

CHAPTER 6**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.

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 use services*
7. *Management of chronic medical conditions*
8. *Acute illness and injury/emergency care*



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.

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 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.

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. 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.

- ➔ Build on the relationship with the primary care provider, which began with the initial health evaluation by providing relevant information about the child and agency, making sure that the child’s medical records are up-to-date, and continuing to gather information from the 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 have been adopted by the New York State Medicaid program. Go to <https://www.aap.org/periodicityschedule> for the AAP periodicity schedule. Note that the schedule has been updated since the development of 18 NYCRR 441.22(f) and 507.1(c). 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
At age: 3 years, 4 years, 5 years, 6 years	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.



Components of Well-Child Visits

Well-child visits 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 New York State Department of Health (DOH) and New York City Department of Health and Mental Hygiene 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 DOH website at least annually for updates to the immunization schedule: <https://www.health.ny.gov/publications/2378.pdf>.
- 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.
- Review and updating of the problem list and treatment plan at each well-child visit.

Components of Well-Child Visits

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

- 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.

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.

All children up to age 3 must have their mouths examined at each periodic individualized medical examination, and where appropriate, be referred for dental care as required by regulation. All children 3 years of age or over must have a dental examination by a dentist annually and must be provided with any dental care as needed. The presence of any risk factors or abnormal findings requires referral to a pediatric oral health care professional or general practice dentist, regardless of the child’s age.

Dental decay can be advanced by 3 years of age. Decay of primary teeth can affect a child’s growth, lead to malocclusion, and result in significant pain and life-threatening swelling. From age 3 to age 6, annual clinical oral examinations continue per regulation or as indicated by the individual patient’s risk status or likelihood of disease. From age 3 to age 12, the examinations are repeated as required by the dentist, with a minimum of one examination per year, providing there is no identification of needed treatment. Commensurate with age, anticipatory guidance increases relative to hygiene and protecting teeth. At age 12 and older, dental needs become more defined due to:

- a potentially higher cavity rate;
- increased risk for traumatic injury and periodontal disease;
- a tendency for poor nutritional habits;
- an increased appearance awareness;



- complexity of combined orthodontic and restorative care;
- dental phobia;
- potential use of tobacco, alcohol, and other drugs;
- eating disorders; and
- unique social and psychological needs.

Each child discharged from care to another planned living arrangement with a permanency resource must have a comprehensive medical examination to include a dental screening prior to discharge unless the child has undergone such an examination within one year prior to the date of discharge.

Each child/youth in foster care must have complete periodic individualized medical examinations to include dental or oral screenings as applicable based on age. The results of which must be maintained in the child's uniform case record. Such examinations must be provided per the following schedule:

- for children aged 0-1 year: at 2-4 weeks; 2-3 months; 4-5 months; 6-7 months; 9-10 months;
- for children aged 1-6 years: at 12-13 months; 14-15 months; 16-19 months; 23-25 months; 3 years; 4 years; 5 years; and
- for children aged 6-21 years: at 6 years; 8-9 years; 10-11 years; 12-13 years; 14-15 years; 16-17 years; 18-19 years; and 20 years.

When a condition indicated by medical examination requires follow-up care, as determined by the child's physician or dentist, the agency responsible for the child's care must provide or arrange for such follow-up care as recommended by the child's physician or dentist.

Dental care is included in the early and periodic screening, diagnostic, and treatment (EPSDT) scope of services that are covered by the Child Health Plus A (Medicaid) program.

EPSDT dental services include:

- periodic oral evaluations;
- preventative services (including application of dental sealants or topical fluoride varnishes, gels, or foams);
- restorative (fillings, crowns, bridges, and implants);
- emergency dental care; and
- orthodontia (limited to the treatment of physically handicapping malocclusions).

The required schedule of examinations and the EPSDT scope of services allows the dentist to assess risk and recommend interventions. Follow-up care for all conditions identified in oral screenings/dental assessments are required.¹

Referral to a dentist is recommended no later than six 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.

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. The following activities are required:

¹ 17-OCFS-ADM-12.



- Diagnosis and treatment of all identified needs.
- Medically necessary psychiatric and psychological services.
- Care, services, and treatment to ameliorate defects, physical and mental illness, and conditions discovered by early and periodic screening, diagnostic and treatment (EPSDT) screenings.

It is not unusual for children in foster care to experience serious emotional and behavioral issues and need 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.

For information on consent for outpatient mental health services and administration of psychiatric medications, see Chapter 2, Medical Consents, and [08-OCFS-INF-02](#), The Use of Psychiatric Medications for Children and Youth in Placement – Authority to Consent to Medical Care.

- ➔ 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 that the primary care provider consider emotional problems when evaluating these physical complaints or symptoms.

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 Chapter 5, Initial Health Evaluation).

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.
- With cognitive-behavioral therapy (CBT) for children, the therapist helps the child see the connection between the child’s thinking and behavior.
- Group therapy is commonly used, especially psychosocial or psychoeducational 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 9, Medication Administration and Management). Additional related treatment may include substance abuse treatment services, when needed.

Flexible wraparound services are an essential component of individualized, community-based care for children and ad-



olescents with serious emotional disturbance (SED). These services are flexible and child/family-focused. The services follow or “wraparound” the child or adolescent to facilitate return to optimal functioning at home and in the community. Examples include after-school programs, summer camp, recreation programs, mentoring, life coaches, and community supervision.

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. Components include:

- Eliciting and attending to parental concerns.
- Obtaining a relevant developmental history.
- Making accurate and informed observations of children’s developmental strengths and challenges.
- Sharing opinions and concerns with other relevant professionals.

Child development monitoring can be strengthened by utilizing high quality, developmental screening tools at some visits. The use of a developmental screening tool is particularly important and recommended for children who receive inconsistent health care supervision. Those children who are at risk for delay, including all who were born prematurely, those born to mothers with alcohol and/or substance abuse problems, and all HIV-infected children, should have formal developmental assessments every six months in order to identify developmental delays as soon as possible.

Developmental services include the diagnosis and treatment of all developmental delays and deficits identified as well as 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 (EI) 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.

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

Referral to the early intervention program (EIP) - Children under 3 who have a suspected or established developmental delay or disability likely to cause developmental delays (such as Down syndrome or cerebral palsy) are required to be referred to the early intervention program in their county of residence for a multidisciplinary evaluation to determine their eligibility for early intervention services. Children with certain medical-biological risk factors associated with disability are also required to be referred to the early intervention program child find system for tracking to make sure that children are engaged in primary health care and receiving developmental screening and surveillance by their health care providers or other available community resources. Each county and New York City have designated early intervention officials responsible for receiving early intervention referrals and for educating health care providers about referral criteria and procedures. Most early intervention officials (EIOs) are directors or commissioners of county health departments; however, this differs in some counties. For information about EIOs in your area, call the New York State Department of Health Growing Up Healthy Hotline at 1-800-522-5006. TTY 1-800-655-1789 or visit https://www.health.ny.gov/community/pregnancy/health_care/prenatal/guh.htm.

For referred children under 3 years of age - Children under 3 years of age referred to the early intervention program will have a comprehensive evaluation. If the child is found eligible, an individualized family service plan (IFSP) will be developed. The IFSP clearly delineates all early intervention services planned for the infant/toddler and the frequency and location of the services. The early intervention program and/or family may ask you to provide input into the development of the IFSP and request that you participate in the IFSP development meeting. The family may also request that you receive copies of the initial and all subsequent IFSPs and periodic progress notes on the infant/toddler. For preschool children, if you identify children aged 3 to 5 as having a suspected or established developmental delay or disability that may affect their school performance, you should refer them to the child's school district for an evaluation by the school committee on preschool special education (CPSE). Children whom you refer for special education evaluation may have an individualized education program (IEP). You may be asked to provide input.

For school-age children - For all school-aged children, assessment of developmental status and psychosocial adjustment needs to include a discussion of school performance, peer and family relationships, and evaluation of physical development. If you identify a child as having a suspected or established developmental delay or disability that may affect school performance, you should refer the child to the child's school district's committee on special education (CSE) for an evaluation. For adolescents, your assessment of developmental status and psychosocial adjustment needs to include a confidential discussion of peer and family relationships; school/job performance; injury and violence prevention; use of tobacco, alcohol and other drugs; sexual development and activity; HIV, STD and pregnancy prevention; depression/risk for suicide; eating disorders; physical, sexual, and emotional abuse; and an evaluation of physical development, including sexual maturity rating (Tanner staging).

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.

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 local department of social services (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 2, 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 LDSS 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 LDSS 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 the child 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 3 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.
- 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.

➔ Designate an LDSS early intervention program liaison. Urge LDSSs 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 the 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 3 years of age between January 1 and August 31 are eligible to continue to receive early intervention services until September 1 of the calendar year.
- Children who turn 3 years of age between September 1 and December 31 are eligible to continue to receive early intervention services until January 2 of the following calendar year.



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.

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

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. 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 would have either a significant delay or disorder in one or more functional areas related to cognitive, language and communicative, adaptive, socioemotional, 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.

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. 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.

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.

- ➔ Encourage 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.

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.

6. Substance Use 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 aged 13 and older should be part of the comprehensive health evaluation that is completed when a child is placed. Adolescents in foster care are more likely than their same age peers to use drugs, tobacco, and alcohol even after controlling for their demographic background characteristics. These results were found by using a more representative and community-based sample of youth than were used in other existing studies. However, there are no existing national school-based programs that specifically target substance use by adolescents in foster care. 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 use disorders (SUD). Treatment and services for any alcohol or substance use disorders identified as part of the screening and assessment process should be provided in accordance with the current standard of care for adolescents (see [Screening and Treatment of Substance Use Disorders among Adolescents \(samhsa.gov\)](#))

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 a New York State Office of Alcohol and Substance Abuse Services (OASAS)-approved (licensed) substance use treatment program.
- A medical professional 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.

A screening may show that a child is at risk or is using alcohol or substances. Whenever possible, refer children to programs licensed by OASAS. These programs provide preventive and treatment services in a variety of settings (see <https://oasas.ny.gov/harm-reduction>).

¹⁹ 14 NYCRR 853.3 (d).

²⁰ NYCRR 441.22(b).



➔ Make sure that your agency has the OASAS provider directory available for staff who make referrals. 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 use. 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 use on children and adolescents should include detecting substance use and procedures for handling emergencies. Staff and foster parents should be familiar with and alert to behaviors that may be signs of substance use. 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.

Opioids

In response to the growing opioid public health crisis and recommendations to improve the timeliness of reporting opioid-related data, the New York State Department of Health (NYSDOH) Opioid Prevention Program provides opioid-related data to support statewide prevention efforts. These efforts include improving timely opioid overdose reporting to key stakeholders. This information is a valuable tool for planning and can help identify where communities are struggling, help tailor interventions, and show improvements. This website is designed to provide comprehensive and useful data and information regarding opioid use and misuse. See https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/HeroinTaskForceReport_3.pdf.

Fentanyl

Fentanyl is a powerful narcotic that reduces pain and can create a feeling of euphoria. Unfortunately, the potency of fentanyl can make its use lethal, especially when the user is unaware of its presence in the substance they are using.

According to OASAS, overdose deaths are at a record high nationwide. The ubiquity of fentanyl and its analogues has much to do with the rise in overdose deaths. Fentanyl, a synthetic opioid 50-100x stronger than morphine, and its analogues, which are often even more potent, have been found mixed in cocaine, heroin, MDMA/ecstasy/Molly, and pressed into pills – essentially anything purchased illicitly – often unbeknownst to both dealers and end users. This increases the risk of overdose for people who use any substance, including those using them for the first time.

Tools are available, such as naloxone nasal spray, to combat an overdose in progress and test strips to detect the presence of fentanyl, both of which are part of OASAS's efforts toward harm reduction. <https://oasas.ny.gov/harm-reduction>.

Methamphetamine

Methamphetamine (meth) is a powerfully addictive drug with an added risk: clandestine manufacturing 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.

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.



➔ 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 use 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 SUD. Persuading children or youth that they need services may be the first challenge faced by staff in dealing with substance use. Some tips for initial engagement include:

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

Youth transitioning from foster care to adulthood as a group have endured maltreatment, trauma, and mental health intervention at rates much higher than the general population. Although the desire to refrain from further contributing to trauma is understood, the potential harm that may come to youth who do not receive any education or preparation around avoiding substance-related challenges cannot be overlooked. Finding a way to provide these youth with prevention programming that enhances rather than undermines their self-determination is one potential way to overcome this ethical dilemma.

Tobacco Use/Vaping

Public Health Law §1399-o states that smoking and vaping are not allowed in group homes, public institutions, youth centers, and facilities for detention. OCFS regulation 18 NYCRR 441.23 prohibits the use of tobacco products by staff, residents, or visitors on the grounds of institutions, group residences, group homes, or agency-operated boarding homes. In addition, the OCFS regulation prohibits the use of inhaling devices by staff, residents, or visitors, not prescribed by a medical professional, on the grounds of institutions, group residences, group homes, or agency-operated boarding homes.

The known effects of second-hand smoke should be carefully considered when selecting a foster home for children. LDSSs and voluntary authorized agencies should avoid placing very young, allergenic, or asthmatic children in homes where one or more residents smoke. Foster parents should be advised to do the following:

- 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.

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

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 21 to buy tobacco products (e.g., cigarettes, cigars, chewing tobacco, e-cigarettes, vapor, or liquid nicotine).

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. 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. 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. [18 NYCRR 442.21(g)]

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. 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.

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 and Prevention (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 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 certain communicable diseases; however, each school district’s policies may vary slightly. It is important that foster parents are aware of and receive a copy of the child’s school health policy.