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HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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Chapter Two

Preventive and Ongoing Health Care

To maintain overall health and well-being, children in foster care need ongoing medical assessment, treatment, and services provided in a coordinated, comprehensive manner. This chapter describes the ongoing health services – medical, dental, mental health, developmental, and substance abuse services – that continue the assessment and treatment recommended in the initial comprehensive health evaluation when children are placed in foster care.

Depending on the findings of the initial health evaluation, children in care will differ in their need for health services. While all children must receive routine preventive health care, some will be referred for further assessment and treatment. Others with specific identified conditions or problems will need to receive ongoing treatment.

This chapter outlines the standards for routine preventive health care; health care services; management of medical conditions and chronic illness; and care of acute illness and injury.



Sections in this chapter include:

1. Comprehensive plan of care
2. Routine preventive health care
3. Dental care services
4. Mental health services
5. Developmental services
6. Substance abuse services
7. Management of chronic medical conditions
8. Acute illness and injury/emergency care
9. Resources

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1 Comprehensive Plan of Care

Each initial health assessment (i.e., medical, dental, mental health, developmental, and substance abuse) included in the comprehensive health evaluation should result in an individual treatment plan. The plan should address the child's needs identified in each of the assessments and include recommendations for treatment, referral information, and follow-up appointments. The plan should also include information and tips for caregivers about healthy growth and development. The overall health assessment should be included in the child's case planning to enhance service coordination and monitoring.



Health Care Coordination Activities

To coordinate the child's treatment, individual treatment plans should be integrated into one comprehensive "plan of care" that formulates how the child's health care needs in every area will be addressed. With an overall plan of care, all providers are aware of the child's various health care issues, medications are managed properly, and casework planning for the child and family incorporates the child's health.

As with any service planning, all those involved with the child should be informed about the plan and have an opportunity to contribute to it. This includes the child's birth parents or prospective adoptive family, as appropriate.

Often foster parents will be responsible for carrying out the plan by accompanying the child to appointments or administering medication. Communicate with the foster parents clearly and consistently to help them understand the child's treatment plan and their role in the plan. This will help them to effectively support and implement the plan.

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2 Routine Preventive Health Care

Routine preventive health care promotes the health and well-being of all children. To help achieve optimum preventive health care, each child must have periodic comprehensive medical assessments, also known as well child visits, on an ongoing basis.¹ Even when a child is receiving regular treatment from a specialist for a medical condition (e.g., chronic asthma), well-child visits are necessary as they have a broader scope and purpose.



Health Care Coordination Activities

Build on the relationship with the primary care provider, which began with the initial health evaluation. You can do this by providing relevant information about the child and your agency, making sure that the child's medical records are up to date, and reinforcing with the foster parents and birth parents how important a "medical home" is both for the child and for their own care of the child. Continue to gather information from the birth parents about the family's and the child's medical history.

Schedule for Routine Well Child Care

Following the initial medical assessment, periodic well child visits must take place according to the current American Academy of Pediatrics (AAP) *Recommendations for Preventive Pediatric Health Care* schedule, which has been adopted by the New York State Medicaid program. Go to <http://practice.aap.org/content.aspx?aid=1599> for the AAP periodicity schedule. Note that the schedule has been updated since the development of 18 NYCRR 441.22(f). Due to the greater health needs of children in foster care, OCFS recommends additional well-child visits for children under the age of 6. The AAP schedule and the enhanced recommendations for children in foster care are shown below:

Schedule for Well-Child Care	
AAP 2008 schedule (minimum)	Recommended for Foster Care
At age: 4-5 days, 1 month, 2 months, 4 months, 6 months, 9 months	At age: 4-5 days, 1 month, 2 months, 3 months, 4 months, 5 months, 6 months, 9 months
At age: 12 months, 15 months, 18 months, 24 months, 30 months	At age: 12 months, 15 months, 18 months, 24 months, 30 months
At age: 3 years, 4 years, 5 years, 6 years	At age: 3 years, 3 ½ years, 4 years, 4 ½ years, 5 years, 5 ½ years, 6 years
Every year from age 7 to age 21	Every year from age 7 to age 21

Additional visits must occur consistent with current standards for primary care of specific conditions that may be present, e.g., HIV infection, prematurity, cystic fibrosis.

¹ 18 NYCRR 441.22(f) ("periodic individualized medical examinations").

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Components of Well Child Visits

Well child visits should include:

- Clinical examination by a primary care provider who is a pediatrician, family physician, physician's assistant, or nurse practitioner with pediatric training and experience – preferably, the same provider who conducted the initial medical assessment (the “medical home” for the child).
- Immunizations consistent with current NYS/NYC DOH recommendations for age, with special immunization recommendations for specific conditions that may be present such as HIV infection, sickle cell, asthma, or diabetes. It is important to check the following New York State Department of Health website at least annually for updates to the immunization schedule: http://www.health.state.ny.us/prevention/immunization/childhood_and_adolescent.htm. (See Chapter 1, *Initial Evaluation of Child's Health*, section 7, *Resources, for the Recommended Childhood Immunization Schedule for New York State*.)
- Periodic screening tests consistent with the current AAP well child visit schedule and DOH regulations for age and current professional standards for specific conditions, e.g., blood tests for lead poisoning.
- Health education and anticipatory guidance consistent with current AAP recommendations for age (see section 9, *Resources*).
- Review and updating of the problem list and treatment plan at each well child visit.

Follow-Up Activities

To coordinate follow-up after each visit, staff involved with the child's case are responsible for:²

- Reviewing the child's medical examination record form to determine whether further treatment is recommended, including referrals and medications.
- Contacting the provider, if necessary, to obtain information on follow-up care and treatment.
- Offering to assist the foster parent with follow-up care and transportation.
- Encouraging the provider to contact the agency about follow-up, referrals, missed appointments, or other important information.

² 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

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3 Dental Care Services

Comprehensive dental care for children in foster care includes routine restorative care and ongoing dental examinations, preventive services, and treatment as recommended by the dentist. Follow-up care for all conditions identified in the initial dental assessment is required.³

Dental care services include:

- Initial exam, preventive services, and sealants on permanent molar teeth at the time of entry into care.
- Ongoing routine dental care for children age 3 and older [*Note: NYC Administration for Children's Services (ACS) requires an exam by a dentist at age 2*]:
 - Preventive care every 6 months
 - Examination by dentist annually⁴
- Sealants on newly erupted molars at preventive visits.
- Ongoing restorative care to promptly address every problem identified:
 - Timely access to restorative care
 - Fillings
 - Root canals
 - Replace missing and damaged teeth
 - Periodontal care for gum disease
- Immediate access to dentist or oral surgeon for pain or dental trauma.
- Immediate access to effective medication to relieve pain.
- Orthodontics based on NYSDOH Physically Handicapped Children's Program (PHCP) standards for severe handicapping dental conditions (*see section 9, Resources*).

Dental decay can be advanced by 3 years of age. Decay of primary teeth can affect children's growth, lead to malocclusion, and result in significant pain and life-threatening swelling. To prevent cavities in children, high-risk individuals must be identified at an early age, and aggressive strategies should be adopted, including anticipatory guidance, behavior modification (oral hygiene and feeding practices), and establishment of a dental home by 1 year of age for children deemed at risk.⁵

³ 18 NYCRR 441.22(g).

⁴ 18 NYCRR 441.22(f)(2)(viii).

⁵ Oral Health Risk Assessment Timing and Establishment of the Dental Home. 2003. Available at: <http://aappolicy.aappublications.org/>.

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Referral to a dentist and establishment of a dental home is recommended no later than 6 months after the first tooth erupts, or by 12 months of age, whichever comes first. This practice allows the dentist to assess risk and recommend interventions. The dentist can instruct parents and caregivers on oral hygiene for infants and toddlers and make sure the child receives fluoride. It also provides an opportunity for the dentist to intervene in the oral hygiene habits of the primary caregivers to reduce the risk of colonization of the infant by the bacteria that cause tooth decay.

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4 Mental Health Services

Children in foster care should receive professional diagnosis, treatment, and services for any mental health needs identified in the initial mental health assessment. Psychiatric, psychological, and other essential services must be made available appropriate to the needs of children in care.⁶ The following activities are required:

- Diagnosis and treatment of all identified needs.⁷
- Medically necessary psychiatric and psychological services.⁸
- Care, services, and treatment to ameliorate defects, physical and mental illness, and conditions discovered by Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings.⁹

It is not unusual for children in foster care to experience serious emotional and behavioral issues and be in need of mental health services. Keep in mind that children who do not “act out” may need assistance as much as those who present behavioral challenges. It is important for children to receive mental health services on an ongoing basis, rather than waiting for a crisis to occur. Regular services allow clinicians to form a therapeutic alliance with the child and provide ongoing guidance to caregivers in how to ameliorate or manage crisis situations. Services should be consistent with current professional standards of care for children and adolescents (Practice Parameters of the American Academy of Child and Adolescent Psychiatry) (www.aacap.org) (see section 9, *Resources*).

For information on consent for outpatient mental health services and administration of psychiatric medications, see Chapter 6, Medical Consents, and Appendix B, 08-OCFS-INF-02 The Use of Psychiatric Medications for Children and Youth in Placement – Authority to Consent to Medical Care.



Health Care Coordination Activities

Be aware that some psychiatric disorders in children and adolescents (e.g., anxiety, depression) can present with physical complaints or vague somatic symptoms. Examples are sleep and appetite changes, fatigue, decreased energy, pain, headaches, dizziness, palpitations, and shortness of breath. It is important the primary care provider consider emotional problems when evaluating these physical complaints or symptoms. As part of your role to integrate and coordinate the physical and mental health care of children in foster care, provide the guidance to caseworkers and caregivers that emotional and physical problems are often intertwined.

⁶ 18 NYCRR 441.15.

⁷ 18 NYCRR 508.8(e).

⁸ 18 NYCRR 441.15.

⁹ EPSDT 5122.E and 5124 A.4 and B.1.

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Using DSM-IV-TR

A child's mental health assessment may contain terms describing a child's diagnosis and references to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR).¹⁰ The DSM-IV-TR is the manual used by physicians, psychiatrists, psychologists, therapists, and licensed certified social workers to diagnose mental illness (*see section 9, Resources*). This manual spells out the specific diagnostic criteria. When diagnosing a client, the American Psychiatric Association recommends that the clinician use a multiaxial Assessment System, as follows:

- Axis I – Clinical Disorders (i.e., Mental Health)
- Axis II – Personality Disorders and Mental Retardation
- Axis III – General Medical Condition
- Axis IV – Psychosocial and Environmental Factors
- Axis V – Global Assessment of Functioning

Axis I includes all mental health conditions except personality disorders and mental retardation, which are in Axis II; Axis III is used for reporting any major medical conditions that may be relevant to treatment of the mental health disorder; Axis IV is used to report psychosocial and environmental factors affecting the child; and Axis V is the clinician's assessment of the child's overall level of functioning.

Components of Mental Health Treatment

In general, management of identified mental health needs includes mental health intervention/treatment services; development of a mental health crisis plan; periodic review and revision of the individual treatment plan; and periodic re-evaluation of the child (*see section 9, Resources*).

It is helpful for the caseworker, foster parents, and birth parents to know what to expect when a child receives mental health evaluation and treatment. Issues they may have to deal with include the kind of counseling or therapy recommended, medication, and other interventions such as family support or respite services. The more information they have about such approaches the better equipped they will be to support them.

Mental health treatment services include various therapeutic approaches to individual and family counseling:

- Using verbal psychotherapy, commonly known as “talk therapy,” the therapist meets with the child in individual or family sessions.
- In interactive psychotherapy, commonly known as “play therapy,” the child explores issues with the therapist through play with toys or other items designed for this purpose.

¹⁰ American Psychiatric Association, Arlington, VA, 2000.

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- With cognitive-behavioral therapy (CBT) for children, the therapist helps the child see the connection between his/her thinking and behavior.
- Group therapy is commonly used, especially psychosocial or psycho-educational groups. Adolescents in particular may not respond well to individual therapy and may be more expressive with peers in the group therapy setting.

Additional types include dialectical behavior therapy (DBT), family therapy, interpersonal therapy (IPT), psychodynamic therapy, behavior therapy, and expressive therapies (e.g., art and music). Depending on the diagnosis, psychiatric medication may be prescribed along with psychotherapy or other individual or group services (*see Chapter 5, Medication Administration and Management*). Additional related treatment may include substance abuse treatment services, when needed.

Flexible wrap-around services are an essential component of individualized, community-based care for children and adolescents with SED (Serious Emotional Disturbance). These services are flexible, and child/family-focused. The services follow or “wrap around” the child or adolescent to facilitate return to optimal functioning at home and in the community. Examples include afterschool programs, summer camp, recreation programs, mentoring, life coaches, and community supervision.

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5 Developmental Services

Children in foster care often experience problems in growth and development resulting from growing up with abuse, neglect, and family substance use as well as other factors such as premature birth and poor prenatal and infant health care. Developmental services for children in foster care include timely access to services identified in the initial medical or developmental assessments and age-appropriate assessment at routine periodic medical visits.

It is recommended that each well child visit include an assessment of the child's developmental, educational, and emotional status based on an interview with the foster parents, standardized tests of development, and/or review of school progress. Children at known risk for developmental delay, including those born prematurely, those born to mothers with alcohol or substance abuse problems, and all HIV-infected children, should have formal developmental assessments at regular intervals to identify developmental delays as early as possible.

Developmental services include the diagnosis and treatment of all developmental delays and deficits identified and developmental treatment services such as speech and language therapy; occupational therapy; physical therapy; and services for the hearing and visually impaired.

There are several routes to access developmental services depending on the child's age:

- Early Intervention Program (up to age 3) through referral to the local EI Officer for evaluation and services.
- Preschool Special Education (ages 3-5) through referral to the local school district or regional preschool special education program for evaluation and services.
- Special Education (ages 5-21) through referral to the local school district or regional special education programs for evaluation and services.
- Section 504 (Education Law) (ages 5-21) services for general education students.

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Health Care Providers and Other Professionals

In addition to health practitioners, other professionals who may be involved in the assessment or treatment of children and adolescents in foster care may include:

- Speech and language pathologists with training and/or experience in child speech pathology.
- Physical and occupational therapists with training and/or experience in the motor problems of children.
- School psychologists.
- Certified family therapists.
- Certified arts therapists (art/music/dance).

Early Intervention Program

Children ages birth through three years may be eligible for participation in the Early Intervention (EI) Program because they are experiencing developmental delays or disabilities. The Early Intervention Program is a voluntary program offering a variety of therapeutic and support services to eligible infants and toddlers and their families.

If parents are the subject of an indicated child protective report and have a child under the age of three, the local social services districts must inform the parents of the EI program and refer them to the county EIP. If the child is in foster care, the foster care agency must initiate a screening or referral to the EIP (*see Appendix B, 04-OCFS-LCM-04*).

The EI Program is administered locally in each of the 57 counties and New York City. An Early Intervention Official/Designee (EIO/D) in each municipality is responsible for identifying eligible children and ensuring that EI services contained in the family's Individualized Family Service Plan (IFSP) are delivered. Most EIOs are directors or commissioners of county health departments. The New York State Department of Health is the lead state agency responsible for the Early Intervention Program (*see Appendix D for the Protocol: Children in Foster Care Who Participate in the Early Intervention Program*).

The following services can be included in the IFSP: assistive technology devices and services, family training and counseling, home visits, parent support groups, special instruction, speech-language pathology and audiology, occupational therapy, physical therapy, psychological services, service coordination, nursing services, nutritional services, social work services, vision services, and transportation-related costs necessary to enable a child to benefit from other EI services while the child is receiving these services.

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To be eligible for services, children must be under 3 years of age and have a disability or developmental delay. In New York State, children must meet the eligibility criteria to receive EI services. The EI Officer is responsible for identifying, tracking, and periodic developmental screening of children at risk of developmental delay or using available resources. Although the program is voluntary, under certain circumstances there may be a court order requiring that EI services be provided.

The EI Program requires the appointment of a “surrogate parent” to assume the responsibilities of a birth parent/guardian when a child in foster care is eligible for EI services and is either a ward of the state – i.e., in the custody and guardianship of the local commissioner of social services – or is not a ward of the state but whose birth parent/guardian is unavailable. The EI Officer should designate the foster parent or an appropriate and available relative as the surrogate parent for the EI Program.

Regarding consent for EI services, note that although the LDSS commissioner can generally consent to medical, dental, and hospital services for children who are in the commissioner’s custody, the Individuals with Disabilities Education Act (IDEA) specifically excludes state officials from acting as a surrogate parent in the EI Program (*see Chapter 6, Medical Consents, for detailed information on consent for Early Intervention services*).

Caseworker and EI Program: Working Together

Professionals working in the Early Intervention Program and the local district must communicate and work together when involved with the same child and family. Once a child in foster care has been deemed eligible for EI services, it is important that the EI Program inform the caseworker about the child’s EI status, service plan, and progress so that the local district can more effectively carry out its responsibilities for general management of the child’s foster care program, taking into account what is happening to the child while he/she is receiving EI services.

At the same time, it is important for the caseworker to keep the EI Program up to date about the child’s placement, location, health and medical status, and social services status. Ongoing awareness of the child’s whereabouts and foster care status will allow the local EI Program to develop and implement a supportive, appropriate service plan and to appropriately claim and receive reimbursement from the state program.

Regarding EI services, the caseworker is responsible for the following:

- As a primary referral source, identifies and refers children under the age of three who were part of an indicated child protective report or are at risk of having a disability to the program.
- Participates in IFSP development.
- Documents the outcome of all IFSP meetings in the case record and ties this information to permanency planning and planning for other services.
- Considers early intervention services when coordinating permanency planning and other services.

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- Shares basic information about the EI Program with birth parents and foster parents.
- If the foster parents did not participate in IFSP development, notifies them of how the plan will be implemented and their obligations when EI services are being delivered.
- Coordinates with the EI Officer to transition child into preschool special education or other services as appropriate as child's third birthday approaches.

➔ **See Appendix D for the Protocol: Children in Foster Care Who Participate in the Early Intervention Program.** The protocol outlines the responsibilities and procedures for the LDSS caseworker regarding identification of children eligible for the Early Intervention Program, referral to the program, intake, evaluation, IFSP, delivery of services, mediation, and transition and discharge.



Health Care Coordination Activities

Designate an LDSS Early Intervention program liaison. Urge local districts and local Early Intervention Programs to collaborate and develop a general consent form that will meet both system requirements and facilitate sharing of information. Encourage staff to attend state-sponsored training on EI services. Help develop an interagency agreement between the municipal EIP and LDSS to address the referral process of children transitioning from the EI Program to preschool special education.

Transition from EIP to Preschool Special Education

If a child has been determined eligible for Early Intervention programs and services, the child can transition smoothly into preschool special education services. If the child is referred to the Committee on Preschool Special Education (CPSE) and determined eligible for preschool special education programs and services, early intervention services may continue past the child's third birthday as follows:

- Children who turn three years of age between January 1st and August 31st are eligible to continue to receive early intervention services until September 1st of the calendar year.
- Children who turn three years of age between September 1st and December 31st are eligible to continue to receive early intervention services until January 2nd of the following calendar year.¹¹

If the child is not referred to the CPSE and determined eligible for preschool special education programs and services, early intervention services will end at the child's third birthday.¹²

The Early Intervention Official (EIO) is required, with consent of the parent or surrogate parent, to notify the school district of the child's potential transition to preschool special education at least 120

¹¹ Public Health 2541(8)(a).

¹² Public Health 2541(8)(b).

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days before the date of the child's first date of eligibility.¹³ The EIO must also convene a transition conference at least 90 days before the child's first date of eligibility for preschool special education.¹⁴

Preschool Special Education Services

Children ages 3 to 5 who have not transitioned from EIP to preschool special education and are suspected of having a disability that may affect their school performance may also be referred for services. A written referral for an individual evaluation and determination of eligibility for special education programs and services should be sent to the Chairperson of the Committee on Special Education (CSE) or Committee on Preschool Special Education (CPSE) or to the building administrator in the school district where the child is placed.¹⁵ The CPSE is responsible for evaluating all students referred and placing all those in need of special education. If the evaluation determines that the child is in need of special education, an individualized education plan (IEP) will be developed for the child.

To be identified as having a disability, a preschool child has either a significant delay or disorder in one or more functional areas related to cognitive, language and communicative, adaptive, socio-emotional or motor development which adversely affects the child's ability to learn, or meets the criteria for: autism, deafness, deaf-blindness, hearing impairment, orthopedic impairment, other-health impairment, traumatic brain injury, or visual impairment.



Health Care Coordination Activities

Develop a list of schools approved to conduct initial evaluations of preschool students in your county and surrounding counties and the procedures that must be followed to select one of the approved evaluators to conduct the initial evaluation on the child. Assist the foster parents in obtaining the evaluation.

Special Education Services

A student suspected of having a disability must be referred in writing to the Chairperson of the Committee on Special Education (CSE) or to the building administrator of the relevant school district.¹⁶ The CSE is responsible for evaluating all students referred and placing all those in need of special education. If the evaluation determines that the child is in need of special education, an individualized education plan (IEP) will be developed for the child.

¹³ Public Health 2514(14).

¹⁴ 10 NYCRR 69-4.20(b).

¹⁵ *Individual Evaluations and Eligibility Determinations for Students with Disabilities*, New York State Education Department, Office of Vocational and Educational Services, revised January 2002.

¹⁶ *Ibid.*

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Special Education services cover a range of services and settings. In addition to modified and specialized instructional services provided in self-contained classes and special schools, special education students may receive developmental treatment services in regular schools. The CSE coordinates with the therapists, arranges placement and transportation services, and evaluates students who are not attending public schools (e.g., preschool, private/parochial). A CSE includes clinical supervisors who supervise psychologists, social workers, education evaluators, and other school personnel.

A student with a disability means a student who is entitled to attend public schools and who, because of mental, physical, or emotional reasons, has been identified as having a disability, including: autism, deafness, deaf-blindness, emotional disturbance, hearing impairment, learning disability, mental retardation, multiple disabilities, orthopedic impairment, other-health impairment, speech or language impairment, traumatic brain injury, or visual impairment including blindness.



Health Care Coordination Activities

Encourage birth parents and foster parents, as well as casework staff, to attend the periodic CSE meetings that evaluate the child's progress and treatment plan. Attending the meetings provides a way to learn about the services the child is receiving and an opportunity to contribute information about the child and to advocate for the child's needs.

Section 504 Services for Children in General Education Classes

Section 504 of the Rehabilitation Act of 1973 makes it possible for students with certain special needs to remain in a general education class. Section 504 establishes that disabled or "medically fragile" students, whose impairments do not directly limit their ability to learn, have a right to a free, appropriate public education. School districts have to provide the necessary educational services, aids, and accommodations to ensure this right. Certain types of schools (e.g., Union Free and 853 schools) provide Section 504 services on site.

If possible, students should be in a general education school program and fully take part in all the activities of the class. Section 504 requires that students with special needs due to physical and mental impairment be accommodated in the least restrictive educational environment. Such services and aids should be delivered in a way that does not stigmatize the student.

Adjustments or services may include (1) modifications to a student's general education program, such as preferential seating, alternative testing techniques, classwork/homework modifications, barrier-free placement, bus transportation, an elevator pass, and counseling; and (2) provision of certain health-related services to help the student attend school, such as monitoring the administration of oral medication and the use of inhalers; monitoring of blood sugar levels; injections; clean intermittent catheterization; and emergency administration of medication.

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Examples of protected students are children with asthma, diabetes, allergies, cerebral palsy, cancer, HIV-related illnesses, epilepsy, dyslexia, and spina bifida.

Children in foster care will either be referred from the CSE to Section 504 services, or by the agency as a result of the developmental assessment. Upon request for services, the evaluation by the school will determine if the student has a mental or physical impairment; if the impairment substantially limits one or more of the student's major life activities; and if the student is a qualified disabled student within the meaning of Section 504.

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6 Substance Abuse Services

Children in foster care should be screened for a family history of alcohol and drug use, a history of their own use, and other risk related behaviors. The screen for individuals age 13 and older should be part of the comprehensive health evaluation that is completed when a child is placed. Youth of any age who are identified as having alcohol or/other drug related problems should receive professional services that include a comprehensive assessment for alcohol and substance abuse disorders based on DSM-IV-TR diagnosis. Treatment and services for any alcohol or drug abuse problem identified as part of the screening and assessment process should be provided in accordance with the current standard of care for adolescents (*see section 9, Resources, for Treatment of Adolescents With Substance Use Disorders*).

Note: “Substance” or “drug” includes all alcohol and chemicals improperly used either by inhalation, smoking, ingestion, or injection. The terms “chemical dependence” or “chemical abuse” may also be used by clinicians and treatment providers. The difference between dependence and abuse is explained in the definitions below:¹⁷

- Substance abuse is characterized by a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. In order for an abuse criterion to be met, the substance related-problem must have occurred repeatedly during the same 12-month period or been persistent.
- Substance dependence is characterized by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive [substance]-taking behavior.

Drug Screening

OCFS recommends the use of urine drug testing for children in foster care only in one or more of the following circumstances:

- A court has ordered such screening or testing.
- The child has consented to such screening or testing as a condition of participation in an approved (licensed) substance abuse treatment program.
- A clinician or certified alcohol and substance abuse counselor (CASAC) has directed that testing be done as part of the child’s services/treatment plan to determine if the child is using a substance that may present a risk to the child’s health and safety. The clinician or CASAC should oversee the testing protocols.

¹⁷ DSM-IV-TR.

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- The clinician or CASAC has reasonable cause to suspect that the child is unlawfully under the influence of a drug or controlled substance, and the executive director of the authorized agency or his or her designee has approved of the testing. Reasonable cause to suspect should be based on specific, reliable observations that can be articulated, not solely upon information received from other children or anonymous sources, and should be documented in the child's case record.

A screening may show that a child is at risk or already has alcohol or substance abuse problems. Whenever possible, refer children to programs licensed by the New York State Office of Alcohol and Substance Abuse Services (OASAS). These programs provide preventive and treatment services in a variety of settings (*see section 9, Resources*).



Health Care Coordination Activities

Make sure that your agency has the OASAS Provider Directory available for staff who make referrals (*see section 9, Resources*). The directory lists providers by county and identifies program type (e.g., crisis services/medically monitored withdrawal; chemical dependency youth/outpatient) as well as contact information. To achieve continuity of substance abuse services when children are discharged from foster care, refer them to OASAS school-based student assistance programs, where available. Also, learn which schools in your community have programs on alcohol and substance abuse. Many schools have a school-based prevention/intervention program, which offers a curriculum and instruction for staff and assistance for youth in crisis.

Training for Staff, Caregivers, and Health Care Providers

Topics for staff and caregiver training on the impact of substance abuse on children and adolescents should include detecting substance abuse and procedures for handling emergencies. Staff and foster parents should be familiar with and alert to behaviors that may be signs of substance abuse. These include disorientation, confusion, euphoria, auditory and visual hallucinations, delusions, distorted sensory perception, drowsiness, lack of coordination, feelings of detachment, incoherent speech, disruption of thought processes, and unconsciousness. Pronounced pinpoint pupils of the eyes and needle marks on the arms and other parts of the body are probable physical signs indicative of drug use.

Methamphetamine

Methamphetamine (meth) is a powerfully addictive drug of abuse with an added risk: clandestine manufacture in homes, outbuildings, and even vehicles. The chemicals found in clandestine laboratories can damage the respiratory tract, mucous membranes, eyes, and skin. Some of the chemicals can produce a fire or explosion. Meth production contaminates surfaces such as walls, floors, counters, and children's toys and clothing. If a child found at a meth lab shows signs of exposure such as respiratory distress, eye irritation, chemical residue, or obvious injury, seek immediate medical attention. See section 9, Resources, for more information.

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Immediately leave the scene and contact law enforcement if you encounter what you believe is a clandestine laboratory. Inform law enforcement if you believe children are present. Be aware that some meth producers may set booby traps at the site to deter authorities. OCFS provided teleconference training on methamphetamine and worker safety on March 26, 2006. Copies are available from the OCFS library. This training is recommended for all staff. Contact your staff development coordinator for more information.

All mandated reporters of suspected child abuse or maltreatment who travel to children's homes must be informed by their employer of the signs of a clandestine methamphetamine laboratory.¹⁸ A brochure with this information can be downloaded from the Office of Alcoholism and Substance Abuse (OASAS) Methamphetamine Clearinghouse at <http://www.oasas.state.ny.us/meth/index.cfm>. The brochures should be printed in color to obtain the full benefit of the lab photographs.



Health Care Coordination Activities

Be familiar with your agency's procedures for drug-related emergencies, which should be handled quickly and properly. Depending on the child's particular behaviors and symptoms, staff may need to have the child transported by ambulance to a hospital or take other actions to monitor the situation. Observe for signs of respiratory distress, avoid rough handling, and provide comfort and reassurance.

At the same time, health care providers of substance abuse services should receive training on the broad health needs of children in foster care. If your agency has ongoing relationships with specific providers, it should make this type of training available for them.

Engaging and Counseling Children

Children may not want to recognize or acknowledge that they have a substance abuse problem. Persuading the child or youth that they need services may be the first challenge faced by staff in dealing with substance abuse. Some tips for initial engagement include:

1. Review the child's health record, including the extent of substance abuse problems and risk behaviors.
2. Establish an atmosphere of trust and confidence with the child, birth parents, foster parents, and staff. Support a "no blame" approach.
3. Interview the birth parent and foster parent to determine whether there is a need for assessment and referral for substance abuse services.
4. Interview the child privately to determine the extent and nature of the child's substance abuse problem.

¹⁸ SSL 413.4.

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5. Prepare the child for referral and assess readiness to engage in treatment.

If it is not time for a regularly scheduled Service Plan Review, call a case conference to discuss the situation and develop a plan for services and follow-up. The meeting should be conducted in such a way that the child, birth parent (if present), and foster parent are not frightened by the information, but at the same time the problem is not minimized.

Tobacco Use

Public health law states that smoking is not allowed in group homes, public institutions, youth centers and facilities for detention.¹⁹ The known effects of second-hand smoke should be carefully considered when selecting a foster home for children. Local districts and voluntary agencies should avoid placing very young, allergenic, or asthmatic children in homes where one or more residents smoke. Foster parents should be advised to:

- Limit smoking in their homes to the extent possible.
- In particular, avoid smoking in all areas where a foster child sleeps, eats, and/or spends a lot of time.
- Avoid smoking in vehicles, especially when transporting foster children.
- Be extra diligent in avoiding exposing very young, allergenic, or asthmatic children to second-hand smoke.²⁰

Case planners and foster parents should actively discourage foster children from smoking or continuing to smoke. They must not assist the foster child in purchasing or obtaining cigarettes. Foster parents are on firm ground in preventing a foster child from smoking in their home.²¹

Agencies should offer prevention education programs to educate children and youth on the harmful effects of smoking and other tobacco use. They should also provide smoking cessation treatment for children and youth who smoke.

Note: It is illegal for children under the age of 18 to buy tobacco products (e.g., cigarettes, cigars, chewing tobacco).

¹⁹ PHL Article 13-E, 1399-o.

²⁰ 04-OCFS-INF-05.

²¹ Ibid.

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7 Management of Chronic Medical Conditions

Many children in foster care experience serious, chronic medical conditions that need ongoing treatment and monitoring (e.g., asthma, diabetes, skin problems, seizures, vision and hearing problems, and chronic infectious diseases). Ongoing, primary health care includes the management of such conditions.

When a child has a chronic illness or condition requiring long-term medical, mental health, dental, or other services, a treatment plan should be developed detailing the proposed treatment, alternative treatments, and risks/benefits. Staff should make reasonable efforts to engage the birth parent and obtain informed consent for the treatment plan.

Health care coordination activities necessary to effectively manage these situations include:

- Treatment planning – to coordinate treatment between primary care and specialty care providers.
- Specialty referrals for conditions that cannot be fully managed by a primary care provider.
- Follow-up care for any conditions identified as recommended by the primary care provider.²² Periodic visits should occur at a frequency consistent with current professional standards for management of specific conditions – usually at least every three months when the child with chronic illness is stable and doing well.
- Multidisciplinary approach for children with complex chronic medical, mental health, and behavioral problems.

Provide or arrange for diagnostic and treatment services for conditions identified during a comprehensive medical evaluation (*see Chapter 3, Special Health Care Services*). If a finding requires more extensive diagnosis and/or treatment than is immediately available, schedule an appointment for these services without delay.

Note: Institutions must provide glasses, hearing aids, and prosthetic or other adaptive devices when needed.²³

²² 18 NYCRR 441.22(g).

²³ 18 NYCRR 442.21(g).

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8 Acute Illness and Injury/Emergency Care

Comprehensive health care includes treatment for acute illness and injury. At a minimum, make sure that children experiencing an acute illness or injury receive the following:

- Timely access to appropriate health professional services.
- After hours (24 hours a day) advice and care which is available and accessible.
- Medications:
 - Prompt access to prescribed medications.
 - Administration as ordered by the health practitioner.
 - Monitoring and accountability for proper administration.
 - In congregate care facilities, routine documentation of medical administration.

Emergency Procedures

Agencies must inform foster parents of procedures for obtaining care for suspected illness or medical emergencies.²⁴ This includes providing an after-hours or emergency contact list. In foster parent training, handbooks, and case contacts: (1) cover what constitutes an emergency, and (2) inform foster parents of procedures for calling “on-call” staff or going to the emergency room (*see Chapter 10, Supporting Caregivers, for tips and a sample fact sheet on emergencies for foster parents*).

Emergency rooms are to be used only in the following situations:

- When medically necessary.
- When no other 24-hour care is available.
- When injuries indicate the need.
- When hospitalization is recommended.

Communicable Diseases and Schools

Schools are responsible for carrying out policies to temporarily exclude students from school if they have certain communicable and/or infectious diseases. Schools follow the recommendations of the federal Centers for Disease Control (CDC) and the local health department. The principal has the final responsibility to isolate the student with suspected communicable disease and to notify the foster

²⁴ 18 NYCRR 441.22(j)(i)(ii) and (iii). In New York City, a form W-853D must be completed to begin an investigation into serious accidents, incidents, illnesses, injuries, and deaths (including suicides) that “do not rise to the level of a child abuse/neglect report acceptable to the New York State Central Register.”

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parent to remove the student from school. If the student is acutely ill and the foster parent or caseworker cannot be reached to remove the child from school, the principal arranges for the removal of the student to a hospital.

Schools generally have exclusion policies for the following communicable diseases:

- chickenpox (varicella)
- pink eye (conjunctivitis)
- beaver fever (giardiasis)
- hand, foot and mouth disease
- Coxsackie virus
- hepatitis A
- impetigo
- infectious mononucleosis
- measles (rubeola)
- meningitis
- mumps
- head lice (pediculosis)
- German measles (rubella)
- scabies
- streptococcal infection (sore throat, scarlet fever)
- shigellosis (bacillary dysentery)
- whooping cough (pertussis).²⁵



Health Care Coordination Activities

Caregivers should also be familiar with the school's exclusion policies on communicable diseases. A checklist for conditions that are contagious and require staying away from school would be helpful for foster parents. Check with the schools in the community to see if they provide a list of such conditions and illnesses to parents, what the rules are for returning the child to school, and opportunities for the child to continue studies with work sent home.

²⁵ Bureau of Communicable Disease Control, New York State Department of Health, April 1996.

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9 Resources

Health Guidance Materials

American Academy of Pediatrics (AAP)

The AAP publishes a wealth of information for practitioners on topics ranging from nutrition to mental health to adolescent health and sexuality. Go to www.aap.org. Click on Member Center, then select Policy Statements/Practice Guidelines. The Bookstore & Publications link offers additional materials, including Fostering Health, recommended for all clinicians treating children in foster care.

Bright Futures

Bright Futures, <http://www.brightfutures.org/>, is a national health promotion and disease prevention initiative that addresses children's health needs in the context of family and community. The centerpiece of Bright Futures is a comprehensive set of health supervision guidelines developed by multidisciplinary child health experts – ranging from providers and researchers to parents and other child advocates – that provide a framework for well-child care from birth to age 21. These guidelines are designed to present a single standard of care and a common language based on a model of health promotion and disease prevention.

Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents—Third Edition (2008) combines the authoritative *AAP Guidelines for Health Supervision III* with the practical approach used by Bright Futures. Chapters can be downloaded from: http://brightfutures.aap.org/3rd_Edition_Guidelines_and_Pocket_Guide.html; or the materials can be purchased from the AAP Bookstore at https://www.nfaap.org/netFORUM/eweb/DynamicPage.aspx?webcode=aapbks_productdetail&key=68eca6db-7d0d-4ffd-b264-a334b9876ea6.

The *Guidelines* are organized as follows:

Part 1 features 10 chapters on key themes that recur in each stage of child development.

Part 2 provides health supervision guidance and anticipatory guidance for the 31 recommended health supervision visits from infancy through late adolescence. Each visit:

- Starts with a context that captures the child at that age.
- Contains handy lists and tables that summarize interval history questions, parent-child and developmental observation, physical exam, medical screening, and immunizations.

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- Lists five priorities that help you focus your discussions with parents and children on the most important issues for that visit.
- Provides anticipatory guidance for each priority with sample questions and discussion points.

Healthy People 2010

Healthy People 2010 is a comprehensive set of disease prevention and health promotion objectives for the Nation to achieve over the first decade of the new century. Created by scientists both inside and outside of Government, it identifies a wide range of public health priorities and specific, measurable objectives. Its overarching goals are to: (1) increase quality and years of healthy life; and (2) eliminate health disparities. The website is <http://www.healthypeople.gov/>.

The 28 focus areas of Healthy People 2010 were developed by leading federal agencies with the most relevant scientific expertise. The development process was informed by the Healthy People Consortium—an alliance of more than 350 national membership organizations and 250 state health, mental health, substance abuse, and environmental agencies. In addition, through a series of regional and national meetings and an interactive website, more than 11,000 public comments on the draft objectives were received. The Secretary's Council on National Health Promotion and Disease Prevention Objectives for 2010 also provided leadership and advice in the development of national health objectives.

Individuals, groups, and organizations are encouraged to integrate Healthy People 2010 into current programs, special events, publications, and meetings. Businesses can use the framework, for example, to guide worksite health promotion activities as well as community-based initiatives. Schools, colleges, and civic and faith-based organizations can undertake activities to further the health of all members of their community. Health care providers can encourage their patients to pursue healthier lifestyles and to participate in community-based programs. By selecting from among the national objectives, individuals and organizations can build an agenda for community health improvement and can monitor results over time.

Following are examples of nutrition and physical activity objectives for children and youth:

- Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardio-respiratory fitness three or more days per week for 20 or more minutes per occasion.
- Reduce the proportion of children and adolescents who are overweight or obese.
- Increase the proportion of persons age 2 and older who consume 2,400 mg. or less of sodium daily.
- Increase the proportion of persons age 2 and older who meet dietary recommendations for calcium.

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- Reduce iron deficiency among young children and females of childbearing age.
- Reduce noise-induced hearing loss in children and adolescents age 17 and under.

Dental Services

Orthodontia

Orthodontia is covered under Medicaid for children with severe handicapping dental conditions. The child's basic dental needs will need to be met by their primary dentist prior to the initiation of the referral to the orthodontist. Teeth that are in need of cleaning or fillings should be taken care of and good oral hygiene established.

Outside of NYC, a dentist refers the child to an orthodontist to determine if treatment is needed. If families or providers need assistance locating a dentist or an orthodontist who will accept Medicaid or PHCP, they should call the Growing Up Healthy Hotline at 1-800-522-5006. The orthodontist screens the child, and sends in a request for prior approval of treatment to the NYS Department of Health.

In NYC, the dentist or foster care staff should call 212-788-5538 at the NYC Department of Health to request a referral to an orthodontist that accepts Medicaid. As above, the orthodontist screens the child and sends in a request for prior approval of treatment to the NYS Department of Health.

National Maternal and Child Oral Health Resource Center

The purpose of the National Maternal and Child Oral Health Resource Center (OHRC) is to respond to the needs of states and communities in addressing current and emerging public oral health issues. OHRC supports health professionals, program administrators, educators, policymakers, and others with the goal of improving oral health services for infants, children, adolescents, and their families. The resource center collaborates with federal, state, and local agencies; national and state organizations and associations; and foundations to gather, develop, and share high-quality information and materials. <http://www.mchoralhealth.org/default.html>

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Mental Health Services

New York State Office of Mental Health

<http://www.omh.state.ny.us/>

The American Academy of Child and
Adolescent Psychiatry (AACAP)

The AACAP has published over 25 Practice Parameters. The Parameters are published as Official Actions of the AACAP in the *Journal of the American Academy of Child and Adolescent Psychiatry*. The AACAP Practice Parameters are designed to assist clinicians in providing high quality assessment and treatment that are consistent with the best available scientific evidence and clinical consensus. The Parameters may be downloaded from the website: <http://www.aacap.org/>. Click on Physicians and Allied Professionals, then Practice Information, then Practice Parameters.

Bright Futures Mental Health Guide

The information and resources in Volume 1 provide primary care health professionals with the tools needed to promote mental health in children, adolescents, and their families. It also helps them recognize the early stages of mental health problems and mental disorders, and be able to intervene appropriately. Volume 2 is a tool kit that provides hands-on tools for health care professionals and families for use in screening, care management, and health education.

Website: http://brightfutures.aap.org/practice_guides_and_other_resources.html. This guide is endorsed by the National Institute for Health Care Management (NICHM), www.nihcm.org.

DSM-IV-TR

To obtain a copy of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Revision, Text Revision (DSM-IV-TR), go to the American Psychiatric Publishing, Inc. website at <http://www.appi.org/>. You can learn more about the DSM at <http://www.dsmivtr.org/2-1faqs.cfm>.

National Alliance on Mental Illness (NAMI)

NAMI, the nation's largest grassroots organization for people with mental illness and their families, is dedicated to the eradication of mental illnesses and to the improvement of the quality of life for persons of all ages who are affected by mental illnesses. Their website, <http://www.nami.org/>, contains descriptions of mental health disorders and comprehensive information on medications used to address symptoms. The Helpline is 1-800-950-6264.

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Types of Preventive Mental Health Services

Preventive mental health services include universal, selective, indicated, and prevention-minded treatment:

- *Universal prevention* is targeted to the general population or whole population of a specific eligible group but is not identified on the basis of individual risk. Examples include adequate diet, seat belts, prenatal care, conflict negotiation training for kindergarten children, and increasing social competence.
- *Selective prevention* is targeted to individuals or subgroups whose risk of developing a disorder is above average. Examples include social cognitive skill building with children in families with mothers who are depressed or with children of parents undergoing separation or divorce.
- *Indicated prevention* is targeted to high-risk individuals who, on examination, manifest a risk factor, condition, or abnormality that identifies them, individually, as being at high risk for the future development of the disease. Examples include psychosocial and/or pharmacological interventions with persons in the initial phase of a disorder.
- *Prevention-minded treatment* is targeted to individuals who are at risk of more severe progressions of the mental illness, relapse, or co-morbidity. Examples include early identification of symptoms in a primary care setting, use of interdisciplinary (including pharmacological and behavioral) approaches in relapse prevention, prevention of substance abuse as a complication of social phobia, substance abuse as a complication of a childhood mental health disorder, and preventing the evolution of borderline and dissociative disorders in children currently in treatment for trauma and depression.

Developmental Services

Early Intervention Program

Bureau of Child and Adolescent Health
New York State Department of Health
Corning Tower, Room 208
Albany, NY 12237-0618
518-473-7016
518-486-1090 fax
“Growing Up Healthy” 24-Hour Hotline
1-800-522-5006
1-800-577-2229 (New York City)

For information on developmental screening instruments for specific conditions, go to the New York State Department of Health’s website: www.health.state.ny.us. Click on the A-Z index, then on “Early Intervention Program.” Select Memoranda, Guidance, and Clinical Practice Guidelines.

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AAP Policy

<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405>

The American Academy of Pediatrics (AAP) updated their guidelines for developmental surveillance in July 2006. Use the above link to access the policy statement: *Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening*.

Substance Abuse Services

Child Welfare Information Gateway

http://www.childwelfare.gov/systemwide/service_array/substance/

Formerly the National Clearinghouse on Child Abuse and Neglect, The Child Welfare Information Gateway has reorganized and substantially updated the Substance Abuse section of its website. Designed for child welfare, substance abuse, and other related professionals working with children, youth, and families affected by substance abuse, the section provides an [overview of the impact of substance abuse on child welfare](#), [resources for families](#), and information on [prevention](#), [assessment](#), [casework practice](#), [treatment services](#), [cross-system collaboration](#), and [drugs of particular concern](#).

New York State Office of Alcoholism and Substance Abuse Services (OASAS)

For referrals to licensed treatment programs and substance abuse prevention services, contact OASAS at 1-800-522-5353 or go to www.oasas.state.ny.us. To request a listing of programs and services, contact OASAS publications at 518-457-9208. A national searchable treatment provider locator is also available on-line and may be accessed by going to <http://DASIS3.SAMHSA.gov/>

Methamphetamine

The OASAS Methamphetamine Clearinghouse at <http://www.oasas.state.ny.us/meth/index.cfm> provides links to resources and information. For children exposed to meth, the Colorado Alliance for Drug Endangered Children site (<http://www.colodec.org/index.asp>) provides guidance. Select DEC Papers from the left side of the webpage to access the documents *National Protocol for Medical Evaluation of Children Found in Methamphetamine Labs* and *Medical Evaluation of Children Removed from Clandestine Labs FAQ #2*.

Note: These documents have not been endorsed by the NYS Department of Health or Office of Children and Family Services. They are referenced here for informational purposes.

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Treatment of Adolescents With Substance Use Disorders

Treatment Improvement Protocol (TIP) Series 32

(available from <http://ncadi.samhsa.gov/>)

Excerpts from the Executive Summary and Recommendations:

This document, *Treatment of Adolescents With Substance Use Disorders*, is a revision and update of Treatment Improvement Protocol (TIP) 4, published in 1993 by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA). Like TIP 4, this document aims to help treatment providers design and deliver better services to adolescent clients with substance use disorders.

...Adolescent users differ from adults in many ways. Their drug and alcohol use often stems from different causes, and they have even more trouble projecting the consequences of their use into the future. In treatment, adolescents must be approached differently than adults because of their unique developmental issues, differences in their values and belief systems, and environmental considerations (e.g., strong peer influences). At a physical level, adolescents tend to have smaller body sizes and lower tolerances, putting them at greater risk for alcohol-related problems even at lower levels of consumption. The use of substances may also compromise an adolescent's mental and emotional development from youth to adulthood because substance use interferes with how people approach and experience interactions.

The treatment process must address the nuances of each adolescent's experience, including cognitive, emotional, physical, social, and moral development. An understanding of these changes will help treatment providers grasp why an adolescent uses substances and how substance use may become an integral part of an adolescent's identity.

Regardless of which specific model is used in treating young people, there are several points to remember when providing substance use disorder treatment:

- In addition to age, treatment for adolescents must take into account gender, ethnicity, disability status, stage of readiness to change, and cultural background.
- Some delay in normal cognitive and social-emotional development is often associated with substance use during adolescence. Treatment for adolescents should identify such delays and their connections to academic performance, self-esteem, or social interactions.
- Programs should make every effort to involve the adolescent client's family because of its possible role in the origins of the problem and its ability to change the youth's environment.
- Although it may be necessary in certain geographic areas where availability of adolescent treatment programs is limited, using adult programs for treating youth is ill-advised. If this must occur, it should be done only with great caution and with alertness to inherent complications that may threaten effective treatment for these young people.

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- Many adolescents have explicitly or implicitly been coerced into attending treatment. Coercive pressure to seek treatment is not generally conducive to the behavior change process. Treatment providers should be sensitive to motivational barriers to change at the outset of intervention. Several strategies can be used for engaging reluctant clients to consider behavioral change.

...Treatment interventions fall along a continuum that ranges from minimal outpatient contacts to long-term residential treatment. All levels of care should be considered in making an appropriate referral. Any response to an adolescent who is using substances should be consistent with the severity of involvement. While no explicit guidelines exist, the most intensive treatment services should be devoted to youth who show signs of dependency – that is, a history of regular and chronic use – with the presence of multiple personal and social consequences and evidence of an inability to control or stop using substances.

Informational Brochures

Publications available from the New York State Office of Alcoholism and Substance Abuse Services (OASAS) at <http://www.oasas.state.ny.us/pio/catalog.cfm> include:

- BR71 [Not Just a Game of Chance - Problem Gambling and Adolescents](#)
- BR16 Questions and Answers about Alcohol and Drugs
- PKT3 Tips for Teens packet (alcohol, crack/cocaine, hallucinogens, inhalants, marijuana)
- BR81 Tobacco Independence: Freedom from a Deadly Addiction
- BR26 FYI: Common Drugs and Symptoms of Abuse

Keeping Your Teens Drug-Free: A Family Guide (National Youth Anti-Drug Media Campaign). There are also guides for African-American Parents and Caregivers and Hispanic Families (bilingual). For copies, call 1-800-788-2800 or go to <http://www.theantidrug.com>.

Growth and Development Charts

Health practitioners complete growth charts at regular check-ups and well child visits. Copies of these charts for boys and girls ages 0 to 36 months and 2 to 20 years can be found in the following pages and at http://www.kidshealth.org/parent/growth/growth/growth_charts.html. A Child Development Chart for the first five years is also included. These charts can be helpful to caseworkers and caregivers as they observe the child's growth and achievement of developmental milestones.

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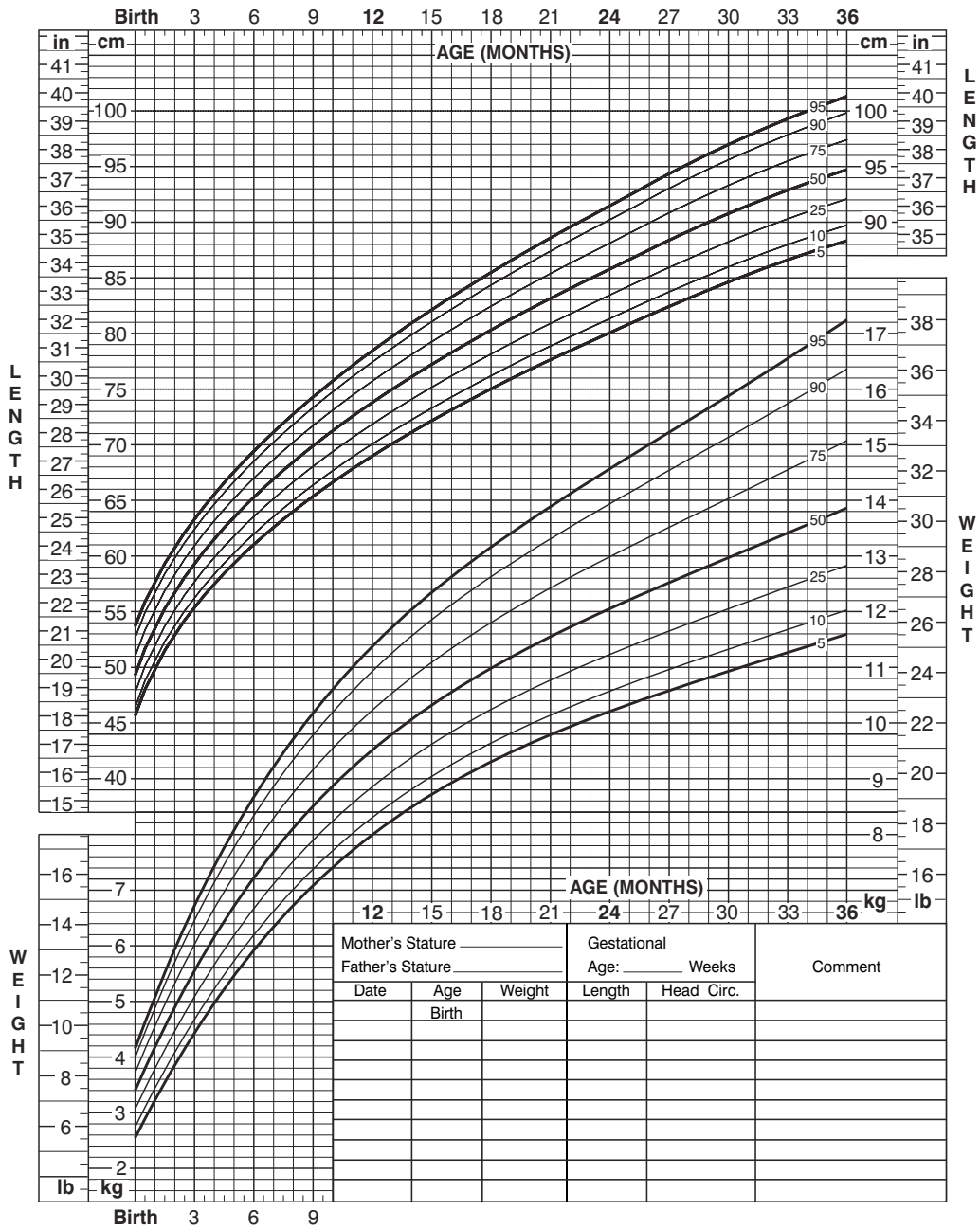
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Birth to 36 months: Girls

NAME _____

Length-for-age and Weight-for-age percentiles

RECORD # _____



Published May 30, 2000 (modified 4/20/01).
 SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000).
<http://www.cdc.gov/growthcharts>



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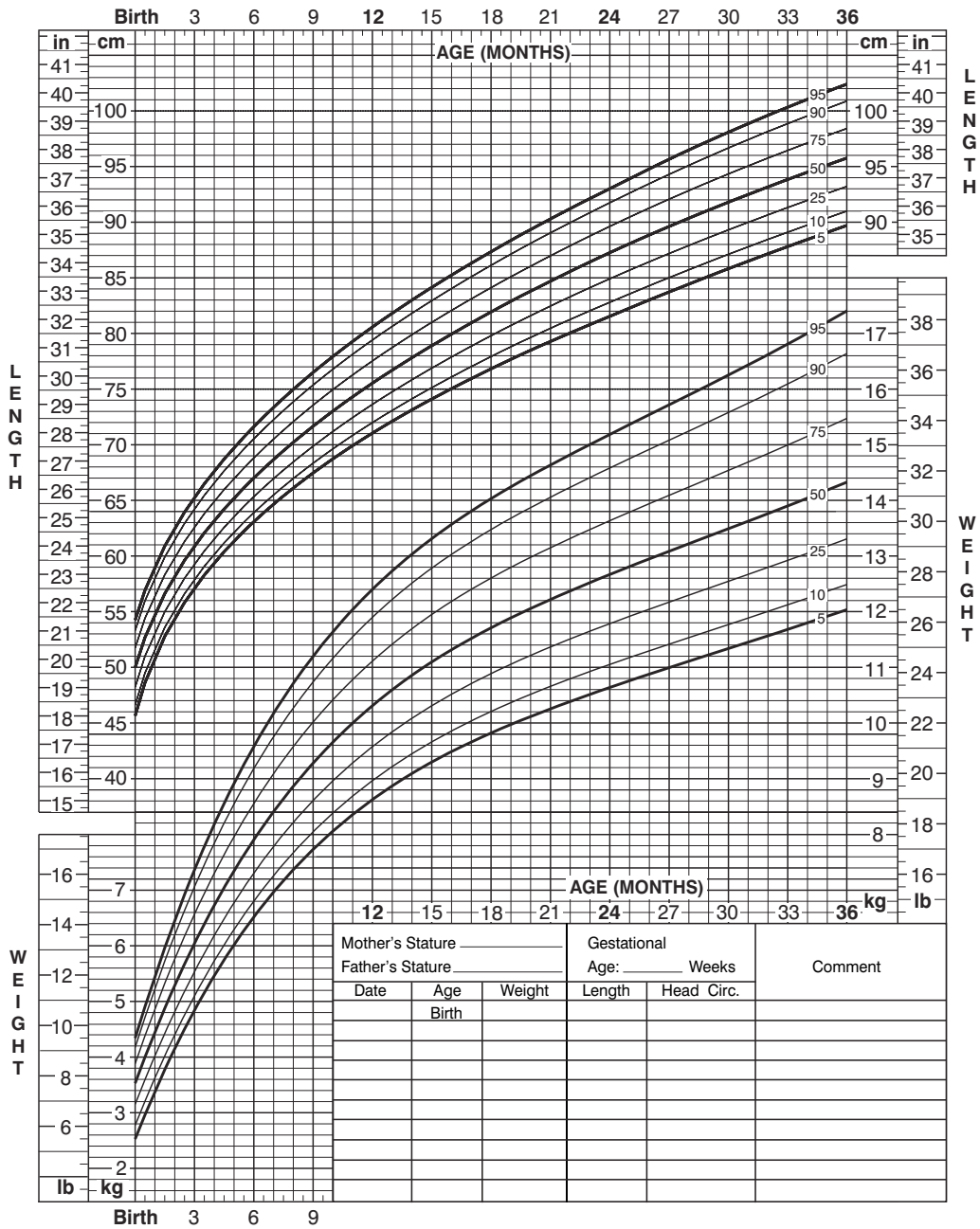
NYS Office of Children and Family Services

Birth to 36 months: Boys

NAME _____

Length-for-age and Weight-for-age percentiles

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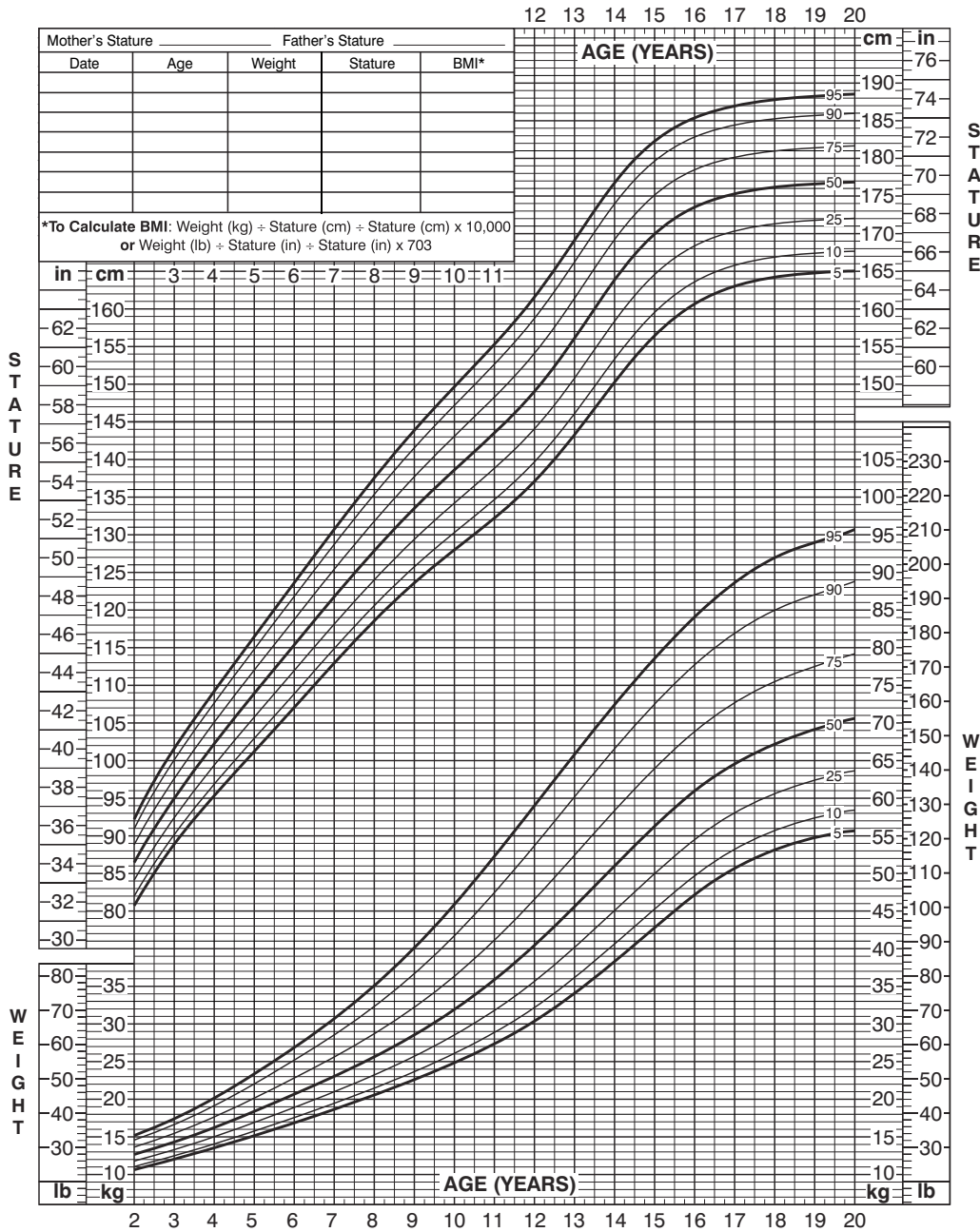
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2 to 20 years: Boys

NAME _____

Stature-for-age and Weight-for-age percentiles

RECORD # _____



Published May 30, 2000 (modified 11/21/00).
SOURCE: Developed by the National Center for Health Statistics in collaboration with
the National Center for Chronic Disease Prevention and Health Promotion (2000).
<http://www.cdc.gov/growthcharts>



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Child Development Chart – First Five Years

SOCIAL	SELF-HELP	GROSS MOTOR	FINE MOTOR	LANGUAGE
Birth to 6 Months				
Social smile Distinguishes mother from others	Reacts to sight of bottle or breast Comforts self with thumb or pacifier	Lifts head and chest when lying on stomach Turns around when lying on stomach	Looks at and reaches for faces and toys Picks up toy with one hand	Reacts to voices – vocalizes coos, chuckles Vocalizes spontaneously – social
6 to 9 Months				
Reaches for familiar persons Pushes things away he/she doesn't like	Feeds self cracker	Rolls over from back to stomach Sits alone...steady without support	Transfers toy from one hand to the other Picks up object with thumb and finger grasp	Responds to name – turns and looks Wide range of vocalizations (vowel sounds, consonant-vowel combination)
9 to 12 Months				
Plays social games, peek-a-boo, bye-bye Plays patty-cake	Picks up a spoon by the handle	Crawls around on hands and knees Walks around furniture or crib while holding on	Picks up small objects – precise thumb and finger grasp	Word sounds – says "Ma-ma" or "Da-da" Understands words like "No" "Stop" or "All gone"
12 to 18 Months				
Wants stuffed animal, doll or blanket in bed Gives kisses or hugs Greet people with "hi" or similar	Lifts cup to mouth and drinks Feeds self with spoon Insists on doing things by self such as feeding	Stands without support Walks without help Runs	Stacks two or more blocks Picks up two small toys in one hand Scribbles with crayon	Uses one or two words as name of things or actions Talks in single words Asks for food or drink with words
18 Months to 2 Years				
Sometimes says "No" when interfered with Show sympathy to other children – tries to comfort them Usually responds to correction – stops	Eats with fork Eats with spoon, spilling little Takes off open coat or shirt without help	Kicks a ball forward Runs well, seldom falls Walks up and down stairs alone	Builds towers of four or more blocks Turns pages of picture books, one at a time	Follows simple instructions Uses at least ten words Follows two-part instructions
2 to 3 Years				
"Helps" with simple household tasks Plays with other children – cars, dolls, building Plays a role in "pretend" games – mom-dad, teacher, space pilot	Opens door by turning knob Washes and dries hands Dresses self with help	Climbs on play equipment – ladders, slides Stands on one foot without support Walks up and down stairs – one foot per step	Scribbles with circular motion Draws or copies vertical lines Cuts with small scissors	Talks in two-three word phrases or sentences Talks clearly, is understandable most of the time Understands four prepositions – in, on, under, beside
3 to 4 Years				
Gives direction to other children Plays cooperatively, with minimum conflict and supervision Protective toward younger children	Toilet trained Washes face without help Dresses and undresses without help except for shoelaces	Rides around on a tricycle, using pedals Hops on one foot without support	Draws or copies a complete circle Cuts across paper with small scissors	Combines sentences with the words "and" "or," or "but" Identifies four colors correctly Counts five or more objects when asked "How many?" Understands concepts – size, number, shape
4 to 5 Years				
Follows simple rules in board or card games Shows leadership among children	Buttons one or more buttons Usually looks both ways before crossing street Goes to the toilet without help	Skips or makes running "broad jumps" Swings on swing, pumping by self	Draws recognizable pictures Draws a person that has at least three parts – head, eyes, nose, etc. Prints first name (four letters)	Follows a series of three simple instructions Reads a few letters (five +) Tells meaning of familiar words