute to the low R-squared values and very modest explanation of the models for predictors of placement disruption. Interestingly, among children without a diagnosed disability that entered foster care in 2017, 4456 (or 0.7%) had disability listed as the initial removal reason. It is possible that children were removed due to a disability but did not have an official diagnosis, or this could be due to data error. A lack of official diagnosis can lead to an absence of needed support such as early intervention or special education programs through schools. These government funded programs require documentation of specific disabilities in order to qualify for support and interventions. It also may imply that the number of children with disabilities in foster care may be underreported or that parental/caseworker perceptions of disability status differ from the medical or legal diagnosis of disability. Furthermore, terminology used to report disability status within the foster care system is outdated and offensive. For example, the term "mentally retarded" is a specific term used within the data set. This term lacks a true medical diagnosis and further labels vulnerable children. Even the term "foster child" is still used within the literature. Reporting agencies should focus on revising data entry options to have medically accurate options for describing a child's unique needs. Focusing on person-first language as opposed to identity-first language reduces stigma and recognizes individuals first instead of disabilities (Flink, 2021).

Another area of inequality for CDFC might also be availability of kinship compared to those without a disability. This study found that CDFC are less likely to be placed with known family or kinship compared to children who enter the foster care system without a disability. This could be due to the complexity of care required, but may also be due to underreporting or lack of assessments for children in kinship care compared to youth in group or clinical settings. Current research indicates that foster children placed with kinship statistically have improved adult outcomes, such as increases in employment and education, with a reduction in homelessness, public assistance, and incarceration (Lovett & Xue, 2020). Yet, CDFC were more likely to be placed in restrictive settings such as group homes. It is possible that

given the disabled child's extra needs, caseworkers look for foster homes that have medical backgrounds or training compared to non-trained relatives. More research into the reason that CDFC are more likely to be placed in particular settings is needed.

Children with disabilities have higher vulnerabilities within foster care as demonstrated by their increased disruptions and length of stay in the system. CDFC require a higher level of care, for which few foster parents are trained or prepared (Vasileva & Petermann, 2018). Especially among children who have developmental disabilities, moving from home to home and, as a result, school to school can cause fragmented educational instruction (Mires et al., 2018). A stable family environment with members prepared to meet the diverse needs of children with disabilities may be key in promoting resiliency. Education of foster parents through the child welfare system is not consistent and may fall short when preparing families to care for children with special needs. Healthcare providers should participate in educating foster parents regarding typical responses to trauma and placement in foster care (Taussig et al., 2016). Professions such as nursing have unique skills and access to these families, and could be key in promoting stable families with skills and knowledge regarding care for children with developmental delays and/or disabilities.

Implications for nursing practice and future research

These results show that CDFC experience more disruptions than other children and spend significantly more time in the foster care system. The next steps will be to undertake studies that address the causes for placement disruption, create interventions to decrease disruption, and examine impacts on foster care length of stay. The potential impacts on patient outcomes from this research are multifaceted and profound. Being a child in foster care correlates with poor determinants of health. The combination of high adverse childhood experience (ACE) scores, the loss of family and continuity of care, and the lack of a consistent community or family place these children at great risk. With tailored interventions targeting known risk factors, the integrity of a placement may be strengthened, providing resiliency and support to the child. Improved health and wellbeing could impact health outcomes through adulthood. The financial and social impact are far reaching and illustrate the need for further research to investigate underlying causes, develop interventions, and produce improved outcomes for such a vulnerable population.

Nursing is uniquely positioned to influence and affect health outcomes for CDFC. Many state agencies employ nurses for intake assessments and insurance enrollment for foster children. The professional nursing scope and knowledge could greatly influence a family's ability to properly care for children at risk for poor health outcomes. Child welfare agencies should include nurses on placement committees and in educator roles during prelicensure training for foster parents. Child welfare nurses can monitor, influence, and promote training for families that focuses on the unique needs of children with disabilities. Nurses also are highly influential, through case management, in improving care for patients that need lifelong care (Joo & Liu, 2019). School nurses, if allowed greater coordination with the foster care team, can evaluate needs and connect families to education and healthcare resources within their community, particularly for families who are unfamiliar with accessing early intervention programs or individualized education plans that federal regulation provides for persons with disabilities (McClanahan & Weismuller, 2015; Pufpaff et al., 2015).

Future endeavors and research involving foster families would be strengthened and would benefit from incorporating a nursing perspective, particularly through strengthening theoretical concepts and assumptions distinct to foster families. The use of Schlossberg's Transition Theory and Meleis' Transition Theory was valuable because their concepts were consistent with variables for protective factors within this study (Meleis, 2010; Schlossberg, 1981). Research into why certain placement settings are chosen over others would prove valuable. Studies examining foster parents' perceptions, skills, and

support needs may promote family hardiness and decrease disruptions. Healthy foster families in turn could provide consistent, long-lasting support, thereby decreasing poor health outcomes for CDFC. By integrating strengths of the foster family into future studies, as opposed to the current literature which focuses on foster child risk factors, researchers and child advocates may find novel avenues to increase hardiness within the foster family unit. The risk-focused approach excludes potentially effective resiliency-based research designs.

Study strengths and limitations

This study involved secondary analysis of population-level data. While many foster care studies focus on individual regions or states, this study provides a more comprehensive view of CDFC across all regions of the United States. The study illustrates a disproportionate number of children with disabilities in foster care. It provides solid prevalence and incidence data, showing increased instability and disruptions for an already vulnerable population. The study also provides information on removal reasons associated with a child's disability. It also provides direction for potential interventions to strengthen both biological and foster families by shedding light on the reasons for removal.

While results provide valuable descriptive data on CDFC, several limitations of this study are noted. Limiting the analysis to 2017 provided a snapshot that could be compared to placement disruptions from other years. Spanning several years and following specific cases would provide a better understanding of the phenomena. Looking at the data from a longitudinal perspective or a several-year period is challenging because definitions of disability have changed greatly over the last decade, particularly relating to in-utero drug exposure which can lead to learning disabilities and mental health disorders (Ross et al., 2015). How states report disability status has also changed over time. Comparing case numbers and state reporting over time would be complex but, if feasible, would likely provide additional insight or reinforce the knowledge gained from this study.

Using administrative data to determine disability status is not without shortcomings. It is very possible that disability status is highly underreported due to lack of information given to state caseworkers and whether or not the state requires specific details in their reporting. Youth in institutional or congregate setting are more likely to be connected to assessment screenings. Kinship and in-home foster care may experience a longer lag in diagnosis or underdiagnosis. Yet, using large data sets such as the AFCARS does provide valuable information, shedding light on the issues even if the precise numerical extent of the problem is not currently available.

Additionally, transitions theory helped to guide the questions that were asked. Children and families involved in foster care go through numerous changes and choices lending to the appropriateness of the theory. However, the current theoretical basis does not distinguish between foster families and a typical family unit. The complex adaptive systems (the child, the governmental systems, and the multiple family systems) interact with and influence the foster placement substantially. Research designs investigating interventions to decrease disruptions may need a more specific and robust theoretically-informed design to factor in unique characteristics of foster care. For example, in a foster home, a child may gain and lose a sibling several times during a year, causing an experience of loss and grief on a much more frequent scale than a child in a typical home. Such a design might potentially include a mix of concepts gleaned from family systems theory, complex systems theory, and transition theory built together to better guide studies unique to the fostering experience.

Conclusion

This study contributes to our knowledge regarding CDFC: the prevalence of CDFC was described, the number of disruptions analyzed, and the length of time spent in foster care for children with disabilities was

compared to their non-disabled peers. Demographics of children in foster care, reasons for removal, and foster family structure were statistically analyzed. This study informs scholars, policymakers, concerned citizens, advocates, and professional practitioners by assessing the disparities in outcomes for CDFC. By integrating this information into practice, school nurses, public health nurses, social workers, and other providers better position themselves to assist families. Researchers should consider the complexities involved in caring for a child with disabilities and test interventions to decrease disruptions, thereby helping families provide stable environments for CDFC. Future explorations into reasons for removal could inform design of interventions to strengthen the stability of placements and foster family systems to optimize health for CDFC.

Author information

1. Christine Platt, FNP-c, MSN, Sigma Theta Iota Iota Chapter
2. Sheila Gephart, PhD, RN, FWAN, FAAN, Associate Professor, Sigma Theta Beta Mu Chapter

CRediT authorship contribution statement

Christine Platt: Conceptualization, Methodology, Validation, Formal analysis, Investigation, Data curation, Writing – original draft. **Sheila M. Gephart:** Writing – review & editing, Supervision.

Declaration of Competing Interest

Acknowledgments

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.pedn.2022.05.004.

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