Chapter Three

Special Health Care Services

To address the significant health issues of children in foster care, agencies are responsible for providing comprehensive health services, documenting such services, and maintaining current records.[1] This chapter describes services ranging from the Bridges to Health Waiver Program to HIV-related services.

Sections in this chapter include:

[1] 18 NYCRR 441.22(a); 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

1 Bridges to Health

Bridges to Health (B2H) is a home and community-based Medicaid waiver program for children in foster care. B2H is one state program that consists of three Home and Community Based Medicaid Waivers serving children in three disability groups:

- B2H for children with Serious Emotional Disturbances (SED)
- B2H for children with Developmental Disability (DD)
- B2H for children with Medical Fragility (MedF)

Once in the B2H program, children may be eligible for B2H services after discharge from foster care until age 21 if the child remains otherwise eligible.

A Medicaid waiver offers services not otherwise available in the community that will be provided and paid for through Medicaid. B2H is specifically tailored to address unmet health and other needs related to a child's serious emotional disturbances, developmental disabilities, and/or physical health issues. B2H services supplement and complement, but do not replace, existing Medicaid and child welfare services.

This program provides services to children with complex medical conditions in the context of their family and caregiver network. By supporting children in foster care in the least restrictive home or community setting, the B2H Waiver Program provides opportunities for improving the health and well-being of the children served, and supporting permanency planning. B2H is a voluntary program and cannot be mandated. Freedom of choice of services and service providers is fundamental.

Participation in the program may:

- allow the child to step down a level of care (e.g., move from a psychiatric hospital to a foster home);
- avert a higher level of placement for the child (e.g., from a foster home to a medical institution);
- avert the placement of a child out of state; or
- allow the child to move out of foster care sooner.

Waiver Services

The B2H Waiver Program services are available to all waiver enrollees, regardless of the qualifying diagnosis. This means that B2H is able to assist children with cross-system needs.

The 14 services are as follows:

- Health Care Integration
- Family/Caregiver Supports and Services
- Skill Building
- Day Habilitation
- Special Needs Community Advocacy and Support
- Prevocational Services
- Supported Employment
- Planned Respite
- Crisis Avoidance, Management, and Training
- Immediate Crisis Response Services
- Intensive In-home Supports
- Crisis Respite
- Adaptive and Assistive Equipment
- Accessibility Modifications

Eligibility and Enrollment in B2H Waiver Program

Eligibility criteria, including qualifying diagnoses, are listed in the B2H Program Manual, accessible on the B2H website: http://www.ocfs.state.ny.us/main/b2h/. A child must be Medicaid eligible (all children in foster care who are citizens or have satisfactory immigration status are categorically eligible for Medicaid).[2] The child must also be in foster care or in OCFS Division of Juvenile Justice and Opportunities for Youth (DJJOY) community services supervision to enter B2H. Once enrolled, the child may continue to receive B2H waiver services until age 21 if he or she continues to meet eligibility requirements, even after discharge from foster care.

The formal referral of children to B2H must come from the local department of social services (LDSS) or DJJOY. The LDSS/DJJOY first determines if the child is a candidate for the program and the availability of waiver slots. Then the LDSS/DJJOY prepares an application which includes documentation of a qualifying diagnosis, and submits it to a Health Care Integration Agency (HCIA) selected by the child or medical consenter. From that point on, the LDSS/DJJOY and HCIA will work closely with the child and medical consenter to enroll the child, if appropriate, and coordinate services.

Coordinating B2H and Foster Care Services

A Health Care Integrator (HCI) from the HCIA will work directly with each child enrolled in B2H to oversee waiver services. Routine health care outside of waiver services continues to be the responsibility of the foster care case manager. It is important for the HCI and case manager to form a complementary relationship and share information in support of the child's permanency, health, and well-being.

The HCI will develop an Individualized Health Plan for B2H waiver services that is subject to approval by the LDSS/DJJOY. This plan should be considered a component of the Family Assessment and Service Plan (FASP). To promote a free flow of information, the HCI enters progress notes into CONNECTIONS and should be included as a participant in team meetings and service plan reviews.

[2] GIS 05 MA/041.

2 HIV-Related Services

Required HIV-related services for children in foster care include:

- HIV risk assessment.
- Assessment of capacity to consent to an HIV test.
- Counseling and HIV antibody testing for children at risk.
- Referral of HIV-infected children for appropriate medical and psychological services. [3]

(See Chapter 1, Initial Evaluation of Child's Health, for information on HIV risk assessment when children enter foster care; see Chapter 6, Medical Consents, for a discussion of the consent issues related to HIV risk assessment and services; see Chapter 7, Confidentiality of Health Information, for a discussion of confidentiality and HIV.)

The AIDS Institute of the New York State Department of Health (DOH) recommends that agencies provide the following special services related to the special needs of HIV-infected children. If your agency does not provide these services, make sure that you know where you can refer children to obtain them.

Prevention Education

Whether provided by the health practitioner, agency health staff, or caseworkers, information on the risks and prevention of HIV is essential for children and youth in foster care. As appropriate for age and risk, such anticipatory guidance can be part of a broader health education program that includes discussion on sexuality, family planning, and sexually transmitted disease (STD) prevention. Be prepared and trained with current information if it is your role to interview and counsel children in foster care about these matters.

Agency staff should become comfortable with discussing sexual topics in general and in relation to HIV/AIDS. The next step is to help foster parents also become comfortable in discussing these issues with the children and youth in their care. Training and ongoing discussion with foster parents can assist in furthering their ability. Contact the staff development coordinator in your local district for information.

[3] 18 NYCRR 441.22(b); 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure.

HIV Counseling and Testing

Counseling and testing services should be readily available to all children and youth. These services may be offered by a counselor certified by a DOH-sponsored counselor training course or by an organization such as a community health care agency.

Remember that counseling about HIV may be used as an opportunity to provide individual prevention education, including advice on changing behavior.

When a foster child has the capacity to consent, and HIV risk has been identified, the child or youth has the right to make all decisions about an HIV test, the type of test, and a *limited right* to make certain decisions about disclosure of information related to an HIV test. Part of the counseling of children with capacity to consent is informing them about these rights (*see Chapter 7, Confidentiality of Health Information).*

After being counseled about testing, the child or youth has the right to decide whether to have agency-supervised confidential HIV-related testing or the alternative of anonymous testing. If the choice is confidential testing, the test results will be included in the child's confidential health record. When anonymous testing is chosen, only the child or youth will receive the test result, and no information linking the youth's identity to the test request or result will be gathered or kept.

Points to remember about HIV testing include:

- HIV testing is done only with appropriate consent *(see Chapter 6, Medical Consents).*
- Results of HIV testing will be in the confidential health record unless the child has chosen anonymous testing.
- Results of HIV testing will be made available only to persons authorized to receive such information under law and regulation, or by consent.[4]

For more information on HIV counseling and testing, contact:

- New York State Department of Health: HIV/AIDS Counseling/Testing Hotline (800-962-5065); or go to www.health.state.ny.us, and click on HIV/AIDS (or http://www.health.state.ny.us/diseases/aids/testing/).
- Your county health department.
- In New York City, the Pediatric AIDS Unit (PAU) (212-341-8943) of the New York City Administration for Children's Services (ACS).

[4] 18 NYCRR 441.22(b); 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure.

Placement of HIV-Infected Children

Children with HIV may require specialized services and extra efforts to meet their often complicated and enhanced needs. Whenever possible, HIV-infected children should be placed with an agency that has staff and foster parents who are knowledgeable about issues related to HIV. Certain agencies receive enhanced rates to provide specialized services.

When children with HIV are not placed in a special program, the agency needs to provide the necessary supportive nursing and psychosocial services and training to the child and foster family. For example, a child may be placed in a foster home with a sibling and is discovered later to have HIV. In the interest of keeping the siblings together, HIV-related training should be provided to the foster parents.

Health Care Coordination Activities

Make sure that medical follow-up is taking place, the caregiver is adhering to the child's medication schedule, and the child's counseling needs are being met. Remember that many children with HIV have also suffered family losses. These issues of loss and grief need to be addressed. Adolescents need to assess the impact of HIV on their sexual development and exploration.

Medical Care for HIV-Infected Children

Children in foster care who are HIV-infected should receive medical care from specialized pediatric or adolescent HIV/AIDS providers that have 24-hour coverage, seven days a week, including after-hours coverage. Providers should offer a comprehensive package of health care and support services to meet the multiple needs of children with HIV and their families. Whenever possible, care should be continued with the HIV specialist (who may be the primary care provider) who provided care to the child prior to foster care placement.

Foster parents who are caring for children with HIV will find helpful information in the NYS DOH/OCFS manual, *Caring for Children with Special Needs: For Parents, Foster Parents, and Other Caregivers Caring for Children with HIV,* September 2003. To obtain a copy of the manual, contact the NYS Department of Health at 518-474-9866. It can also be downloaded from http://www.health.state.ny.us/diseases/aids/resources/child/index.htm.

It is crucial that foster care agencies, foster parents, and congregate care facilities strictly adhere to the medication schedules that are prescribed for each child with HIV. Your agency should have methods for monitoring and assuring that medication schedules are followed precisely as written by the prescribing practitioner *(see Chapter 5, Medication Administration and Management).* If adherence to the medication schedule is problematic, the prescribing practitioner should be consulted.

An enhanced chronic care schedule for clinical monitoring of HIV-positive infants and children is recommended by the AIDS Institute (http://www.hivguidelines.org/):

- Monthly for the first year of life.
- Every three months thereafter.

Clinical Trials for HIV-Infected Children

A clinical trial is a research study in human volunteers to answer specific health questions. Carefully conducted clinical trials are the fastest and safest way to find treatments that work in people and ways to improve health (see http://www.clinicaltrials.gov/, a site of the National Institutes of Health). Access to clinical trials for children with HIV infection can be provided following the procedures established by the local social services district and approved by NYS OCFS, Division of Strategic Planning and Policy Development (SPPD).

Newborn Screening Program

Under New York State law, a sample of blood is taken from every newborn to test for over 40 disorders. Since February 1, 1997, the Newborn Screening Program has included an HIV antibody test. Although most of the screened disorders are rare, they are usually serious. Some may be life threatening; others may slow down a baby's physical development or cause mental retardation or other problems if left untreated. None of the disorders can be cured. However, serious side effects can be lessened, and often completely prevented, if a special diet or other medical intervention is started early.

Blood is usually taken for the Newborn Screening on the day that the infant is discharged from the hospital. The screening results are provided to the pediatrician. Request this information from the pediatrician and include the screening results in the medical record maintained by the foster care agency for each child in care. If you have difficulty accessing the screening information, assistance is available. The OCFS Office of Regional Operations and Program Improvement (ROPI) is responsible for coordinating Newborn Screening requests by local departments of social services (not including New York City) to the NYS DOH for children in foster care. Call ROPI at 518-474-8629 (currently Michael Monahan) for counties outside of New York City; in NYC, call the ACS Pediatric AIDS Unit (PAU) at 212-341-8943.

Results of the entire Newborn Screening panel should be reviewed by the child's medical home. Follow-up may be needed to rule in or rule out a condition or monitor a disease process. If the screening is positive for HIV antibodies, this means that the mother was HIV positive and the child has been exposed to the virus. HIV-exposed newborns need repeat testing to see if they are infected. Testing and treatment protocols are included in the Clinical Guidelines, found at http://www.hivguidelines.org/.

Information about the Newborn Screening Program is available at http://www.wadsworth.org/newborn/.

Risk Assessment[5]

The skillful gathering of information related to the risk of HIV infection should become standard practice in compiling histories of children, youth, and their families. Knowledge of the risk of HIV infection must become part of everyday awareness, as has knowledge of alcoholism or drug abuse, and be incorporated into routine history-taking.

The best starting point in determining the risk level for a particular infant, child, or youth is a careful assessment of the birth parents.

Medical and psychosocial history of parent or sexual partner of parent *(perinatal transmission)*	The parent or parent's sexual partner has: ■ diagnosis of HIV infection, symptoms of HIV, or died due to HIV. ■ had male sexual partner who was a male who sleeps with males (MSM). ■ history of STDs.* ■ had multiple sex partners or exchanged sex for money, food, housing, etc. prior to child's birth. ■ history of tuberculosis. ■ injected illegal drugs, shared needles, or other equipment involved with drug use or piercing. ■ used non-injection illegal drugs. ■ had a blood/blood products transfusion between January 1978 and July 1985 in U.S. ■ had blood transfusion in other country at time when blood was not screened for HIV.
Risk factors for infants & preschool children *(perinatal transmission: pregnancy, birth, breast-feeding)*	The child: ■ has positive drug toxicology/drug withdrawal at birth. ■ tests positive for syphilis at birth. ■ has symptoms consistent with HIV infection. ■ has/had sibling with HIV, or initially tested positive but seroreverted to negative. ■ was abandoned at birth with no risk history available. Assessment should continue with examination of the child's behavior. This information should be gathered carefully, with respect for privacy and confidentiality.
Child's behavior *(direct transmission)*	The child has: ■ symptoms of HIV infection. ■ been sexually abused. ■ engaged in sexual activity. ■ history of STDs.* ■ had multiple sex partners or exchanged sex for money, food, housing, etc. ■ history of tuberculosis. ■ injected illegal drugs, shared needles, or other equipment involved with drug use or piercing. ■ used non-injection illegal drugs. ■ had a blood/blood products transfusion between January 1978 and July 1985 in U.S. ■ had blood transfusion in other country at time when blood was not screened for HIV.
The above risk factors are listed in 97 ADM-15.	
As a result of recent research on HIV, additional risk factors have been identified by the NYS DOH AIDS Institute:	The child has: ■ tattoos ■ hepatitis C

*Sexually Transmitted Disease such as syphilis, gonorrhea, hepatitis B, or genital herpes.

[5] 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure.

3 Family Planning, Sexuality Education, and Reproductive Health Services

Youth in foster care age 12 and older, and younger children who are known to be sexually active, need age-appropriate education and counseling on sexuality, pregnancy prevention, family planning, and sexually transmitted diseases. These services may be provided directly by your agency or by agreements with health-related community organizations. In any case, such services must be readily available and provided by professionals trained and experienced in family planning education, gynecological care, and contraception for adolescents. The discussion of these subjects, along with the family planning notice *(see below)*, should begin at the first conference with the foster parents and the youth, if appropriate.

➔ See section 6, Resources, for a list of resources and websites related to reproductive and sexual health. Also provided is a list of health websites specifically for teens.

Notice of Family Planning Services

When a youth age 12 or older is placed in foster care, his or her foster parent must be informed in writing within 30 days of placement, and annually thereafter, of the availability of social, educational, and medical family planning services for the youth.[6] This notice, or offer, may be made orally as long as it is also made in writing *(see Appendix A for a sample Family Planning Notice)*. Place a copy of the family planning notice and the date it was made in the youth's medical and case records.

If the local district's policy is to make an offer directly to all adolescents within the district, the notice of family planning services also must be made directly to the youth in foster care.[7] As with the notice to foster parents, you may discuss the availability of services orally, but you must also provide written notice and file a copy of the notice in the youth's record. Minors can consent to their own treatment regarding STD testing and counseling, contraceptive services, and pregnancy, including abortion *(see Chapter 6, Medical Consents).*

[6] 18 NYCRR 441.22(l)(1) and 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.
[7] 18 NYCRR 441.22(l)(2) and 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

Family Planning Services

State and federal mandates require that family planning services be provided to youth in foster care age 12 and older, upon request.[8] Referrals should be made within 30 days of the request to services provided directly by your LDSS, through contract agencies, or by community health care providers. For information on family planning programs in your community, contact the NYS Department of Health at 518-474-3368.

Health Care Coordination Activities

Develop a list of family planning providers in your community. Share this list of resources with youth and caregivers. Be sure to update the list regularly.

Community Prevention Programs

The Adolescent Pregnancy and Prevention Services (APPS) program assists high need communities to develop a comprehensive array of services to prevent unwanted pregnancies for at-risk youth through 21 years of age. This is accomplished through coordination of existing services in the community and creation of new services to meet needs identified by a community needs assessment. The Teenage Services Act (TASA) provides case management for teens who are pregnant or parenting and receiving temporary assistance. The program focuses on pregnant adolescents to assist them in accessing prenatal care and services to avoid complications such as low birth weight and fetal deaths. TASA is provided or arranged for by the LDSS in each county.

Routine Gynecological Care

As part of routine health care, all female adolescents age 12 and older or at the onset of puberty should be referred for a gynecological examination, as appropriate. Examples include adolescents who are thinking about becoming sexually active or who are already sexually active, or when there are medical concerns such as menstrual problems.

Pregnancy

When an adolescent is pregnant, or pregnancy is suspected, the first step is to obtain prompt medical care and counseling. Emergency contraception should be offered to any young woman who does not wish to become pregnant and has had unprotected sexual intercourse within the preceding three days.

If pregnancy is confirmed, the adolescent needs care and support in exploring and deciding upon a possible course of action. Topics to cover in counseling an adolescent who is pregnant include:

[8] 18 NYCRR 507.1(c)(9).

- Identifying her concerns, fears, and wishes.
- Discussing whether she wants to involve her birth parents and/or the baby's father in planning.
- Determining whether she will be able to remain in her current foster care placement.
- An objective review and discussion of the alternatives and their implications, including adoption of the baby, pregnancy termination, living arrangements if she keeps the baby, and school attendance (education).
- Helping her implement her decisions.

Prenatal/postpartum care should be consistent with current professional standards of care. American College of Obstetricians and Gynecologists (ACOG) Standards for reproductive health and the birth process should be employed.

The privacy (confidentiality) of an adolescent who objects to her parent/guardian being informed of the possibility of pregnancy is protected under New York State Law. However, continuing efforts should be made (and documented) to encourage her to involve her parent/guardian, if appropriate, and caregivers as early as possible as these individuals can provide valuable support and resources.

Health Care Coordination Activities

Pregnant adolescents may be able to continue attending school and participating in activities up to a point recommended by their doctor. Monitor the ongoing medical care during and following pregnancy, verifying that she keeps her appointments and that the foster parents are informed and involved in the situation. Keep in mind that teens in foster care may consent for their health care during pregnancy. It is not necessary to obtain consent from the parent or guardian for services related to prenatal care (*see Chapter 6, Medical Consents*).

Good sources of support available through the New York State Department of Health are the Growing Up Healthy Hotline, the Prenatal Care Assistance Program (PCAP), the Medicaid Obstetrical and Maternal Services (MOMS) Program, the Comprehensive Prenatal Perinatal Services Network, and the Community Health Worker Program (CHWP) *(see section 4, Resources)*.

Sexually Transmitted Diseases

Children and adolescents who engage in unprotected sexual activity have high rates of sexually transmitted diseases and are at risk of HIV infection. As part of the family planning discussion, provide age-appropriate instruction regarding abstinence, safer sex, prevention of STDs, diagnosis and treatment, and the risk of repeated infections.

A new study from the Centers for Disease Control (CDC) indicates that approximately one in four (26%) female adolescents (age 14-19) in the United States has at least one of the most common sexually transmitted infections (STIs). The infections included were human papillomavirus (HPV)

infection, chlamydia, herpes simplex virus type 2 (HSV-2) infection, and trichomoniasis. African-American teenage girls had the highest prevalence, with an overall STI prevalence of 48 percent compared to 20 percent among both whites and Mexican Americans.[9]

STDs, particularly for females, may have no obvious symptoms. Urine screening is useful to identify asymptomatic chlamydia and gonorrhea. STD testing should be a routine part of primary care for sexually active adolescents. Testing should also be considered when a child returns from an absence without consent if there are concerns that sexual activity occurred.

Current STD treatment guidelines are available from the CDC at http://www.cdc.gov/std/treatment/2006/toc.htm.

Human Papillomavirus (HPV)

It is estimated that 20 million people in the U.S. are currently infected with HPV.[10] Different strains of this virus cause genital warts and cervical cancer. Though it is important to note that most HPV infections clear on their own, some may persist, putting the young woman's health at risk.

A vaccine to protect against HPV is available and should be administered as a routine immunization. *(see Recommended Childhood Immunization Schedule, page 1-25).* To be most effective, the vaccine should be given before the girl is sexually active. However, it is appropriate for all women and girls ages 8 to 26, regardless of whether they are sexually active or already infected with HPV. Females entering and already in foster care should receive the HPV series of vaccinations if they have not yet been administered. The parent/guardian's signed consent for routine medical treatment is sufficient; no additional consent is required.

[9] 2008 National STD Prevention Conference. *Oral Abstract–Prevalence of Sexually Transmitted Infections and Bacterial Vaginosis among Female Adolescents in the United States: Data from the National Health and Nutrition Examination Survey (NHANES) 2003-2004.* http://www.cdc.gov/stdconference/2008/media/summaries-11march2008.htm#tues1

[10] NYS Department of Health. *Questions and Answers about Human Papillomavirus (HPV) Vaccine* (http://www.nyhealth.gov/diseases/communicable/human_papillomavirus/fact_sheet.htm)

4 Services for Gay, Lesbian, Bisexual, Transgender, and Questioning Youth

Be sensitive to the reality that some young people in foster care are gay, lesbian, bisexual, transgender, or questioning their sexual orientation or gender identity (GLBTQ). This means that the child may be sexually attracted to and/or sexually involved with people of the same gender. A transgender child identifies with a gender that is different from his/her birth-assigned gender *(see section 5, Resources, for definitions and terms)*.

These youth face special challenges as they negotiate their sexual orientations in a society often hostile to nontraditional sexual identities. They may be targeted for bullying and violence because of others' inability to accept alternative lifestyles and sexual orientation. The risks of running away, suicide, and other acting out behaviors are high.

"Child welfare organizations that understand and address the needs of these youth will, over the long term, create safer, more open agencies and improve the quality of services they provide to all the children and youth in their care, regardless of their sexual orientation or gender preference."[11] At a minimum, GLBTQ youth in foster care need:

- A safe, secure, accepting environment with tolerance for self-expression in areas such as dress and behavior.

- Health services to meet the special health needs of gay, lesbian, and transgender youth by professionals who are experienced in their care.

A recent survey of high school youth found that 5.5 percent self-identified as gay, lesbian, or bisexual and/or reported same-gender sexual contact.[12] Since this may not include transgender and questioning youth or those who are fearful of sharing this personal information, it is likely that the numbers are higher.

In addition to being aware about sexual orientation issues, keep the following risk factors in mind:[13]

- Violence in school
- Lack of role models
- Substance abuse
- STD/HIV infection
- Depression and suicide
- Cultural rejection

[11] Teresa DeCrescenzo and Gerald P. Mallon, *Serving Transgender Youth: The Role of Child Welfare Systems* (Washington, D.C.: Child Welfare League of America, 2000), p. v.
[12] Massachusetts Department of Education. *Massachusetts High School Students and Sexual Orientation: Results of the 1999 Youth Risk Behavior Survey* (Boston, MA: The Department, 1999).
[13] Advocates for Youth, www.advocatesforyouth.org/publications/factsheet/fsglbt.htm.

Health Care

Tips for staff working with GLBTQ youth in foster care include:[14]

- Youth who engage in heterosexual sexual relations may not be exclusively heterosexual (this includes pregnant teenagers who may be lesbians but also engaged in heterosexual intercourse).
- Gynecological visits can often alienate lesbians because of prevailing heterosexual assumptions.
- Gay males may learn about being gay through sexual experiences, thereby increasing the risk of STD/HIV exposure.
- Gay males may be at risk for eating disorders (in contrast to young lesbians, with whom this does not seem to be an issue).
- Many transgender youth do not seek services in the health care system due to fear of ridicule, rejection, or harassment.
- Be aware of cultural issues related to sexual orientation and self-identification.

Mental Health

Recognize the inherent psychological stress of being stigmatized and/or keeping secret one's sexual orientation. The chronic stress of fear for safety, others finding out, and coming out (realizing sexual orientation), when combined with the stress of moving into a foster home or residential setting increases anxiety and mental health problems. Multiple and unstable placements are not uncommon for adolescents, and especially for GLBTQ youth.

The term *transgender* refers to all those who challenge the socially-accepted definitions and boundaries of sex and gender. Puberty is a particularly difficult time for youth struggling with their gender identity since these youth rarely have support systems to make sense of their physical changes. These changes may shame or repulse transgender youth and lead to attempts to change their physical appearance by concealing and/or injuring unwanted body parts. Some transgender males engage in high-risk behaviors to purchase feminizing hormone drugs. The unsupervised use of hormones presents physical as well as mental health issues that should be addressed by the treatment team, with the adolescent's participation. Another risk for transgender youth is alcohol and substance use to cope with feelings of depression and anxiety.

Be aware that teens who feel alienated from the health care system may not follow through with recommended treatment. As a result, they may not receive health care on a consistent basis.

[14] Gerald P. Mallon, *Lesbian and Gay Youth: A Practical Guide for Youth Workers* (Washington, D.C.: CWLA Press, 2001).

Note: It is important to remember that GLBTQ youth may seek or require mental health services for reasons unrelated to their sexual orientation.

Health Care Coordination Activities

To address the special needs of GLBTQ youth, consider the following three areas: organizational changes, in-service trainings, and welcoming strategies.

Organizational Changes

Consider the following questions to determine whether your agency provides a positive, healthy environment for GLBTQ youth:

- Has your agency worked with GLBTQ youth in the past?
- How often has your agency's staff had training, and of what type, in working with GLBTQ youth?
- What is your agency's treatment philosophy for working with GLBTQ youth?
- Do agency policies specifically address the needs of GLBTQ youth?
- Do agency brochures and outreach materials include photos or references to GLBTQ youth?
- Does your agency have linkages with GLBTQ youth organizations?
- Is the issue of acceptance of GLBTQ children addressed in certification interviews with foster parents who may be caring for them?
- Are the health care providers you use familiar with the unique needs of GLBTQ youth?

In-Service Trainings

To address the needs of GLBTQ youth, training for agency staff and caregivers should:[15]

- Identify appropriate language.
- Counteract common myths and stereotypes.
- Replace myths with accurate information.
- Teach how to create a safe environment.

[15] DeCrescenzo and Mallon.

- Assess personal biases and prejudices.
- Identify community resources.
- Show videos and have guest speakers [e.g., Parents and Friends of Lesbians and Gays (PFLAG) can often provide well-trained speakers for in-service training programs].
- Be offered on an ongoing basis.

Welcoming Strategies

Create an open and respectful waiting room, including reading materials and signs or symbols that specifically spell out your agency's attitude about respect for all people. This can include "Hate-Free Zone" posters and subtle posters or signs (e.g., a rainbow) that indicate acceptance of all youth.

5 Special Services for School-Age Youth

Additional important services address concerns, issues, and activities that have health and mental health implications for school-age youth.

Violence and Trauma

History of violence in the family, peer-induced violence, and exposure to violence are crucial parts of the history-taking portion of the comprehensive health assessment. Assessment of family violence is also an integral part of the child abuse and neglect evaluation and may yield information about other types of violence. For example, many youth are exposed to violence through peers, such as gangs, sports, and in school. The objectives are to determine the effect of the trauma when a child has experienced or witnessed an act of violence and to refer the child or youth for counseling, school violence programs, or other mental health services, as needed.

Points to remember regarding violence as a health concern include:

- Assessment of risk of violent behavior and past exposure to violence.
- Violence prevention education.
- Counseling for children or youth who have been abused or witnessed abuse of others.

Programs that address bullying and teach conflict resolution skills and peer mediation are available in most communities and schools. Be familiar with the prevention programs (e.g., domestic violence programs) in your area as resources for children affected by and/or involved in violence.

Suicide

Young people often give clues to peers, teachers, and foster parents or other adults of their intent to commit suicide. Therefore, it is important that all staff and caregivers be aware of behavioral clues that may suggest suicidal behavior. Some behavioral and informational indicators are:

- Previous suicide attempts.
- Signs of depression and undue stress.
- Threats of suicide (verbal or written).
- Isolation/withdrawal.
- Any self-injurious behavior.
- Dramatic changes in behavior (e.g., use of drugs and/or alcohol; school failure or truancy).
- Low self-esteem or extensive self-criticism.
- Giving away of personal belongings.

When a young person in the community has committed suicide, there is a heightened possibility that others may "copy" the same behavior. When a community experiences this phenomenon, communication and coordination among various service providers may be helpful in providing grief and loss and prevention services.

Be familiar with your agency's intervention procedures for handling suicide attempts and threats or talk of suicide. Caregivers should be trained in and familiar with these procedures. Staff training should include screening of foster children for risk of suicide, recognition of suicidal behaviors, suicide prevention, need for enhanced supervision, and referral to mental health services.

Child and Adolescent Sexual Offenders/Reactors

Agencies should train staff periodically on the assessment and treatment of child and adolescent sexual offenders and sexual abuse reactors. Child and adolescent sexual abusive behavior covers a continuum including mutually engaging in adult sexual behavior and being sexually aggressive or abusive to others. Children identified as sexual abuse reactors have been abused in some way and are reacting in sexually inappropriate ways. Areas for training and development include: [16]

- Developing a core of specially trained foster parents who care for sexually abused and/or sexually aggressive children. In cases where children who have been placed in regular foster homes turn out to be sexually abused or sexually aggressive, it is recommended that more experienced foster parents mentor the less experienced foster parents.

- Identifying and developing relationships with clinicians who specialize in work with sexually abused children in foster care. Therapists who specialize in treating sexually abused children may need training in working with children in foster care.

- Accomplishing teamwork among caseworkers, therapists, and other mental health professionals for treating these children.

- Identifying placement settings that are appropriate to address the safety needs of the children. This includes looking at the layout of bedrooms, lighting, and bathroom facilities, as well as supervision practices. Consider whether the setting provides spaces where it may be difficult for adults to supervise children's activities.

- Integrating strategies for involving the birth families into treatment approaches. Reunification is more difficult to achieve if the birth family members have not been involved closely in sexual abuse treatment. In particular, treatment for the sexually aggressive child in foster care who is transitioning back to the community needs to be developed in conjunction with the family or discharge resource and local mental health providers.

[16] Sally G. Hoyle, *The Sexualized Child in Foster Care* (Washington, D.C.: CWLA Press, 2000), pp. 97-99.

To address the needs of this population, topics to cover in staff training include, at a minimum:[17]

- Recognizing indicators of sexually abusive behaviors.
- Conducting initial screening and informal assessments to identify children for referrals for clinical assessments.
- Communicating with professionals who conduct clinical assessments.
- Recommending the appropriate level of care to meet all the needs of the child, and the child's family, in determining treatment.

Health Care Coordination Activities

Develop a library of materials for staff, including books, videotapes, foster parent and staff training materials, and therapeutic books on sexual abuse for children. Identify sources of funding for staff and foster parents to attend conferences on child sexual abuse. Information and materials gathered at conferences can help build the library and provide information about new developments in the field. Staff will also gain information on new developments by attending meetings of local chapters of the organizations listed in section 5, Resources.

General Principals for the Treatment of Juvenile Sexual Offenders[18]

- Juveniles are best understood within the context of their families and social environments.
- Assessment and treatment of juveniles should be based on a developmental perspective, should be sensitive to developmental change, and should be an ongoing process.
- Assessment and treatment should include a focus on the youth's strengths.
- The development of sexual interest and orientation is dynamic. The sexual interests of youth can change over the course of adolescence and this is the period when sexual orientation immerges.
- Youth who have committed sexual offenses are a diverse population. They should not be treated in a "one-size-fits-all" approach.
- Treatment should be broad-based and comprehensive.

[17] Welfare Research, Inc., *Resource and Referral Guidebook for the Assessment and Treatment of Adolescent and Pre-Adolescent Sexual Abusers and Sexual Abuse Reactors* (NYS Office of Children and Family Services, 1998), p. 42.
[18] Michael H. Miner, et al. *Standards of Care for Juvenile Sexual Offenders of the International Association for the Treatment of Sexual Offenders*. (International Association for the Treatment of Sexual Offenders, 2006), p. 2-5. http://www.iatso.org/care/MinerSOT3-06.pdf

- Labels can be more iatrogenic in children and adolescents than in adults. The juvenile and his/her family/primary care-giving system should be treated with respect and dignity. (**Note:** Iatrogenic means "Induced in a patient by a physician's activity, manner, or therapy." In this context, the use of labels such as deviant or perverted by adults working with the youth is inherently harmful.)

- Sexual offender registries and community notification should not be applied to juveniles.

- Effective interventions result from research guided by specialized clinical experience, and not from popular beliefs, or unusual cases in the media.

6 Resources

Bridges to Health (B2H)

http://www.ocfs.state.ny.us/main/b2h/

The B2H website provides comprehensive information on all aspects of the program, including links to forms and the B2H Program Manual.

HIV-Related Services

Information

New York State Department of Health HIV/AIDS section has extensive resources, including materials in English and Spanish on talking to children about HIV: http://www.health.state.ny.us/diseases/aids/index.htm.

Caring for Children with Special Needs is written for parents, foster parents, and other caregivers raising infants, children, and adolescents with HIV. This resource was developed collaboratively by DOH and OCFS. To receive a copy, call 518-474-9866; or download it from http://www.nyhealth.gov/diseases/aids/resources/child/index.htm.

HIV Counseling and Testing

New York State Department of Health: HIV/AIDS Counseling/Testing Hotline (800-962-5065); or http://www.health.state.ny.us/diseases/aids/testing/

In New York City: Pediatric AIDS Unit (PAU) (212-341-8943) of the NYC Administration for Children's Services (ACS).

Pediatric and Adolescent HIV Guidelines

For information on the guidelines of The New York State Department of Health AIDS Institute, go to www.hivguidelines.org, and click on Clinical Guidelines. The site provides information about HIV screening, testing, diagnosis, and treatment.

The AIDS Treatment Data Network
611 Broadway
Suite 613
New York, NY 10012
800-734-7104 (NYS only)
http://www.atdn.org

The Network is a national, not for profit that provides case management, treatment and care access information, advocacy and counseling, education, and other services for people with HIV or chronic hepatitis.

Newborn Screening Program
For more information about this New York State Department of Health program, go to http://www.wadsworth.org/newborn.

Reproductive and Sexual Health

Planned Parenthood

New York City: http://www.plannedparenthood.org/nyc/
Mid-Hudson Valley: http://www.plannedparenthood.org/mid-hudson-valley/
Mohawk-Hudson: http://www.ppmhchoices.org/
Northern NY: http://www.ppnny.org/
Rochester/Syracuse: http://www.pprsr.org/home/
Western NY: http://www.ppwny.org/
Southern Finger Lakes: http://www.plannedparenthood.org/ppsfl/index.htm
Upper Hudson (Albany): http://www.plannedparenthood.org/uhpp/

Information for Youth

Note: The following sites are listed so that caseworkers and caregivers can give youth reliable sites where they can get their questions answered.

Advocates for Youth (www.advocatesforyouth.org)
Helps young people make informed and responsible decisions about their reproductive health and sexual health. Site focuses on many social and political issues. Also available in Spanish and French.

I Wanna Know (www.iwannaknow.org)
Provided through the American Social Health Association. Answers questions about teen sexual health and sexually transmitted diseases, including puberty, "sex on the brain," prevention, and a parent's guide.

It's Your (Sex) Life (www.itsyoursexlife.org)
Provided through Kaiser Family Foundation. A teen's guide to safe and responsible sex; topics include pregnancy and contraception, HIV/STDs, and communication.

Sex, Etc. (www.sexetc.org)
The Network for Family Life Education, State University of New Jersey at Rutgers, publishes this print and web-based newsletter written by teens for teens. Site covers a wide variety of sex-related topics, including girl's health, guy's health, GLBTQ, teen parenting, abortion, adoption, and body image.

Teenwire (www.teenwire.org)
Provided through Planned Parenthood Federation of America. Site addresses a variety of teen issues, interactive contraceptive information, sexuality, and relationship information.

KidsHealth (www.kidshealth.org/teen)
Provided through the Nemours Foundation, Center for Children's Health Media. Offers comprehensive overall health information for teens, including body, mind, food and fitness, school and jobs, drugs and alcohol, sexual health, and answers and advice.

New York Civil Liberties Union
On the website http://www.nyclu.org/, select Resources – Know Your Rights. Information on reproductive rights is available.

Statewide School Health Services Center (http://www.schoolhealthservices.org/)
43 Turner Drive
Spencerport, NY 14559
585-349-7630

The New York Statewide School Health Services Center (SSHSC) is a statewide technical support center funded through the Student Support Services Team of the New York State Education Department. The mission is to promote the health, learning, and overall well-being of all students, thereby strengthening and improving academic performance. The vision is to ensure that school health services are effective in addressing the health and safety needs of students by providing leadership and direction to school health professionals, parents, school districts, and community organizations to provide the critical linkage between health and student achievement.

Pregnancy Services — Programs of the Department of Health

For a listing of providers in your area for the following programs, see the Department of Health website on Women's Health Issues: http://www.health.state.ny.us/nysdoh/perinatal/en/index.htm.

Growing Up Healthy Hotline – This toll-free hotline (1-800-522-5006) operates 24 hours a day, seven days a week, and provides information and referral for individuals, including teens, about pregnancy care services, family planning, health care, nutrition, and other health and human services. Information is available in English, Spanish, and many other languages.

Prenatal Care Assistance Program (PCAP) – A comprehensive prenatal care program that offers complete pregnancy care and other health services to women and teens who live in New York State and meet certain income guidelines. (Women are eligible for services up to 200% of the federal poverty level.) PCAP offers routine pregnancy check-ups, hospital care during pregnancy and delivery, full health care for the woman until at least two months after delivery, and full health care coverage for the baby up to one year of age.

Medicaid Obstetrical and Maternal Services (MOMS) Program – This program provides complete pregnancy services in areas of the state where PCAP health centers are not located. Medical services are provided in private physicians' offices with other necessary services (nutrition, social work, etc.) being provided by a Health Supportive Services Program (HSSP). MOMS physicians are connected with a HSSP to ensure all women receive complete pregnancy care.

Comprehensive Prenatal Perinatal Services Network – The Networks are community-based organizations whose purpose is to organize the perinatal (pregnancy, delivery, post delivery and infancy) service system at the local level to improve pregnancy outcomes and promote better children's health. Networks accomplish this through working with a Consortium of local health and human service providers and consumers of services that helps the Networks identify and address issues. There are currently 15 Networks across the state that target women at highest risk for poor pregnancy outcomes.

Community Health Worker Program (CHWP) – The CHWP provides one-on-one outreach, education, and home visiting services to pregnant and parenting women and families at highest risk for poor health outcomes, particularly low birth weight infants and infant mortality (infant deaths). Services are provided by paraprofessionals who live in the area they serve and are trained to provide referrals for a wide range of services, and to provide support and assistance for families trying to obtain needed services, including accompaniment to scheduled visits when needed. There are currently 23 Community Health Worker Programs throughout the state.

Perinatal Regionalization Program – Perinatal regionalization ensures that there are hospitals that can provide a full range of services for pregnant women and their babies in a geographic region. This means parents-to-be can be sure that there are hospitals near where they live that can provide everything from a basic, uncomplicated delivery to those that can serve mothers and babies with the most complex, critical problems.

Breastfeeding Promotion Program – The program provides training and guidelines to encourage more mothers to breastfeed and to get them to breastfeed longer.

Services for GLBTQ Youth

Note: The following sites are listed so that caseworkers and caregivers can give youth reliable sites where they can get their questions answered.

GLBTQ: The Survival Guide for Queer and Questioning Teens by Kelly Huegel, Free Spirit Publishing, 2003 (paperback).

GLBT National Help Center: http://www.glnh.org/index2.html

GLBT National Youth Talkline 1-800 246-7743. Hours: Mon-Fri 8 pm-midnight Eastern time. E-mail: youth@GLBTNationalHelpCenter.org. The GLBT National Youth Talkline provides telephone and e-mail peer-counseling, as well as factual information and local resources for cities and towns across the United States.

"We Are…GLBTQ," a video co-produced by Washington State's Department of Social and Health Services Children's Administration and Department of Information Services, sheds light on the lives of GLBTQ youth who find themselves in the state child welfare system. It is used in Washington State to train foster parents and kinship caregivers. For more information, contact the Communications Division at 360-902-8007. The discussion guide may be downloaded from: http://www1.dshs.wa.gov/pdf/ca/We%20Are%20GLBTQ%20Discussion%20and%20Resource%20Guide.pdf.

CWLA Best Practice Guidelines: Serving LGBT Youth in Out-of-Home Care, 2006. http://www.lsc-sf.org/publications/bestpracticeslgbtyouth.pdf

Definitions of Sexual Orientation and Gender Identity (from *Practice Brief: Providing Services and Supports for Youth who are Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex or Two-Spirit*, Spring 2008. Georgetown University) http://www11.georgetown.edu/research/gucchd/nccc/documents/lgbtqi2s.pdf

Lesbian: Females who are emotionally and sexually attracted to, and may partner with, females only.

Gay: Males who are emotionally and sexually attracted to, and may partner with, males only. "Gay" is also an overarching term used to refer to a broad array of sexual orientation identities other than heterosexual.

Bisexual: Individuals who are emotionally and sexually attracted to, and may partner with, both males and females.

Transgender: Individuals who express a gender identity different from their birth-assigned gender.

Intersex: Individuals with medically defined biological attributes that are not exclusively male or female; frequently "assigned" a gender at birth, which may differ from their gender identity later in life.

Two-Spirit (2-S): A culture-specific gender identity for Native Americans (American Indians or Alaska Natives) with homosexual or transgendered identities. Traditionally a role-based definition, two-spirit individuals are perceived to bridge different sectors of society (e.g., the male-female dichotomy, and the Spirit and natural worlds).

Sexual Minority: The term "sexual minority" is inclusive, comprehensive, and sometimes used to describe youth who are LGBTQI2-S. However, it may have a negative connotation because minority suggests inferiority to others.

Other Terms: Youth also may use other terms to describe their sexual orientation and gender identity, such as homosexual, queer, gender queer, non-gendered, and asexual. Some youth may not identify a word that describes their sexual orientation, and others may view their gender as fluid and even changing over time. Some youth may avoid gender-specific pronouns.

Trauma

National Child Traumatic Stress Network: http://www.nctsn.org/

OCFS provided teleconference training on trauma on May 1, 2008 and June 25, 2008. In addition to these programs, a folder of materials and resources on trauma were provided to each agency. Check with your staff development coordinator.

Suicide

National Suicide Prevention Lifeline: 800-273-TALK (8255); TTY line: 800-799-4889

Voice-Diagnostic Interview Schedule for Children (V-DISC) is a comprehensive, structured interview that uses DSM-IV criteria to screen for more than twenty mental health disorders as well as suicidal ideation found in children and adolescents. The V-DISC is a self-administered test. For more information, see Columbia University: http://www.promotementalhealth.org/overview.htm and NYS Division of Probation and Correctional Alternatives: http://dpca.state.ny.us/technology.htm.

SPEAK (Suicide Prevention Education Awareness Kit) is an initiative of the Office of Mental Health. http://www.omh.state.ny.us/omhweb/speak/index.htm

Assessment and Treatment of Child and Adolescent Sexual Offenders

Identifying and Treating Youth who Sexually Offend: Current Approaches, Techniques and Research by Robert Geffner (Editor), Kristina Crumpton Franey (Editor), Teri Geffner Arnold (Editor), Robert Falconer (Editor). Haworth Press, 2004. Co-published simultaneously as *Journal of Child Sexual Abuse*, Volume 13, Numbers 3/4 2004.

Association for the Treatment of Sexual Abusers (ATSA)
4900 S.W. Griffith Drive, Suite 274
Beaverton, OR 97005
503-643-1023
www.atsa.com

Incorporated in 1984, the Association for the Treatment of Sexual Abusers is a nonprofit, interdisciplinary organization. ATSA was founded to foster research, facilitate information exchange, further professional education, and provide for the advancement of professional standards and practices in the field of sex offender evaluation and treatment. ATSA is an international organization focused specifically on the prevention of sexual abuse through effective management of sex offenders. The organization convenes an annual conference and publishes a journal and other documents.

New York State Association for the Treatment of Sexual Abusers & New York State Alliance of Sex Offender Treatment Providers
P.O. Box 3115
Albany, NY 12203-3115
http://www.nysatsa.com/

The Alliance is a voluntary public and private sector initiative established in 1988 to promote the enhancement and quality of services available for sex offenders with the goal of keeping communities safe. The Alliance, which is sponsored by membership dues, presents regional trainings and an annual statewide conference. The organization also sponsors the New York State chapter of the Association for the Treatment of Sexual Abusers (ATSA) and publishes a quarterly newsletter.

The Safer Society Foundation, Inc.
(formerly The Safer Society Program)
P.O. Box 340
Brandon, VT 05733-0304
802-247-3132
www.safersociety.org

The Safer Society Foundation, Inc., a nonprofit agency, is a national research, advocacy, and referral center on the prevention and treatment of sexual abuse. Founded in 1964 as the Prison Research Education Action Project (PREAP) by Fay Honey Knopp, PREAP evolved into the Safer Society Program in 1985, and became the Safer Society Foundation, Inc. in 1995. The Safer Society Foundation, Inc. provides a variety of services related to the prevention and treatment of sexual abuse.

The Safer Society Press, a small nonprofit press operated by the Safer Society Foundation, Inc., publishes relevant research, studies, video and audio tapes, and books that contribute to the development of sexual abuse treatment, sexual abuse prevention, emerging topics, and developments in the field.