

Promoting Healthy Outcomes for Children in Substitute Care:

A Guide for Judges, Court Personnel
and Child Welfare Professionals
in Philadelphia



Subcommittee on Children in Substitute Care
of the Pennsylvania Children's Health Coalition

Promoting Healthy Outcomes for Children in Foster Care

CHECKLIST

- Does the child have an identified primary health care provider and medical home?
- Has the child received a comprehensive health evaluation since entering foster care? (i.e., within 30 days of placement in foster care)
- Was the child's physical health evaluation congruent with EPSDT guidelines?
 - Are the child's immunizations up to date for age?
 - Has the child received hearing and vision screening?
 - Has the child received screening for lead exposure?
 - Has the child received screening for anemia?
- Has HIV testing been considered for this child?
- For adolescents, has the teen received reproductive health care?
- For children under 3 years: has the child received a developmental assessment for Early Intervention services?
- For children 3 years and older: has an evaluation for special education and related services been considered for this child?
- Has the child received regular dental services?
- Has the child been seen by any medical specialists?
 - Which specialists?
- Has the child received a mental health and substance abuse assessment?
- Has parental consent been obtained for all needed assessments and treatments, or are any court orders required?

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About the authors: In 1996 a group of pediatricians in training organized a grass-roots effort to reduce barriers to health care for children in foster care. This group joined the Pennsylvania Children's Health Coalition as its *Subcommittee on Children in Substitute Care*. Membership on this subcommittee includes professionals from both the public and private sectors in the fields of pediatrics, child welfare, allied health care, early intervention, behavioral health, education, and law, with foster parent involvement. For more information on the activities and publications of the *Subcommittee on Children in Substitute Care* contact us at fosterkidshealth@jlc.org. This publication may be downloaded in a PDF file at no cost from Juvenile Law Center's website at www.jlc.org.

Acknowledgments: Production of this guide was made possible by a grant from the Philadelphia Department of Public Health, Division of Early Childhood, Youth and Women's Health. The opinions expressed in this report are those of the author and do not necessarily reflect the views of the Philadelphia Department of Public Health, Division of Early Childhood, Youth and Women's Health.

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RESEARCH ON PHILADELPHIA'S CHILDREN IN SUBSTITUTE CARE

National studies indicate that 18% of children in the U.S. have chronic medical, developmental, or mental health conditions and, among children under 6 years old, 10-12% have significant delays in the development of their communication, cognitive, motor, social-emotional, and self-help skills. How do Philadelphia's children in foster care compare to U.S. children on these health status indicators?

Health Passport for Philadelphia Children in Substitute Care Pilot Study, October 2002*

The health status of 100 children in substitute care, ages 2-19 years, was followed for one year by the Department of Human Services (DHS) and the Department of Public Health:

- 56% of the children had a diagnosed chronic medical condition
- 55% had allergies
- 24% had mental health problems and/or mental retardation diagnosed (sometimes co-occurring with physical health problems)
- 19% had one or more hospital admissions

The Starting Young Program, January 1999**

Comprehensive pediatric developmental evaluations were conducted on 308 children ages 2-30 months who had open DHS cases:

- 60% had chronic medical conditions
- 49% had developmental delays
- 22% were under-immunized
- 20% had growth delays or failure to thrive

United States General Accounting Office Report on Foster Care:

Health Needs of Many Young Children are Unknown and Unmet, May 1995***

Review of the records of 22,755 children under 3 years of age placed in foster care in Philadelphia, New York City, and Los Angeles indicated that:

- 12% received *no* routine preventive health care
- 34% did not receive immunizations
- 32% had some known health needs that were unmet
- 78% of the children were at high risk for being HIV positive, yet only an estimated 9% were tested for it
- Less than 10% received services for developmental delays
- Children in kinship care received fewer health care services than those in foster care
- Public child welfare agency health care records were woefully incomplete

Box 1

* Division of Early Childhood, Youth and Women's Health (2002). *Health Passport for Philadelphia Children in Substitute Care: Report on the Pilot Project*. Philadelphia Department of Public Health.

** Silver, J., DiLorenzo, P., Zukowski, M., et al. (1999). Starting Young: Improving the Health and Developmental Outcomes of Infants and Toddlers in the Child Welfare System. *Child Welfare*, 78, 148-165.

*** U.S. General Accounting Office (1995). *Foster Care: Health Needs of Many Young Children are Unknown and Unmet* (GAO/HEHS-95-114). Washington, DC.

INTRODUCTION

With the passage of the Adoption and Safe Families Act (ASFA) of 1997, Congress **mandated** that child welfare agencies take steps to ensure children's **health** as well as their safety and permanence. ***Children in foster care must have access to quality and timely health care, early intervention, and behavioral health services to promote their healthy well-being and support their opportunities for stable placements and permanency.*** Courts and child welfare professionals are at a unique advantage to ensure that these services are in place. At every hearing, the Court can review that children are receiving all appropriate health care by requiring child welfare professionals to document what specific health and related services are in place.

This booklet is intended as a practical guide to securing resources for children in substitute care. It outlines what the Court and child welfare professionals can do to support children's healthy development and to comply with federal mandates. Ultimately, if this comprehensive care is provided, we can improve children's outcomes, promote their permanency, and support their families.

Overview of the Health Care Needs of Children in Foster Care

Children in foster care are a medically vulnerable group. Most receive inadequate health care prior to placement. Their health and development are further compromised by risks such as parental substance abuse and experiences of physical abuse, sexual abuse, and severe neglect. ***Many children in foster care continue to receive insufficient health services even after placement due to bureaucratic obstacles.*** Barriers include turnovers in child welfare personnel, changes in placements, lack of available medical records, and a lack of sufficient community capacity to provide mental health and dental services. When children change placements they usually change health care providers, which disrupts their continuity of health care. Additional barriers include poor coordination of physical health, behavioral health, and child welfare services, as well as poor communication among the different systems and with foster and biological parents.

Although these problems are national in scope, the need is especially acute in Philadelphia. According to the U.S. Government Accounting Office, nearly one-third of Philadelphia foster children under age 3 had unidentified and unmet health care needs. Foster children in Philadelphia have high rates of chronic and acute medical conditions, developmental delays, and lead poisoning (*see Box 1*). We know that when developmental and behavioral problems go untreated, children are much more likely to experience failed placements, additional maltreatment, and problems achieving permanency.

FEDERAL AND STATE LAWS AND REGULATIONS GOVERNING THE HEALTH AND WELL-BEING OF CHILDREN IN FOSTER CARE

ASFA mandates that states must implement standards to ensure that both public and private child welfare agencies provide quality health services to children in foster care.¹ Similarly, Pennsylvania's Juvenile Act charges the child welfare system with providing for the "wholesome mental and physical development" of children in its care.²

State Regulations

The Department of Human Services (DHS) is responsible for securing appropriate health care for children committed to its custody.³ Case plans must include an identification of those health services to be provided to the child, and a timetable for the delivery of these services. ***Updates specifying what services actually were provided and any changes to the health plan must be submitted to the court at permanency hearings.*** At a minimum, the agency is required to ensure that a child receives:

- A complete physical examination by a physician within 60 days of admission to foster care, as well as periodic well-child visits for routine preventative health care
- A dental examination within 60 days of admission, and check-ups every 9 months thereafter
- Immediate medical attention for all problems identified at these examinations
- All necessary medical care when the minor is ill
- A case plan that records the information listed below. ***This information must be reviewed and updated each time a child changes placement, and provided to the child's new foster care provider to ensure continuity of care:***
 - All medical problems, including known physical, mental or emotional disabilities
 - Names and addresses of the child's health care providers
 - All medications the child is taking
 - Immunization records
 - Any other relevant health information

EPSDT

In addition, all children in DHS custody are eligible for the federal Medicaid program, which is called Medical Assistance (MA) in Pennsylvania. As MA recipients, children from birth to their 21st birthday are entitled to comprehensive health care according to ***EPSDT guidelines (Early Periodic Screening, Diagnosis and Treatment)***. Under EPSDT, children are entitled to:

- Periodic screening examinations. These include a physical examination, laboratory tests, and assessments to identify mental health problems and disorders, and developmental delays or disorders such as mental retardation
- All medically necessary follow-up care that the child needs to:
 - correct a condition discovered during the screens; OR
 - lessen the condition's effects; OR
 - achieve and maintain maximum functional capacity to perform daily functions

¹ 42 U.S.C. § 671(a).

² The Juvenile Act, 42 Pa.C.S.A. § 6301(b)(1.1).

³ 42 U.S.C. § 675(1)(B); 42 Pa.C.S.A. §§ 6301(b)(1.1), 6351(f)(2); 55 Pa. Code §§ 3130.31(3), 3130.34(4), 3130.38, 3130.61, 3130.67, 3700.39, 3700.51.

See page 4 for additional information on EPSDT.

Medical Assistance (MA) and HealthChoices

MA is the most comprehensive program through which children can obtain health services as it pays for all medically necessary treatment for enrolled children. Some counties still provide MA through the traditional fee-for-service system. However, many Pennsylvania counties – including Philadelphia, Bucks, Chester, Delaware, and Montgomery – currently provide MA through a managed care system named HealthChoices. Under the HealthChoices managed care system, the Pennsylvania Department of Public Welfare contracts with physical health and behavioral health managed care organizations – PH-MCOs and BH-MCOs – to provide treatment and services to MA recipients in certain counties. MA recipients in HealthChoices counties must select among network providers to obtain physical and behavioral health services.

WHAT IS COMPREHENSIVE HEALTH CARE FOR CHILDREN IN FOSTER CARE?

As explained above, the law requires that children in foster care receive comprehensive health care services to address their physical, dental, developmental, mental and emotional health needs. However, the laws and regulations do not provide sufficient detail regarding what these services should include, nor do they take into account the medical complexity of the health care needs of children in foster care as documented by national and local studies. To redress this gap, the following section presents the basic standards necessary to ensure the healthy development of children in foster care. These guidelines were developed by pediatric health care professionals with expertise in treating children in the foster care system.

Physical Health

Each child in foster care should have an identified primary health care provider and medical home.

Primary Care services provide continuous preventive health care, including well-child visits (“check-ups”) for screening and evaluations, immunizations, and guidance for the child and caregiver to enhance health and development. The primary care professional creates a **medical home** where children receive care for acute and chronic illness, coordination of medical subspecialty care, and where information on health history, services and insurance coverage is housed. ***It is crucial that children in foster care have a medical home because they are a medically complex population with high rates of chronic illness, infectious disease, developmental and behavioral health needs.*** Multiple changes in homes, caregivers, and caseworkers also increase their need for a consistent health care provider who will get to know them well. All of their health care services (routine preventive, acute illness, chronic illness) should be available at one site.

Within 30 days of placement in foster care the child must have a comprehensive health evaluation.

Although current state regulations require the evaluation to take place within 60 days of placement, more stringent practice is warranted. Too many children in foster care have undiagnosed and unmet

health care needs.⁴ By failing to identify and document such conditions, these children are at risk for medical crises.

A comprehensive health evaluation includes a review of all available data and medical history about the child, a physical examination, and screenings to identify medical, developmental and/or mental health problems that require attention. Based on this information the health care professional develops an individualized treatment plan. To do this well, the health care professional relies on the child welfare professional to provide information on past medical history, which in turn depends on the release of medical records.

Each child should receive on-going primary health care in accordance with EPSDT standards.

Under the EPSDT periodicity schedule, children must receive EPSDT exams at the following specified intervals:

- Infants: Due to their rapid growth and greater vulnerability, infants have the most intensive schedule, requiring EPSDT exams at birth, 2, 4, 6, 9, and 12 months of age
- Toddlers: 15 and 18 months of age
- From 2 – 5 years: Exams every year
- From 6 – 21 years: Exams are recommended every two years by EPSDT. But as noted above, Pennsylvania state foster care regulations require annual examinations

EPSDT exams must include:

- an unclothed physical exam
- evaluation of hearing and vision
- immunizations
- laboratory tests (including tests for anemia and lead)
- mental health and developmental screenings

HIV testing should be considered on a case-by-case basis for each child in substitute care.

Children and adolescents in foster care, just as those who are not in care, may acquire HIV infection as a consequence of many factors:

- Perinatal transmission during birth
- Sexual abuse/sexual assault
- Drug abuse with unclean hypodermic needles
- Unprotected sexual activity

Many children who have HIV will not have ANY symptoms for 3 to 10 years following infection. ***Currently medications are available to treat children with HIV infection, which can greatly extend their lives and improve their health. HIV testing should be strongly considered for ALL children in substitute care with one or more risk factors, because HIV is uniformly fatal when undiagnosed and untreated.***

The HIV test is *not* considered a routine test, and separate consent from the child's legal guardian must be obtained to perform HIV testing. *See page 13 on obtaining consent.*

⁴ U.S. General Accounting Office (1995). *Foster Care: Health Needs of Many Young Children Are Unknown and Unmet* (GAO/HEHS-95-114). Washington, D.C.

Reproductive health must be addressed for all appropriate youth in foster placement.

The sexual health of adolescents in foster placement often is influenced by their histories of abuse and neglect. Many teens in care have been sexually abused or sexually assaulted, and these experiences place them at risk for early sexual activity and high-risk behavior. Reproductive health interventions for teens in foster placement also should be sensitive to the issues of gay, lesbian, bisexual and transgender teens. ***Parent/guardian consent is not required for reproductive health visit or services.*** See pages 11-14 on consent and information-sharing issues.

Routine health care for adolescents should include:

- Sensitive and gender-neutral sexual history by a health care provider who is comfortable with asking these questions
- Genital exam
- Gynecological exam for young women who have had a previous exam or sexual contact
- Preventive interventions to reduce the likelihood of getting sexually transmitted diseases (STDs)
- Screening for STDs, with treatment and follow-up as needed

Children with chronic medical conditions will often require specialty care.

If the primary health care provider identifies a health problem during the EPSDT exam, the child may be referred to a medical specialist and/or allied health specialist, who may be located elsewhere. Specialty care providers include neurologists, ophthalmologists, orthopedic specialists, allergists, and numerous others. The specialist will conduct additional evaluations and may provide necessary treatment and/or make referrals to other physicians or to allied health professionals. Children with chronic illnesses or developmental disorders often have these conditions monitored by specialty care providers, while their primary care needs for preventive and routine care, health guidance and treatment of acute illness continue to be met by the primary care provider. ***Children in foster care have much higher rates of chronic conditions and need continuity in terms of the specialists who care for their often complex conditions.*** Thus, when children who change placements change primary health care providers, it is essential that they continue to have follow-up visits with the various medical specialists who monitor their conditions.

Dental Health

Every child in foster care should have an identified dentist.

Dental decay is epidemic among children in foster placement. The oral exam also can reveal evidence of abuse. The consequences of poor dental health include an inability to eat or speak well, gum and facial infections, pain, and poor self-image. Dental services are covered under EPSDT and MA. Although MA will not pay for a routine examination until the child is 3 years-old, any sign of dental decay, especially “baby bottle caries” when the front teeth are obviously decayed, are covered at any age, due to the urgent need for intervention.

Early Intervention Services for Infants and Toddlers

ALL children birth through age two should be referred for a developmental assessment within one month of entering foster care.

Children in foster care have extremely high rates of developmental delays and physical disabilities. Many young children in foster care need specialized interventions to address these conditions. Under federal and state law, eligible children with disabilities from birth through age 2 are entitled to Early Intervention services.⁵ ***Young children who have developmental disabilities and delays, or physical or mental conditions likely to result in delays, can receive services through the Early Intervention Program of the federal Individuals with Disabilities Education Act (IDEA).*** Eligible infants and toddlers include those who experience a delay in their physical, communication, cognitive, social-emotional, self-help and/or motor development. Infants and toddlers whose diagnosed physical or mental conditions have a high probability of resulting in developmental delays also are eligible. *See Box 2.*

Medical Conditions Which Entitle Infants and Toddlers to Early Intervention Services

- Autism
- Blindness/severe vision impairment
- Deafness/hearing impairment
- Chromosomal conditions (i.e., Downs Syndrome and Fragile X Syndrome)
- Epilepsy
- Failure to Thrive
- Low Birth Weight
- Fetal Alcohol Syndrome
- Microcephaly
- Cerebral Palsy
- And more . . .

Box 2

Early Intervention services have been shown to improve children's functional abilities and outcomes, regardless of whether their delays are due to medical conditions or to the extreme deprivation associated with neglect. All children entering foster care should receive a developmental assessment, with re-evaluations conducted for eligible children and those in “at-risk tracking” (see below) every six months until the child is 3 and every two years thereafter until the child begins elementary school. ***Children ages birth through 2 can be referred to ChildLink (215) 731-2110 as the initial point of contact.*** Services are coordinated by ***the Office of Mental Retardation (215) 686-0297*** for children from birth through age 2. When children in foster care ages birth through two are placed outside of Philadelphia, the county where they are residing is responsible for providing Early Intervention services. *Box 3 on page 7 lists some of the services available through the Early Intervention entitlement.* An Individual Family Services Plan (IFSP) will be developed to address the child’s needs.

Children ages birth through 2 who do not qualify for Early Intervention but who meet certain “at risk” categories are eligible for tracking by ChildLink at four- to six-month intervals until their third birthday. These risk factors include children who experienced neglect, abuse, low birth weight, high lead levels, maternal drug use during pregnancy, or care in the Neonatal Intensive Care Unit (NICU).

⁵ 20 U.S.C. § 1431 et seq.; 34 C.F.R. Part 303; 11 P.S. § 875-101; 55 Pa. Code Chapters 4225 and 4226.

Early Intervention Services for Infants and Toddlers

- Assistive Technology Services
- Audiology
- Family Training, Counseling and Support
- Health Services
- Medical Services for Diagnosis and Evaluation
- Nursing Services
- Nutrition Services
- Occupational Therapy
- Physical Therapy
- Psychological Services
- Service Coordination
- Special Instruction for the Child
- Speech-Language Pathology
- Transportation
- Vision Services
- And more...

Box 3

Children with mental retardation who are ages 3 and older should be registered with the mental retardation system

Children who are registered in the mental retardation system are entitled to various supports and services, including supports coordination (case management). Once registered, a child in foster care also may be eligible for Family Driven Support Services (FDSS), which include such supports as respite, family aid and recreation. To register a child who is developmentally delayed, contact the ***Philadelphia Office of Mental Retardation Services at (215) 686-0297***. (Note that a child in DHS custody who is placed in another county still needs to be registered in Philadelphia.) The following documents are needed to register the child:

- A psychological evaluation that indicates an IQ below 70. For children under the age of 6, a physician's note or an evaluation indicating a 50% delay in the cognitive area is acceptable
- A physical evaluation (conducted within the last year)
- A notice of MA eligibility. If the child does not have MA, DHS should enroll the child

Special Education and Other Disabilities-Related Services for Pre-schoolers and School-aged Children

Child welfare professionals should ensure that eligible pre-schoolers and school-aged children have access to special education and related services.

Children in foster care have extremely high rates of academic problems. Although histories of maltreatment, separation from family, and placement disruptions contribute to their academic problems, a large number of foster children also have developmental delays and disorders, learning disabilities, attention deficit disorders, emotional/behavioral problems, mental retardation, or other conditions which can also interfere with academic achievement. ***IDEA and Pennsylvania regulations entitle eligible children with disabilities ages 3 - 21 to appropriate special education services.***⁶ Note that these disabilities may or may not be visible to the layperson. The Pennsylvania Department of Education (PDE) is responsible for ensuring that eligible pre-schoolers ages 3-5 have access to Early Intervention services. The School District of Philadelphia is responsible for ensuring that school-aged children ages 6-21 can receive special education and

⁶ 20 U.S.C. § 1400 *et seq.* and § 1419 *et seq.*; 34 C.F.R. Parts 300 and 301; 11 P.S. 875-101; 22 Pa. Code Chapters 14 and 342.

disabilities-related services. In Philadelphia, PDE has contracted with ***Elwyn, Inc. Philadelphia Preschool Early Intervention (215) 222-8054*** to carry out its responsibilities with respect to pre-schoolers ages 3-5. To be eligible, a child must have a developmental delay or an identified disability and, by reason thereof, a need for special education and related services. The school district (and, in the case of children ages 3-5 in Philadelphia, Elwyn, Inc.) must locate, identify, and evaluate all children with disabilities residing in the district who are in need of special education.

Pre-schoolers who are experiencing delays in such areas as language development, socialization and self-help skills should be referred for a developmental screening. But it is important to note that as with infants and toddlers, ***it is recommended that ALL pre-schoolers ages 3-5 be referred for a developmental screening within one month of entering foster care.*** Elwyn, Inc. is the point of contact for this age group. ***If a school-aged child has demonstrated significant academic or behavioral problems, the child welfare professional or court personnel should suggest to the child's parent, guardian, caregiver and/or the school district that the child be evaluated. A parent or guardian has the right to obtain an evaluation by making a written request to the child's principal or counselor.***

Once a child is evaluated and determined to be eligible, the district (or, for preschoolers, Elwyn) must develop an Individualized Education Plan (IEP) to provide an appropriate education in the least restrictive environment. The law sets forth a timeline for this process, including time frames within which an evaluation must occur, an IEP developed, and services implemented.⁷ The law also requires that the child's parent/guardian be invited to participate in this process, and that their approval be obtained before the IEP is implemented. If the parent cannot be located or is otherwise not available, a surrogate parent must be appointed. *For more information on the surrogate parent process, see page 14.*

Special Education Programs and Related Services

Services are provided through an Individualized Education Program (IEP) and may include:

- Special Instruction
- Occupational Therapy
- Physical Therapy
- Speech-Language Therapy
- Emotional Support
- Assistive Technology
- Behavior Intervention Programs
- Transition to Adulthood Services
- Learning Support
- Extended School Year

Box 4

If a child already has been identified as eligible for special education programs and related services, the child welfare professional must ensure that his new school receives his IEP.

Under federal law, when a child enters a new school or school district within the same state, the child's IEP from the previous school should be implemented until a new IEP is developed. ***The IEP follows the child.*** The child welfare professional should ensure that the new school/school district receives and acts upon the child's special education records.

School-aged children with disabilities are entitled to reasonable accommodations in school, even if they do not qualify for special education.

⁷ For information about special education timelines, see the Education Law Center's website at <http://www.elc-pa.org>.

Section 504 of the federal Rehabilitation Act of 1973 and Pennsylvania’s corresponding Chapter 15 state regulations prevent school districts from discriminating against otherwise qualified students who have physical, mental or health impairments simply because of those impairments.⁸ School districts are required to provide aids, services and accommodations designed to meet the educational needs of each student as adequately as the needs of non-disabled students. Examples of aids, services and accommodations may include, but are not limited to, special transportation, modified equipment, adjustments in the student’s roster or the administration of needed medication. These are outlined in what is called a service agreement.

Behavioral Health

Children placed in foster care have experienced real trauma and dramatic disruption in their lives and critical relationships. Research indicates that up to 80% of children in foster care have significant developmental or mental health problems, compared to 25% of children in the general population. Although placement in substitute care may be necessary to ensure their safety and well-being, it also may contribute to their emotional difficulties by disrupting their bonds with family members, friends and communities.⁹ Additional placement changes can further disrupt the formation of important emotional attachments and intensify stress and anxiety for the child.

Indications for a Comprehensive Mental Health and Substance Abuse Assessment

- History of mental health and/or substance abuse in child and/or family
- The appearance of extreme, or minor but prolonged, emotional or behavioral problems
- Staff or foster family concerns that there are mental health/behavioral problems
- Staff or foster family concerns that the child may be using alcohol, drugs, or inhaling toxic fumes to get high
- Results of an initial mental health/substance abuse screening indicate clinical levels of emotional/behavioral problems
- Children suffering from the trauma of sexual abuse and exploitation
- Children who “act out” by exhibiting inappropriate sexual behaviors
- Children struggling with emotional issues related to their sexual identity or sexual orientation
- Other indications that require a formal behavioral health assessment to rule out a significant problem, or to initiate intervention planning and treatment

Box 5

An initial mental health and substance abuse screening must be conducted within 24-hours of the child's placement.

This screening should rely on published screening instruments and behavior checklists available to DHS workers and foster care agency case managers and staff. These screening tools *supplement* other indications to determine the need for a comprehensive mental health and substance abuse assessment (*see Box 5 above*). This screening also can be conducted as part of the child's health examination upon entry into care, since mental health screens are a mandatory component of EPSDT exams.

⁸ 29 U.S.C. § 701 *et seq.*; 34 C.F.R. Part 104; 22 Pa. Code § 15.1 *et seq.*

⁹ American Academy of Child & Adolescent Psychiatry (2001). *Psychiatric Care of Children in the Foster Care System. Policy Statement*. Washington, D.C.

Children should be referred for a comprehensive mental health and substance abuse evaluation within 60 days of placement, or sooner depending on the severity of the child's and family's needs.

Children should be referred for a comprehensive evaluation when:

- their initial screening indicates problems OR
- they score in the clinical range on published measures or checklists OR
- they meet any of the criteria listed in Box 5 on page 9

All children entering foster care should receive this comprehensive evaluation. However, currently our community does not have the resources for universal mental health evaluations of children in foster care. ***Children already in placement should be referred for a comprehensive mental health and substance abuse evaluation if they meet any of the criteria listed in Box 5 and have not received such an evaluation in the past six months.***

Note that many children entering or already in the foster care system have had one or more behavioral health evaluations by the time the court is asked to intervene. Yet few of these children actually receive the recommended services. It is crucial for court personnel to determine first if the child has received an assessment within the past six months. If not, a comprehensive behavioral health and substance abuse assessment should be obtained. Informed consent, including the consent to share information regarding the evaluation with mental health and substance abuse treatment providers, should be obtained for this evaluation (*see pages 11-14 regarding consent and confidentiality issues*). If assessments *were* conducted within the past six months, the results should be obtained and recommended services implemented.

Child welfare professionals must know how to access comprehensive mental health/substance abuse assessments and treatment services.

All children and adolescents in foster care are eligible for MA and, if they are placed in DHS custody, are eligible for enrollment in Community Behavioral Health (CBH), the city's behavioral health managed care organization. ***CBH is the point of entry for mental health and substance abuse services for children in DHS custody who are residing or placed within the five-county area (Bucks, Chester, Delaware, Montgomery, and Philadelphia). For behavioral health plan information for children placed outside of the five-county area, contact the DHS Behavioral Health and Wellness Center Help Line at (215) 683-0497.***

- To initiate evaluation for mental health and substance abuse treatment, or for information about evaluation and treatment, the child's foster care worker or DHS caseworker should call the Behavioral Health Services-Family Court Unit (BHS-FCU) at (215) 686-7731
- To verify enrollment and eligibility, call CBH at (888) 545-2600
- For DHS personnel who need assistance with all court-ordered and sex abuse evaluations, contact the DHS Clinical Management Unit at (215) 683-5760, (215) 683-5763, 6207, or 0418
- Contact the DHS Behavioral Health and Wellness Center Help Line at (215) 683-0497 if you have questions or concerns about a child's behavioral health

CONSENT AND INFORMATION SHARING ISSUES

Delays in obtaining consent for evaluations and services, and for the release of medical records, pose a significant barrier to children in foster care who need medical treatment.

This section briefly outlines the laws and regulations pertaining to consent to treatment and information-sharing as they affect children in foster care. For a comprehensive discussion of these laws, as well as legal citations to the information presented below, the reader is referred to *Consent to Treatment and Confidentiality Provisions Affecting Minors in Pennsylvania* (L. Rosado, 2002), which can be downloaded from Juvenile Law Center's website at www.jlc.org. The website also provides updates.

Authorizing Evaluations and Tests

The Dependency Court may order evaluation and/or treatment.

In an ongoing dependency case, the Court of Common Pleas may order a physical or mental examination of the minor, and may also order medical or surgical treatment of a minor who is suffering a serious physical condition or illness which, in the opinion of a physician, requires prompt treatment. The court may order the treatment even if the parent, guardian or custodian has not been given notice of the pending hearing, is not available, or without good cause informs the Court that he or she does not consent to the treatment.

In some circumstances, DHS may authorize evaluation and treatment for children committed to its custody.

When a child is in DHS's legal custody, the Commonwealth's Department of Public Welfare (DPW) regulations come into play. Regulations governing children and youth agencies, private foster care agencies, foster families, and child residential facilities distinguish between **routine versus non-routine** medical and dental examinations and treatment for purposes of consent. The regulations do not define routine and non-routine treatment but instead offer examples of each (*see Box 6*).

When the minor has been **involuntarily** removed from the home and is in DHS's legal custody, but parental rights have not been terminated, the DHS caseworker can authorize **routine** examination and treatment for the minor; the consent of the parent/guardian is not needed. *However*, the minor's parent or legal guardian must still give prior written consent to *each instance* of **non-routine** examination or treatment for the minor. Again, if the parent/guardian does not consent or cannot be located, a court order must be obtained.

Pennsylvania Department of Public Welfare Examples of Routine and Non-Routine Treatment

ROUTINE

- Well child visits and child health examinations
- Dental care
- Vision careHearing care
- Immunizations
- Treatment for injuries and illnesses

NON-ROUTINE

- Non-emergency (elective) surgery, even surgeries needed for various medical conditions if they are not emergencies
- Cosmetic surgery
- Experimental procedures or treatment

When DHS has custody of a minor for whom a decree of **termination of parental rights** has been entered, the agency can consent to all **major medical, psychiatric and surgical treatment for the minor**.

Also note that when a child is in DHS custody, only designated DHS personnel may enroll/dis-enroll a child from a HealthChoices managed care organization or change the child's primary care physician or dentist. *See page 14 for information on HealthChoices.*

The law permits minors to consent to various health care testing and treatment.

The law permits minors – defined as persons under the age of 18 -- to consent to a wide variety of medical testing, treatment and health services without parental consent, if the minor is capable of giving his/her consent. For example, minors can consent to testing and treatment for a long list of what are known as “reportable diseases.” If a minor in foster care is not sufficiently mature to give consent, then the consent of the minor's parent/guardian or a court order must be obtained. Below we note those health services for which the law permits minors, including minors in foster care, to consent.¹⁰

For minors too immature to provide consent, the consent of the minor's parent/guardian or a court order must be obtained.

When a minor in foster care is not sufficiently mature to consent to testing or treatment (such as an infant or toddler), then the consent of the minor's parent/guardian or a court order must be sought. ***Pre-printed parental consent forms and court orders authorizing various types of testing and treatment, as well as the release of medical records, are available for use at Philadelphia Family Court.***

- DHS workers should attempt to get necessary parental consent forms signed when they attend scheduled court hearings in the child's case either at
 - pre-hearing conferences OR
 - while waiting for the hearing to begin
- If the parent/guardian is not present or refuses to sign the consent form, the city solicitor or child advocate can prepare the pre-printed court orders to present to the judge during the hearing
- When there is no hearing scheduled and the DHS worker has been unsuccessful in obtaining parental consent to needed testing or treatment, the city solicitor or child advocate can file a petition to treat with the court

Courts and child welfare professionals should familiarize themselves with the laws as to when minors can consent to their own health care as compared to when parental consent must be obtained.

Reproductive Health

- ***Pregnancy Testing, Prenatal Care and Contraception.*** Any minor can consent to testing for pregnancy, as well as medical and health services to treat pregnancy, including all prenatal care. This does not include abortion. *See below.* The law also permits minors to obtain contraception (birth control).

¹⁰ In addition, minors who have graduated from high school, been married and/or have been pregnant can consent to *all* medical, dental, and health services for themselves, with the exception of abortion.

- **Abortions.** When a minor wants to obtain an abortion, the provider must obtain the informed written consent of the minor and one of her parents or legal guardians. If the pregnant minor's parents are divorced, the consent of the custodial parent is sufficient. If the pregnancy is the result of incest by the minor's father, the minor need only obtain consent from her mother. If neither the minor's parent nor legal guardian is available to the physician in a reasonable period of time, the consent of an adult person standing *in loco parentis* is sufficient. **Note that when DHS places a child with foster parents, the foster parents do not stand in loco parentis to the child. Nor does the agency stand in loco parentis if parental rights have not been terminated.** Without consent of a parent/guardian or an adult standing *in loco parentis*, there are two circumstances in which a minor can obtain a non-emergency abortion in Pennsylvania:
 - The minor is emancipated OR
 - The minor has received authorization from the Court of Common Pleas in the judicial district either where she resides or where she seeks to have the abortion performed.

Sexually Transmitted Diseases, Including HIV/AIDS

- A minor can consent to testing and treatment for *any* venereal or Sexually Transmitted Disease (STD). These include but are not limited to HIV and AIDS, chlamydia, gonorrhea, and syphilis.
- If a provider recommends HIV testing for a minor in foster care who is not capable of giving consent (i.e., an infant or toddler), written consent from the child's parent/guardian or a court order must be obtained.

Mental Health Evaluation and Treatment

- **Minors 14 years and older.** A minor who is 14 years of age or older may consent to *both* voluntary inpatient and outpatient mental health evaluation and treatment.
 - ***With respect to voluntary inpatient treatment, the consent of the minor's parent/guardian is not valid.*** If a parent/guardian or third-party (i.e., DHS) wants to obtain inpatient treatment for a non-consenting minor who is 14 years or older, they must pursue an involuntary commitment through the courts as per the Mental Health Procedures Act.
 - ***With respect to voluntary outpatient treatment, a DPW bulletin advises that either the minor or the minor's parents can lawfully provide consent.*** When a parent/guardian consents to outpatient care on behalf of a non-consenting minor in this age group, and the parent is still able to "present" the youth for treatment, DPW advises that the mental health provider make efforts to engage the youth in treatment.
- **Minors under the age of 14.** The parent/guardian of a minor under the age of 14 must give consent to both voluntary inpatient and outpatient evaluation and treatment. Absent parental consent, a court order must be sought.

Substance Abuse Evaluation and Treatment

- Minors can consent to medical care and counseling related to the diagnosis or treatment of a substance abuse problem. ***There is no age limit for giving consent to substance abuse treatment.*** A provider may treat a minor who has consented to treatment if the provider determines that the consent is knowing and voluntary.

Early Intervention and Special Education

- For a child to be evaluated for and/or receive Early Intervention or special education services, the child's parent/guardian must consent. If the child is living with a relative who is acting in place of the child's parent, then the relative caretaker may consent to evaluation and/or services. (For school-aged children, the School District of Philadelphia requires either a written delegation of authority from the biological parent, or that the "person acting as a parent" be appointed as a "Surrogate Parent" by the School District (*see below regarding the "Surrogate Parent" process*)).

- When a child is in the legal custody of DHS and parental rights have not been terminated, the consent of the child's parent/guardian must be obtained. If there is documentation that the parent/guardian's whereabouts are unknown or that they are otherwise not available, DHS should contact the appropriate service provider to pursue appointment of a "Surrogate Parent." For children birth through 2 years of age, contact the **Office of Mental Retardation (215) 686-0297**. For children 3-5 years of age, contact **Elwyn, Inc. Philadelphia Preschool Early Intervention (215) 222-8054**. **For children 6-21 years of age, contact the School District of Philadelphia (215) 875-3746**. The Surrogate Parent acts on the child's behalf by giving the necessary consents for Early Intervention or special education services, and participating in the planning and implementation of the child's service plan. In many instances, the child's foster parent would be the first choice to act as the Surrogate Parent. It is important to note that under federal law, a county employee (that is, a DHS employee, and the foster care agency employee) cannot be appointed as a Surrogate Parent and the dependency court cannot order Early Intervention or special education services.

Information Sharing

DHS and private foster care agencies may share certain information in the child's case record with the child's health care providers.

For children who are in DHS custody, the DHS caseworker may disclose information about the child from the child's family case record to health care providers without obtaining prior written consent. The caseworker may only disclose that information needed by the child's health care providers to carry out their responsibilities in serving the child. Similarly, the child's foster care placement agency caseworker may disclose otherwise confidential information about the child in the case records to the child's health care providers to the extent that the information is needed by the providers to carry out their responsibilities. ***Prior written consent is never needed to disclose information to health care providers in emergencies when the child is at risk of serious harm or death.***

DHS may also share pertinent health information with the child's foster parents.

According to state regulations, ***foster families are to be provided with information from a child's case record "which is necessary to protect the child's health and safety."*** Although there is no regulation that explicitly authorizes a foster parent to disclose health information to the child's current health care provider, ***the authority for such disclosure is implicit in the foster parent's responsibility to protect the child's health.*** Moreover, as a matter of practice, private agencies enter into agreements with their foster parents that require foster parents to escort children to routine medical examinations where disclosure of pertinent health information would occur.

DPW guidelines govern the disclosure of information about children in foster care by the HealthChoices MCOs to child welfare professionals.

The Department of Public Welfare has established guidelines for the release of patient information by the HealthChoices MCOs to agencies which and individuals who care for children in the child welfare system. MCOs may release limited information about a child, including the child's member number, assigned primary care physician, and assigned dentist, only to the following:

- county children and youth agency with legal custody of the child
- private agency providing placement for the child
- child's foster parents or kinship caregivers
- attorney representing the child
- court-appointed special advocate

RESOURCES

Consent and Confidentiality:

Rosado, Lourdes M. (2002). *Consent to Treatment and Confidentiality Provisions Affecting Minors in Pennsylvania*. Philadelphia: Juvenile Law Center. This book can be downloaded in a PDF file at no cost from the JLC website: <http://www.jlc.org>.

Stotland, J.F., Fieo, A., & Bush, E. (1998). *Children in Placement: Their Rights to Education and Health Care Services*. Philadelphia: Education Law Center. <http://www.elc-pa.org>.

Pennsylvania Education Law Center website: <http://www.elc-pa.org>.

Juvenile Law Center website: <http://www.jlc.org>.

Health and Development for Children in Foster Care:

Dicker, S. & Gordon, E. (2001). Early Intervention and Early Childhood Programs: Essential Tools for Child Welfare Advocacy. *Journal of Poverty Law and Policy*, vol. 34, nos. 11-12, pp. 727-743.

Howze, K.A. (2002). *Health for Teens in Care: A Judge's Guide*. Washington, D.C.: The American Bar Association, Center for Children and the Law. For information on obtaining copies write to The American Bar Association, Center for Children and the Law 740 15th St. NW, 9th Floor, Washington, D.C. 20005-1022; phone 202-662-1720. <http://www.abanet.org/child>.

McCarthy, J. (2002). *Meeting the Health Care Needs of Children in the Foster Care System: Summary of State and Community Efforts*. Washington, D.C.: Georgetown University Child Development Center. Available by contacting Georgetown University Child Development Center, 3307 M Street, NW, Suite 401, Washington, DC 20007, (202) 687-5000 or on the web at <http://www.guccdc.georgetown.edu/foster.html>.

New York Permanent Judicial Commission on Justice for Children (1999). *Ensuring the Healthy Development of Foster Children: a Guide for Judges, Advocates and Child Welfare Professionals*. White Plains, New York: Author. This pamphlet can be obtained by contacting the NY Permanent Judicial Commission by phone: (914) 948-7568 or mail: 140 Grand Street, Suite 404, White Plains, NY 10601.

Silver, J., Amster, B., & Haecker, T. (1999). *Young Children and Foster Care: a Guide for Professionals*. Baltimore: Paul H. Brookes Publishing Company. <http://www.brookespublishing.com>.

Task Force on Health Care for Children in Foster Care, American Academy of Pediatrics, District II, New York State (2001). *Fostering Health: Health Care for Children in Foster Care*. Lake Success, NY: Author. To purchase this guide, contact the AAP, District II, NYS by phone at (516) 326-0310 or by mail at 420 Lakeville Road, room 244, Lake Success, NY 11042.

Woolverton, M. (2002). *Meeting the Health Care Needs of Children in the Foster Care System: Strategies for Implementation*. Washington, D.C.: Georgetown University Child Development Center. Available by contacting Georgetown University Child Development Center, 3307 M Street, NW, Suite 401, Washington, DC 20007, (202) 687-5000 or on the web at <http://www.guccdc.georgetown.edu/foster.html>.

Behavioral Health and Children in Foster Care:

American Academy of Pediatrics Committee on Early Childhood and Adoption and Dependent Care. (2000). Developmental issues for young children in foster care. *Pediatrics*, 106, 1145-1150.

Forkey, H.C. (2002) *Mental Health Services for Children in Substitute Care in Philadelphia: CATCH Report*. Philadelphia. For copies contact H. Forkey at forkey@email.chop.edu.

Hepburn, K. & Mc Carthy, J. (2003). *Promising Approaches for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems: 3: Making Interagency Initiatives Work for Children and Families in the Child Welfare System*. Washington, D.C.: Georgetown University Center for Child and Human Development. Available by contacting Georgetown University Center for Child and Human Development 3307 M. Street, NW, Suite 401, Washington D.C 20007, 202-687-5000 or on the web at <http://www.gucdc.georgetown.edu>.

McCarthy, J. & McCullough, C. (2003). *Promising Approaches for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems: 2: A View From the Child Welfare System*. Washington, D.C.: Georgetown University Center for Child and Human Development. Available by contacting Georgetown University Center for Child and Human Development 3307 M. Street, NW, Suite 401, Washington D.C 20007, 202-687-5000 or on the web at <http://www.gucdc.georgetown.edu>.

Philadelphia Citizens for Children and Youth. (2003). *The Mental Health System for Low Income Children: The Philadelphia Story*. To obtain copy contact PCCY: (215) 563-5848 or info@pccy.org, or <http://www.pccy.org>.

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