Foster Care of HIV-Positive Children in the United States

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Synopsis

A national study regarding the foster care of children identified as human immunodeficiency virus-positive (HIV-positive) was conducted in 1991. A survey form was sent to the administrators of the State agency responsible for foster care in each State, the District of Columbia, and U.S. Territories for a total sample size of 55. After followup, all 55 responded for a response rate of 100 percent. The number of children in foster care was ascertained for the current year and cumulatively.

In 1991, 1,149 HIV-positive children were reported to be in foster care. Most States (49) had a general foster care policy and 21 had specific policies regarding care of a foster child who is HIV-positive.

Measures and criteria used for recruitment were examined. In regard to recruitment policies, only seven States mandated recruitment of families specifically for children with HIV and acquired immunodeficiency syndrome. The major topics covered in training for HIV foster families included confidentiality, behavioral management, working with natural families, emotional factors, separation and loss, and others.

Other issues discussed are foster parent training, supplemental services, later adoption possibilities, payments, and the expressed fears and doubts of foster parents caring for HIV-positive children. It is recommended that a national conference address the issues.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) infection and acquired immunodeficiency syndrome (AIDS) in children result in both medical and social problems that cannot be overlooked. As of September 30, 1993, 4,906 cases of AIDS in children younger than 13 years had been reported to the Centers for Disease Control and Prevention (CDC) (*1*). In the United States alone, it has been conservatively estimated that 10,000 to 20,000 children are already infected with HIV (*2,3*).

Although reporting is inaccurate in some countries, the World Health Organization has estimated that there are at least 500,000 cases of pediatric AIDS worldwide (*4*). These statistics mean that HIV disease has the potential to become the leading pediatric infectious cause of neurological and developmental handicaps, as well as a leading cause of death in children younger than 5 years; in some geographic locales, it already is (*5*). Further, the majority of reported cases have occurred in socioeconomically deprived populations who are already struggling against disadvantages and even day-to-day survival (*6*).

CDC classifies cases of pediatric AIDS into hierarchical exposure categories. These are (*a*) hemophilia or coagulation disorder (4 percent); (*b*) mother with or at risk for HIV infection (88 percent); (*c*) recipient of blood transfusion, blood components, or tissue (7 percent); and (*d*) risk not identified (1 percent) (*1*).

The vast majority of cases of pediatric HIV disease result from vertical transmission of the virus (*1*). Thus, each perinatally HIV-infected child represents both a HIV-infected mother and an affected family. The mother may not be able to care for her child, either because of the physical effects of HIV or for other reasons. Thus, the foster care system has, within a relatively short period, had to assume care and placement for some of these children in either kinship or nonkinship foster family situations.

The overall purpose of this research was to

ascertain specific policies, procedures, practices, and problems surrounding foster care placement for children with HIV infection or AIDS within each State, Washington, DC, and the U.S. Territories. Some specific questions were

1. How many HIV-positive children in each State are in foster care?
2. What are the specific policies regarding placement of probable HIV-infected infants and children?
3. How are foster parents recruited to care for potentially or actually HIV-infected children?
4. What type of special training (if any) is given to foster parents with whom HIV-positive children are placed?
5. Are there special support services available to foster parents of HIV-positive children?
6. What doubts or fears do foster parents express about caring for children who are HIV-positive?

Review of the Literature

It is estimated that about 20 to 30 percent of infants born to HIV-infected mothers are themselves infected with HIV. The presence of transplacentally acquired maternal antibodies that can persist as long as 15 months meant that, until very recently, the establishment of an accurate HIV diagnosis in infants born to HIV-infected women was not possible at birth or in early infancy; all of these infants tested HIV-positive at birth whether or not they were truly HIV-infected (*7,8*). Newer techniques such as polymerase chain reaction, viral culture, immune-complex-dissociated HIV antigen, and others have more recently made earlier diagnosis possible, even in the absence of clinical evidence, with the eventual goal being the identification of HIV-infected infants at birth (*9*).

In addition to conditions such as diarrhea, otitis media, fever, and failure to thrive, neurological conditions are prominent in infants with HIV infection. Neurological findings can include failure to attain new developmental milestones, chronic encephalopathies, seizure disorders, progressive motor delays, ataxia, spasticity, paralysis, microcephaly, and abnormal CT scans (*10*). Psychosocial and emotional concerns and problems add to the complex health situation.

In a 1992 study, Leeds found that among 148 children born HIV-positive and placed in foster care from a New York agency, 99 percent had mothers who were drug users. Half of these children had low birth weight (one-tenth of these had very low birth weight), were shorter, weighed less than their same-age peers, and 20 percent had head circumferences in the lower 5 percent. Moreover, of the children who remained HIV-positive, 60 percent had neurological deficits, and 80 percent were developmentally delayed. Of those children who later tested HIV-negative, 30 percent had neurological impairments, and 55 percent were developmentally delayed. Last, 75 percent of all the children in foster care had experienced frequent bouts of diarrhea or persistent respiratory infections often clinically present with HIV infection (*11*).

The concept of foster parenting was informally practiced prior to 1909, but as a result of the White House Conference on Children in that year, the principles of placing a child in another setting if the parents were unable to care for the child and consequent reunification with the parents were discussed and adopted (*12*). A formal law concerning foster care and financial aid to both widows and widowers was developed in 1935 with the advent of Title IV-A, "Aid to Dependent Children," under the Social Security Act. This title was later changed to "Aid to Families with Dependent Children." Under this legislation, the Federal Government matches funds with States for maintenance payments for care of eligible children (*13*), although until 1968, foster children were the responsibility of State and local municipalities (personal communication, W. F. Horn, Commissioner, Administration on Children, Youth and Families, August 1992). Over the years, children who might have once been placed in orphanages were placed in foster care (*14*).

The Office of Civil Rights sets requirements for foster care to which States must comply (personal communication, W.F. Horn, Commissioner, Administration on Children, Youth and Families, August 1992). In 1980, Congress passed the Adoption Assistance and Child Welfare Act (Public Law 96-272) which was designed to prevent "lost" children; it is administered by the Children's Bureau. Title IV-E of this act provides for out-of-home placement or foster care. In contrast, Title IV-B of the act provides for family support, prevention, and reunification of natural families.

The total number of children placed in State foster care homes as of September 1991 was 429,000 (personal communication, W.F. Horn, Commissioner, Administration on Children, Youth and Families, August 1992). In 1985, 43,412 (16 percent of the total number in that year) of the children in foster care were designated as handi-

'The current number of children born to HIV-positive mothers placed in foster care in 1991, as reported by respondents to this survey, was 1,149, of which 857 (74.7 percent) were from the top 10 AIDS high prevalence States.'

capped (*15,16*). The numbers of children with complex medical needs, including HIV infection or AIDS, needing foster care placement are growing. Other children are being placed in foster care as a result of poverty, drugs, sexual and physical abuse, and teenage pregnancy (*17*).

HIV-infected children in the following situations are most often placed in foster care: (*a*) HIV-positive infants given up to foster care shortly after birth; (*b*) children already placed within the foster care system who are diagnosed as HIV-infected; (*c*) HIV-infected children who can no longer be cared for by their natural family; and (*d*) children who may or may not be HIV-infected who need placement after their parent(s) becomes too ill to care for them or dies of AIDS. This final group is the fastest growing one in the United States (*18*).

Longer survival rates for HIV-infected children will also impact upon the foster care system. Palacio and Weedy (*19*) emphasized that "the difficulty in providing HIV foster care is hardest felt in rural areas where the number of potential foster families and financial resources are lowest. In addition, children with HIV compete for these low resources with other foster children who have specialized needs" (*19a*). Michaels and Levine estimate that, by the year 2000, 82,000 children will survive their parent's deaths due to AIDS (*20*). Therefore, managers of the foster care system, at both the Federal and State level, will need to examine the number of foster families and services available and make needed changes (*21*).

Method

A survey form was sent to the administrators of each State agency responsible for foster care. They were asked to respond to questions regarding the numbers of children in foster care, presence or development of State HIV foster care policies, licensure, recruitment, training, payments, supplemental services, HIV testing policies, adoption, problem areas, and others. Responses to each of these areas follow.

Instrument. A questionnaire was developed based on items in the literature. After it was examined by experts both in HIV infection and in social welfare systems for relevance and importance, it was revised. The final version was pilot-tested and again revised. Thus, content validity was implied. The final questionnaire was composed of 48 multiple choice and open-ended questions.

Sample and procedure. The agency handling the foster care program for each State or Territory was identified through "The Public Welfare Directory 1989/1990" (*22*). The survey form was mailed to the agency administrators in January 1991. A second mailing was completed 2 months later, and any unreturned questionnaires were followed with a phone call, resulting in a response rate of 100 percent.

Data collection took place over 9 months and ended in September 1991. The total sample size was 55, which included all 50 States, Washington, DC, Puerto Rico, American Samoa, U.S. Virgin Islands, and Guam and are hereafter referred to as "the States."

Results

State policies. Respondents to this survey were asked to indicate whether they had a general foster care policy. Forty-nine (89.1 percent) indicated that they did have a general policy. States without a separate policy might have one that is subsumed under a broader policy affecting the care and treatment of children in general.

Twenty-one States (38.2 percent) responded that they did have specific foster care policies regarding the care of children with HIV-AIDS. The content of these policies varied. Other States indicated that their foster care policies regarding children with HIV infection or AIDS were either under development or included under a broader policy.

The States were also asked to indicate what issues were important in the development of their HIV-AIDS policies. In descending order of frequency, these issues were confidentiality, HIV testing, care of the child in the least restricted environment, training of providers and foster families, day care and school issues, up-to-date medical information, transmission risks, planning for permanent placement, special services, use of universal precautions, identification of high-risk behaviors by infected children, HIV seroconversion in infants, standards of practice, legal issues, adolescent issues, psychological needs of the child or foster

family, and prevalence of pediatric AIDS cases in individual States.

Besides a general policy on HIV foster care, States were asked if they had other specific HIV-related policies. The table that follows indicates the percent of responding States with these specific policies:

Policies of 55 States and Territories	*Percent*
Confidentiality	63.6
HIV testing	63.6
Sex education for adolescents	34.5
Natural child younger than 5 years	27.3
Seroconversion	18.2
Drug research	18.2
HIV research	14.5

There were differences in how the States categorized HIV-positive children who were in foster care (table 1). The States were then asked to indicate the number of children born to HIV-positive mothers placed in foster care by specified age groups. The specific breakdowns of current (1991) and cumulative numbers through 1991 for each State are given in table 2. In 1991, 1,149 children born to HIV-positive mothers were reported to be placed in foster care. The majority (74.7 percent) of this number came from the top 10 AIDS prevalence States. Seventeen (30.9 percent) States reported that they had yet to place a child at risk for HIV infection in foster care. The States that did not offer estimates of the number of HIV-positive children placed in foster care either kept local (by county or municipality) data, or they were not able to provide statewide data for other reasons.

In July 1993, a telephone survey of some of the States was done to update the table 2 information. For current placement of HIV-positive children the results were Illinois, 144; Maryland, approximately 200; Massachusetts, 147; New York, 620; Rhode Island, 8. For cumulative placement the results were Illinois, 317; Maryland, unknown; Massachusetts, 147; New York, 1,333; and Rhode Island, approximately 40.

Licensure of foster parents. In most States, persons wishing to become foster parents must be licensed. In this study, 49 (89.1 percent) States indicated that they required licensure for general foster parents. A specific foster parent license for children with special needs, including HIV infection, was required in 46 (83.6 percent) States. The length of time required for licensure to become final, as expected, varied among States. The median period was reported to be 3 months for categories of both general and HIV foster care (range = 1 to 12 months, standard error = .298).

Table 1. Categorization of HIV-positive children or children with AIDS in foster care in 38 States, 1991

Category	*Number*	*Percent*
General foster care	19	50.0
Medical foster care	7	18.4
Special needs or foster care of medically fragile children	6	15.8
HIV children's foster care	4	10.5
Specialized or therapeutic foster care	2	5.3

Some States indicated that they did not recognize different categories of care or did not respond because they have never had a child with HIV in foster care. Respondents for others wrote that licensure requirements differed for foster parents of children with HIV infection due to (*a*) the need for additional foster parent training, (*b*) the need to cover more death and dying issues in training, (*c*) the limitations in numbers of special needs children allowed to be placed in a single home, and (*d*) the willingness to take a HIV-infected child.

Recruitment of foster families. States were asked about recruitment for both general and HIV foster families. For general foster families, 22 (40 percent) of the States indicated that recruitment in general was mandated by State policy, whereas only 7 States (12.7 percent) mandated recruitment for HIV foster families.

States were asked if they provided active recruitment measures in the form of incentives, such as monetary payments, transportation, services, and counseling for foster families. Forty-three States (78.2 percent) reported such incentives. On the other hand, only 13 States (23.6 percent) offered specific recruitment measures for foster families caring for children with HIV or AIDS.

States reported various means of recruitment for HIV-related foster care. More than 50 percent used the following means: personal contact with foster care families, the pool of licensed foster care families, community presentations, the media, and personal contact with professional staff to recruit potential foster families.

Individual personal characteristics, experiences, and knowledge were also considered in recruitment. Criteria specified by States that were used in HIV foster parent selection included medical skills or training, a willingness to accept the diagnosis, character, nondiscriminatory attitudes, a willingness to take additional training, knowledge of HIV and AIDS, stability, time, a survivor of a loss,

Table 2. Frequencies of current and cumulative placements of HIV-positive children in foster care in the United States

Place	Current (1991)	Place	Cumulative through 1991
New York	494	New York	614
New Jersey	115	Massachusetts	130
Massachusetts	94	Illinois	125
Rhode Island	90	Rhode Island	120
Illinois	66	Maryland	66
Maryland	66	Puerto Rico	41
Puerto Rico	41	South Carolina	36
Georgia	31	Georgia	31
South Carolina	28	Michigan	24
Michigan	20	North Carolina	24
North Carolina	16	Ohio	14
Texas	16	Washington, DC	12
Washington, DC	12	Wisconsin	10
Ohio	10	Colorado	9
Colorado	9	Nevada	7
Wisconsin	8	Delaware	6
Nevada	7	Tennesse	5
Washington	5	Washington	5
Louisiana	4	Louisiana	4
Tennessee	4	Utah	4
Kentucky	3	Arizona	3
Arizona	2	Nebraska	3
Hawaii	2	Kentucky	3
Nebraska	2	New Hampshire	2
Alabama	1	Hawaii	2
Delaware	1	West Virginia	2
Indiana	1	Alabama	1
New Hampshire	1	Arkansas	1
Alaska	0	Indiana	1
American Samoa	0	Alaska	0
Arkansas	0	American Samoa	0
Guam	0	Guam	0
Idaho	0	Idaho	0
Iowa	0	Iowa	0
Kansas	0	Kansas	0
Maine	0	Maine	0
Mississippi	0	Mississippi	0
Montana	0	Montana	0
New Mexico	0	New Mexico	0
Oklahoma	0	Oklahoma	0
South Dakota	0	South Dakota	0
Utah	0	Vermont	0
Vermont	0	Virgin Islands	0
Virgin Islands	0	Wyoming	0
Wyoming	0		
Total[1]	1,149	Total[2]	1,305

[1] Unknown—California, Connecticut, Florida, Minnesota, Missouri, North Dakota, Oregon, Pennsylvania, Virginia, West Virginia.
[2] Unknown—California, Connecticut, Florida, Minnesota, Missouri, New Jersey, North Dakota, Oregon, Pennsylvania, Texas, Virginia.

willing to support reunification with the child's family, and a willingness to adopt long-term foster children.

Since it is known that a majority of pediatric HIV-AIDS cases occur in children who are members of minority groups, questions were asked regarding special placements. Greater than 85 percent of the States responded that they attempted to make social (90.9 percent) or ethnic (87.3 percent) matches. Also, placement with relatives (kinship foster care) was attempted most of the time (81.8 percent) and, when possible, the relatives usually received the same supports as other foster families (76.4 percent).

Training and education of foster parents. Forty States (72.7 percent) stated that they directly provided education and training to all of their foster parents. Twenty-nine States provided specific training in regard to HIV infection to the foster parents in their State caring for a child who was HIV-positive. In 20 States not providing training, the State agency contracted with local agencies, county departments, universities, State foster parent associations, hospitals, and home finding units. To train foster parents to care for children with HIV infection, 28 States (50.9 percent) contracted for these services outside of the State agency with medical and community experts, private agencies, community health agencies-departments, county departments, area AIDS programs, special HIV training packages, hospitals, universities, and the American Red Cross. Registered nurses and social workers predominated as the directors of such training efforts.

For this study, States were asked to indicate whether specific topics were covered in training. The top 10 topics covered in approximately 75 percent of the States included confidentiality, behavior management, working with the natural family, emotional factors, separation and loss, legal and policy issues, community resources, agency forms, transmission of HIV, and how to handle questions from family and friends.

Foster care payments. The 55 States indicated that general foster care payments ranged from $100 to $1,800 per month. For 46 States, HIV foster care payments ranged from $182 to $2,709 per month. State payments differed in monetary amount, amount and type of supplemental services, and in the complexity or level of care recompensed depending on the child's age and needs for the foster care of children infected with HIV. Some States determined payments on a case-by-case basis. Others did not distinguish payments by health status, age, or care categories thereby maintaining one payment. A step structure for HIV monthly foster care payments existed in 20 States (36.4 percent). Of these, only 6 States (10.9 percent) reported that they used the CDC classification system as a basis for determining payment. Others set a rate based upon the "difficulty of care."

Supplemental services. Forty-six States (83.6 percent) use or have supplemental services for foster families caring for children with HIV or AIDS. Those mentioned most often by the States were special medical services (including Special Supplemental Food Program for Women, Infants, and Children [WIC], medical supplies and equipment, and home health aides), counseling services (for both the child and foster families), supplemental payments (including health insurance and financial aid), transportation, and emotional needs. Of those States not responding, the majority had no reported cases of pediatric HIV-AIDS.

Adoption. In 49 States, foster parents could later adopt their foster child with HIV-AIDS. One State agency reported getting many calls from couples inquiring about adoption of children with HIV-AIDS because they were unable to have their own children. Forty-eight States (87.3 percent) explained that a subsidy for adoption was also available. Under Title IV-E, Adoptive Assistance, both monetary assistance and Medicaid was available. Other subsidies depended on the child's needs and included additional monies or services. Some States indicated that they provided the same monetary assistance that was received as the foster care rate.

Fears and disruptions. Caring for a child with HIV infection in a foster home requires great thought and consideration on the part of potential foster parents. States were asked to document the greatest expressed fears and doubts experienced by current foster parents of children with HIV-AIDS, and their responses are shown in descending order of frequency in the box. Thirteen States (34.2 percent) noted that they had had disruptions in placing children with HIV and AIDS in foster care. The disruptions reported included hard-to-manage behaviors, personal problems in the foster family, rejection of the foster child with HIV-seropositivity by other natural family members (that is, older natural siblings), and disclosure that the foster child was HIV-positive.

Greatest Expressed Fears and Doubts of Foster Parents of Children with HIV Infection or AIDS in 38 States (in Descending Order of Frequency)

Fear of infection or transmission
Child dying while in care (fear of being blamed for death)
Stigma, community opinion, or discrimination
Day care, school issues
Grief
Universal precautions
Dealing with natural family (especially those who are HIV-positive)
HIV testing availability and results
Medical crises
Child's presenting issues
Child returning to natural family
Availability of support services
Intrastate foster care (specifically, eastern States and California)
Special care required
Fear agency will not inform of HIV status
Inadequate reimbursement

Discussion and Conclusions

Foster care, in general and specifically, in regard to children with HIV disease varies greatly by State. Differences exist in areas of licensure, recruitment, training, supplemental services, and payments. The numbers and type of children being placed in foster care varies by State and, therefore, may dictate how foster care is carried out by that State. For example, those States reporting more cases of AIDS appeared to have a more organized system for the foster care of children with HIV disease than those with fewer cases.

It is clear that the majority of States have addressed the issue of children with HIV or AIDS in their foster care systems, as evidenced by the growing number of specific State policies. Not surprisingly, most States developed their policies and procedures after a child with HIV was presented for placement in foster care. As a representative of one State reported, "The first time this came up, we were not prepared; we had no policies or resources ready."

It is, therefore, the potential increase in the number of HIV-infected and affected children in need of foster care at present or in the near future that must receive our attention. The number of children born to HIV-positive mothers placed in foster care in 1991, as reported by respondents to this survey, was 1,149; of these 857 (74.7 percent) were from the top 10 AIDS high prevalence States. Although they used a different methodology, in 1989, Baughman and coworkers (*23*) reported an estimated cumulative number of 1,004 HIV-seropositive children in foster care in the United States, Washington, DC, and Puerto Rico.

While our study examined only the foster care placement of HIV-positive children, Michaels and

Levine (*20*) estimated the number of youths (regardless of HIV status) who would be motherless because of the mother's dying from HIV infection. These children and adolescents are predicted to need an array of services, which may include kinship and nonkinship foster care (*20*). Also, of importance is the number of uninfected siblings in foster care. Current policies and procedures by State, county, or local agencies do not account for these children when addressing the true impact of HIV. When foster care placement for both HIV-infected and uninfected siblings is contemplated, many complexities may arise, particularly in regard to keeping them together.

At present, licensure for foster parents caring for children with HIV requires additional training and incentives in the majority of States. The length of time for potential foster parents to become licensed is relatively short and can be shortened in individual cases. As knowledge about pediatric HIV disease becomes more widespread, more comprehensive licensing standards should be written.

Both individuals and representatives from agencies have written about the importance of recruitment and various recruiting strategies. Gurdin (*24*) described recruitment measures and the qualifications that appropriate foster parents need to care for HIV-infected children. She lists word of mouth, community presentations, health professionals, network of AIDS groups, media, incentives (both monetary and supplemental services), and other foster parents as successful sources for recruitment.

Specific qualifications mentioned include (*a*) no natural children in the foster home younger than 6 years, (*b*) belief that casual contact will not cause infection, (*c*) an understanding of the disease process, (*d*) a support system with someone at home at all times, (*e*) the ability to care for the foster child, and (*f*) some medical knowledge and the ability to respond to an emergency (*24*). South Florida's AIDS Network also described a similar approach to recruitment specifically appointing an AIDS task force for recruitment (*25*). Specific recruitment measures were available in most States that had identified cases of children with HIV and AIDS.

In 1987 the Child Welfare League of America's Task Force on Children and HIV Infection recommended a range of subjects for foster parents' education surrounding medical, psychosocial, and practice issues. Medical issues should cover basic information on infectious diseases, specific information on HIV-AIDS, and infection control procedures. Psychosocial issues should include death and dying and grief, quality of life and self-esteem, emotional responses, ethnic and cultural concerns, drug and alcohol addictions, types of crises experienced by HIV-AIDS patients, and social networking. Furthermore, practice issues should highlight confidentiality, care, HIV testing, epidemiology of HIV, child development, and attitudes. Finally, HIV-AIDS training should be integrated into the general training of foster parents, taught alone or provided through tutorials completed on an individual basis or through support networks (*26*).

Few well-developed or standardized specific curriculums for the training or education of foster parents caring for HIV children appeared to exist at the time of this study. The depth of the specific HIV training also appeared to depend on the State's pediatric AIDS prevalence rate and categorizations of HIV infection (that is, by itself or subsumed under, for example, infectious diseases or medically fragile children). New Jersey and New York, both high AIDS prevalence States, as well as other States, have developed curriculums which could and should be shared nationwide because of their comprehensiveness.

Foster care payments, either for general foster care or HIV-AIDS foster care, will continue to vary among the States. It is important to understand how these rates are determined for each State, taking into account the monetary payments and supplemental services.

Pressma and Emery (*27*) stressed that hospice, homemakers, support groups, respite care, group homes, transportation, housing, dental care, and prevention education were necessary supplemental services. Oleske (*28*) emphasized that respite services were most important. Regardless, States must provide supplemental services, and these services must be available and provided either by a diagnostic or need basis. States' agencies indicated that they did not provide supplemental services because of the few children with HIV in their care, inadequate funds, lack of policies or rules, using need rather than illness criteria, and the inadequacy of services available in specific geographic areas.

The results of this study suggest that the need for an organized State tracking system for these children is imperative, although maintaining confidentiality is an issue. In addition to numbers by age, children with HIV infection should be counted by type of placement (for example, foster home, group home, shelter, transitional setting, and residential facility). Uninfected siblings in foster care must also be accounted for and given appropriate emotional and physical supports.

A national conference to discuss issues and share materials developed for training, recruitment, and licensing would be useful. Such written material could also be shared at regional and national meetings of specific disciplines (that is, medicine, nursing, social work) which interact with foster children. Pediatric HIV infection and AIDS unfortunately continue to carry a stigma with the diagnosis. This stigma may extend to the foster family if the child's diagnosis is known to others outside the family. It must always be remembered that each child presented for foster care placement deserves the same dignity, care, and services that would be available for any other foster child, regardless of the child's special needs.

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