CHAPTER 7

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. This chapter describes services ranging from the Bridges to Health Waiver Program to HIV-related services.

Sections in this chapter include:

1. *1915(c) Children's Waiver*
2. *HIV-related services*
3. *Sexual health, sexuality education, and reproductive health services*
4. *Services for lesbian, gay, bisexual, transgender, queer and/or questioning (LGBTQ+) youth*
5. *Special services for school-age youth*

The Office of Children and Family Services (OCFS) recommends that the best practices described in this chapter be completed for each child in foster care. Footnote citations to a law or regulation indicate that an activity or component is required and provide the legal or regulatory source for the requirement. The use of the term "should" indicates that an activity is recommended by OCFS but is not required by law or regulation.

1. 1915(c) Children's Waiver

In 2019, New York State consolidated six Medicaid 1915(c) waivers into one 1915(c) waiver, called The Children's Waiver. The previous waivers include the three Bridges waivers for children in foster care, also known as B2H, OMH Serious Emotional Disturbance (SED) waiver, and the OPWDD/DOH Care at Home waivers.

The Children's Waiver provides home and community-based services (HCBS) to eligible children. The waiver 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. HCBS services supplement and complement, but do not replace existing child welfare services.

By supporting children in foster care in the least restrictive home or community setting, the Children's Waiver provides opportunities for improving the health and well-being of the children served and supporting permanency planning. The program is voluntary 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

HCBS services are provided where children are most comfortable and help them be successful at home, in school, and other environments. Services are personal and flexible to meet the health, mental health, and/or developmental needs of each child.

HCBS provides the following services:

- Community habilitation
- Day habilitation
- Caregiver family supports and community advocacy services
- Respite services
- Prevocational services
- Supported employment
- Palliative care (expressive therapy, massage therapy, bereavement services, and pain and symptom management)
- Adaptive and assistive equipment
- Vehicle modifications
- Environmental modifications
- Non-medical transportation

Eligibility and Enrollment in The Children's Waiver Program[1]

To be eligible for the Children's Waiver, children must be under 21 years old, eligible for Medicaid and meet the following three criteria:

[1] Children's Home and Community Based Services (HCBS) Waiver Enrollment Policy (ny.gov).

1. Target Populations:
   - Serious emotional disturbance (SED)
   - Medically fragile (MF)
   - Developmental disability (DD) and medically fragile (MF)
   - Developmental disability (DD) and foster care

   *Children must meet one of the four target populations and may be eligible under one or more population.

2. Risk Factors: Risk factors vary by target population and demonstrate the high-level need of the individual to obtain HCBS.

3. Functional Limitations: Functional criteria determines that the child's diagnosis, behavior, and/or condition impacts the child's daily living. Several of the target populations have a subset of questions located within the CANS-NY tool where the responses are driven by an algorithm that, together with risk factors, determines whether there is a need for HCBS based on the child's present level of functioning.

All three criterions are separate and distinct and need to be met to become eligible for the Children's Waiver.

Only health home care managers (HHCM) or child and youth evaluation services (C-YES) can determine eligibility. Since children in foster care already have Medicaid established, they must be referred to a health home to determine eligibility and receive the Children's Waiver (See 18-OCFS-ADM-14, *Health Home Referral Requirements for Children in Foster Care*).

Once a child is determined eligible for HCBS, the HHCM will develop a plan of care (POC) with the child and family/caregiver, identifying and including needed HCBS. The HHCM will then make referrals to chosen HCBS providers. Once enrolled, the child may continue to receive waiver services until age 21 if they continue to meet eligibility requirements, even after discharge from foster care.

Enrollment and eligibility criteria, including qualifying diagnoses, can be found in the *Children's Home and Community-Based Services Manual*. Additional information on the Children's Waiver can be found on the Department of Health website: 1115 Waiver/Home and Community Based Services (HCBS) (ny.gov).

Coordinating the Children's Waiver and Foster Care Services

The HHCM will work directly with each child 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 HHCM and case manager to form a complementary relationship and share information in support of the child's permanency, health, and well-being.

The HHCM will develop an individualized health plan for 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).

Article 29-I Voluntary Foster Care Agencies (VFCA) Health Facilities Licensure:

Pursuant to Article 29-I of Section 1 of the Public Health Law (PHL), volunteer foster care agencies (VFCAs) must be licensed as a VFCA health facility to provide core limited health-related services and other limited health-related services. The 29-I licensure applies to all children whom the VFCA has responsibility for the care of and/or boards out.

It is expected that 29-I VFCA health facilities provide, or make available through a contract arrangement, all core limited

health-related services as well as the required clinical consultation/supervision and administration.

The Article 29-I licensure authorizes VFCAs to provide the following core limited health-related services:

- Nursing
- Skill building (provided by a LBHP)
- Medicaid treatment planning and discharge planning
- Clinical consultation/supervision
- Medicaid managed care liaison/administration

The 29-I VFCA health facilities may also provide other limited health-related services that are consistent with the treatment plans. These other services are additional and are limited to:

- Medicaid home and community-based services (HCBS) for children
- Medicaid state plan services

Other limited health-related services do not include surgical services, dental services, orthodontic care, and general hospital services, such as emergency intervention for major trauma, or treatment of life-threatening or potentially disabling conditions.

More information on services can be found in the *Article 29-I VFCA Health Facilities License Guidelines.*

2. HIV-Related Services

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 and reproductive health, 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 LDSS for information (see *Talking With Young People* brochure from the DOH/AIDS Institute).

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 child in foster care 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 the capacity to consent is informing them about these rights (see Chapter 3, Confidentiality of Health Information).

Points to remember about HIV testing include:

- HIV testing is done only with appropriate consent (see Chapter 2, 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.

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 HIV/AIDS Testing Sites - New York State Department of Health (ny.gov), and click on HIV/AIDS.
- *HIV Testing Toolkit: Resources to Support Routine HIV Testing for Adults and Minors.*
- 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).

Placement of Children HIV-Infected

Children with HIV may require specialized services and extra efforts to meet their often complicated and enhanced needs. Whenever possible, children HIV-infected 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.

Medical Care for Children HIV-Infected

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 https://www.health.ny.gov/diseases/aids/general/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 9, 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.

Newborn Screening Program

The New York State Newborn Screening Program (NYS NBSP) is a public health service provided to all infants born in NYS for early detection of treatable disorders that can affect newborns. The NBSP screens for more than 50 disorders, which without treatment, may permanently impact the health and overall quality of life of newborns. Because the early recognition and treatment of these disorders can be lifesaving, newborn screening is mandated under the PHL and written permission from parents is not required to conduct this screening.[2]

A small blood sample is collected from the newborn and the blood is used to screen for 50 different disorders, including 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 and mental development or cause 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.

The screening results are provided to the pediatrician. LDSSs or VAs request the screening results from the pediatrician and include this information in the medical record maintained by the foster care agency for each child in care. The 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/.

3. Sexual Health, Sexuality Education, and Reproductive Health Services

Youth in foster care aged 12 and older, and younger children who are known to be sexually active, need age-appropriate education and counseling on sexuality, pregnancy prevention, sexual and reproductive health (SRH), 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 sexual health and sexuality education, gynecological care, and contraception for adolescents. The discussion of these subjects, along with the SRH notice (see below), should begin at the first conference with the foster parents and the youth, if appropriate.

Note: Staff and foster parents cannot opt out of providing access to SRH information and services based on their personal or religious feelings, beliefs, or practices for any other reason.

The New York State Department of Health funds 34 agencies in more than 160 sites that provide accessible, confidential, reproductive health care services to adults and adolescents, especially low-income individuals and those without health insurance. In many cases, services are provided at no charge (see Comprehensive Family Planning and Reproductive Health Care Services Program).

Notice of Sexual and Reproductive Health (SRH) Services

Youth in foster care aged 12 years and older and youth under 12 who are known to be sexually active must be notified of their right to receive age-appropriate SRH services.[3] LDSSs and VAs must offer and provide or arrange to provide SRH services to youth in foster care within 30 days of youth's request for them.[4]

When a youth aged 12 or older is placed in foster care, their foster parent must be informed in writing within 30 days

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[2] Public Health Law Section 2500-a, 10 NYCRR Section 69-1.4.
[3] 18 NYCRR 463.1 (a).
[4] 18 NYCRR Section 463(b) (2) and 18 NYCRR Section 507.1(c) (9).
[5] 18 NYCRR 441.22(l)(1) and 11-OCFS-ADM-09, *Reproductive Health and Services for Youth in Foster Care.*

of placement, and annually thereafter, of the availability of social, educational, and medical family planning services for the youth.[5] This notice, or offer, may be made orally, as long as it is also made in writing. Place a copy of the SRH notice and the date it was made in the youth's medical and case records.

If the LDSSs policy is to make an offer directly to all adolescents within the district, the notice of SRH services also must be made directly to the youth in foster care. 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.[6] Minors can consent to all SRH services, including STD testing and counseling, contraceptive services, and pregnancy, including abortion (see Chapter 2, Medical Consents).

Sexual and Reproductive Services

State and federal mandates require that SRH services be provided to youth in foster care age 12 and older, upon request.[7] Some referrals should be made immediately following the youth's request (i.e., request for emergency contraception, termination of pregnancy, prenatal and postpartum care, etc.). Referrals for youth who request routine appointments for SRH services must 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 SRH programs in your community, visit the Department of Health, Comprehensive Family Planning and Reproductive Health Care Services Program website at https://www.health.ny.gov/community/pregnancy/family_planning/.

Community Prevention Programs

The Adolescent Pregnancy and Prevention Services (APPS) program assists high-need communities to develop a comprehensive array of services to prevent unintended 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 & Sexual Health Check-ups

As part of routine health care, all adolescents aged 12 and older or at the onset of puberty should be referred for a gynecological examination and/or sexual health check-ups, 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. It is recommended that adolescents who are sexually active have regular sexual health checkups.

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 person who does not wish to become pregnant and has had unprotected sexual intercourse within the preceding five 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:

- Identifying their concerns, fears, and wishes.
- Discussing who they want to involve in planning, included but not limited to the birth father.
- Determining whether they will be able to remain in the current foster care placement.

[6] 90 ADM-21, *Foster Care: Medical Services for Children in Foster Care.*
[7] 18 NYCRR 463.2 & 507.1(c)(9).

- An objective review and discussion of the alternatives and their implications, including adoption, abortion, living arrangements, and school attendance if they decide to parent.
- Helping them implement their decisions.

Prenatal/postpartum care should be consistent with current professional standards of care.

The privacy (confidentiality) of an adolescent who objects to their 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 them to involve their parent/guardian, if appropriate, and caregivers as early as possible as these individuals can provide valuable support and resources.

Information on prenatal care is available at: https://www.health.ny.gov/community/pregnancy/health_care/prenatal/#about.

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).

Sexually Transmitted Infections

Children and adolescents who engage in sexual activity without the use of barrier methods, such as condoms, have high rates of sexually transmitted infections (STI) and are at risk of HIV infection. As part of the SRH discussion, provide age-appropriate instruction regarding abstinence, safer sex, prevention of STIs, diagnosis and treatment, and the risk of repeated infections.

LDSSs and VAs should acquire a referral, if necessary, for laboratory tests for HIV and other sexually transmitted infections for all adolescents as well as young children, when indicated clinically or by history. The pediatrician may elect to defer laboratory work until a later visit depending on the child's level of cooperation and distress. Occasionally, a child is so traumatized that deferring parts of the physical examination and any potentially painful procedures until the child establishes some rapport with the physician may be appropriate. All communicable diseases must be noted and treated promptly.

The Centers for Disease Control (CDC) estimates that youth ages 15-24 account for almost half of the 26 million new sexually transmitted infections that occurred in the United States in 2018.

STI 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 STI treatment guidelines are available from the CDC at STI Treatment Guidelines (cdc.gov).

Human Papillomavirus (HPV)

HPV is the most common STI in the U.S. About 80 million people in the U.S. have HPV infection and nearly half of infections occur in teens and young adults ages 15 to 24.[8] HPV can cause genital warts and can eventually lead to cancer. Most people with HPV infection do not show symptoms. There is no treatment for HPV. Nine out of ten infections clear on their own within two years. Though most HPV infections clear on their own, some may persist, putting the young person'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 becoming sexually active. The HPV vaccination is routinely recommended for all adolescents at age 11 or 12 years. However, it can be given starting at age 9 and is recommended for all persons through age 26, regardless of whether they are sexually active or already infected with HPV. Children entering and already in foster care should receive the

[8] Human Papillomavirus (HPV) - NYC Health.

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.

Information on HPV can be found at: https://www.health.ny.gov/diseases/communicable/human_papillomavirus/.

Monkeypox (Mpox)

Monkeypox, now recognized by the World Health Organization as "mpox," is a rare, viral infection that does not usually cause serious illness. However, it can result in hospitalization or death. Mpox is spread through close, physical contact between individuals. This includes:

- Direct contact with mpox sores or rashes on an individual who has mpox.
- Respiratory droplets or oral fluids from someone with mpox, particularly for those who have close contact with someone or are around them for a long period of time.
- It can also be spread through contact with objects or fabrics (e.g., clothing, bedding, towels) that have been used by someone with mpox.
- It is possible for mpox to spread to the fetus during pregnancy, or to the newborn during or after birth via close contact.

Mpox is also a zoonotic disease, meaning it can spread to humans who have close contact with an infected animal. While no one knows how prevalent mpox is among small mammals (e.g., rope and sun squirrels, giant-pouched rats, African dormice), small mammals are thought to maintain the virus in the environments of West and Central Africa.

The two-dose JYNNEOS vaccine is available throughout NYS. Individuals who are more likely to be exposed to mpox or experience severe illness are encouraged to get vaccinated. Information on Mpox can be found at Mpox (ny.gov).

4. Services for Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning (LGBTQ+) Youth

Research shows that LGBTQ+ youth are over-represented in the foster care system (Human Rights Campaign, 2015).[9] Many LGBTQ+ children and youth enter foster care as a result of familial conflict, neglect, exploitation, or hostility about their sexual orientation, gender identity, or gender expression. Stigma, discrimination, and other factors put LGBTQ+ youth at increased risk for negative health and life outcomes. Compared to their heterosexual and cisgender peers, LGBTQ+ youth are at a higher risk for substance use, sexually transmitted diseases (STDs), cancers, obesity, bullying, and anxiety (Hafeez, Hudaisa et al., 2017).[10] These youth also experience homelessness at disproportionately high rates, sometimes before entering foster care. These traumatic experiences correlate with increased rates of suicide and depression.[11]

"Child welfare organizations that understand and address the needs of these youth will, over the long term, create safer affirming and welcoming environments 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."[12] At a minimum, LGBTQ+ 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.

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[9] LGBTQ Youth in the Foster Care System: HRC-YouthFosterCare-IssueBrief-FINAL.pdf (hrc-prod-requests.s3-us-west-2.amazonaws.com).

[10] Hafeez, H., Zeshan, M., Tahir, M. A., Jahan, N., & Naveed, S. (2017). "Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review." *Cureus, 9*(4), e1184. Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review - PMC (nih.gov).

[11] Wilson, B.D.M., Cooper, K., Kastansis, A., & Nezhad, S. (2014). *Sexual and Gender Minority Youth in Foster Care: Assessing Disproportionality and Disparities in Los Angeles:* The Williams Institute, UCLA School of Law.

[12] 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.

Transgender and Gender Non-Conforming Youth and the Importance of Affirming Health Care

The term *transgender* (often abbreviated as *trans*) refers to people whose gender identity and/or gender expression differs from the sex they were assigned at birth. The term gender non-conforming refers to people who express gender or have gender characteristics that do not conform to the expectations of society and culture. Some, but not all gender non-conforming people, identify as transgender.

Limited research has been conducted on the specific experiences of transgender and gender non-conforming (TGNC) youth in foster care; however, the overall vulnerabilities of TGNC people are well documented. TGNC people face intense prejudice and discrimination that contribute to poor health outcomes. TGNC people experience higher rates of disordered eating, smoking, obesity, and poor mental health outcomes including depression, anxiety, and suicide.[13] Since TGNC youth in foster care are particularly vulnerable, it is crucial that they have a safe and affirming health care environment.

Studies indicate that TGNC people experience hurdles in accessing quality health care. Some of the hurdles include mistreatment by health providers and health provider's discomfort or inexperience with treating TGNC people. These hurdles can discourage TGNC people from seeking routine health care and medical care related to gender transition.[14] It is vital that service providers for TGNC individuals in foster care be affirming. All health service referrals for TGNC youth that are not related to gender transition, such as general health/well-being screenings and sexual health services, should be pre-screened so that providers are affirming and culturally competent in working with TGNC individuals. If a TGNC youth needs medical care related to gender transition, it is important that they receive gender-affirming care. Gender-affirming care is a supportive form of health care that helps treat individuals to align their outward physical traits with their gender identity. It consists of an array of services that may include counseling, puberty-blocking treatment, hormone therapy, and surgical procedures. Gender-affirming care improves the mental health and overall well-being of TGNC individuals and can increase their confidence while navigating the health care system.

Transition-Related Care

Medicaid coverage (with prior approval from the health insurance company) is available for youth who need transition-related treatment. Coverage can include hormone therapy (i.e., cross-sex hormones and pubertal suppressants), surgeries, and other procedures. In general, Medicaid regulations[15] require that a youth have a diagnosis of gender dysphoria and a medical necessity determination by a qualified medical professional in order to receive coverage for transition-related care. Some services, such as hormone therapy and transition-related surgeries, have additional criteria and prerequisites that need to be met to qualify for coverage.

Note: In most cases, if a youth in foster care is under the age of 18, parental consent for any and all medical treatment for transitional care is required, unless the youth has the legal right to consent under Public Health Law 2504. (see Chapter 2 on Medical Consents).

For more information on Medicaid regulations and coverage for transition-related care, see Transgender Related Care and Services Update: New York State Medicaid Update - January 2017 Volume 33 - Number 1 (ny.gov).

Health Care

Tips for staff working with LGBTQ+ youth in foster care include:

- Create safe and inclusive environments.
- Affirm gender identity when disclosed.
- Respect preferred names and pronouns.

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[13] Teti, M., Kerr, S., Bauerband, L. A., Koegler, E., & Graves, R. (2021). *A Qualitative Scoping Review of Transgender and Gender Non-conforming People's Physical Healthcare Experiences and Needs.* Frontiers | A Qualitative Scoping Review of Transgender and Gender Non-conforming People's Physical Healthcare Experiences and Needs (frontiersin.org).

[14] The Report of the U.S. Transgender Survey (2015). USTS-Full-Report-Dec17.pdf (transequality.org).

[15] 18 NYCRR 505.2(l).

- Avoid unnecessary gendered language.
- Do not assume someone's gender identity.
- Respect privacy and confidentiality of LGBTQ+ youth.

Mental Health

LGBTQ+ youth experience disparate rates of mental health issues like anxiety and depression and are at an elevated risk for suicide compared to their non-LGBTQ+ peers.[16]

In a 2022 national survey on mental health by The Trevor Project, survey results showed that LGBTQ+ youth experience a variety of mental health difficulties:

- 73% reported symptoms of anxiety.
- 58% had symptoms of depression.
- 45% considered suicide in the past year.
- 82% wanted mental health care.
- Out of the 82% who wanted mental health care, 60% were not able to access care.

LGBTQ+ youth are not prone to suicide risk because of their sexual orientation or gender identity. The risk stems from experiences of minority stress including rejection, stigmatization, and being mistreated by society. For LGBTQ+ youth in foster care, higher numbers of placement changes and lower rates of permanency contribute to an even greater risk of negative mental health outcomes. So that LGBTQ+ youth receive appropriate health care and mental health services, it is important that youth have access to resources that promote healthy development and self-esteem.

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.

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

➔ Actively affirming a youth's identity is a vital part of addressing disparities and supporting LGBTQ+ youth in thriving. It is important that mental and physical health care providers actively engage in supportive affirming practices to meet the needs of LGBTQ+ youth. Affirming practices can include 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 LGBTQ+ youth:

- Has your agency worked with LGBTQ+ youth in the past?
- How often has your agency's staff had training, and of what type, in working with LGBTQ+ youth?
- What is your agency's treatment philosophy for working with LGBTQ+ youth?
- Do agency policies specifically address the needs of LGBTQ+ youth?
- Do agency brochures and outreach materials include photos or references to LGBTQ+ youth?
- Does your agency have linkages with LGBTQ+ youth organizations?
- Is the issue of acceptance of LGBTQ+ 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 LGBTQ+ youth?

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[16] Eisenberg ME, Resnick MD. *Suicidality Among Gay, Lesbian and Bisexual Youth: The Role of Protective Factors.* J Adolesc Health. 2006;39(5):662-668.
[17] DeCresczenso and Mallon.

In-Service Trainings

To address the needs of LGBTQ+ youth, training for agency staff and caregivers should:[17]

- Identify appropriate language.
- Counteract common myths and stereotypes.
- Replace myths with accurate information.
- Teach how to create a safe environment.
- 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, 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 (oral 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 children in foster care for risk of suicide, recognition of suicidal behaviors, suicide prevention, need for enhanced supervision, and referral to mental health services.

Children and Youth With Sexual Behavior Problems

Sexual exploration and play are a natural part of childhood and help children learn about their own bodies. Many sexual behaviors in children are developmentally normal. However, some children and youth may display sexual behaviors that are problematic. Sexual behavior problems (SBP) are behaviors that are developmentally inappropriate, intrusive, or abusive. In some cases, SBP can pose a risk to the safety and well-being of others. Children who come from homes where they experience physical abuse, sexual abuse, and neglect are more likely to have SBP than children who are not from such homes. This puts children in foster care at higher risk. Sexual abuse can be a common factor linked to SBP, but research shows that there are multiple factors and situations associated with SBP in children. Factors include a dysfunctional home environment such as — life stresses, exposure to violence, criminal activity, incarceration, or illness.

Note: The majority of children who display sexual behavior problems do not go on to more dangerous behaviors (i.e., abusing others).

Children in foster care who have been identified as having SBP may require special attention and care. They will need consistent calm correction and support — including educating about boundaries and sharing accurate information about sex to help them learn healthy ways to have their needs met. Many children with SBP will require a referral to therapists for further assessment and treatment. Agencies should train staff periodically on the assessment and treatment of children with SBP. Areas for training and development include:

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

- 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 in treatment approaches. Reunification is more difficult to achieve if the 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.

Resources (Factsheet for Families, *Parenting a Child or Youth Who Has Been Sexually Abused: A Guide for Foster and Adoptive Parents*).

General Principals for the Treatment of Juvenile Sexual Offenders[19]

Sexual exploration and play are a natural part of childhood and help children learn about their own bodies. Many sexual behaviors in children are developmentally normal.

- 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 emerges.
- 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.
- Labels can be more iatrogenic in children and adolescents than in adults. The juvenile and their family/primary caregiving 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.