

A GROUNDED THEORY STUDY OF THE PERCEPTIONS  
OF CASEWORKERS AND FOSTER PARENTS  
REGARDING THE HEALTH CARE  
OF CHILDREN IN FOSTER CARE

by

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## ABSTRACT

Children in foster care have more health problems and more health care service needs than similar children in the general population. In addition, children in foster care often have a lack of continuity in care. This study aims to identify the perspectives of foster parents and social workers as they relate to the health care of children in foster care. Using a grounded theory method, interviews were conducted of eight foster parents and four social workers regarding who they perceive to be responsible for the health of children in foster care. The interviews were recorded and transcribed. The transcriptions were then coded using NVivo. The two main themes that emerged were communication and expectations. These themes were used to create the emerging theory of the interwoven set of conditions that occurs for foster parents and social workers to determine who is responsible for the health of children in foster care.

## DEDICATION

This dissertation is dedicated to my family, who has always believed in me even when I didn't believe in myself, to my friends who have encouraged me throughout this process, to my colleagues who continued to remind me of the importance of this work, and to all of my former foster children who inspired me to make things better for them.

## LIST OF ABBREVIATIONS AND SYMBOLS

|       |   |
|-------|---|
| DHR   | Department of Human Resources                           |
| EPSDT | Early and Periodic, Screening, Diagnosis, and Treatment |
| ISP   | Individualized Service Plan                             |

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## CHAPTER I

### INTRODUCTION

#### **Overview of the Study**

This dissertation addresses the challenge of ensuring adequate and appropriate health care for children in foster care. The topic is motivated, in part, by my own experiences as a foster care caseworker. The study investigates whether difficulties in assuring adequate health care for children in foster care reflect a problem of diffusion of responsibility among foster care caseworkers and foster parents. The following is a qualitative study that takes a grounded theory approach and involves interviews with foster care caseworkers and foster parents.

#### **Overview of the Organization of the Study**

This study is arranged into the following sections: literature review, research questions and rationale, methods, results, discussion, implications, and conclusion. These sections together provide an overview of the research that has been conducted on this topic; explain the research questions and the reasoning behind the questions; identify the methods that are being proposed to answer the research questions; explain the results of the interviews; and provide information about how the results can be used in the future.

#### **Motivation for the Study**

As a former foster care social worker, I often encountered situations where ambiguities in roles and responsibilities regarding health care for children in foster care negatively influenced the well-being of the children on my caseload. For example, an infant was not taken to the doctor over the weekend, even though having a high fever, because the foster parent perceived

that it was my responsibility as the social worker to take the child to medical appointments. In another case, a child was taken to see a doctor over a weekend, but, due to paperwork issues, the foster parents were personally billed an extreme amount. This paperwork issue could have been prevented if an agency social worker had been present to complete the paperwork. In both instances, misunderstandings about health-care-related roles and responsibilities of social workers and foster parents influenced the well-being of the child.

However, my personal experiences offer only a small glimpse into the larger issue that is the health of children in foster care. According to the American Academy of Pediatrics (2014), about half of children in foster care have a chronic health problem, such as asthma, vision loss, hearing loss, or neurological disorders. Children in foster care are also at an increased risk for negative psychological, neurobiological, and behavioral outcomes (Leve et al., 2012).

### **Primary Background**

When comparing children in foster care to children in the general population, children in foster care are less likely to be up-to-date on immunizations (Schneiderman & Villagrana, 2010); more likely to be in poor health (Ziol-Guest & Dunifon, 2014.); seven times as likely to have depression; six times as likely to have behavioral problems; five times as likely to have anxiety; three times as likely to have ADD/ADHD, and hearing and vision problems; and twice as likely to have learning disabilities, developmental delays, asthma, obesity, and speech problems (Turney & Wildeman, 2016).

These issues occur even though children in foster care most likely have public health insurance, such as Medicaid (Allen & Hendricks, 2013; Ziol-Guest & Dunifon, 2014), and receive Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings more frequently than other children who have Medicaid insurance (Landers et al., 2013).

Health care follow up can also be a challenge for children in foster care. There is often a need for social workers and foster parents to continue to provide services, even after initial health care appointments. For example, Scozzaro and Janikowski (2015) found that almost half of their sample of children in foster care reported taking medication, and these medications often required follow-up appointments and monitoring. Also, services beyond initial appointments might be needed due to health-compromising and health-risk behaviors that are more likely in children in foster care (Farruggia & Sorkin, 2009; Gramkowski et al., 2009).

There are many things to consider when addressing a problem as widespread and multi-layered as the health of children in foster care. Through this study I investigated perceptions related to sense of responsibility and diffusion of responsibility in order to illuminate a specific aspect of the issue and to generate new knowledge that can be used for future research and policy formation. A grounded theory approach is most appropriate for this study because grounded theory research focuses on “interaction, action, and processes” (Savin-Badin & Major, 2013, p. 183). Through this study we are able to investigate the perspectives of foster parents and social workers in order to gain understanding and to develop a theory related to their interactions and decision-making process as it relates to the sense of responsibility for the health of children in foster care.

## CHAPTER II

### LITERATURE REVIEW

#### **Organization of this Chapter**

This chapter is arranged into the following sections: importance of health care for children in foster care; diffusion of responsibility theory; roles and role confusion in health care for children in foster care; delivery of mental health services to children in foster care; and knowledge gaps and purpose of study. The chapter will begin with a discussion of the importance of health care for children in foster care in order to identify why this topic is important and why it should be studied. Next, this chapter will identify the various theories that were considered when developing the study and research questions, as well as why certain theories were rejected in favor of the diffusion of responsibility theory. Then, this chapter will discuss the diffusion of responsibility theory. This theory will be explained and placed into context for how it relates to and can be used to study the topic of health care for children in foster care. The topic of roles and role confusion in health care for children in foster care will then be discussed. This section will take information from the previous two sections and explain how they relate to each other and to the overall research topic. Lastly, I will identify the knowledge gaps in the current literature and explain how this study aims to fill some of the current gaps in knowledge.

## **Importance of Health Care for Children in Foster Care**

Access to pediatric health services is vital for children in foster care, as they are considered a vulnerable group, and as they have been found to have more health problems than similar children, especially existing problems and risk factors, such as premature birth, chronic health conditions, and hospitalizations (Hansen et al., 2004). Children in foster care also have more health care service needs than children in the general population, and children in foster care often have a lack of continuity of care (Deutsch & Fortin, 2015; DiGiuseppe & Christakis, 2003). Also, children in foster care are more likely than children who are involved in child welfare but stayed at home with their parents to have complex physical, developmental, and behavioral issues, and they are less likely to be vaccinated (Rienks et al., 2017; Schneiderman et al., 2010). Of the children who are placed into foster care, 32% have a diagnosed medical need, and the longer a child is in foster care, the more likely the child is to have a medical need (Sullivan & van Zyl, 2008). Compared to children who are not in foster care, children in foster care are more likely to be in fair or poor health, and this is true compared to children in various family situations in economically disadvantaged families (Turney & Wildeman, 2016; Ziol-Guest & Dunifon, 2014).

The health of foster children is also important because of the concerns for adolescents in foster care and adults who age out of the foster care system (Farruggia & Sorkin, 2009; Viner & Taylor, 2005). Studies have determined that adolescents who are in foster care or have previously spent time in foster care are more likely to report high levels of health-related problems and participate in health-compromising behaviors (Farruggia & Sorkin, 2009). Youth in foster care are more likely to participate in health risk behaviors when placed in non-relative foster homes than if they are placed with relatives (Gramkowski et al., 2009), and children

placed in foster care are less likely to have continuity of their health care services (DiGiuseppe, & Christakis, 2003). Rubin et al. (2004) found that as the number of foster care placements increased, the number of emergency department visits increased. The number of emergency department visits is important because an increase in emergency department visits is associated with incomplete well-child care, underimmunization, and lack of continuity of care (Rubin et al., 2004).

Adolescents in foster care are also more likely to have health and psychological problems that continue into adulthood (Viner & Taylor, 2005). Adults are twice as likely to receive Social Security Disability Insurance for mental or physical problems that prevent them from working if they have spent time in foster care (Zlotnik et al, 2015). These studies identify that health access for foster children is important because health issues can continue to be present even after a child has become an adult.

Concern about health problems of children in foster care led the American Academy of Pediatrics (AAP) to consider foster care as one of its top priority areas in 2006 (American Academy of Pediatrics, 2015). By establishing foster children as a top priority, the AAP developed a task force that had the goals of increasing awareness about the health concerns of children, as well as providing information to health care providers and others who are involved in the care of foster children (American Academy of Pediatrics, 2015). However, even with implementation of such initiatives, and even with policies such as the 2009 Children's Health Insurance Program Reauthorization Act, the 2010 Patient Protection and Affordable Care Act (ACA), the 2008 Mental Health Parity and Addiction Equity Act, and the 2008 Fostering Connections to Success and Increasing Adoptions Act (Fostering Connections) at the federal

level, there is still a need for state- and local-level implementation and policy development to address the specific health needs of children in foster care (Zlotnik et al., 2015).

However, it should also be noted that addressing concerns for the health of children in foster care can improve outcomes. According to Jaudes and colleagues, “children and adolescents in child welfare with a quality health care system improve not only their health, but also in additional domains of wellbeing” (2016, p. 281). Also, policies that are put in place to require health checks upon placement into foster care are associated with significantly greater Early and Periodic Screening, Testing, and Diagnostic (EPSDT) screenings for children in foster care when compared to other children who receive Medicaid (Landers et al., 2013).

### **Theories Considered**

In qualitative research, there is some concern in using theories to develop the research. Padgett (2008) identifies that qualitative studies do not take place in a “conceptual vacuum” (p. 11). Instead, we must consider theories in order to help frame the research. These types of theories can inform the research and provide a way to organize the research without predicting the results of the research. For this study, I considered several possible theories before focusing on the Diffusion of Responsibility theory that informs the research approach. Each of the theories identified in this section helped me develop my research ideas and thoughts in order to create the current study.

### **Model of Health Access**

Aday and Andersen's (1974) model of health access uses predisposing factors, enabling factors, and need factors to determine a person's individual characteristics that affect that person's access to health services. In Aday and Andersen's (1974) model, the predisposing factors are the individual's propensity to use health care services. In this model, foster parents

could be considered to be predisposing factors, since the individual child is not an adult whose opinions and ideas influence the way that he or she uses health services. Considering the foster parent as part of an individual child's characteristics also aligns with Andersen and Newman's (1973) health care utilization model, because a foster parent could be considered as part of the individual determinants of the foster child's utilization of health care services. Another component of Andersen and Aday's access to health care model is the needs of the individual, which includes health conditions and problems that cause a person to seek health services. By looking at different aspects of a foster child's access to health care, we could better determine ways to improve the health of children who are placed in foster care. Andersen (1995) discussed that use of health services leads to improved health status and improved satisfaction in health services. The theoretical framework developed by Aday and Andersen (1974) looks at the inputs and outputs of health care as it relates to access to health care services. By looking at the inputs and outputs as factors in a way that expresses a multi-faceted approach to health care access, they explain that accessibility is more than the existence of available resources at a given point in time. The variables involved in Aday and Andersen's (1974) framework of health care utilization are divided into five main variables: health policy, characteristics of population at risk, consumer satisfaction, utilization of health services, and characteristics of health delivery system. For my research, the focus could be on the characteristics of the population at risk, as the study focuses on the particular population of children in foster care. Aday and Andersen (1974) describe the population at risk to be the individual factors that determine the utilization of health care services. They divide the population at risk into three subgroups, which include the predisposing, enabling, and needs of the population, and describe the components separately to further explain the characteristics of population at risk area of their model.

I chose not to use Aday and Andersen (1974) for the main conceptual theory for this study due to its focus on the characteristics of the populations at risk. The theory of utilization of health care services requires the use of health information that would be difficult to obtain due to the vulnerability of the population, since they are children and placed in state custody. Also, as this is preliminary research into this area, I did not want to focus on outcomes at this point in the research. However, this theory could be used to inform future research on the topic.

### **Health Care Utilization Model**

Andersen & Newman's (1973) health care utilization model was also considered as a guiding theory because the social worker or foster parent could be considered to be part of the individual determinates of the utilization of health care services. I chose not to use this theory because it focuses on the inputs to the system (parents, social workers, and foster parents, culture, and perceptions of their roles), and how these inputs could influence the outputs (health care services to foster children). Again, this theory could be used for later research related to outcomes, but it is not appropriate for the current study due to the preliminary nature of this research.

### **Organizational Climate**

Another concept that was considered for this study is organizational climate. When an organization has a positive work climate, there is role clarity and the service coordination responsibilities are focused rather than diffused (Glisson & Hemmelgarn, 1998). The concept of organizational climate is important in health care services and child welfare services, which makes it appropriate for this study.

For those involved in health care, the American Academy of Pediatrics (AAP) (2014) identifies the importance of care coordination, which includes having assigned roles, quality

communication, and positive relationships between team members, all of which are seen as factors that are part of a positive organizational climate. The AAP (2014) also mentions that care coordination improves outcomes and is an essential part of the American health care system. The AAP (2015) identified that care coordination can be especially difficult for children in foster care due to the transient nature of the foster care population.

Organizational climate is also important in relation to child welfare services because “organizational climate is a major predictor of the quality and outcomes of children’s services” (Glisson & Hemmelgarn, 1998, p. 402). So, as child welfare agencies improve organizational climate, it could improve outcomes for youth in child welfare (Williams & Glisson, 2014).

Although some of the organizational climate research was used in forming ideas regarding this study, it was ultimately ruled out due to the differences in the organizations who provide care for children in foster care. Although the Department of Human Resources (DHR) oversees all foster care cases, some children are housed in foster homes that are also part of private foster care agencies. Also, the DHR offices are divided into separate offices by county, so the idea of organizational climate would not be appropriate for this particular population since it involves many organizations rather than one singular organization that provides services. If this study had been developed to look at one specific foster care agency or county DHR office, then this theory might have been more applicable.

## **Diffusion of Responsibility Theory**

### **Overview of Theory**

The study conceptualization is informed by the concept of diffusion of responsibility. This concept was originally discussed by Darley and Latané (1968). They looked at how bystanders intervene during emergency situations, and they found that people are less likely to

intervene in a situation if they think that others are available to help. This can be used to understand how people behave in groups, based on factors related to the members of the group and factors related to who needs help. For example, in Darley and Latané's (1968) study, when presented with a recording of an emergency, every person in two-person groups reported the emergency, while only 62% of people in six-person groups reported the emergency. So, the more people who were available to help, the less likely the individuals were to take action toward helping those in need. For those who didn't respond, Darley and Latané (1968) believe that the non-responders didn't make a choice not to respond but instead were indecisive about whether they should report or not.

The concept of diffusion of responsibility is also described in the literature as social loafing (Latané et al., 1979). The phrase, "many hands make light the work" is often used to explain the benefits of working as a group in order to aid individuals in meeting their goals, as well as to allow individuals to not have to work as hard when working toward group goals (Latané et al., 1979). However, this is unfortunately not true. Instead, the "group product suffers as a result of group inefficiency" (Latané et al., 1979, p. 825). When motivation to do the work comes from outside the group and when the group members cannot be identified individually for their work, each individual doesn't work as hard as they would if they could be identified for their work. Latané et al. (1979) use these findings to describe social loafing as a "disease" that reduces efficiency. However, they explain that the "cure" isn't to get rid of groups, but instead find ways to channel social forces to increase each individual's responsibility rather than diffusing it.

It should also be noted that the concept of diffusion of responsibility is different from the concept of de-individuation. Although both attempt to explain how people behave in groups, the

concept of de-individuation focuses on situations where people act a certain way in groups that is different from how they would act alone (Festinger et al., 1952). According to Festinger et al. (1952), in de-individuation, group members do not pay attention to other individuals, and the way that the individuals act in the group is in a less reserved way than they would act if they could be identified individually. De-individuation is what is used to explain why individuals might participate in deviant behavior as part of a group that they might not participate in if they were able to be singled out as an individual. This de-individuation is different from diffusion of responsibility because de-individuation promotes negative behavior, while diffusion of responsibility hinders positive behaviors.

Throughout the diffusion of responsibility literature, there are three main factors that influence the extent to which responsibility will be diffused when people are part of a group. These factors are: size of the group, the relationships between members of the group, and the anticipated outcome of the event.

### ***Size of the Group***

Darley and Latané (1968) found that if there are more people in a group available to report a problem, then the likelihood of a person reporting will decrease. This was also found by Ahmed (1979) who identified that individuals are more likely to help a motorist on a lonely road versus a busy road, because they presumed that there are fewer people available to help on a lonely road than on a busy road.

Wegner and Schaefer (1978) expounded on this by finding that the number of victims can also influence how members of a group react, based on how self-aware the bystander is. For example, a bystander is more self-aware when there are fewer victims or more bystanders. Also, a bystander is less self-aware when there are more victims and fewer bystanders. These

bystanders, or potential helpers, were more likely to help when there were three victims versus when there was only one victim, and potential helpers helped less when they were part of a three-person group than when they were alone. Overall, potential helpers gave the most help when the victim group was large and the helper group was small (Wegner & Schaefer, 1978). This can also be seen in other helping behaviors, such as charitable giving. For example, individuals are more likely to donate to a charity if they are alone than if they are in a group, and smaller groups are more generous than larger groups (Wisenthal et al., 1983).

Another aspect that can influence the group behavior is that people help the least when the costs of helping are low and the costs of not helping are high, which indicates that people are concerned about their own risk and danger when deciding to help. This is true as well in situations where someone needs help, but the situation isn't emergent or the victim isn't in physical distress (Fritzsche et al., 2000).

### ***Relationship of Group Members***

The relationship with other bystanders also influences how people will behave. For example, an individual in a group with low-cohesion is more likely to intervene if the group is small, but an individual in a group with high-cohesion is more likely to intervene in a four-person group than in a two-person group (Rutkowski et al., 1983). However, Rutkowski et al. (1983) also argued that this could be due to the fact that even though the group had high cohesion, they were very unlikely to ever interact again after the experiment, and that the social forces that might influence decisions during the experiment might exist only because the participants knew that they would not interact as part of this same group again in the future. The same question was further studied by Levine and Crowther (2008) by using groups of friends and groups of strangers to observe the influence of diffusion of responsibility. They found that

participants are less likely to show intention to help when they are with five strangers than when they are with one stranger, which supports the concept of diffusion of responsibility. However, they also found that participants were more likely to show intention to help when they were with five friends versus when they were only with one friend. This indicates that the relationships of the people within the groups can influence the degree to which the diffusion of responsibility will occur.

### *Anticipated Outcomes*

The literature suggests that people feel more responsibility when they act alone versus when they act in a group (Feidman & Rosen, 1978). This is especially true when the group is involved in a situation that causes the group as a whole to lose or have a negative outcome (Mynatt & Sherman, 1975). Also, if a certain action had a negative outcome, people who participated in the action felt less responsibility for the outcome if more people were involved in the action (Feidman & Rosen, 1978). However, if the outcome was good, people were more likely to take responsibility. Mynatt and Sherman (1975) suggested that the diffusion of responsibility is an individual's cognitive response as a way to avoid internal conflict. The individual avoids this internal conflict by relegating some of the responsibility of the negative outcome onto the others of the group rather than taking on all of the blame for the negative outcome.

Darley and Latané (1968) also explained that fears related to anticipated outcomes might be associated with why people don't intervene in certain situations. These fears could be fear of physical harm, fear of public embarrassment, fear of lost workdays, or fear of job loss. However, "if people understand the situational forces that make them hesitate to intervene, they may better overcome them" (Darley & Latané, 1968, p. 383).

Overall, the literature indicates that making decisions to help is influenced by the size of the groups (Ahmed, 1979; Darley & Latané, 1968; Latané et al., 1979; Wegner & Schaefer, 1978). Also, our relationships with the people in the groups, and the anticipated outcome can influence the way we react in situations where help is needed (Feidman & Rosen, 1978; Levine & Crowther, 2008; Mynatt & Sherman, 1975; Rutkowski et al., 1983). By using the concept of diffusion of responsibility to investigate the perceptions and behaviors of individuals who are a part of the group providing health care services to children in foster care, I plan to better understand the possible motivations, perceptions, and behaviors of these individuals.

### **Diffusion of Responsibility in Health Care Systems**

Understanding the reasons behind the diffusion of responsibility in groups can also be applied to help understand flaws in systems that function together at both an individual level and a group level. One such system is the health care system; the literature on diffusion of responsibility also identifies factors that can influence how health care system groups will function.

Compher (1987) explains that one reason for dysfunction of systems is the rejection of a whole system because each individual sub-system is too concerned about itself and cannot function together with other members of the system. Such dynamics can interfere with the delivery of community health services. One reason for this could be that, in organizations, blame is designated less for groups than for individuals (Gibson & Schroeder, 2003).

Henriksen and Dayton (2006) specified the importance for health care leaders and managers to understand the complexity of systems, and to “understand the impact of social factors on group behavior and the potentially harmful consequences of conformity, diffusion of responsibility, and microclimates of distrust” (p. 1551). For the concept of diffusion of

responsibility, specifically in the health care setting, diffusion can occur when there are several providers who care for a patient, but the roles of those providers are assumed rather than specified (Henriksen & Dayton, 2006).

Stavert and Lott (2013) found that often health care professionals wait for someone else to do something for a patient due to the ambiguity of roles. It was only when there was an acute deadline related to a patient that someone took responsibility and acted decisively (Stavert & Lott, 2013). Although all of the providers for the patient may believe that they are providing adequate services, they might be contributing less than they would if their roles were more clearly defined because there is the assumption that others are doing the tasks that need to be completed (Henriksen & Dayton, 2006).

### **Roles and Role Confusion in Health Care for Foster Children**

Related to diffusion of responsibility, when a large group is involved in a task, there are benefits to the members having differentiated roles (Roberts & Goldstone, 2011). Children in foster care have multiple care providers (e.g., social workers, foster parents, other caregivers, and pediatricians) involved in their use of health care services, and these care providers function as a group in helping the children in their care. The literature specifies role definitions for different health care providers, but official definitions can differ from how group members perceive their roles, which could cause confusion. The literature identifies how members of the group should view their own roles, but the roles identified in the literature often differ from how members view their own roles, which can cause role confusion.

Stavert and Lott (2013) found that there was often ambiguity among health care providers over who took ownership of a patient, and that for the patient, knowing who their doctor is could be complex, and often unclear, due to diffusion of responsibility and role confusion. In nursing

homes, this role confusion can hinder communication between the health care providers and a patient's family, which in turn can hinder the teamwork of the health care team (Majerovitz et al., 2009). This is also seen in addiction and mental health services, as many factors, including leadership and roles, can influence the health service team coordination (Guerrero et al., 2016).

Some of this role confusion begins during medical training, as shift-work in medical residency reduces responsibility because the person who will take over the case during the next shift is unknown. This lack of identification can contribute to a lack of motivation for the medical resident to do his/her best (Dubov et al., 2016). This then flows into role confusion for interdisciplinary teams in health care. Some performance indicators in health care settings do not equally reflect the roles of the different disciplines, and some members of the health care team identify that it is hard to measure the work that they do in primary care teams (Johnston et al., 2011). However, when the roles of interdisciplinary teams that include members from medical, pharmacy, nutrition, occupational therapy, physical therapy, audiology, and nursing students are clarified, it leads to a better understanding of the roles of the various members of the team as well as improves communication skills (Barnett et al., 2011).

### **Self-Identified Roles in Health Care for Children in Foster Care**

The literature indicates that the social workers involved in a foster child's case have a relationship with health care access due to their overall involvement in the lives of the children on their caseload, but there is little information concerning how social workers perceive their roles as it relates to the health of children in foster care. In fact, social workers themselves felt that it was hard to identify and measure the work that they do (Johnston et al., 2011).

The foster parent or caregivers' view of themselves in providing health care services has been studied, and caregivers see themselves as integral in the health of children in foster care

(Schneiderman et al., 2011). Schneiderman et al. (2011) found that caregivers for children involved in the child welfare system (including foster children) felt at a disadvantage due to their lack of knowledge about the child's history and past health information. This study also found a need for caseworkers to provide as much information as possible to the caregivers in order to assure that all information is available to them.

Foster parents also view a lack of role clarity as a challenge to providing health and mental health care to children in foster care (Pasztor et al., 2006). Foster parents may already feel overwhelmed due to the responsibilities of caring for a foster child, but they feel that they have a critical role in the foster child's life, including the health care aspects of the child's life (Sobel & Healy, 2001). Foster parents find it difficult to find medical providers who take Medicaid or who will take on a complex case, such as a child in foster care, and even once a provider is found, logistical issues, such as transportation to appointments, can be a challenge (Pasztor et al., 2006). Foster parents also indicate that logistical issues can be further compounded due to the issue of inconsistency in the quality of case workers, and foster parents think that the caseworkers should help the caregivers/foster parents seek, access, and use health care services for children in their care (Schneiderman et al., 2012).

### **Role Confusion in Health Care for Foster Children**

Even though both social workers and foster parents are involved in the health care of children in foster care, a lack of role clarity can prevent children from receiving the basic medical care that they need (Simms, Dubowitz, & Szilagyi, 2000). For example, caregivers identify themselves as being integral to providing health care services (Schneiderman et al., 2011; Sobel & Healy, 2001), but they are often not given medical information by the provider team (Barnett et al., 2016). Foster parents also see themselves as responsible for medical

decisions, but they might not be legally allowed to make decisions due to concerns related to consent (Barnett et al., 2016). Some of this confusion could be due to foster parents learning about roles and responsibilities during training to become foster parents, but forgetting some of the expectations over time (Hebert & Kulkin, 2018).

On the other hand, foster parents see social workers as the gatekeepers of medical information, and the foster parents often do not have access to a child's medical information unless they obtain it from the social workers (Greiner et al., 2015; Ogg et al., 2015; Schneiderman et al., 2011). However, the social workers might not receive the medical information from the providers, so they don't have the information available to give to the foster parents (Barnett et al, 2016). This lack of communication between providers regarding medical information could be especially problematic because, according to the American Academy of Pediatrics (2015), the social workers are ultimately responsible for ensuring that children in foster care receive all appropriate and recommended health care.

Schneiderman et al. (2011) also found that foster parents said that social workers did provide general support and assistance with transportation related to health care, even if some foster parents don't think that social workers help at all in getting pediatric care for children in foster care. Some of this confusion could be due to a lack of communication between foster parents and social workers (Barnett et al, 2016).

There is further confusion when looking at roles at the agency level. Risley-Curtiss and Kronenfeld (2001) found that agencies primarily identified the caseworker as being responsible for making appointments and taking children to those appointments for initial health screenings, but the caregiver was then responsible for other appointments (including follow-up

appointments). However, Schneiderman et al. (2016) found that 39% of all caregivers (who were primarily foster parents) did not adhere to follow-up appointments.

Another agency level concern is the lack of policy related to responsibility regarding health care. Risley-Curtiss and Kronenfeld (2001) found that over half of the states they surveyed didn't have a written policy to identify who is responsible for the health care for children in foster care. This lack of policy was also mentioned as a barrier in other studies (Barnett et al., 2016; Hebert & Kulkin, 2018; Simms et al., 2000).

### **Knowledge Gaps and Purpose of Study**

The literature indicates that adequate health for children in foster care is an important concern; diffusion of responsibility influences how people work in groups in order to provide (or not provide) help to those in need; the knowledge or lack of knowledge about roles for members in a group can also influence how people behave in groups; role descriptions and organizational climate can further influence why people in an agency decide to help; and that organizational culture may also explain things that are being done in mental health to address some of the issues related to service provision. However, to my knowledge, no previous studies have investigated how health care providers' general sense of responsibility and/or perceived organizational diffusion of responsibility connect to feeling responsible for providing health care services to children in foster care, or how different perceptions of responsibility could influence how members of the health care team work together to ensure the health of children in foster care.

The purpose of this study is to (a) investigate perceptions about the concepts of sense of responsibility and diffusion of responsibility in social workers and foster parents; (b) gain an understanding of how social workers and foster parents view their own responsibility for ensuring appropriate health care for children in foster care; and (c) develop a theory based in data

on how perceptions of “sense of responsibility” and “diffusion of responsibility” may relate to provision of health care for children in foster care. As identified in the literature, positive work climates create better outcomes in health roles and responsibilities (or a lack thereof), and can influence how members of a group work together when there is someone in need. However, many studies conclude that more research is needed in the area of child welfare and role responsibility as it relates to service provision. This study aims to gain a better understanding of these factors as they relate specifically to social workers and foster parents, which can ideally lead to research and policy that can improve health outcomes for children in foster care in the future.

## CHAPTER III

### METHODS

In this Methods section, I will restate my research questions and describe the study design, the sampling method, and the qualitative analysis. For my research I used a grounded theory approach because, among other reasons discussed below, classic grounded theory is appropriate for a researcher who has a pragmatic worldview (Savin-Badin & Major, 2013). Through my study I hope to identify not only perceptions about responsibility for medical visits, but also the ways the perceptions among caseworkers and foster parents influence their behavior. In order to best identify this, I have determined three research questions that can be used in determining the answer to the main research question:

1. How do foster parents determine who is responsible for the health care of children in foster care?
2. How do social workers determine who is responsible for the health care of children in foster care?
3. What influences who is responsible for the health care of children in foster care?

#### **Approach**

For my study, I used a grounded theory approach. This approach is ideal for my research because it focuses on “interaction, action, and processes” (Savin-Badin & Major, 2013, p. 183). In my research I am interested in the perceptions and behaviors of case workers and foster parents who are involved in the health care visits for children in foster care, which includes various interactions, actions, and processes to be explained. A grounded theory approach is best

suited for this type of study because I am drawing information from the literature and other theories, but the process is primarily inductive and allows a hypothesis to develop directly from the data collected (Padgett, 2008; Savin-Badin & Major, 2013). The grounded theory approach involved in-person interviews with foster parents and public child welfare caseworkers.

In grounded theory research, there are several approaches to consider as the researcher. Classic grounded theory was developed by Glaser and Strauss, and focused on the importance of allowing concepts expressed as “codes” to develop from the data. They also emphasized the importance of field notes or memoing as being one of the data sources for the research, and they developed grounded theory out of a pragmatist view (Savin-Badin & Major, 2013). After developing grounded theory, Glaser and Strauss disagreed on the approach, which led them develop different views that were used to comprise modified grounded theory (Savin-Badin & Major, 2013). Another development in grounded theory occurred with the development of Charmaz’s constructivist grounded theory. Charmaz’s ideas on grounded theory differ from Glaser and Strauss in that Charmaz sees grounded theory as something that is constructed rather than something that emerges from the data (Charmaz, 2014).

Personally, my philosophy falls somewhere between pragmatism and constructivism, so I find usefulness in both modified grounded theory and constructivist grounded theory. As a former child welfare social worker, I have always seen my interest in research as pragmatic. When questioned about why I decided to pursue a PhD, I often tell people that I wanted to “fix things.” I’m aware that this is a common theme for many in the social work field, but I felt as if my experience as a front-line social worker gave me insight into some of the differences between theory and practice. I wanted to use that insight in a pragmatic way to reconcile some of those differences between theory and practice in order to improve the care received by children in

foster care. However, my experience in the field is also what provides me with a constructivist perspective. In doing research, there is no way for me to completely remove myself from the research. In fact, my past work experience in child welfare was important during interviews because often there were statements from participants such as, “Well, you know” or “You understand.” There are some benefits to having this connection to the research, and I want to make sure that I acknowledge it and embrace it as I know that my background does influence the results of my research.

It is this combination of philosophical views that guided my research. I allowed my experiences to guide my research questions while also trying to be open to the data. I used several methods of coding to help me understand the information on its own while also viewing it through the lens of my own experience. I think that using a combination of the ideas of Strauss, Glaser, and Charmaz allowed me to embrace my influence on the research while also allowing the results to emerge from the data.

## **Procedures**

### **Preliminary Procedures**

Once my study was approved by my dissertation committee, I submitted an application to the Institutional Review Board (IRB) at The University of Alabama. As part of my IRB application, I included letters from the leaders of the foster parent groups giving permission to interview group members and ensuring that each participant’s involvement will be voluntary and confidential. Once I received approval from the IRB, I began recruitment of participants for my study.

In order to complete my study with social workers who are employed by DHR, I obtained appropriate permissions from the State DHR office. This included sending a proposal to Mandy

Andrews in the Staff Development office of the Field Administration Office. Once approved by the State DHR office, I spoke with Mandy Andrews about recruitment of participants. I was told that I could not interview DHR workers from Jefferson County due to the possible conflict of interest since I was at one time employed at Jefferson County DHR, but that I could interview workers from other Alabama counties.

### **Data Collection**

The study involved in-person interviews with foster parents and caseworkers. For the foster parent interviews, I contacted foster parents in person at a foster parent support group meeting to explain the study and invite participation. Potential participants provided their contact information so that I could follow-up with them regarding details of the study. I also provided the group members with my contact information in case they wanted to provide my information to other potential participants.

In order to recruit more participants, I utilized online social networking sites to provide information about my study. I posted on the Facebook forum “Samford Gals Mommy Talk,” which is an online group for alumni of Samford University who are parents. I also posted on my personal Facebook page, making the post “public” so that it could be shared by others on Facebook. Another way that I tried to recruit participants was through my own personal network of friends, colleagues, and former classmates who had experience in child welfare. Through these methods of outreach, I was able to identify 12 participants for my study. There were other potential participants who had to be ruled out due to location (living outside of Alabama) or time constraints (volunteered after I had completed data collection).

The participants were given the option of completing the interview in person or via telephone. The option of in-person interviews was preferable, but telephone interviews were

accepted based on the participant's preference. Telephone interviews became necessary during the data collection time period due to social distancing requirements of the COVID-19 pandemic. Prior to that point, having an option of an in-person or telephone interview provided the participants with the opportunity to choose whichever was most convenient for them.

Once I interviewed some of the foster parents, I then began to interview the caseworkers. The interviews of the foster parents and caseworkers occurred individually; some took place in a public area that was convenient for the participant. Some examples of places where interviews occurred were a local church and various coffee shops. Most interviews were completed over the telephone. As mentioned, telephone interviews became necessary due to state mandates that required people to stay home to prevent the spread of the COVID-19 virus.

### **Sample**

My study involved a sample of foster parents and caseworkers. For my study I began with a purposeful sampling method. I began my sampling from support groups in order to identify foster parents who had sought out some type of support as a foster parent. I utilized a foster parent support group because it also allowed an opportunity for me to meet and recruit from a large group of foster parents at one location. As I spoke with these foster parents, I realized that having support could be an important concept for the research, so I expanded my recruitment to include foster parents who were not part of a foster parent support group as part of a theoretical sampling method. A theoretical sampling method is used for grounded theory research as a way to sample based on concepts that are proven to be relevant to the theory that is emerging (Strauss & Corbin, 1990). As I coded the data, I made adjustments to my sample in order to identify incidents that provided variation in the views and perceptions that I was studying. For example, I originally aimed to sample participants who lived in central Alabama,

but I noticed that access to resources might be an important piece of data, and this access could be different for people who lived farther away from the resources available near Birmingham. Consequently, I worked to also obtain participants from more rural areas of the state.

### **Foster Parents**

My preliminary sample included foster parents from foster parent support groups in central Alabama. The current leader of the foster parent support group at Hunter Street Baptist Church is Ms. Holly Lewis, and she granted me permission to speak to the support group members at a group meeting. This support group is only open to people who are currently licensed as foster parents in the state of Alabama. In December 2019, I attended a meeting to describe the study, distribute an information sheet, and obtain names, email addresses, and telephone numbers of potential participants. When I attended this meeting, there were only four members present, even though there are approximately 15 members who attend on a regular basis. I invited all members to participate in my study. I attended a second meeting of the foster parent support group, and only three members were in attendance. I provided them with information about my study and asked them to help recruit other participants. I also began recruiting participants through social media in order to recruit those who might not have the support of a group of other foster parents and to increase the size of my sample. I posted in the “Samford Gals Mommy Talk” Facebook group in order to recruit foster parents and social workers who have the support of an online group that is for parents, not just foster parents. The “Samford Gals Mommy Talk” Facebook group consists of people who have graduated from Samford University and identify as mothers. It is a private group that did not require me to request permission to join the group since I am currently a member. Other parenting groups on

Facebook require membership, so I did not have access to other similar groups in order to recruit from other parenting groups.

I also posted on my personal Facebook page in order to recruit participants through my personal and professional connections. I use my personal Facebook page as a way to connect with people who I know on a personal basis, but I also use it to connect with others professionally, which includes foster parents and social workers. I also recruited participants by contacting DHR directors because I knew that they would be able to connect me with social workers and foster parents who would be willing to participate in my study.

### **Caseworkers**

For my caseworker sample, I included social workers and caseworkers who have a child in foster care on their caseload. The title of social worker or caseworker is given to certain employees based on their educational background and licensure. For the purposes of this study, both social workers and caseworkers were included in the caseworker group, as they both complete the same or similar duties as they relate to the clients on their caseload. However, I did ask participants to identify their job title to ensure that there was no difference between the groups of social workers and case workers.

### **Measures**

For the semi-structured interviews, I used a set of questions that focused on the participants' personal views and perceptions of their experiences related to the roles and responsibilities of addressing the health of children in foster care. The questions for the interviews are as follows:

1. Describe the ideal foster parent. OR Think of a foster parent you really like. What is that person like?

2. Describe the ideal caseworker. OR Think of a caseworker you really like. What is that person like?
3. How does that person act in providing health care to children in foster care?
4. What would it take for you to be able to provide health care to your child in foster care in the same way? OR What would it take for you to be able to provide health care to the children on your caseload in the same way?
5. How does getting health care for foster children work?

Possible follow-up questions:

What part do foster parents play?

What part do caseworkers play?

What part do medical doctors play?

How has the process worked for you?

What challenges or barriers have you experienced?

What would improve the process for you and/or for your foster child?

6. Think of the best experience you've had in getting health care for a child in your care. What about that experience stands out to you? OR Think of the best experience you've had in getting health care for a child on your caseload. What about that experience stands out to you?
7. Think of the worst experience you've had in getting health care for a child in your care. What about that experience stands out to you? OR Think of the worst experience you've had in getting health care for a child on your caseload. What about that experience stands out to you?
8. Imagine that you are given the chance to make any changes you want in the way that children in foster care receive health care. What would you change?

For the interviews, I spoke with each participant at least once. I also spoke with Foster Parent-1 and Social Worker-2 three times, and Foster Parent-2, Foster Parent-3, and Social Worker-1 two times in order to get clarification or to get feedback on my coding process. My first interview took place on January 10, 2020, and my last interview took place on May 5, 2020. The interviews ranged in length from 23 minutes to 1 hour and 26 minutes. In total, I recorded 8 hours of information from my participants. The participants sometimes continued talking after I had stopped recording, and I took handwritten notes in those instances.

I recorded the interviews using an audio recorder. For in-person interviews, I attached a lapel microphone to the audio recorder, and each participant wore the microphone during the interview. The in-person interviews took place at coffee shops and a church classroom. For telephone interviews, I used the speakerphone function on my iPhone and placed the audio recorder near my iPhone. I conducted the telephone interviews in a room in my home where I could be alone with a closed door for privacy.

The audio from the interviews was stored online with UA Box. These audio files were then transcribed. Transcription was completed by myself or by professional transcribers through Rev transcription service.

### **Analysis**

For my analysis I transcribed the interviews and completed four cycles of coding. This coding was completed in accordance with a grounded theory approach and is outlined below.

### **Transcription**

I transcribed the first interview in order to benefit from the advantages of self-transcription. Through self-transcription, the interviewer can provide explanations or clarifications as well as fill in where the recording is unclear (Padgett, 2008). This also allowed

me to observe my own interviewing and improve upon my interview technique as needed. For the remainder of the transcribing, I used professional transcribers; however, I did check the transcripts with the audio from the interviews to determine accuracy.

### **Coding Technique**

I completed four coding cycles. Each new cycle built on the previous cycle with additional categorization, comparisons, contrasts, and connections among codes and developing themes. In the first cycle of coding, I used open coding. According to Strauss and Corbin (1990), open coding is the first basic step that the data analysis is built upon. During the open coding phase, the data is conceptualized in order to make comparisons and ask questions (Strauss & Corbin, 1990). By answering the questions that arise and comparing the data, the data can then be placed into categories that allow for the organization of the data. In order to place the data into categories, I used in vivo coding. According to Saldana (2013), in vivo coding is appropriate for researchers who are learning to code data, and is often used in initial coding for grounded theory research. In vivo coding was also appropriate for my study, as it allows the participants' language to guide the coding rather than the language of the researcher (Saldana, 2013).

For the second cycle of coding, I used focused coding. In focused coding, I looked at which codes were used most frequently in order to determine what major themes were developing from the data (Saldana, 2013). In this cycle of coding, I compared prior codes to newly identified codes to look for possible similarities. This also guided my data collection to see how the other participants' interviews compared with the previous codes and categories.

As part of my focused coding, I also used axial coding. Charmaz (2014) indicates that there is some disagreement regarding the use of axial coding in grounded theory research, but it can help clarify ideas that are emerging in the data. In axial coding, the data is put back together

and divided into categories based on the context and interactions (Strauss & Corbin, 1990). During this phase, the data were categorized based on the context and the conditions that cause the phenomenon to occur. For example, in my study, the context could be when a foster child is sick, and a causal condition could be a foster parent's description of what occurs when the child is sick and the foster parent feels ultimately responsible for assuring the health of the foster child. I would then focus on the phenomenon that occurs when this particular condition is described. The categories that are determined during this coding process sometimes had subcategories that described interactions that took place in similar specific conditions. These subcategories would then link to the consequences of that particular interaction (Strauss & Corbin, 1990).

Once I completed the axial coding, I moved to the process of selective coding. During this process, I selected a core category and then related the other categories and subcategories to the core category (Strauss & Corbin, 1990). It was during that phase of coding that I determined the relationship of the data to the core category that became my theory.

### **Strategies to Promote Trustworthiness**

During the coding and analysis of the qualitative data, I took several steps to insure the trustworthiness of my work. First, I used analytical memos, which included notes from the interviews as well as notes on the criteria used to determine codes and all aspects of the coding process. The use of the analytical memos allowed me as the researcher to continuously document my role in decision making and reasoning related to the analysis. These memos created an audit trail of all the decisions made throughout the process of analyzing the qualitative data. Use of the analytic memos allowed me to address the four criteria that Lincoln and Guba (1985) identified for addressing issues of trustworthiness: credibility, transferability, dependability, and confirmability. By using analytic memos, I was able to hold myself accountable to the research

decisions that I made during the process of coding. These memos could be viewed by members of my committee, if needed, to show the steps that I took during the coding process. Using analytic memos allowed me to be transparent about my decisions as well as to refer back to choices that were made while determining codes and coding the data.

I also strengthened the trustworthiness of my research by making my coding process transparent to my committee members. I discussed my process of assigning, classifying, and categorizing codes with my advisor. Another step I took to strengthen the trustworthiness was involving the participants in reviewing my codes. I contacted five participants by phone and discussed the codes from their individual interviews as well as the codes that had developed throughout the coding process. I discussed with them any concerns or other thoughts related to my findings.

## CHAPTER IV

### RESULTS

The purpose of this study was to determine how social workers and foster parents determined responsibility for themselves and others as it relates to providing health care to children in foster care. This study was guided by the research questions, which ultimately led to the development of a theory. In this chapter I will identify my findings based on my three research questions:

1. How do foster parents determine who is responsible for the health care of children in foster care?
2. How do social workers determine who is responsible for the health care of children in foster care?
3. What influences who is responsible for the health care of children in foster care?

#### **Participants**

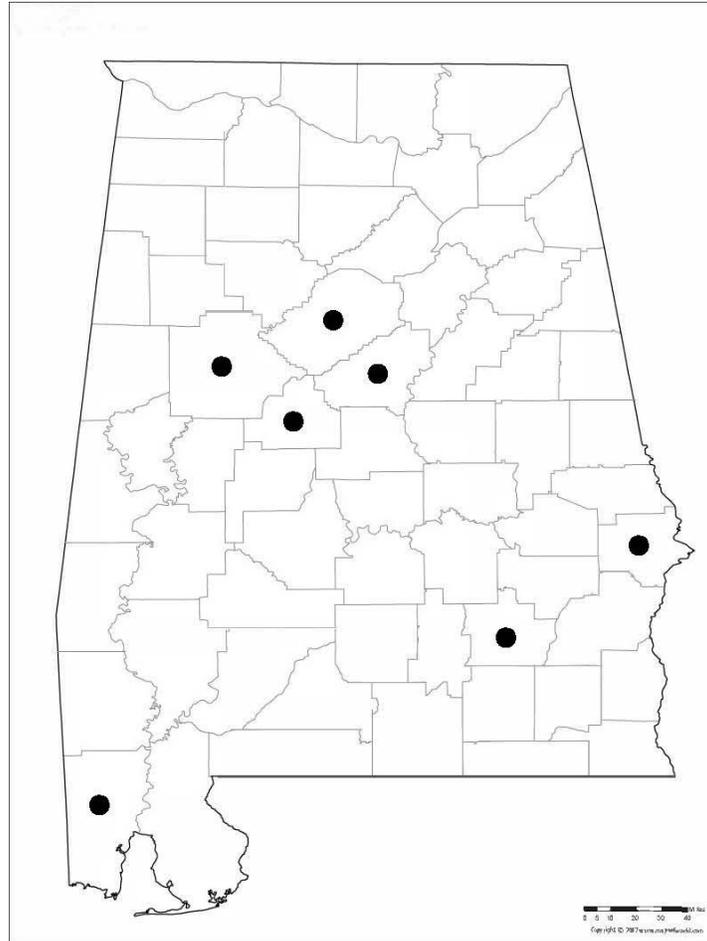
Through multiple methods of recruiting participants, I was able to recruit 12 people to participate in my study (see Figure 1). I interviewed eight foster parents and four social workers. The participants consisted of 11 females and one male, and 11 Caucasians and one African American. The participants were aged in range from 24 to 46 years of age. The average age of foster parents was 38.6 years, and the average age of social workers was 24 years. There were seven Alabama counties represented by the participants: Bibb, Jefferson, Mobile, Pike, Russell, Shelby, and Tuscaloosa. (See Figure 1.)

**Table 1***Description of Participants*

| <b>Participant identifier</b> | <b>Type of interview</b> | <b>Age</b> | <b>Race</b> | <b>Gender</b> | <b>Location</b>   | <b>Experience</b>                 |
|-------------------------------|--------------------------|------------|-------------|---------------|-------------------|-----------------------------------|
| Foster parent-1               | In person                | 46         | White       | Female        | Jefferson County  | 7 years as foster parent          |
| Foster parent-2               | In person                | 37         | White       | Female        | Shelby County     | 7.5 years as foster parent        |
| Foster parent-3               | In person                | 37         | White       | Male          | Jefferson County  | 2 years as foster parent          |
| Foster parent-4               | In person                | 43         | White       | Female        | Jefferson County  | 2 years as foster parent          |
| Foster parent-5               | Telephone                | 40         | White       | Female        | Jefferson County  | 8 years as foster parent          |
| Foster parent-6               | Telephone                | 36         | White       | Female        | Jefferson County  | 6 years as foster parent          |
| Foster parent-7               | Telephone                | 35         | White       | Female        | Russel County     | 1.5 years as foster parent        |
| Foster parent-8               | Telephone                | 35         | White       | Female        | Mobile County     | 5 months as foster parent         |
| Social worker-1               | Telephone                | 24         | White       | Female        | Pike County       | 2 years as licensed social worker |
| Social worker-2               | Telephone                | 27         | White       | Female        | Bibb County       | 5 months working at DHR           |
| Social worker-3               | Telephone                | 25         | Black       | Female        | Bibb County       | 3 years working at DHR            |
| Social worker-4               | Telephone                | 24         | White       | Female        | Tuscaloosa County | 1 year working at DHR             |

## Figure 1

*Map of Counties Represented*



In qualitative research, sampling is not probabilistic, but is instead purposeful. For this study my sample is not “representative” because generalization is not needed (Savin-Badin & Major, 2013). However, I would like to comment on this. I understand that the experiences being described are more reflective of white women in their 30s. Some of this can be attributed to my recruitment strategy, but it also could be related to the fact that I am a white woman in my 30s. By choosing grounded theory, specifically a constructivist grounded theory approach, I

understand that my own background and experience influences my research. As a qualitative researcher, I cannot take myself out of my research, but instead I must take myself into account as I collect and analyze the data. I considered this information throughout all phases of my study.

### **Coding**

The transcriptions from the interviews were coded in the process discussed in the Methods section. During the first cycle of coding, I completed thematic coding to gain a better understanding of the data (Strauss & Corbin, 1990). I then completed line-by-line coding of each interview transcript and developed codes based on the information in the transcripts through in vivo coding. Next, I began the second cycle of coding, which was focused coding. I looked at the frequency of codes and compared the codes to each other. I then began the axial coding phase, where I “put the data back together” (Strauss & Corbin, 1990). It was during this phase that I began to determine relationships between codes. For example, I merged the “Knowledge” and “Information” codes into one code titled “Information.” This “Information” code was then broken into three sections: missing information, obtaining information, and information from training. Another example of my coding during this phase was the code “Appointments.” It was divided into the following sub-codes: Being available, Scheduling, Taking, and Updating/Giving Information. See Table 2 for more examples of codes and sub-codes.

**Table 2**

*Axial Coding – Examples of Codes and Sub-Codes*

| Code          | Sub-codes   |
|---------------|---|
| Appointments  | Being available<br>Scheduling<br>Taking<br>Updating/giving information  |
| Changing      | Medicaid<br>Social workers  |
| Communication | Doctor and social worker<br>Email<br>Fax<br>Foster parent to social worker<br>Phone<br>Social worker to foster parent<br>Text                 |
| Relationships | Children’s Health System<br>Foster parent and doctor/medical team<br>Foster parent and social worker<br>Social worker and doctor/medical team |

After completing the axial coding, I began the selective coding process where I related the subcategories to the core categories (Strauss & Corbin, 1990). It was during this phase of coding that I determined the core categories of Communication and Relationships as they relate to the perceptions of foster parents and social workers regarding the health care of children in foster care. I also compared the answers from foster parents and social workers to these core categories to determine similarities and differences in the perceptions of the two groups.

In order to promote trustworthiness in my coding, I sent an example of a coded transcript to my dissertation chair. I also contacted five participants and reviewed my codes with them. I provided them with information regarding the codes related specifically to their individual

interviews. I also provided information about the core categories that I had selected and allowed each participant an opportunity to clarify or add information to my findings. None of the participants wanted to add anything, and they all agreed with my coding, of both the individual and overall codes. In agreeing with the codes, one participant said, “They all go together like a web” (FP-2). Another participant said that the findings “were what [she] figured” (SW-1).

### **Foster Parents’ Perceptions about Responsibility for Health Care**

The foster parents largely saw it as their responsibility to ensure the health care of children in foster care. According to one foster parent: “We're the ones that are there to provide that health care just like we would for our own kids. There's no difference” (FP-4). This was a common theme among the foster parents as they discussed their role as a parent, and how being a parent relates to providing health care.

One foster parent explained how she believed her responsibility connected to quality health care, “The foster parent is the person who really takes the lead on appointments. And takes them, and I know that technically it's DHR's responsibility... having a social worker take 'em to an appointment is not going to get them the best health care, because they [social workers] don't know them like we do” (FP-2).

Another foster parent argued that responsibility for the health care of foster children was similar to any parental responsibility, “Just like with our own kids: we're the parent” (FP-3). In explaining how she executes her responsibility for assuring her foster child received health care, one foster parent said in a matter-of-fact manner, “I will schedule the appointment and I will go” (FP-5).

However, even though the foster parents felt responsible for the children and appointments, they often wanted the social workers to be involved. One foster parent said that

usually she will call her social worker before an appointment, but she did not actually expect the social worker to come to the appointment.

I will call and be like, 'Hey, just want to give you a heads up. Um, we have a doctor's appointment on this date.' And she's like, 'Okay, do you need me to go?' And I was like, 'No, it's just a follow up if you'd like to go, this is where I'll be.' She says, 'If you need me to go, I'll go.' And I was like, 'No, we're really fine.' (FP-5)

Other foster parents had similar conversations with their social workers.

Like I said, at first, um, they were coming to, you know, sort of the bigger doctor visits and then it was like, 'Well, I don't think I need...' And- and I said, 'Oh, we have this doctor visit on this date. Are you coming?' And it kind of started to become, 'No, I don't think I need to come to that,' you know or whatever. (FP-6)

"Usually if I had an appointment, I would let the social worker know, um, what kind of appointment it was or whatever" (FP-2).

There also appeared to be some confusion and frustration over the appointments when social workers said that they would attend appointments but did not come to those appointments. As one foster parent reported, "I would usually communicate that with the caseworker. And for any of the doctor's appointments that we went to, at least the initial ones, um, she would typically go, actually.... Uh, yeah. Um, at least...I mean, but sometimes, she didn't show up despite that she would say that she would be there" (FP-7). In fact, one foster parent had never had a social worker attend any of the medical appointments for children in her home. She explained, "I've never had a social worker attend....And the, I've never had a, um, DHR worker or a social worker, anybody meet me at a single appointment" (FP-5).

Another point of frustration among foster parents was the frequent change in workers that could cause problems with continuity of care. According to one foster parent, the social worker's lack of knowledge about the child's medical history "caused me to be the one to say, 'No, I'm going to- I'm taking my daughter,' you know, 'I'm taking her to all of these appointments. I'm going to be the one who knows all of the things because you people keep changing'" (FP-6). The foster child being discussed had four different caseworkers over a period of 19 months. Another foster parent had a similar experience. "There's such a big turnover in social workers. You know, we've had four in eight months" (FP-1).

### **Social Workers' Perceptions about Responsibility for Health Care**

The social workers I interviewed had different perceptions of their own responsibility in assuring health care for the children in foster care on their caseload. Most social workers viewed themselves as responsible for having the information about the health care of children on their caseloads. However, even though they identified as being responsible for knowing the health information, that information isn't always provided to them.

One social worker described the lack of information, "Um, I think a lot of times we as workers, I mean, honestly sometimes it's our fault, but...when a child comes into care we don't really have, like, all of their medical information" (SW-3). Another social worker agreed, reporting, "When kids come into custody, we have to figure it out" (SW-4).

Social workers described challenges associated with required documentation. One worker said, "You need this documentation, this documentation. Sometimes with foster kids, sometimes we don't have that documentation right away" (SW-3). Once the social workers receive information, they try to share that information if possible. As one worker explained, "Uh, with their, you know, date of birth, social, their Medicaid number, and that, um, that letter. So that's

usually what I give my foster parents right off the bat” (SW-3). However, some of social workers indicated that just because they take on the responsibility of getting the health care information, not all social workers do this.

When it comes to the health care part is that, um, that the workers being knowledgeable of your kid's health as well. Because most of the time, some workers can put it off on the foster parents of, ‘Okay, you need to know this or know this.’ But I feel as though, as workers, you need to know, you know, your kid's medication. You need to know how to give your kids their medication. (SW-3)

For one social worker, some responsibility is dictated by policy of the health clinic. “They [the clinic] require us [social workers] to be there for the initial appointment for the foster clinic” (SW-4). However, another social worker identified that her responsibility is to take a child to a health appointment even though it isn’t an official policy. “It's just like one of those things that you're like, "Okay, yeah. I do that ... I do this, but it's ... It probably won't be, you know, nowhere written” (SW-3). Another social worker mentioned the initial appointment because they “know a lot of the kids' health history by going to the doctor in a reasonable amount of time and knowing, ‘Oh well, they've been diagnosed with say, failure to thrive, and that's why they are like this.’ So, it's really important, um, for DHR to go to that first meeting I believe” (SW-1).

When social workers do take children to health care appointments, they described passing along the information to foster parents as much as possible. According to one social worker, “Um, I made sure to, uh, get paperwork from them [doctor]. I would wait there to tell them, ‘Could you just write this down for me?’” (SW-3).

And I paid- I paid really close attention, especially at medication, um, and I just told the foster parents, "Hey, this is what's going on. Um, I took really good notes while there."

Um, so that I could explain it to them, and of course, if they had any troubles or if I didn't know the answer to their questions, we could always call the provider back and ask.

(SW-3)

Social workers also identified ways of creative problem-solving to ensure that children get the appointments that they need. One social worker even took a novel approach when she couldn't get an appointment for a child in the foster care clinic.

If you say they're a foster child then they're [the foster care clinic staff] like, 'Well you have to go through the clinic.' I'm like, 'Well the clinic won't respond to me,' and they're like, 'Well you have to.' And they won't let you make an appointment. [So] I just said the child was my child instead of a foster child to get her appointment. (SW-4).

The social workers mostly agreed that it is the foster parents' responsibility to continue to ensure health care services once an initial appointment has occurred. "Once they're in the system, we [social workers] don't have to make any further appointments. From there on the foster parent can do it" (SW-4). If that plan doesn't work, then the social worker has to have a plan moving forward. One social worker said that she struggled with getting a foster parent to take children to appointments, "And that's when I started making all of the children's appointments myself and said, 'You have to take them.' And as she did not take them, after rescheduling and rescheduling, um, we had a meeting and I practically told her we were going to move the kids in a week"

(SW-1).

## **Themes Related to Roles and Responsibility**

Along with addressing the research questions about the foster parents' and social workers' perspectives on their roles and the roles of others, this study aligns with current literature related to diffusion of responsibility. The two main themes identified from the data were communication and relationships. These factors both seem to influence how decisions were made regarding the health care of children in foster care. These factors also reiterate how multi-faceted the groups are who are involved in the health care of children in foster care.

### **Communication**

Communication was a theme that was woven throughout the responses from foster parents and social workers. However, even though participants were aware of the importance of communication, they didn't always agree on how, and when, that communication should occur. There were also some discrepancies about who should be communicating when it comes to the health of children in foster care.

### ***Social Workers' and Foster Parents' Communication***

The communication related to health care between social workers and foster parents occurs at various times. Some communication occurs before an appointment. One foster parent explained how communication could work.

Usually if I had an appointment, I would let the social worker know, um, what kind of appointment it was or whatever. And then, especially for my medically fragile child, I would update them on everything. When they get back to the room, they would text me and say, 'Hey, we're back here, just to let you know.' So, then I would be ready. They would call, and I would be on speakerphone with the doctor, usually, so that they could ask questions and, and talk to 'em. (FP-2)

However, sometimes there wasn't communication before a visit and instead the communication occurred after the appointment. As one foster parent described it,

So, once a month, when we had our home visit, that's when I would go through my phone and be like, 'Okay, on such and such a date, we went to this doctor and this is what they said. And on such and such a date, we went to this doctor and this is what they said, and we went to this doctor and this is what they said.' Those are the four doctor visits we've had this month. (FP-6)

However, communication, or lack thereof, can influence the relationship between the foster parent and social worker if the expectations for availability are different. For example, a foster parent and social worker, who are not from the same county, both described a similar situation with very different expectations regarding when a foster parent needed a social worker outside of normal office hours. A foster parent expressed frustration that her social worker "would just turn her phone off, and she went on vacation, you weren't gonna get in touch with her." While a social worker expressed great frustration recalling when a foster parent tried to call her on a state holiday.

I mean I have one foster parent that- that got mad....The state was closed yesterday. Got mad 'cause I didn't answer the phone. And [she] was calling everybody out, saying my social worker don't answer her phone. Everybody told them we're closed. And then she apologized- apologized today, 'Oh, I didn't know y'all were closed.' Well, if I didn't answer the phone, please just leave me alone. It's like, give me a break. (SW-2)

### ***Communication with DHR***

One of the topics that came up frequently when talking about communication was how the

various DHR county offices differed. Foster parents and social workers both discussed how the expectations are different, which can create a difficulty in communication.

The foster parents were concerned that the DHR social workers have information that they aren't providing to the foster parents. As one foster parent described it:

They don't give you the info... So as far as DHR ever giving me medical records or information on them? No, they do not. Um, we were called one night to do, um, a weekend for a child. Um, and I've, you know, doing this for eight years, I've learned, especially being a house full of boys and an infant girl. Um, there's questions that you know, now I know to ask. And so, um, is there any things that I need to know about this child? No, she's a good child, there's no problem. Um, they tell me that um, dad's girlfriend was beating her up. Um, and she had been in a fight with and being beaten or abused by dad's girlfriend, they, DHR should have taken her to the hospital and not to my house. (FP-5)

Another foster parent also expressed frustration about communicating with DHR, "Um, one of the things that I found very frustrating, um, was when a caseworker, um, wouldn't respond to me and my questions...Do they know general expectations for returning emails, you know?" (FP-7).

One foster parent described how communicating with DHR social workers varied with different workers,

Um, now we have had different social workers through DHR. Um, you know, and the DHR social workers, I mean it's just ... It's hit or miss what, like, personality type you get, you know? And some of them are very thankful that you know what you're talking about, and some of them are really clueless that you know what you're talking about. (FP-4).

However, even though the foster parents seemed to expect the social workers to provide all of the information about a child, they also suggested that the foster parents didn't always provide the information they had with the social worker. One foster parent implicitly conveyed regret at the quality of her communication with the social worker, "I would usually communicate that with the caseworker...Like, I should probably tell them what's going on" (FP-7).

There were also concerns that the communication coming from DHR, at the state and local level, required expectations that social workers are unable to meet. One social worker lamented,

The ideal social worker to them [DHR] is someone who can do 100% of their paperwork and 100% of their visits and have all the visits meaningful...But they never hire anymore and you cannot be (laughs) the perfect social worker when you've got state DHR constantly breathing down your neck....So, um, I- I just think a lot of people just need to be more educated on- on what DHR does. I have mad respect for DHR and- and just the workers there. And, uh, because I know they're overloaded. I know you all are overloaded and, um, there's too much to do. (SW-01)

Another attributed communication challenges to the workload, "And I think that part of that is because the system's so over-logged between kids that are in care and social workers, the number of cases they have" (FP-4).

### ***Communication with Other Providers***

Both foster parents and social workers identified the importance of communicating with the health care providers, but they were also aware that this is an area where there is a need for improvement.

A foster parent described a need for improvement, “Like, it would be actually really great if-if there was some kind of way for, um, physicians and caseworkers to communicate... Maybe we could add in there communicating the results of those appointments, including any medication changes or additions to the social worker” (FP-7).

A social worker expressed a similar view, “I would say most definitely our communication with the health providers, whoever they might have seen. Um, I think that could ... could be better, um, in certain aspects” (SW-3).

The same social worker described a consequence of communication challenges,

Yeah, it can go both ways because it can be something that they'll [doctors' office] tell the foster parent, and if we [social worker] go back, uh, you know it can be a, ‘Well, we said this, but it kind of ... Well, we kind of didn't explain it like how ... How she made it seem.’ So, another communication problem. (SW-3)

## **Expectations**

Another theme that emerged from the interviews was the varied expectations of the foster parents and social workers related to the health care of children in foster care. Through these expectations, social workers and foster parents explained how the actions—or inactions, in one scenario—influenced their expectations for future situations. Also, the expectations of the foster parents and social workers were not always the same, even when related to the same factors.

### ***Foster Parent Expectations***

Although foster parents often identified themselves as being responsible for the health of children in foster care, they did often invite social workers to attend the visits. However, even when the foster parents told the social workers that they did not need to attend an appointment,

the foster parents conveyed some frustration when social workers did not come to the appointment. As one foster parent put it:

Like I said, at first, um, they [social worker] were coming to, you know, sort of the bigger doctor visits and then it was like, 'Well, I don't think I need...' And - and I said, 'Oh, we have this doctor visit on this date. Are you coming?' And it kind of started to become, 'No, I [social worker] don't think I need to come to that,' you know or whatever. So it wasn't like a, um, 'Okay, here's the torch. It's now your job,' but in the same respect, it was like, 'Well, I'm not going to come to that.' Therefore, the decision made at that doctor's visit was sort of left in my hands. (FP-6)

Another foster parent complained that the only time a social worker attended a visit was when the social worker was court ordered to do so, but that same foster parent said that when her current social worker asks if she needs to attend a medical appointment, the foster parent says that it is not required. She explained with frustration:

Um, to where the judge says, I order this to happen. Um, and so her ordering it in the courtroom is the only reason that I got done. That social worker did not care...I've never had a social worker attend...That's the only time. Um, we've had some boys in our care, um, for over two and a half years now. And the, I've never had a, um, DHR worker or a social worker, anybody meet me at a single appointment...

Um, I try, I have one worker that I talk to frequently, um, and I will call and be like, 'Hey, just want to give you a heads up. Um, we have a doctor's appointment on this date.' And she's like, 'Okay, do you need me to go?' And I was like, 'No, it's just a follow up if you'd like to go, this is where I'll be,' she says, 'If you need me to go, I'll go.' And I was like, 'No, we're really fine.' (FP-5)

### *Social Worker Expectations*

One example of expectations was related to the availability of foster parents who work full-time outside the home versus foster parents who do not work outside the home. Social workers did not expect as much from employed foster parents as they did from other foster parents. One social worker explained: “Um, it depends on their foster home and their foster parent. Um, I mean I have some foster parents that they are involved when it comes to that and they want to be involved, but I also have foster parents who have a nine to five and can't” (SW-3).

However, the foster parents who do work outside of the home full-time said that they wanted to be involved in the care of the children in their home. One foster parent explained:

Because a lot of times, yeah I'm, I'm single, so when I'm, when I've got three kids in my home, and I've got to take one of them to the doctor, like I, I have to take time off or else I have to find somebody else to do that for me. And I don't wanna find somebody to do that for me. So it's, it's different... I'm a teacher, so, Lord knows it takes an act of Congress to get off. (FP-2)

These varied expectations based on employment status then led to certain expectations of other foster parents who also work full-time. For example, one social worker described her interactions with a particular foster parent who works full-time.

And the foster parent I was telling you about that ... who works full time-... I hear from her at a weekly basis-... because she's a newer foster parent, and it's- it's very ... I don't want to call it annoying....

Like, the foster parent who works full time, she was like, Um, she has a kid...He's three. So he's going through that terrible twos, terrible three stage and she's like, ‘My kid never

did that. So what do I do when this kid's throwing a tantrum?' And I'm like, 'Wh- ... uh, have you never been a mother?' ...They need to understand that, um, not every kid's the same. And then just like, be ... take care of things on your own. Like, don't call us all the time. (SW-2)

### ***Expectations of Others***

As seen above, the expectations of the foster parents and the social workers not only influenced one particular scenario, but they subsequently influenced the expectations that members of each group had for other situations. Similarly, the actions of one could get applied to the whole group. For example, one social worker recalled a specific foster parent who asked her to take the children to a health appointment. She recalled, "When she asked me to take, um, one of the kids to the doctor, I literally looked at my co-worker, [name], I asked her like, 'Is this normal?' She was like, 'Yeah, you were spoiled with the other one.' And I was like, 'Oh crap!'" (SW-02). Another worker argued that some foster parents try to take advantage of the social workers, "I feel as though at DHR, we all have experienced foster parents that ... just that they are lazy. They don't want to do it. They look at you as you are the worker, and this is your responsibility" (SW-3).

### **Other Themes**

Although this study focused mainly on responsibility and decision making processes for foster parents and social workers, there were some other topics related to health care that emerged from the data. This information is important, and should be considered, especially for future research.

## *Relationships*

Overall, most social workers and foster parents agreed that foster parents are responsible for scheduling appointments and taking children to appointments, even though there were a few exceptions. However, the relationships between the foster parents, social workers, and providers emerged as very important when determining who is perceived as being responsible for a child's health care. When foster parents and social workers had good relationships with each other and with providers, it seemed to be helpful in determining who was responsible for health care, but respondents described how a lack of relationship or a bad relationship could hinder the provision of health care services. In some situations, the relationship between the foster parent and social worker was important to ensure health care. One foster parent said, "...working together between the foster parents and the social workers is to make sure that the child gets everything they need" (FP-4).

The relationship with service providers was also important. Foster parents and social workers both said that having a relationship with the health care providers influenced how they were able to get appointments and how they were treated when they were seen in the office. Having a good relationship could be beneficial.

And they trust you and they know you. Then you can go in and you can say, 'Listen, this has been an issue. Can we get a referral?' And if you just go ahead and ask for that referral, then you can get that ball rolling faster. Because without a referral, you can't see them at all. (FP-2)

Another foster parent illustrated the importance of relationships with providers in observing, "Like, I've had one pediatrician recognize me. Like, 'Hey! I know you! Don't you work so-and-so?' 'Yes, I do!' You know?" (FP-4).

Another foster parent reported, “Having that relationship with a pediatrician and somebody willing to listen with the med, the, I mean, you know, they, they know the kids” (FP-5).

A social worker conveyed a similar point, “That doctor's office really did respect DHR I believe. And they... I would call them and say, ‘Hey, Britney,’ whatever the woman's name was upfront. We were all on a first name basis...I mean, the doctor's offices, especially that one, would even stay open in the late afternoon for us” (SW-1).

Participants also described how there could even be a mixture of positive and negative relationships within the same office, which could hinder the care received. “Cause he’s [doctor] wonderful. He's amazing with the children. We love his clinic. But it's just this one scheduling person ...we're often late with them, because she won't respond to our referrals.” (SW-4).

### ***Dental Coverage***

Several participants asked if they could discuss dental health and orthodontic appointments. For purposes of this study, I intended to focus only on the physical health care appointments, but participants wanted to share their thoughts on dental health as well because they had some frustrating moments getting dental care for children in foster care. One foster parent said that parents and foster parents are sometimes unaware of standard dental care for children,

If a child's teeth are rotting because they're not brushing, that's a ... that's that's a huge issue. Whereas there's other parents that are just like ... that, maybe from their own upbringing or experience are like, oh, well, that's why you get you know, their adult teeth will grow back in, you know. So, I think that the standards need to be very explicit and trained. (FP-7)

This was reinforced by a social worker who had an experience related to lack of dental care for children on her caseload. “I learned this woman [foster parent] had not taken four children to the dentist in two years” (SW-1).

Another dental health issue that was mentioned several times was the difficulty of getting braces for children in foster care. Several social workers said that Medicaid doesn’t pay for braces unless the braces are deemed to be medically necessary. As one social worker described it, “He [child in foster care] needs braces. Well, Medicaid doesn't cover braces” (SW-1).

Another social worker expressed a similar frustration,

And I know that nothing in life is free and nothing is fair, but, like, my kids who can't get braces.... So why can't we pay for braces? I mean, I know you really can't, but it's very frustrating because when they need braces, we've got to figure out a way to pay for his braces. Braces would be beneficial to him. So why ... If they're beneficial to him, why can't we pay for them with Medicaid? (SW-2)

Social workers’ frustration about braces came out again in another interview,

Or honestly, like, you look at them and they need braces. But according to policy, unless a doctor says that, like, they medically need them, we can't cover it. And I have so many children that you look at their teeth and they need it, but it's not like medically dire need it, but they need it bad. I had one child that swore he would never let me send him out of foster care until I get... until we paid for his braces. And I'm like, ‘Unless you find a doctor that says you medically need them, it's not gonna happen.’(SW-4)

### ***Medicaid***

Along with concerns that Medicaid doesn’t cover braces for children in care, there were many comments about how problems with Medicaid influenced the way that foster parents and

social workers were able to provide care to these children. Even though children in foster care often qualify for Medicaid and can receive Medicaid benefits, the process can be difficult.

Once a child has Medicaid, however, that doesn't guarantee that they will receive health care in a timely or efficient way. In fact, some participants mentioned that providers might treat a child who has Medicaid differently from a child who has another type of health insurance. One participant said that an important part of providing health care to children in her home is by having "a good health care provider, you know, that's used to dealing with Medicaid. And doesn't necessarily treat them different because they have Medicaid" (FP-1). Another foster parent said,

Um, so I think that's really important, and, uh fighting for them [kids in foster care], like for their medical wellbeing. Because a lot of doctors, and I don't know if it's because they're Medicaid or not, I honestly don't know, but I feel like Medicaid patients kinda get the shaft. Like, they get lower, not from every doctor, but I feel like they're provided with a lower quality of care. (FP-2)

When I asked this foster parent about the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) appointment that Medicaid requires each year, she described a troubling situation,

Just because, I mean, it's a Medicaid form. That's all it is. It's a Medicaid form that helps them ... that knows that they have to pick up that child and that that child has been seen, and that that is a real child and not a fake child for fake benefits for someone else. So, I mean that's what it is, and we have to have an EPSDT every year. Well I mean, that's- that doesn't mean a checkup. That means an EPSDT form, it's totally different. So, there's- there's nothing on there that gives any kind of formal procedure of what the doctor needs to

look at or to assess or to ... Now a good doctor's going to do it, but you'd be surprised are many are just ... it's a Medicaid patient. They're pushing them through the office to get through because they don't make money on Medicaid patients. (SW-2)

### *Stigma*

Another theme that emerged was the stigma of foster care (and Medicaid) and how it influenced how children in foster care receive health care services. This was sometimes mentioned as “normalcy,” because participants expressed that the stigma caused the children in foster care to be singled-out and treated differently from other children. As one social worker put it, “And it is solely because, and- and some workers, some of the workers there will tell you, there's a general stigma about children who are under these programs, whether it be Medicaid, Family Guidance, um, EBT.... Um, but I feel like there's just... with the whole system-Um, the whole system has a stigma too” (SW-1).

Another social worker described how stigma can hinder quality health care for foster children,

I have seen some, you know, some doctor's offices look at, ‘Oh, that's a foster child.’ So, I would say not the best treatment, but it's just like, ‘Okay. We can hold off on this because we don't have information, or we just don't know about this kid.’ So, they're not really a high priority I would say.... I feel as though a lot of people try to den- deny foster care children from getting care with just the smallest of- of things. Whether them trying to figure it out or trying to tell the worker, you know, ‘Well, this- how about you try doing this,’ but still being able to see them at the same time. (SW-3)

Since most foster parents and social workers had become accustomed to this stigma, it really stood out to them if they received good treatment. One foster parent praised a doctor by

saying, “Doctor [name] will sit in there with me with his little Medicaid patients for eight hours and leave everybody else in the waiting room. (laughs) Love him!” (FP-2)

### **Emerging Theory**

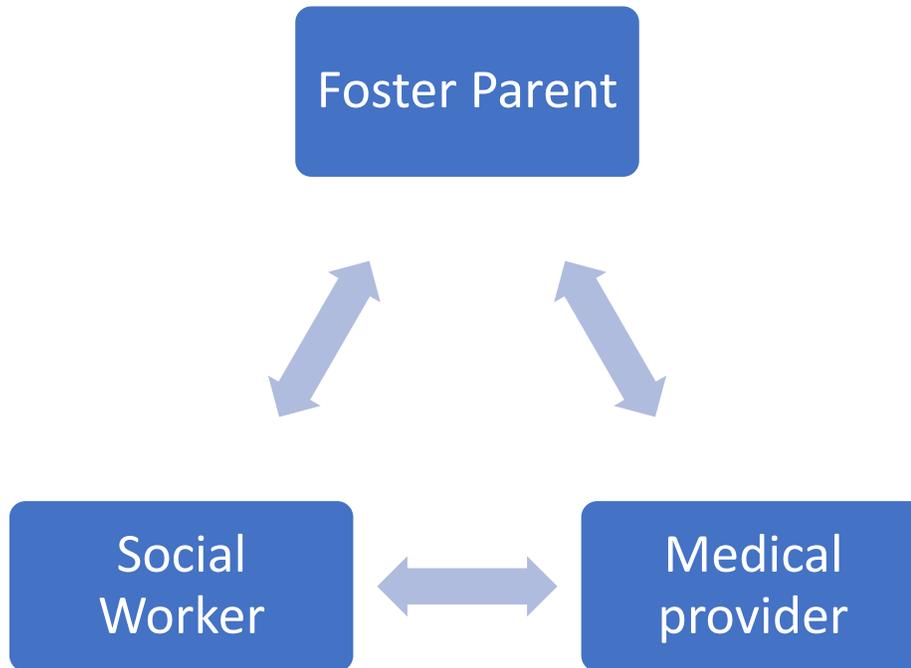
While completing the coding and classification of the data, a theory began to emerge. This theory includes the central themes of communication and expectations. When asked directly “Who is responsible?” many foster parents and social workers had quick answers. For example: “The foster parent is the person who really takes the lead on appointments. And takes them, and I know that technically it's DHR's responsibility. However, um, I mean we're the people who live with them and see them day in and day out” (FP-2). And “It's the responsibility of the foster parent to keep the kid healthy” (FP-7). Also, “In my opinion, that responsibility falls on foster parents” (SW-1).

However, through discussion, the participants provided a much more in-depth description of an interwoven set of conditions that influence who is responsible for the health of children in foster care. This is seen through the themes of communication and expectations. When foster parents and social workers have open lines of communication and agree on the expectations for each other, then there is understanding of responsibility that allows for the health care needs of the child to be met.

In an ideal situation, the foster parents, social workers, and providers would have open communication and well-understood expectations. This would create a flow of information that would include everyone in the process. (See Figure 2.)

## Figure 2

*Flow of Information When There is Appropriate Communication and Understanding Of Expectations*



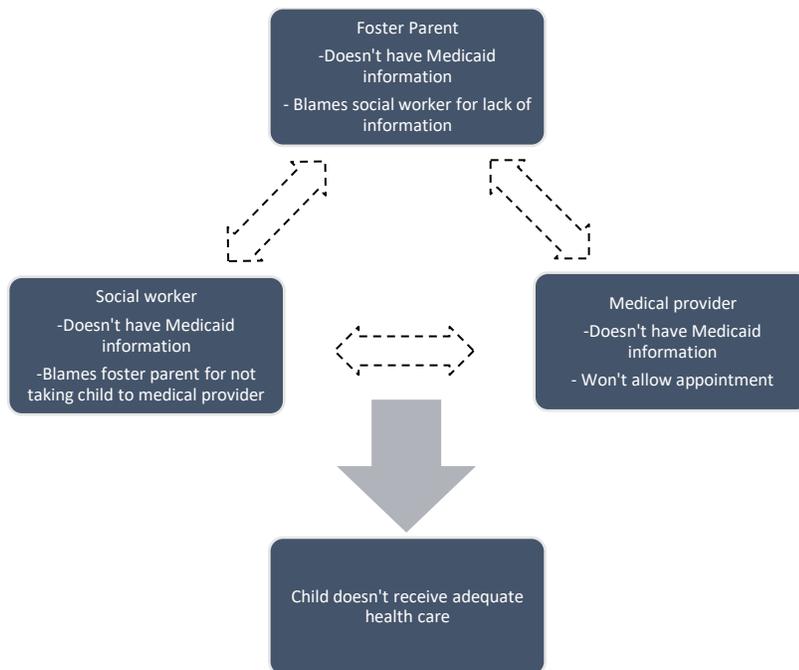
In less than ideal situations, there are disruptions in the communication and differences in expectations. These differences in expectations then cause more disruptions in communication that contribute to further misunderstandings.

For example, the communication that occurs between the foster parents and social workers is influenced by the expectations of these two groups. If the foster parent and social worker have open lines of communication, then there can be discussion and negotiation about who is responsible for taking a child to an appointment. If that communication is lacking, then it is more likely that there will be confusion and blaming. In turn, this confusion and blaming can influence further the relationship between the foster parent and social worker. Tension can create a disruption in the flow of communication between the three parties. This disruption then leads to a compromised, less-than-ideal situation for providing health care for children in foster care.

This dynamic was particularly evident in matters related to Medicaid. Foster parents, social workers, and providers are all influenced by Medicaid. If a child did not have Medicaid, the foster parent commonly blamed the social worker for not filing required information. The social worker blamed the foster parent for not getting the child the health care he/she needs; and the provider refused to see a child without Medicaid. In this situation, the communication among the three parties was disrupted, even if the Medicaid information was out of the control of everyone involved. (For example, if a child had multiple Medicaid numbers.) The child does not get the care needed, and the resulting bad feelings and expectations influence future interactions and affect other children who need services from a particular foster parent, social worker, or provider. (See Figure 3.)

**Figure 3**

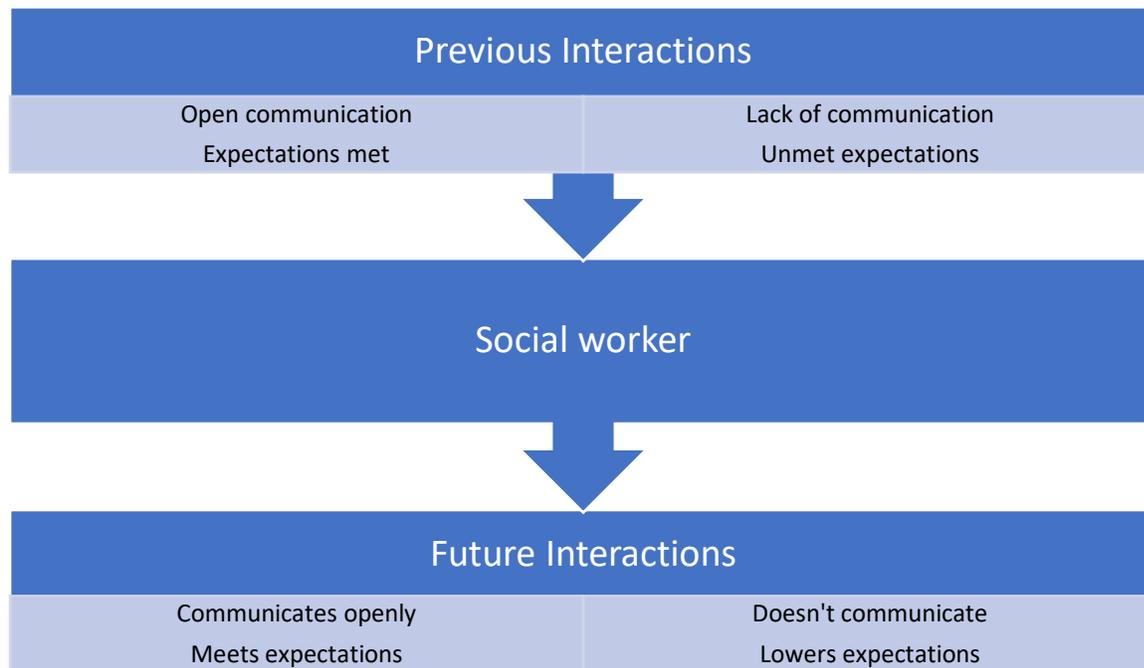
*Example of Lack of Communication and Unequal Expectations*



Also, the communication and expectations among the groups do not only influence any one child who is receiving services. Since social workers have multiple children on their caseload, they are interacting with multiple foster parents and providers. If there is a communication disruption between a social worker and one foster parent, it can cause further disruption between that foster parent and the provider or the provider and other foster parents. These interactions from previous cases then influence other future cases. An example of how this influences a social worker is seen in Figure 4.

**Figure 4**

*How Good and Bad Interactions Influence Social Worker Communication and Expectations*



## CHAPTER V

### DISCUSSION

In this chapter I discuss how the findings of this study fit into the current literature on the topics of the health of children in foster care, the diffusion of responsibility, and the perspectives of foster parents and social workers. I then discuss other information that was found in this study beyond what was originally considered, as well as the limitations of the study. The chapter ends with implications for future research, policy, and practice.

Through this study I wanted to learn about perceptions of foster parents and social workers to see if the concepts of diffusion of responsibility could be applied and considered in developing a new theory about the health of children in foster care. My findings are consistent with current literature on the topic of how foster parents see themselves. My study also provides new information on the views of social workers.

In addition, in several ways, this study also adds to knowledge about the health care of children in foster care. First, this study uses the perceptions of social workers to provide another lens with which to view the health of the children in foster care. Previous studies have examined the perceptions of foster parents, but not of social workers. Secondly, this study identifies some of the nuances of communication among those involved in the health care of children in foster care. My interviews illustrate what things really matter to the people who are on the frontlines of caring for children in foster care. They also highlight how differences in perceptions of different parties can cause confusion. Lastly, this study surely illustrates that there is not a “quick fix” to this complex problem. Even though participants shared suggestions that they thought would

improve the way children in foster care receive services, the study findings illustrate that even in some “ideal” circumstances, there continued to be problems that influenced the health care of children in foster care.

### **Connections to Existing Literature**

As stated in the literature review, the studies on the topic of the health of children in foster care and the topic of diffusion of responsibility have provided some information related to the specific topic of diffusion of responsibility and the health of children in foster care. Findings from this study can be compared to the existing literature in order to continue to broaden our knowledge on the topic.

### **Health Care**

On the topic of the health of children in foster care, the findings of this study are similar to the findings of the AAP (2014) regarding the importance of care coordination, including having assigned roles, quality communication, and positive relationships, as part of a positive organizational climate. This study also supports the findings of Zlotnik et al. (2015), in that there is an identified need of state- and local-level development and implementation of policy regarding the health needs of children in foster care.

### **Diffusion of Responsibility**

The findings of this study also support studies related to diffusion of responsibility. Latané et al. (1979) described the concept of diffusion of responsibility as “social loafing” because working as a group allows individuals to not have to work as hard. This study found that some groups describe other members as “lazy” because they do not do as much of the work as is expected, which is similar to the concept of “social loafing.” As for diffusion of responsibility related to the relationships of group members, the study findings are consistent with the existing

literature about how groups are more likely to help when the group consists of friends or if the group has high-cohesion (Levine & Crowther, 2008; Rutkowski et al., 1983). This study also affirms the importance of relationships between the members of a group who are working in a helping situation.

However, this study's findings contrast with Darley and Latane's (1968) suggestion that the more people there are available in a group, the less likely someone is to help. This study found that having more people involved tended to have a positive influence because larger groups offered more support when help was needed.

Related to the topic of diffusion of responsibility as applied to health care, some findings from this study were similar to findings from previous research. This study illustrated some diffusion of responsibility based on confusion of roles as well as a delay in services due to role ambiguity, which is also seen in the current literature (Henriksen & Dayton, 2006; Stavert & Lott, 2013).

### **Foster Parent and Social Worker Perspectives**

This study confirmed the findings of Schneiderman et al. (2011) that foster parents view themselves as an important part of providing health care, and they feel a disadvantage due to lacking information about past medical history. This study added to that information by providing a more in-depth look into how foster parents view their role in providing health care, while also gaining information from the social workers regarding the reason for a lack of information about past medical history.

The current literature on the health care of children in foster care has focused on the perspectives of the foster parents, but it hasn't included social workers in the discussion. This study supports the current literature in many of the findings pertaining to foster parents, but it

also adds the social worker's perspective, which adds another layer to the challenge of providing health care to children in foster care. For instance, even though the foster parents report that they consider themselves responsible for the health care of children in foster care, there are some instances where they are unable to fulfill that responsibility. It is often the social worker who then steps into that role. Both the foster parents and social workers reported that there are some foster parents who do not want to take children to appointments. Instead, the foster parents request that the social worker take the child. Having the social worker's perspective allows us to see those instances from a different vantage point. Where the foster parents saw it as something that they had to ask of the social workers on a rare occasion, the social workers identified that they had many cases to care for, so a request from one foster parent could actually require the social worker to attend numerous appointments if there are several foster parents with this request.

The larger issue of lack of information about children's health care is also expanded by including social workers. For instance, in this study, and according to Schneiderman et al. (2011), foster parents want social workers to provide them with as much information as possible about the health of the children in foster care. This study expands on that by including that sometimes the social workers don't have that information either. The social workers aren't withholding the information from the foster parents, which might be a concern of the foster parents, but instead the social workers have limitations to the information they can obtain based on what is available to them from the child's biological parents, doctors' offices, or case files.

Another benefit of the social worker's perspective, and a key contribution of this study, is the new window into the nuanced differences in communication between foster parents and social workers. For instance, many foster parents indicated that they would offer information to a

social worker about an upcoming appointment, and the social worker would offer to attend the appointment. The foster parent would then tell the social worker that they did not have to attend the appointment, but the foster parents expressed frustration with the social workers for not attending the appointments. This again shows the importance of the social worker perspective. Without hearing the social worker's perspective, it would be easy to conclude that social workers were shirking their responsibility.

Similarly, the expectations of the foster parents and social workers are better expressed by having the perspectives of both groups. A good example is the scenario discussed in the results section regarding availability. The foster parent was frustrated because she cannot reach her social worker on the phone when needed. However, a social worker told a similar story about how she was frustrated that a foster parent tried to contact her on a day when she was not at work. By having both perspectives, we can see how frustration can occur in a particular instance, even if the frustration is caused by different factors.

Having the perspectives of foster parents and social workers allows us to see the similarities in their concerns and expectations regarding the health of children in foster care, while also seeing how these interactions apply to the diffusion of responsibility theory. In the previous example, the foster parent thought that the social worker should be responsible (and available) for the child in care, while the social worker thought that the foster parent should be responsible (and available) for the child's needs when they arise. Such differences cause frustration that can hinder future communication as well as the ongoing relationship between the foster parent and social worker.

### **Other Information Gained From This Study**

Other information gained in this study is that what might be seen as the ideal situation to one person might not be the ideal situation to others. For instance, when asked about changes they would make to the system so that they could provide better health care, some participants identified the need for a clinic or referral service that is available specifically to children in foster care. From their perspective, this type of service would solve the problems that they encounter when trying to provide health care to children in foster care. However, in talking with a social worker who has access to such a clinic, we see that having what others consider to be a perfect service is in actuality not a perfect service. This is important as we address the problem of the health of children in foster care. We must acknowledge that there might not be a perfect answer to the problem, but instead we must address the various parts in order to address the problem as a whole.

### **Summary**

The results of this study provide insight into how both foster parents and social workers view their own roles and the roles of others in providing health care to children in foster care. Along with the diffusion of responsibility between those involved in the health care of children in foster care, we see how communication between the groups can also influence their interactions. Communication is important to foster parents and social workers, but it is important to make sure that everyone is communicating appropriately to ensure positive outcomes. This communication also relates to the expectations that foster parents and social workers have for each other and for those who provide medical services. When these expectations are not met, there is further confusion that influences communication and future interactions between these groups.

This study also illustrates the importance of stigma, Medicaid, and dental care as it relates to the health of children in foster care. These are areas of importance that emerged unexpectedly through the research, but they were important aspects of health care according to the foster parents and social workers. This information is important to consider for future research that addresses the health of children in foster care.

This study illustrates that diffusion of responsibility is one piece of the puzzle that can be addressed. By considering how the themes of communication and expectations can be addressed, we can make appropriate changes to the ways that foster parents, social workers, and medical providers interact in order to ensure the health of children in foster care.

### **Limitations**

As with all research, there were some limitations to this study. One such limitation was connected to time and consequences for my study sample. Although my dissertation proposal was approved by a committee in August 2019, the state DHR office did not give me approval to talk to DHR caseworkers until March 19, 2020. I had begun recruitment and interviews for foster parents, but recruitment of social work participants was delayed due to the length of time required to gain approval. As a result, I had a limited time period to collect data from social workers. With a longer time period, I might have interviewed more participants, which would have been ideal for my developing theory. I am not confident that I attained “saturation” in my interviews, especially with social workers.

A related matter pertains to the demographic composition of my sample, particularly related to age and race. Although it was not a goal to obtain a statistically generalizable sample, I did hope for a sample reflecting a range of experiences. With a mean age of 24, my social worker sample includes only young workers early in their careers. Ideally, I would have interviewed

social workers with longer work histories. I cannot know the extent to which the experiences and perceptions conveyed by the social workers in my study are a consequence of their age and limited experience. In addition, all but one of my participants was white. Alabama is a racially diverse state with a substantial portion of African-American foster care caseworkers, foster parents, and children in foster care. These perspectives are not reflected well in my study. It would be helpful to know more about how issues of race affect the themes of communication, relationships, stigma, and Medicaid illustrated in the study findings.

Along with the delay in DHR approval, changes also had to be made to my study due to the COVID-19 pandemic. In the original plans for my study, I was to interview participants face-to-face with the option of telephone interviews if needed. The state of Alabama declared a state public health emergency on March 13, 2020. Along with the health emergency, restrictions were put on large gatherings of people, including restaurants and libraries, where I had planned to meet participants for interviews. Due to my desire to complete the dissertation, as well as the uncertainty of the restrictions put on meeting with potential participants, I decided to complete interviews over the phone instead of waiting for the decrease of the COVID-19 risk to make it possible for face-to-face interviews. Conducting the interviews by phone is considered a limitation because in-person interviews are preferable over telephone interviews in qualitative research (Padgett, 2008). The pandemic also possibly influenced participation of social workers due to them being considered essential employees and having to continue work even during the state Stay at Home order. At the same time, some of the COVID-19 restrictions might have helped me to recruit participants, as people were restricted to home.

The pandemic and social distancing that occurred during the time of my study could also have influenced the responses of the participants. During the time of a pandemic, people are

often thinking of health-related issues, so participants' concerns regarding health care might have been heightened due to the circumstances.

Another limitation, which is also connected to time pressure, was my lack of experience in coding qualitative data. In addition to focusing on the substance of my transcripts and codes, I was simultaneously learning how to code, and how to use new software for coding. It was a steep learning curve, and I think that my coding and the sophistication of my data analysis will be much improved in future studies. There are likely elements of the data for this study that can be explored further.

Lastly, another limitation to consider is the participants' decision to participate in my study. There are several ways in which the choice of participating could be connected to the results I obtained. For example, participants who were willing to participate in my study might be more likely to discuss difficult topics. Since communication was found to be important, people who are willing to communicate with me for my study might be more likely to communicate with other members of the child welfare team. However, this could be influenced in the opposite way as participants for my study might have considered my study as an opportunity to discuss topics that they didn't feel comfortable discussing with other members of their child welfare team because I am an outsider and they did not have to fear any retribution for voicing their perspectives. Also, foster parents and social workers who were recommended to participate in my study might be the "ideal" people in those roles. Someone who does not excel in their job as a foster parent or social worker might not have been recommended by their peers or colleagues as someone who I should interview. Due to these possible influence of self-selection on my sample, it can be considered a limitation.

## **Implications**

The implications for this research are multi-faceted and could be applied to various areas of social work. As described above, there are many pieces involved in providing health care to children in foster care, and this study provides guidance to several of those areas.

### **Practice**

For social work practice, this research underscores the importance of communication between social workers and providers. This can influence how social workers interact with foster parents and health care providers. As suggested by previous studies, knowing that having a good relationship with providers may encourage social workers to maintain positive relationships in order to ensure the care of children on their caseload. One of the ways to maintain those relationships is through good communication. Although it might seem that trying to have a good relationship with others would be common knowledge, if we acknowledge its importance, it might be easier to behave in ways that promote good relationships even in situations where that might not be our first reaction.

A focus on the importance of communication has implications in social work practice due to the need to emphasize communication between social workers and their clients and providers. Some ways that communication could be encouraged would be having set rules for who to contact in what situation. For example, a flow-chart type form that foster parents or social workers could use that provides contact information for various people or resources that are needed when working with children in foster care. Something of this sort could prevent some of the situations described in the interviews where foster parents and social workers became upset when they could not contact each other due to changes in hours for state holidays. Another way that practice could be updated to incorporate the information about communication in this study

would be for social workers and foster parents to be open about how they would like to communicate with each other. The participants identified that some social workers prefer phone calls, some prefer text messages, while others prefer email or updates at monthly meetings. Having a pre-determined way of communicating could make it easier for foster parents and social workers to communicate with each other rather than having to navigate the many options for communication that are currently available.

This research could also influence how workers from different locations work together to make sure that everyone involved with DHR has a better experience, since those interactions can negatively influence social worker and foster parent interactions in the future. This study found differences in the experiences of communication and expectations from county to county, which caused problems for foster parents and social workers who work with multiple counties. By offering training state-wide regarding appropriate ways to communicate, as well as what the expectations are for various groups, we could improve the interactions between foster parents, social workers, and medical providers. Knowing what the expectations are without having to guess based on previous experience would reduce the diffusion of responsibility and increase the confidence that the groups have with each other.

Another consideration for practice is how foster parents and social workers might be influenced by the stigma associated with child welfare and foster care. Foster parents mentioned the stigma specifically related to Medicaid and how difficult it is to find providers. This difficulty in finding providers could affect when and where foster parents seek care for children in their care. For instance, if a foster parent has traveled out of town with the child in foster care for a family vacation, the child might not be able to visit a health care provider if needed due to a lack of knowledge of facilities in the area who take Medicaid. If the foster parent was afraid of

not being able to obtain health care services while on a vacation, it might prevent the foster parent from including the child in foster care in their plans for the vacation and cause them to opt to have the child be placed in a respite home until the family returned. If foster parents were able to easily access information about Medicaid providers, this might take away some of the problems related to locating providers when needed.

Some of these concerns related to stigma could be addressed by improving the information that is available to foster parents regarding which providers accept Medicaid. This could also be addressed by encouraging foster parents and social workers to work together to identify providers who have provided a good experience for children in foster care. Continued training for foster parents and social workers regarding when and where a child should have medical attention could also improve upon the quality of health care the children in foster care receive.

Lastly, as it relates to practice, this study provides information about the potentially undesirable consequences related to social worker turnover in child welfare. Several participants noted the number of social workers who had been assigned a case. This study found information regarding the importance of communication and expectations as they relate to how foster parents and social workers perceive the health care of children in foster care. If the social worker for a case is constantly changing, this could cause disruption in communication between the foster parent and social worker due to changes in contact information. Also, the expectations that foster parents have based on a previous social worker could influence how the foster parent interacts with the future social workers on a case. This lack of continuity on a case could hinder the progression of a case if the information has to be provided over and over again at each change in social worker.

## **Policy**

In this study participants identified some confusion based on the ambiguity of policy and its implementation by different foster parents and social workers. Although it is difficult to write policy that is broad enough to encompass all possible scenarios while also being concise enough to be understood, the understanding of policies should be considered when writing policies. Even though policies might be written by people who are in the field of social work or law, there are many people who do not have training in those areas who will be reading and using these policies. Making policies easy to understand, and thus easier to follow, is an important part of the creation of policy.

The information gained from this study has implications for various areas of policy. Based on the main themes and theory, this research can be applied to policy that relates to training, Medicaid usage, information transfer, dental care, and stigma related to children in foster care.

The importance of training social workers and providers is another area of this research that relates to policy. There are currently policies in place regarding how much training foster parents and social workers receive. However, this study shows that there are some differences in how that training is conducted among the various counties. Creating a training program that is applicable to all counties and is implemented equally across counties is important. If the counties worked independently of each other, then the differences in training might not be a concern; however, the overlap of services from county to county can cause difficulty for foster parents and social workers when the training varies by county. The amount of training, as well as the type of training, should be considered. This training could help both social workers and foster parents

gain a better understanding of the importance of communication and relationships on the provision of health care for children in care.

The use of Medicaid for the population of children in foster care is another area of policy that could benefit from this research. The participants identified several instances where problems with Medicaid caused delays in care or lack of care for children in foster care. One of the ways that policy could improve in this area is by providing a central database for Medicaid information. Participants indicated that even if a child has Medicaid, the previous medical information is not available to those who need that information. One of the considerations in this lack of information relates to the timelines required for health visits for children in foster care. Once children are placed into foster care, a foster care physical must take place within 10 days of being placed into custody. However, if the information from Medicaid has not been provided or approved, the child might not have Medicaid coverage during the 10-day time period when the child must be seen by a medical provider. Having a central database for Medicaid information could allow for continued care without gaps in service provision.

Participants said that currently they rely on information from parents, which is sometimes unreliable, in order to piece together the medical history of a child. Having a database of health information for children who have been receiving Medicaid could allow foster parents, social workers, and medical providers to access the information they need to provide appropriate medical care without gaps or overlap. Participants in this study who have access to the Children's of Alabama Health System, which includes the Children's Hospital and various other pediatric clinics in the Birmingham area, stated that the transfer of records through that system works well. A system similar to this could be used for the transfer of information regarding

children in foster care at the Medicaid, state, or county level in order to improve the flow of information among those involved in the health care of children in foster care.

Another implication for policy is having a set form of communication and information transfer between those who need to know about the health of children in foster care. The participants in this study said that there is not a set way that information is given to the various people who need to know about the health of the child. Some participants identified telephone calls as the best way to provide information, while others preferred email or text. This difference in the type of communication used could delay or prevent the transfer of information from one person to another. Having policy that allows for continuity of care and the sharing of information would allow for better paths of communication related to the health of children in foster care.

Lastly, this study provides information for the importance of policy development around the stigma associated with children in foster care. Participants identified that children in foster care are often treated differently than others when it comes to services and care. Having policy that addresses these issues and provides space for children in foster care could help combat some of this stigma. Examples of policy could relate to the availability of clinics who take children in foster care as patients, resources dedicated specifically for children who are placed into foster care, or providing discreet ways of identifying foster children so that they are not easily identified as being in foster care.

### **Future Research**

Throughout this study, participants indicated other areas and topics that they considered to be important related to the health of children in foster care. Some of these topics could not be addressed in this current study due to its focus on the identified research questions, but these questions could be asked in future research studies.

There were certain characteristics related to the participants that could be studied in future research. For example, in this study the average age of the foster parents was 38.6 years, while the average age of the social workers was 24 years. Future research could look at differences in ages of foster parents and social workers and how that might relate to the way that the groups communicate and interact. The list of participants also included some foster parents who are employed in the medical field, and that could influence the way that they make decisions related to the health of children in foster care. Future research could also investigate how the amount of education someone has influences how they make decisions related to health care.

Other issues related to medical providers could also be studied. This study focused on the perspectives of the foster parents and social workers, but future research could include the perspectives of health care providers. The availability of providers, amount of wait time before appointments, distance traveled to appointments, and interactions with health care office staff could also be studied.

Another opportunity for future research could include the perspectives of other members of the service team. This study added to the literature by adding perspectives of social workers, but future research could expand on this topic by including the perspectives of medical providers, foster youth, former foster youth, or biological parents. These perspectives could broaden the knowledge of the experiences related to providing health care to children in foster care. The current study provided insight into how foster parents and social workers view health care, but including other perspectives in future research could allow for other lenses with which to view the issue of the health of children in foster care.

Research is also needed related to the expectations of foster parents and social workers as it relates to the health of children in foster care. Although this study identified a theory relating to the importance of expectations and how they influence future interactions, future research could study the origin of those expectations and the specific factors that bring about changes in those expectations. Although this research is preliminary for the area of the health of children in foster care, the findings are still important and have implications for the areas of practice, policy, and future research.

### **Significance and Conclusion**

As a former foster care social worker, I am personally aware of the importance of this study. During my time working at DHR, I saw first-hand how lack of communication and relationships caused role confusion that could influence outcomes related to the health of children in foster care. This research is important as it has implications for policy and practice related to the areas of health care and child welfare. This research builds upon other research that has been done in the fields of social work, psychology, and health care that could be used to further study this topic and create opportunities for changes in policy that could improve health outcomes for children in foster care. This is especially important as children in foster care continue to have worse health outcomes than similar children who are not in foster care.

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## APPENDIX

THE UNIVERSITY OF  
**ALABAMA**

Office of the Vice President for  
Research & Economic Development  
Office for Research Compliance

November 19, 2019

Laura Boltz  
School of Social Work  
The University of Alabama  
Box 870314

Re: IRB # EX-19-CM-300 "A Grounded Theory of the Perceptions of Caseworkers and Foster Parents Regarding the Healthcare of Children in Foster Care"

Dear Ms. Boltz:

The University of Alabama Institutional Review Board has granted approval for your proposed research. Your protocol has been given exempt approval according to 45 CFR part 46.104(d)(2) as outlined below:

*(2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:*

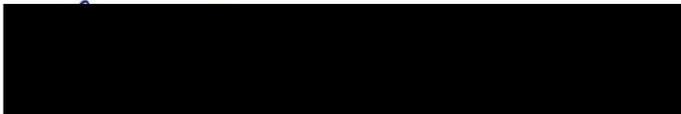
*(iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).*

The approval for your application will lapse on November 18, 2020. If your research will continue beyond this date, please submit the annual report to the IRB as required by University policy before the lapse. Please note, any modifications made in research design, methodology, or procedures must be submitted to and approved by the IRB before implementation. Please submit a final report form when the study is complete.

Please use reproductions of the IRB approved informed consent form to obtain consent from your participants.

Good luck with your research.

Sincerely,



Jessup Building | Box 870127 | Tuscaloosa, AL 35487-0127  
205-348-8461 | Fax 205-348-7189 | Toll Free 1-877-820-3066

### Informed Consent

Please read this informed consent carefully before you decide to participate in the study.

- You are being asked to take part in a research study.
- This study is called A Grounded Theory Study of the Perceptions of Caseworkers and Foster Parents Regarding the Healthcare of Children in Foster Care.
- The study is being done by Laura Boltz, a PhD Candidate in the School of Social Work at the University of Alabama. Ms. Boltz is being supervised by Brenda Smith, PhD, Associate Professor of Social Work at the University of Alabama.
- This study is being done to learn more about how foster parents and caseworkers view their roles in providing healthcare for children in foster care.

**Purpose of the research study:** This study is being done to learn more about how foster parents and caseworkers view their roles in providing healthcare for children in foster care. This information is important because children in foster care aren't as healthy as children who aren't in foster care. The information in this study will be used to better understand who is involved in taking care of the health of children in foster care.

**What you will do in the study:** If you meet the criteria and agree to be in this study, you will be asked to participate in an interview, either in person or by telephone.

**Time required:** Each interview should take about 45 to 60 minutes. You will be interviewed two times. The second interview will be done so that we can make sure that we accurately understood the information you provided in the first interview. The second interview will allow us to ask any other questions and for you to clarify any of your answers from the first interview. The entire study should take no more than 2 hours of your time.

**Risks:** Little or no risk is foreseen related to participation. Some of the questions could remind you of frustrating experiences or situations.

**Benefits:** There are no direct benefits to you for participating. We hope that the information we gain from the study will help us understand how foster parents and caseworkers view their roles in how children in foster care receive healthcare. Also, we hope that information gained from the study will help us begin to understand perceptions about who is responsible for the health of children in foster care. We also hope information from the study will benefit children in foster care and the people who work with children in foster care.

**Confidentiality:** Your name will not be associated with your interview responses. Study materials containing your name, such as this consent form, will be stored separately from interview data. The audio recordings and the transcriptions of the data will be de-identified and code numbers linking you to your interview will be kept separate from the data that is stored electronically on UA Box. (UA Box is a cloud-based storage system that provides a secure place for UA students to store data.)

**Voluntary participation:** Your participation in the study is completely voluntary. You have been asked to be in this study because you are either a foster parent of a child in foster care or you are a

Project Title: A Grounded Theory Study of The Perceptions of Caseworkers and Foster Parents Regarding the Healthcare of Children in Foster Care

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caseworker/social worker who has a caseload that includes children in foster care. You have completed a form indicating that you are interested in participating in this research.

**Right to withdraw from the study:** You have the right to withdraw from the study at any time without penalty

**How to withdraw from the study:** If you want to withdraw from the study, tell Ms. Boltz to stop the interview. There is no penalty for withdrawing. If you would like to withdraw after your materials have been submitted, please contact Ms. Laura Boltz at 205-394-8609 or [ldboltz@crimson.ua.edu](mailto:ldboltz@crimson.ua.edu)

**Compensation/Reimbursement:** You will receive no payment for participating in the study

**If you have questions about the study or need to report a study related issue please contact, contact:**

Primary Investigator: Laura Boltz, MSW, MPH, LICSW, PIP  
PhD Candidate  
Social Work  
Telephone: 205-394-8609  
Email address: [ldboltz@crimson.ua.edu](mailto:ldboltz@crimson.ua.edu)

Faculty Advisor: Brenda Smith, PhD  
Associate Professor and Director of PhD Program  
Telephone: 205-348-6528  
Email address: [bsmith2@sw.ua.edu](mailto:bsmith2@sw.ua.edu)

**If you have questions about your rights as a participant in a research study, would like to make suggestions or file complaints and concerns about the research study, please contact:**

Ms. Tanta Myles, the University of Alabama Research Compliance Officer at (205)-348-8461 or toll-free at 1-877-820-3066. You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach Website at <http://ovpred.ua.edu/research-compliance/prco/>. You may email the Office for Research Compliance at [rcompliance@research.ua.edu](mailto:rcompliance@research.ua.edu).

**Agreement:**

I agree to participate in the research study described above.

I do not agree to participate in the research study described above.

**Agreement to be Audio Recorded:** I understand that part of my participation in this research study will be audio recorded, and I give my permission to the research team to record the interview. I understand that the data will be stored in a secure, password protected data storage system (UA Box) and destroyed at the end of the study.

Yes, my participation in interviews can be audio recorded.

No, my participation in interviews cannot be audio recorded.

Project Title: A Grounded Theory Study of The Perceptions of Caseworkers and Foster Parents Regarding  
the Healthcare of Children in Foster Care

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\_\_\_\_\_  
Signature of Research Participant

\_\_\_\_\_  
Date

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Print Name of Research Participant

\_\_\_\_\_  
Signature of Investigator or other Person Obtaining Consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Investigator or other Person Obtaining Consent