Health for Teens in Care

A JUDGE'S GUIDE

Karen Aileen Howze, Esq.
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American Bar Association
Center on Children and the Law

In conjunction with:
Partners in Program Planning for Adolescent Health
U.S. Department of Health and Human Services,
Health Resources and Services Administration,
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Dedication

We dedicate this book to the late

Juanita Evans, L.C.S.W.,
former Chief
Office of Adolescent Health, Maternal and Child Health Bureau,
Health Resources and Services Administration,
U.S. Department of Health and Human Services

During her lifetime, Juanita Evans educated so many of us, including those in the legal profession, about the importance of addressing the unique health needs of adolescents. She gave us the vision for this book and the inter-professional collaboration that supported it.
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With heartfelt thanks to all of these individuals, we give this Guide to juvenile and family court judges, who so often find themselves guardians of teen health.

Kathi Grasso, J.D.
ABA PIPPAH Project Director
1996 to June, 2001

and

Karen Aileen Howze, J.D.
ABA PIPPAH Project Director
July 2001 —
# Table of Contents

INTRODUCTION ........................................................................................................... 1

PART I: UNDERSTANDING ADOLESCENT DEVELOPMENT ........................................ 9  
Adolescence Transforms Body, Mind, and Spirit
  Physical Development .............................................................................................. 9
  Cognitive and Moral Development ....................................................................... 10
  Social Development ............................................................................................. 11
  Emotional Development ....................................................................................... 13
  Behavioral Development ....................................................................................... 17

PART II: UNDERSTANDING “WELL-BEING” ............................................................. 19  
Ensuring a Successful Journey through Adolescence
  Good Health and ASFA ......................................................................................... 19
  Medical Care ....................................................................................................... 21
  Sexual and Reproductive Health ......................................................................... 24
  Mental Health ..................................................................................................... 28
  Substance Use/Abuse ......................................................................................... 31
  Nutrition ............................................................................................................... 32
  Dental and Oral Health ....................................................................................... 35
  Teens with Disabilities ........................................................................................ 37
  Special Education ................................................................................................ 37

*Chart:*
Child Welfare League Checklist of Needed Services for Children in Foster Care .......... 40

PART III: MONITORING WELL-BEING .................................................................... 41  
Addressing Well-being One Case at a Time
  General Questions ............................................................................................... 41
  Physical Health—Medical Care ......................................................................... 42
Sexual and Reproductive Health ........................................... 44
Mental Health ........................................................................ 45
Substance Use/Abuse .............................................................. 49
Nutrition ............................................................................... 51
Dental Health ......................................................................... 51
Teens with Disabilities ............................................................ 52
Special Education .................................................................. 53
Access to Medical Services ....................................................... 54

Chart:

Mandatory and Optional Title XIX Medicaid Services .................... 55

PART IV: THE ROAD TO EMANCIPATION ................................ 57
The Final Transition

Planning Early for Transition .................................................. 58
Developing the Emancipation Plan ............................................. 60
Monitoring Well-being ............................................................. 64

BIBLIOGRAPHY .................................................................... 69

APPENDICES

Appendix A: EPSDT Laws and Regulations
Appendix B: Reference Guide to Professional Health Standards
Appendix C: SCHIP and Medicaid State by State

INDEX
Introduction

Adolescence: The journey generally takes place between the ages of 10 and 18. During these years the child experiences enormous physical, mental, emotional, social, behavioral, and sexual changes. The changes occur at a different pace for each child. For the adolescent and for those who are responsible for her care and nurture, this stage of development is often an experience with many ups and downs, periods of war and tranquility, and periods of transition and transformation.

This guide is designed to provide judges, attorneys and social workers with information on adolescent development and the issues relevant to adolescent health for youth under court supervision. It begins with a discussion of what the experts consider “normal” adolescent development and includes information regarding the challenges for teens under court supervision that may affect adolescent development.

Part II provides information to assist readers in determining minimal standards to ensure well-being for all youth under court supervision.

Part III includes checklists for judges, attorneys and agency workers who must ensure that appropriate care is provided to adolescents. In addition, this section includes the laws that support good health, and the standards that can be used to monitor whether adolescent care meets the standards set by the health care professions.

Part IV explores the transition to emancipation and the need for a carefully planned process that will end the presumption that at the age of 18 young adults in foster care are somehow magically prepared to take on the world armed with viable housing, employment, education, health care, and parenting abilities.

FOSTER CARE FACTS

The U.S. Department of Health and Human Services reported that as of June 2001:

- Some 581,000 children were in foster care.
- Forty percent of the children entering foster care were 11 years of age or older.
- Forty-four percent who were already in foster care were 11 years or older.
- White children represent 65 percent of all children in the U.S. but represent 43 percent of the children who entered foster care in 1999.
- Latino, Native American and Asian children are, with the exception of some states, proportionately represented in the foster care system nationwide.

WHO ARE THE YOUTH “IN CARE?”

Adolescence is a challenging time for youth who are delinquent and status offenders just as it is for abused and neglected kids. Youth in the child welfare system and the juvenile justice system experience similar disruption, disconnection, dysfunction, and discontent.

DEVELOPING INTERDEPENDENCE

For young men and women to make it through the journey to adulthood in good health, the adults who serve as their guides must look at the whole child becoming a whole adult. Using a holistic approach can be difficult because adult attention is often riveted to one area of change versus another. More often than not, adults focus on the behaviors the adolescent presents, asking:

- Why are his grades suddenly dropping?
- Why doesn’t she ever socialize with other kids?
- Why is every conversation an argument?
- Why doesn’t she eat healthy foods anymore?

For youth in care, the changes that occur in adolescence are often wrapped in the context of disruption, disconnection, dysfunction and discontent. The teen may experience frequent changes of placement that affect the ability to develop appropriate relationships with peers and adult caregivers. The youth may begin to feel a sense of isolation and disconnection from her community—family, school, place of worship, and neighborhood—because of the dynamics of life in care. All of these realities may lead to more risk-taking in a population that often does not have the consistent anchors to help guide them through the “normal” changes of adolescence.

Consider this: The parent is the state. The court acts in parens patriae. Agency workers, probation officers and foster parents come and go, often before the teen has a chance to connect with them. Attorneys, Guardians ad litem and Court Appointed Special Advocates may not remain involved through the end of the young person’s case. Meanwhile, absent parents may be the players in the adolescent’s fantasy about family relationships and family ties.

Some adolescents in foster care may complete the journey through adolescence and foster care without a significant and consistent adult to assist them along the way. Others may identify teachers, foster parents or mentors to provide guidance
and modeling. Others may look to the judicial officer who is responsible for their case as the one who consistently cares. Whether or not the youth can identify an anchor for herself, courts and service agencies involved with adolescents must begin to use a holistic approach to adolescent well-being so that teens can emerge from this stage of development as healthy as they can possibly be.

**THE REQUIREMENTS**

Judges, attorneys, foster parents, and agency and probation workers must take a hard look at the context of each young person’s life. Ask:

- What relationships to parents, teachers, adult neighbors and other significant adults exist?
- Who can the teen count on to guide her through the physical, emotional, behavioral and social challenges she is experiencing in adolescence?
- What does this young adult consider his neighborhood, his community?
- Does she have a faith community?
- Does he have special needs that will affect his journey into adulthood?

**WHAT IS “NORMAL?”**

Much of what is known about normal adolescent development is based on studies of white middle-class adolescents. Minority, homosexual or transgender youth, and teens with disabilities or chronic illnesses have not been studied as much. Therefore, less is known about normal development for these youth.

The exception: The National Longitudinal Study of Adolescent Health. The study, which is known as the Add Health study, is a cross-sectional non-clinical sample of 12,000

**TEENS IN FOSTER CARE**

Youth in foster care have higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, developmental delays, and poor school achievement.

- In San Francisco, physicians found 12 percent of foster care teens had positive TB skin tests, compared with 2.5 percent in a healthy adult population, and 6.1 percent of adult inmates in the Department of Corrections.
- Ninety percent of a large cohort of foster care children screened in Baltimore over two years had an abnormality in at least one body system, 25 percent failed the vision screen, 15 percent the hearing screen, and over half required urgent or non-urgent referrals for dental care and mental health services.

CARE FACTS
Physical Health

Neglected and Abused Youth

- Between 30 and 40 percent of children in the child welfare system have physical health problems. These include delayed growth and development, HIV infection, neurological disabilities, malnutrition and asthma.

- Vision, hearing and dental problems are also especially prevalent among the children in the child welfare system.

- One study revealed that children in out-of-home care check into hospitals more frequently than other low-income children and stay for longer periods of time.


“normal” adolescents from 80 junior high and high schools, their parents and their schools. The study includes a large ethnically diverse sample.

Besides the lack of information on populations other than whites, research is also lacking on the adolescent development process—mind, heart, body and spirit—for those youth who live in substitute care facilities (e.g., foster homes, group homes, detention/treatment centers).

STEPS AWAY FROM “NORMAL”

Whether teens are in foster care or juvenile detention, it is accepted that they have experienced trauma of some sort during their lives.

Once the state is involved, children in foster care and juvenile detention live in an “abnormal” world that may be marked by frequent moves from home to home, congregate-care facility to congregate-care facility. With each move, an adolescent’s relationships, community anchors and role models may be lost. With each move, the adolescent loses the sense of community belonging—a factor that is considered critical for healthy adolescent development.

The adolescent in foster care or juvenile detention does not necessarily know whom she can count on for advice on the changes occurring in her body, mind and spirit. Judges, attorneys and others responsible for monitoring the adolescent’s journey must work with the “norms” of adolescent physical, cognitive, social, emotional, sexual and behavioral development while keeping in mind the special concerns and conditions faced by children under court supervision.
WHAT ABOUT THE ADOPTION AND SAFE FAMILIES ACT?

The Adoption and Safe Families Act (ASFA) places emphasis on permanency, safety, and well-being for children in foster care. The new factor included in the Act is well-being. For adolescents in foster care, well-being means health, education, and transition planning for those who will remain in foster care until they are no longer eligible for services.

By adding well-being to the equation, ASFA sets new thresholds for providing and documenting services that will ensure the good health of teens who remain in Title IV-E foster care until their emancipation. ASFA requires that matters of health and education be reflected in the case records maintained by the court and the agencies responsible for the custody, care and control of the teens.

Case plans and permanency reports are to contain information about the child’s physical, mental, emotional and educational health. The information contained in the reports must be specific to the needs of each adolescent.

ASFA’s requirements are designed to ensure that foster care is a healing process so that each child’s journey to adulthood is as healthy as possible considering the individual needs and strengths of each child.

CARE FACTS

Physical Health

Juvenile Justice Youth

- At least 46 percent of incarcerated youth have documented medical problems, including asthma, hypertension, acne, diabetes, and orthopedic problems.
- Tuberculosis and a prevalence of dental caries, or missing, fractured or infected teeth are also especially prevalent among children in detention centers.
- Only one third of the detainees examined had a regular source of medical care, and only about one fifth had a private physician.

**CARE FACTS**

**Developmental Disabilities**

**Neglected and Abused Youth**

A nationwide study revealed that approximately 20 percent of children in out-of-home care have developmental disabilities, mental retardation, cerebral palsy, and learning disabilities, as well as speech, hearing, and sight impairments.


**Juvenile Justice Youth**

The prevalence of mental retardation among the general juvenile population has consistently been reported as between 7 percent and 15 percent.

The rate of learning disabilities and specific developmental disorders that exists among juvenile offenders ranges from 17 percent to 53 percent.


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**TOOLS TO ATTAIN WELL-BEING**

Meanwhile, states are required by law to provide comprehensive health care for all Medicaid-eligible youth. through the Medicaid Early and Periodic Screening, Diagnostic and Treatment [42 USC sec. 1396 d (r)]. Most children in Title IV-E foster care are Medicaid eligible. However, while children in juvenile detention centers may be technically "eligible for Medicaid," the facilities have not been allowed to claim federal financial participation (FFP) reimbursement since 1984 (42 USC Section 1905 (a)(25)(A)). Even though the facilities can not claim for medical services provided to detained youth, it can be argued that the standards of care envisioned under the Medicaid law should apply to youth in juvenile detention.
MONITORING FOSTER CARE CASES

To monitor compliance with ASFA and Medicaid in foster care cases:

• Should the judge question the social worker regarding the health issues presented in each case?

• Should the judge standing in loco parentis be informed about the basic health issues of the adolescent?

• Should the information regarding medical, dental, nutritional, psychological/behavioral, and sexual development/activity be available to the court in the mandated court reports and case plans?

• Should the court inquire regarding these issues during the hearing when the record evidence is not present?

• Should the court require information regarding the health of the adolescent whenever significant transitions—such as a change in placement, six-months before emancipation—occur?

• Should the judge consider entering a finding that the agency has not made reasonable efforts to achieve permanency when health and education issues have not been adequately addressed by the agency?

The answers to these questions: Yes. As judges across the country attempt to ensure the safety, permanency and well-being of adolescents in foster care, they must demand complete and current information about the health status of all children under court supervision—particularly those who are moving into adulthood while in care.

CARE FACTS

Mental Health

Neglected and Abused Youth

Experts estimate that between 30 percent and 85 percent of youngsters in out-of-home care have significant emotional disturbances. Adolescents living with foster parents or in group homes have about four times the rate of serious psychiatric disorders than those living with their own families.


Juvenile Justice Youth

Mental health problems like attention-deficit/hyperactivity disorder, conduct disorder, oppositional-defiant disorder, and depression are most common among incarcerated youth.

Adolescence Transforms Body, Mind, and Spirit

PHYSICAL DEVELOPMENT

The physical changes in adolescence are center stage from ages 10 to 18. These changes are not acting alone. They may fuel some aspects of the teen's social, emotional, cognitive, and behavioral development.

While the body is changing, appearance commonly assumes paramount importance for both boys and girls. They work hard to fit in, meanwhile they are intent upon developing their own style.

The Growth Spurt

Definition: A rapid change in a child's skeletal structure that begins between ages 9 and 10 in girls and at about age 12 in boys. Growth is usually complete for girls at around age 16; for boys at 17.

Puberty

In Girls: Begins with breast budding around age 10 or earlier. Menstruation follows between ages 12 and 13. Differences may exist for different racial or ethnic groups.

PART I:
UNDERSTANDING ADOLESCENT DEVELOPMENT

This glorious time in every person's life is filled with massive physical, cognitive, moral, emotional, social, and behavioral change. From ages 10 to 18, each day is an adventure. Each day brings personal crisis and personal victory for the adolescent.

The Elements of Development

✓ Physical Development
✓ Cognitive and Moral Development
✓ Social Development
✓ Emotional Development
✓ Behavioral Development
THE ADOLESCENT MIND

During adolescence, the young person:

- Moves from concrete thinking in black-and-white terms to abstract thinking that includes shades of gray.
- Analyzes situations logically, considering cause and effect, and entertains hypothetical situations.
- Uses metaphors and other symbols imaginatively.
- Engages in introspection.
- Shows signs of effective reasoning, problem solving, reflection, and planning for the future that leads to decision making.

In Boys: Enlargement of the testes begins around ages 11 or 12; first ejaculation typically occurs between 12 and 17; secondary sexual characteristics, such as body hair and voice changes, appear later.

COGNITIVE AND MORAL DEVELOPMENT

It may seem that almost overnight teens are able to think about the future, evaluate alternatives, and set personal goals. Despite the pace of their development, adolescents still require assistance from adults to lead them to effective decision making.

The development of values and the basis for ethical behavior are linked to cognitive development. Adolescent cognitive development, in part, lays the groundwork for moral reasoning, honesty, empathy, and other behaviors that indicate the adolescent is thinking and caring about others outside himself or those he cares about.

As with cognitive development, involvement of adults as coaches and role models is critical for adolescent moral development.
SOCIAL DEVELOPMENT

Family Relationships

The experts are clear: Every adolescent yearns for a family bond. However, teens in foster care are more likely not to have consistent parenting or substitute parents.

The reality: The teen's parents are not available. The teen lives in a group setting or has not been able to remain with a substitute family for any length of time. The close bonds between adults and adolescents that are assumed to grow and deepen over time have either not developed or been cut through the trauma of the child's introduction to foster or institutional care. In many instances, the teen may not have experienced the development of healthy family bonds prior to his entrance into out-of-home care.

Friendships

For most adolescents, the basic social skills needed to make and keep friends are in place, or the teen has connected with adults who may fill gaps in social development. However, when there are deficits in the social skills needed for friendships, the adolescent finds it difficult to connect with peers, often experiences rejection and, without assistance, may not be able to figure out how to "fix" relationship problems. These adolescents need help learning how to initiate conversations with peers. They need help learning how to listen. They must learn to share confidences and, at the same time, learn the importance of keeping them.

Dating

Dating typically begins between the ages of 14 and 16. During this period, adolescents primarily socialize in group activities. As the group activity shifts to one-on-one relationships, the pressure, expectations, and interests in adding sex to the relationship equation increases. In addition, romantic relationships between adolescents may last only a few months.

GROWINGSOCIALY

Research shows that adolescents from homes in which the caregivers:

- Are warm;
- Are involved;
- Set limits;
- Have appropriate expectations for the stage of development of the young person;
- Who encourage the teen to develop beliefs and values;
- Who reason and persuade, explain rules, discuss issues, and listen respectfully;

ARE:

- Better in school achievement;
- Less depressed and report less anxiety;
- More self-reliant and have more self esteem;
- Less likely to be involved in delinquent behavior, drug abuse, and early sexual intercourse.
TEENS AND WORK

The National Longitudinal Study on Adolescent Health suggests that teens who work more than 20 hours each week are:

- More distressed emotionally.
- Poor performers academically.
- More likely to smoke cigarettes.
- More likely to become involved in other high-risk behaviors such as alcohol and drug use.

Work

Employment during adolescence is an important activity that can help teens learn how the adult-world works, how to get and keep a job, how to manage time and money, and how to set goals. In addition, maintaining employment provides the youth with a concrete accomplishment that he can take pride in and that may be useful in enhancing self-esteem.

Community

“Community” is a broad term that includes neighborhood, school, and faith. The adolescent’s stability in his or her community is an important part of social development. For teens in foster care, frequent moves interfere with opportunities to grab hold of and explore community connections. With each change of placement, the teen frequently loses his connection with the things that are most familiar about one’s community, neighborhood, school, place of worship, and other institutions. The result: Increased stress and anxiety that may lead to more high-risk behavior.
EMOTIONAL DEVELOPMENT

Emotional development is a lifelong process; however, during adolescence the degree of development is extensive in areas of identity and self-esteem.

The most important skills for adolescents to master for emotional health:

- Sense of identity.
- Ability to relate to others.
- Ability to cope with stress.
- Ability to identify and manage emotions.
- Ability to empathize.
- Ability to resolve conflict constructively.
- A cooperative spirit.

Developing a Sense of Identity

Identity includes two concepts:

- **Self-concept:** the set of beliefs one has about oneself, including beliefs about attributes (e.g., tall, smart, funny), roles and goals (e.g., future occupation), interests, values, and beliefs.

- **Self-esteem:** evaluation of feelings about one’s self-concept.

Low self-esteem develops if there is a gap between one’s self-concept and what one believes one “should” be like.

Raising Self-esteem

Though raising self-esteem is a difficult process, the effort may help to protect the adolescent from depression, anxiety, and high risk behaviors. On the other hand, helping adolescents improve self-concepts is easier. Over time, improved self-concepts may help the teen raise her self-esteem.

THE FACTS

Abused and Neglected Youth

In 1994, the U.S. Department of Health and Human Services found that:

- Some 27 percent of children in foster care were emotionally disturbed.
- Approximately 18 percent had learning disabilities.
- Some 11 percent had developmental disabilities.
- Eight percent had hearing, speech and sight impairments.

Of adolescents in foster care:

- Some 22 percent reported severe post-traumatic stress symptoms.
- Approximately 50 percent had academic problems.
THE FACTS

Juvenile Justice Youth

According to Dr. Steven Matson in Health Needs of Detained Youth, Journal of Correctional Care, Winter 2001, youth in detention facilities have numerous health concerns including:

- Acute and chronic medical problems.
- Alcohol and drug abuse.
- Depression and suicidal behavior.
- Physical and sexual abuse.
- Learning disabilities.
- Pregnancy.
- Sexually transmitted diseases.

To improve self-concept, adolescents should be encouraged to view their personal characteristics; roles in community, school, and family; goals, interests, beliefs, and values on a regular basis to ensure that the process of developing strong self-concepts continues. It is the hope that ultimately the process will also increase the adolescent’s self-esteem.

Finally, psychologists agree that self-esteem is enhanced whenever an adolescent is helped to face a problem instead of avoiding it.

Sexual Identity

Research shows that many teens go through a developmental process as they discover that they are gay, lesbian, or bisexual. According to J.H. Fontaine and N.L. Hammond in their 1996 Adolescence article “Counseling Issues with Gay and Lesbian Adolescents,” attempting to develop a healthy identity is “a draining, secreted, anxiety-provoking, and lonely task for adolescents.”

As with all areas of adolescent development, each teen incorporates sexual orientation into self-concept in her own unique way. However, psychologists outline the steps taken by youth as they grapple with their sexual identity:

**Step I: Awareness of being different**

The adolescent becomes aware that he is not attracted to the opposite sex or that he is attracted to the same gender.

**Step II: Acceptance of sexual orientation**

The result of awareness of being different often leads to fear, denial, or a move to intensify interest and feelings toward the opposite sex. The adolescent may also become keenly aware of negative family, peer, and community responses to homosexuality. However, if the adolescent is in a supportive environment, acceptance may come easier, and the teen may move forward with a sense of relief to Step III.
Step III: Association with others

The acceptance of one's orientation will lead to association with others who are also “different,” which is believed to further the youth’s acceptance of her sexual identity. Much as the development of a strong self-concept can help improve self-esteem, the same holds true for the process of sexual identity.

Step IV: Disclosure to friends and family

The final step in this area of self-concept and identity.

OFFERING HELP

Professionals who work with youth who are in the process of discovering and accepting their sexual identity can:

- Provide accurate information about homosexuality to dispel stereotypes about gay and lesbian sexuality.
- Avoid communicating disapproval of gay or lesbian sexuality.
- Help the adolescent identify homophobia and reject its messages.
- Refrain from pressuring the adolescent to reach a decision about his sexual orientation.
- Be aware of the heightened risk of suicide for some youth, and make appropriate referrals for psychotherapeutic help for distressed youth.
TESTING FOR HEALTHY RACIAL AND ETHNIC IDENTITY

The Casey Family Programs provides the following criteria to describe a youth with a healthy sense of ethnic identity:

- Identifies as a member of a particular ethnic group or groups.
- Has generally positive attitudes about being a member of that group, but also has a balanced view of the positives and negatives associated with it.
- Affiliates with members of his/her own group, but is also generally accepting of people from other groups.
- Is able to cope successfully with perceived or real racism and discrimination and has possibly shown some effective strategies for dealing with it.

Racial and Ethnic Identity

Racial and ethnic identity includes the shared values, traditions, and practices of a cultural group. A strong sense of racial and ethnic identity is a vital component of emotional development. During adolescence, many minority teens confront the social and emotional effect of their culture and its relationship to their place in society as a whole. The elements of culture that will be woven into the youth’s identity will depend upon how much cultural education he receives from important adults earlier in life and his reaction to the reflections of his culture as he views and interacts with the whole community. Media projections and contacts with peers also affect the adolescent’s view of his racial or ethnic identity.

A Conceptual Framework of Identity Formation in a Society of Multiple Cultures: Applying Theory to Practice, 2000 Casey Family Programs.
BEHAVIORAL DEVELOPMENT

Exploratory behavior is natural for adolescents. Exploration and experimentation help teens fine-tune their total development. However, when the exploration creates a risk of harm to self or others, parents and other adults involved in the child’s life are justifiably concerned. And, for some youth, the risk-taking behavior may signal a problem that could lead to significant short- or long-term threats to adolescent well-being.

The High-Risk Behaviors

Alcohol and Drug Use

Is it experimentation or the sign of a deeper problem? There are a few red flags that indicate the teen has moved past experimentation and into the danger zone:

- Use of drugs and alcohol at an early age.
- Use of substances to decrease anxiety or lighten depression.
- Use of drugs and alcohol in peer group as part of regular social activities.

Pregnancy

According to the Centers for Disease Control and Prevention (CDC) 1999 Youth Risk Behavior Surveillance report, a large-scale national survey of individuals ages 10 to 24:

- Half of all high school students have had sexual intercourse; 8 percent had intercourse before the age of 13, and 36 percent had intercourse during the past three months.
- Among currently sexually active high school students, 58 percent used a condom during their last sexual intercourse, with males more likely to report using a condom than females.
- Among sexually active female students, 20 percent report using birth control pills.

Though the teen pregnancy rate is declining in the United States, those adolescents who become pregnant are at high risk for dropping out of school and becoming dependent on welfare.

RISK TAKING

Adolescents may have multiple reasons for engaging in a particular risk behavior. A few examples:

- In a national survey of 12- to 18- year-olds, 61 percent of the girls and 23 percent of the boys stated they had engaged in intercourse because of pressure from someone else.
- Forty-three percent of boys and 38 percent of girls stated they had engaged in intercourse because they did not want other people to tease them.
HIV/AIDS FACTS AND FIGURES

The Centers for Disease Control and Prevention reports:

- HIV-related illness and death now have the greatest effect on young people.


- In 1999, 1,813 young people (ages 13 to 24) were reported with AIDS, bringing the cumulative total to 29,629 cases of AIDS in this age group.

- Among young men aged 13 to 24, 50 percent of all AIDS cases reported in 1999 were among men who have sex with men; 8 percent were among injection drug users, and 8 percent were among young men infected heterosexually.

- While AIDS incidence among both young gay and bisexual men and young injecting drug users was relatively constant during this time period, AIDS incidence among young heterosexual men and women rose more than 130 percent.

Sexually Transmitted Diseases (STDs)

The CDC further found that:

- Nineteen percent of male high school students report having had more than four sexual partners, as do 13 percent of female students.

- Approximately 25 percent of sexually active students used alcohol or drugs at or about the time of their last sexual intercourse.

Meanwhile, Closing the Gap, the Newsletter of the Office of Minority Health, U.S. Department of Health and Human Services, reported at the end of 2000 that:

- Roughly four million teens contract an STD each year.

- Older Hispanic and African American adolescents have higher rates of HIV/AIDS compared to other groups.

School Failure and Drop Out

Each year, about 15 percent of students drop out of school, with higher rates among low-income students in large cities.

Delinquency, Crime, and Violence

Just as in other areas of adolescent development, these risky behaviors can be divided into categories:

- Impulsive adolescent acts that include such things as car theft and shoplifting.

- Violent and aggressive acts that begin before the age of 10, including cruelty to animals or younger children, truancy, shoplifting or car theft.

Clearly, the more aggressive and violent the behavior, the more serious the risk to the adolescent and others in the community.
Ensuring a Successful Journey through Adolescence

GOOD HEALTH AND ASFA

Regular health maintenance visits are critical for healthy development during adolescence. These visits should include complete age and developmentally appropriate physical examinations, assessment, diagnosis, and access to treatment; and services for medical, sexual, and reproductive health, nutrition, dental care, mental health care, special education, and substance use/abuse.

The Child Welfare League of America has devised a health care schedule especially for youth in foster care. The checklist also provides standards of care (see page 40).


Who is Responsible?

The Social Security Act—which includes Medicaid and ASFA—requires the child welfare agency to ensure that processes actually exist for the teen to obtain health care promised by the Medicaid law.

PART II:
UNDERSTANDING "WELL-BEING"

The health of youth in foster care is poor, but the health care benefits the law bestows are comprehensive. The vehicles: Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT), The Adoption and Safe Families Act (ASFA), and your questions during the periodic court reviews.

This section focuses on the health needs of adolescents under court supervision.

It is important to note that youth adjudicated delinquent and placed in detention facilities currently are not eligible for Medicaid. Those adjudicated delinquent and placed in Title IV-E foster care may be eligible for Medicaid. Please check to determine the applicability of the Medicaid mandated EPSDT services for this population in your jurisdiction.

In this section:
✓ Good Health and ASFA
✓ Medical Care
✓ Sexual and Reproductive Health
✓ Mental Health
✓ Substance Use/Abuse
✓ Nutrition
✓ Dental and Oral Health
✓ Teens with Disabilities
✓ Special Education

HEALTH FOR TEENS IN CARE, A JUDGE'S GUIDE
CASE PLANS UNDER ASFA

Courts must ascertain whether a case plan for the child is adequate, and whether its terms have been met. Case plans must include:

- Documentation of a comprehensive assessment of each youth at entry into foster care and periodically throughout the youth's stay.

- A description of services offered and provided consistent with the best interests and special needs of the child.

- As a general policy, a judge may wish to require that case plans include a health schedule for the teen that refers to screening, follow-up care, and processes for meeting the health needs of the teen.

Once a teen is in foster care, the child welfare agency is responsible for health care and other required services to ensure the safety and well-being of the child, even though parents whose parental rights have not been terminated retain the right to participate in and make health decisions. Even where the agency contracts out foster care and independent living services, the ultimate responsibility for the adolescent is with the agency and the court.

The Social Security Act states that the child welfare agency, or an authority that it designates:

*Shall be responsible for establishing and maintaining standards for foster homes and child care institutions which are reasonably in accord with recommended standards of national organizations concerned with standards for such institutions or homes, including standards related to admission policies, safety, sanitation and protection of civil rights, and provides that the standards so established shall be applied by the State to any foster family home or child care institution receiving funds under this part of Part B of this title.* 42 USC sec. 671(a)(10)

ASFA, which amends the foster care provisions of the Social Security Act, places health and safety at the center of the state child welfare agency’s responsibilities.

The case plan, required for every child in Title IV-E foster care, must assure “that the child receives safe and proper care.” 42 USC 675(1)(B). The case plan is to include, if available and accessible:

(v) A record of the child’s immunizations.

(vi) The child’s known medical problems.

(vii) The child’s medications and any other relevant health and education information concerning the child determined to be appropriate by the State agency.

(D) Where appropriate, for a child age 16 or over, a written description of the programs and services which will help such child prepare for the transition from foster care to independent living. 42 USC sec. 675(1)(C)(c)(v) - (viii) – (D).
Reasonable Efforts to Achieve Permanency

Various state child welfare laws require documentation of agency efforts to provide appropriate health, education, and other services to all children in Title IV-E foster care.

Reviewing the record keeping and the quality of the information included in the case plan will also be useful in determining whether the agency has made reasonable efforts to achieve permanency in each case.

MEDICAL CARE

Youth under court supervision are more likely to have serious unmet chronic health needs because of the prevalence of significant health conditions at the time of placement, the lack of proper health care during placement, the frequent changes of placement, and the lack of continuity of care while supervised.

Inconsistent medical care for chronic health conditions, the lack of preventative care, and access to specialized treatment services are major problems in many jurisdictions.

In addition, obtaining comprehensive medical care requires coordination and follow-up to ensure that a health screening occurs and that health care providers are aware of and able to address the potential problems of high-risk youth. Because the teens are in substitute care, agencies must have tighter control and supervision of referrals and follow-up, and they must pay more attention to the coordination of social and medical services.

The research shows that many children under court supervision do not receive basic assessments to determine the presence of significant health problems.

IMMUNIZATIONS

CDC recommends the following:

- **Hepatitis B vaccine [Hep B]**: At ages 2 and 18 if not previously given.
- **Varicella (chicken pox)**: Two doses for susceptible persons age 13 and older.
- **Diptheria and Tetanus (lockjaw) and acellular Pertussis (whooping cough) vaccine [DTaP]**: For children ages 11–12, if at least 5 years have elapsed since the last dose of DTaP; boosters recommended every 10 years.
- **Inactivated poliovirus vaccine [IPV]**: Before age six.
- **Measles, mumps, and rubella**: Two doses before 11–12 years of age.
- **Pneumococcal [PCV] and pneumococcal polysaccharide vaccine [PP]**: For high-risk groups.
- **Hepatitis A**: Consult local public health authority.
- **Influenza**: Annual for children older than 6 months who have asthma, cardiac disease, sickle cell disease, HIV, and diabetes.
Preventive Care and Initial Screenings

Primary care of adolescents during initial and periodic preventive visits should include:

- A comprehensive medical and psychosocial history.
- Assessment for risk factors affecting current and future health.
- Assessment and correction of immunization needs.
- A complete physical examination.
- Developmentally and age-appropriate health counseling.

Medical Histories

Comprehensive medical histories and physical examinations are essential to identify and treat acute and chronic medical disorders.

The primary care clinician often discovers problems during the initial screening, and these problems may require referral of the adolescent to other specialists. Chronic rare conditions may also be discovered, requiring immediate attention and appropriate follow-up.

Continuity of Care

The lack of continuity of health care is a major issue for youth in care because placements are changed frequently. In many instances, with each change of placement, the youth must adjust to a new home, new school, new community, new doctors, new therapists—new everything.

In most cases, the young person's health and education records are not readily available. Placement changes may move children across county or state lines, making provider continuity impossible.

Agency workers frequently do not receive basic background health information on children and adolescents when they are removed from their homes, leaving gaps in medical history of
the adolescent and his family. These gaps may affect assessment, treatment, and preventive care.

Even after entry into care, the transfer of medical information to new health providers and caretakers often is not done.

Some states have begun experimenting with health passports to ensure that records are available for all children in care at all times. Foster parents maintain health notes indicating the results of each health care visit. The notes accompany the child each time his placement is changed.

**COMMON MEDICAL CONDITIONS FOUND IN THE JUVENILE JUSTICE POPULATION**

- The most frequently diagnosed conditions: upper respiratory infection, acne, minor trauma, psychosomatic complaints and scabies.

- Female youth are at greater risk for cervicitis, vaginitis, chlamydia, gonorrhea and pregnancy. Male youth are at heightened risk of a number of STDs and HIV.

- Other medical conditions commonly found in youth in detention: asthma, sickle-cell anemia, juvenile diabetes, hypertension, tuberculosis and dental caries.
FACTS ON SEX
The National Longitudinal Study on Adolescent Health indicates that:

- Nearly 50 percent of white and Hispanic teens have had intercourse by 12th grade.
- Sixty-five percent of black teens have had intercourse by 12th grade.
- Thirty-seven percent of black teens report having intercourse by the 8th grade.

SEXUAL AND REPRODUCTIVE HEALTH

Though there are no data available on the prevalence of STDs among young men and women under court supervision, it is a fact that adolescents have the highest rates of chlamydial infection of any age group.

Sexual health for adolescents may be affected by their histories. Many young men and women in Title IV-E foster care as well as the juvenile justice system have histories that include sexual abuse or sexual assault, which places them at greater risk for early sexual activity and high-risk sexual behavior.

In addition, youth who are gay, lesbian, bisexual, or questioning their sexuality may be unwilling to admit to same-sex contacts.

What Are the Standard Services?

Confidential Sexual Education
All teens should receive comprehensive sex education and anticipatory guidance to prevent unintended pregnancy and sexually transmitted infections.

Counseling and Assessment of Sexual Development and Identity
While counseling on reproductive issues is an acknowledged part of good preventive health care for teens, each state may have a different interpretation about how extensive those services should be.

Routine Care
The following should be included in routine health care:

- A thorough and sensitive gender-neutral sexual history by a provider comfortable with asking questions of youth about sexual behavior.
- A genital examination.
• A gynecological examination of all young women who have ever had sexual contact or had a previous exam.

• Preventive interventions to reduce STDs.

• Automatic screening for STDs.

• Immediate treatment and follow-up services if diagnosed with an STD.

Confidential Care

The services necessary to promote the prevention, screening, diagnosis and treatment of STDs—including HIV exposure—are available to at-risk young men and women who are in Title IV-E foster care and eligible for Medicaid. Youth in non-Title IV-E care (i.e., detention facilities) may have these services covered by state funds but are not eligible for federal funding under Medicaid.

Whether covered by state or federal funding, whether in Title IV-E foster care or a detention center, adolescents are often reticent to access such services for a number of reasons, including the lack of:

Gender-neutral Screening

History and screening for STDs should be gender neutral. Questions should be asked about types of sexual contact and gender of partners in a nonjudgmental fashion.

Confidentiality and Informed Consent

Confidentiality is very important to teens, and yet it is not clear whether medical professionals can share the information with others—including the court and the agency responsible for the teen under court supervision.

How Should Teens be Monitored for HIV or AIDS?

Youth at risk for HIV should be offered confidential testing to occur “only after informed consent” is obtained. They also must be counseled regarding who must be told about their medical status because they are under court supervision, and why disclosure is required.

HIV AND ADOLESCENTS

• Adolescents in foster care and the juvenile justice system, just as those who are not in care, may acquire HIV infection as a consequence of their own sexual activity or illicit drug use or may have been infected by previous sexual abuse or, rarely, by perinatal transmission.

• Adolescents who have been victims of sexual abuse are more likely to engage subsequently in sexual behavior that may place them at increased risk for acquiring HIV infection and other sexually transmitted diseases.

• Homeless adolescents frequently engage in prostitution in exchange for money, food, or shelter; and a period of homelessness may occur before an adolescent is placed in care.

• Cocaine use also has been reported as a risk factor for HIV infection because it may involve the exchange of sex for drugs or engaging in risky sexual behavior while under the influence of the drug.

Committee on Pediatric AIDS, American Academy of Pediatrics, July 2000
PRIVACY AND THE COURTROOM

Confidentiality often is compromised in the courtroom. Health impairments like HIV may be identified in social service reports to the court even though such disclosures are protected by law. Mental health records may be quoted or duplicated.

Discussions and comments about the changes a teen’s body is going through during adolescence can humiliate the young person. Fear of such discussions may discourage teens from participating in their hearings.

Finally, the adolescent’s status as a foster child, and the fact that he may perceive that his health information will be made available to everyone involved in the case, may be a disincentive for the teen to seek health counseling.

Judges may consider:

- Warning parties to respect the privacy and feelings of the teen.
- Inquiring whether the teen is aware that confidential services are available for pregnancy testing, STD diagnosis and treatment, contraception, options counseling, counseling about sexual identity and sexuality,

In most states, HIV testing is available to adolescents without parental or guardian consent through publicly funded testing sites; however, public health reporting also is mandated in many states.

The American Medical Association, American Nurses Association, American Public Health Association, the National Association of Social Workers, Centers for Disease Control and Prevention, and the Society for Adolescent Medicine have policies that support informed consent prior to HIV testing.

Is Birth Control Information Available to Teens?

Many adolescent health care providers also offer information about emergency post-coital contraception in addition to information regarding abstinence, barrier methods such as male and female condoms, and hormonal methods given by pill or injection. Depending upon where they live, teens may be able to obtain emergency contraceptive prescriptions.

Are Abortion Services Available?

Federally reimbursable services for family planning do not include abortion, unless necessary to save the mother’s life, or if she has become pregnant as a result of rape or incest.

Nevertheless, some state health care financing programs use state funds to allow Medicaid and State Children’s Health Insurance Program (S-CHIP) recipients access to pregnancy termination services.

Issues of consent for minors, the “mature minors doctrine,” informed consent, and judicial bypass of parental consent can complicate reproductive health care for youth in care. Judges, attorneys and agency workers should be aware of jurisdictional requirements and agency policy regarding these matters.
What Services Should be Available to Teens During and After Pregnancy?

Youth in care have the same rights as youth in parental care to seek confidential family planning and counseling, and to seek pregnancy termination services within the constraints of the law. EPSDT also covers post-natal care for adolescent mothers.

PRIVACY..., CONT’D

- Emergency contraception, HIV testing and care, and so forth.
- Ensuring that the teen receives information about where confidential services are available.
MENTAL HEALTH DIAGNOSTIC STANDARDS

The American Psychiatric Association has published standards for diagnosis of cognitive, behavioral, and emotional disorders in the *Diagnostic and Statistical Manual-IV* (DSM-IV).

Each diagnosis is reported based upon an Axis that corresponds to an area of functioning:

**Axis I: Clinical Disorders**
Includes: Motor Skills Disorder, Pervasive Developmental Skills Disorder, Attention Deficit & Disruptive Disorders, Tic Disorders, Learning Disorder, Separation Anxiety Disorder, Cognitive Disorders (i.e., Dementia, Delirium), Mental Disorders Due to General Medical Conditions, Eating Disorders, Substance Related Disorders, Schizophrenia and other Psychotic Disorders, Mood Disorders, Anxiety Disorders, Somatoform Disorders, and other disorders.

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MENTAL HEALTH

Adolescents under court supervision have higher rates of mental health issues than teens who are not in care. The trauma of physical or sexual abuse, the loss of family members after placement, and the effects of frequent changes of placement contribute to higher rates of mental health issues in children in care.

The Child Welfare League of America compiled the following list of frequently diagnosed mental, emotional and behavior problems in children and adolescents:

- Anxiety disorders such as phobia, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder.
- Major depression.
- Bipolar disorder or manic-depressive illness.
- Attention-deficit/hyperactivity disorder.
- Learning disorders.
- Conduct disorder.
- Eating disorders such as anorexia nervosa and bulimia nervosa.
- Autism.
- Schizophrenia.

While the data show that youth under court supervision use mental health services at higher rates than other youth, there is no certainty that the services address the complex underlying issues presented by the adolescent in care.

What Should be Done to Meet the Mental Health Needs of Teens in Care?

**Step 1:** Initial screening of youth entering care, as well as routine health care assessments, should include at least a brief psychosocial history and assessments for mental
health problems. The teen’s history of emotional, physical, and sexual abuse should be taken at the initial health screening. In addition, as early in the case as possible, a family history should be provided.

**Step 2:** Further diagnostic evaluation should be completed within 30 to 60 days after placement. Given the prevalence of significant mental health conditions in youth in foster care and the juvenile justice system, all adolescents require a comprehensive assessment.

The diagnostic evaluation should include diagnosis and treatment recommendations designed to address the specific needs of the adolescent. The diagnostic portion of the report should provide information as to the teen’s functioning along the accepted Axis as defined by the DSM-IV and used throughout the profession to diagnosis mental illness. The report of evaluation should be included in the teen’s record and provided to the court.

**Step 3:** Treatment must be based upon the comprehensive assessment and the individual needs of the adolescent. Professionals with expertise in treating vulnerable youth should provide the services. The length of treatment and how many sessions the adolescent requires each month or week should be addressed in the treatment plan.

**Step 4:** Follow-up. The court and the agency responsible for the adolescent should receive information on a regular basis regarding whether the treatment strategies are working, what is the projected length of time for continued therapeutic intervention, and whether the treatment is helpful in the adolescent’s view.

**Who Pays for the Services?**

For all Medicaid-eligible youth in Title IV-E foster care, mental health services are paid for through Medicaid or the SCHIP program in each state.
CAUSES OF MENTAL ILLNESS

Mental health disorders in children and adolescents are caused by:

- Biological factors such as genetics, chemical imbalances or damage to the central nervous system.
- Environmental factors such as exposure to violence, extreme stress or loss of an important person.
- A combination of biological and environmental factors.

Child Welfare League of America

Does the Local Education System Have a Role in Providing Mental Health Services to Adolescents?

The education system may be an additional mental health resource that can be accessed through the application of the federal Individuals with Disabilities Education Act (IDEA).

What Obstacles Impede the Provision of Appropriate Mental Health Services for Adolescents Under Court Supervision?

Mental health services are in short supply in many communities. Many providers with pediatric or adolescent training do not accept Medicaid or S-CHIP financed patients.

Of particular concern is the availability of culturally appropriate services; services for adolescents who do not speak English; and services for adolescents who have physical, cognitive or mental disabilities.
SUBSTANCE USE/ABUSE

Studies show a high correlation between substance use/abuse and mental health problems in youth. Drug use is also considered a risk-taking behavior during this stage of development.

Adolescents who use drugs or alcohol present problems in planning, attention, abstract reasoning, judgement, motor control, and aggression.

The U.S. Department of Health and Human Services Center for Substance Abuse Treatment recommends a substance abuse assessment of any adolescent who is at risk. The assessments should determine whether there has been a history of physical or sexual abuse, status of the teen's school performance, peer involvement in substance abuse and crime, the teen's involvement in delinquent activity, and physical and mental problems that could be symptoms of substance use/abuse.

If an adolescent is found to need substance abuse treatment, access may require enrollment of the teen in programs outside the child welfare agency's authority.

As with other areas of adolescent health, federal and state law require privacy in all records and communications regarding substance abuse treatment.

Teens should be made aware of the right to confidentiality even if they are under court supervision.

COMMON MENTAL HEALTH PROBLEMS FOR YOUTH IN THE JUVENILE JUSTICE SYSTEM

- Between 20 percent and 60 percent of incarcerated youth have been diagnosed with a conduct disorder.
- Attention-deficit/hyperactivity disorder may exist in up to 50 percent of incarcerated youth.
- Affective disorders exist in between 32 percent and 78 percent of all incarcerated youth.
- Between 2 percent and 17 percent had a personality disorder.
- Previous-suicide attempt rate of approximately 28 percent of the juvenile justice population.
- Psychotic disorders are found in between 1 percent and 6 percent of the population.

American Psychiatric Association
IN INVOLVING BIRTH FAMILIES

- Teens in foster care who are in need of health services, whether the parental rights have been terminated or not, may require a reconnection with their parents to resolve issues related to their current status including family history of medical issues, mental health issues, and substance abuse.

- Unless parental rights have been terminated, state law provides otherwise, or by order of the court barring parental involvement, parents have the fundamental right to consent or object to treatment for their children—including mental health treatment.

NUTRITION

The physical changes that occur during adolescence linked with nutritional deficiencies and poor eating habits set the stage for serious medical conditions as the child progresses into adulthood.

During adolescence, young men and women are at higher risk for such conditions as obesity, malnutrition, and eating disorders. Even more than most teenagers, youth in foster care are at risk for poor diets and inconsistent nutritional guidance.

Even when adolescents receive regular physical health care, primary care physicians may overlook nutritional counseling.

According to the Surgeon General’s Report on Nutrition and Health, poor dietary habits may lead to:

- Coronary heart disease
- Stroke
- High blood pressure
- Cancer
- Diabetes mellitus
- Obesity
- Dental disease
- Diverticular disease
Obesity, Anorexia, and Bulimia

Morbid obesity and eating disorders such as anorexia nervosa and bulimia may surface as problems in youth who have been sexually or physically abused or neglected.

**Obesity**

Adolescent obesity warrants meticulous care, for obesity may lead to health problems such as:

- High blood pressure
- High cholesterol
- Type 2 diabetes mellitus
- Cardiac risk factors
- Weight-related orthopedic problems
- Skin disorders
- Potential psychiatric problems
- Significant morbidity

Care for children and adolescents should include prevention (including a health-conscious diet and a regular exercise program), evaluation (including screening for obesity-related diseases), and treatment (including reasonable weight-loss goals, dietary and physical activity management, behavior modification, and family involvement).

**Anorexia Nervosa and Bulimia**

Eating disorders such as anorexia nervosa and bulimia may cause:

- Type 1 diabetes
- Reflux esophagitis
- Abdominal cramping
- Diarrhea
- Rectal bleeding

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**FACTS ABOUT OBESITY**

- Between 16 percent and 33 percent of children and adolescents are obese.
- Obesity most commonly begins in childhood between the ages of 5 and 6, and during adolescence.
- A child who is obese between the ages of 10 and 13 has an 80-percent chance of becoming an obese adult.
- One-in-five U.S. children are currently classified as obese—with a body mass index of 30 or higher.
- More children are being diagnosed with medical conditions that are associated with overweight adults, including Type II diabetes, high blood pressure, heart disease and high cholesterol.
• Amenorrhea
• Hypotension
• Arrhythmias
• Sudden death

Teens diagnosed with eating disorders usually require a multidisciplinary approach involving physicians, nutritionists and mental health professionals experienced in these problems and in working with teens.

Minimally, an experienced mental health professional to work with the teen on behavior modification and a primary care physician to monitor physical status and weight must be involved and work together to treat these disorders.

**What Are the Signs the Adolescent May Be at Risk Nutritionally?**

• Intrauterine growth retardation in pregnant adolescent girls.
• Cessation of menses.
• Iron deficiency and anemia.
• Vitamin A deficiency.
• Calcium deficiency.
• Other specific nutrient deficiencies (e.g., zinc, folate).
• Sexual maturation delays.
• Obesity.

**What Do Medical Professionals Suggest?**

• The teen's child welfare and medical record should include a diet and nutritional history.
• The records should include a history of weight loss or gain.
• The records should indicate the type and amount of physical activity engaged in by the adolescent.
• The records should indicate the quality, quantity and number of meals the adolescent eats per day.

• The records should include a sexual maturation, and, for girls, a menstruation history.

What Preventive Steps are Recommended?

Adolescents should be assessed for organic disease, anorexia nervosa, or bulimia if any of the following are found:

• Weight loss greater than 10% of previous weight.

• Recurrent dieting when not overweight.

• Use of self-induced vomiting, laxatives, starvation or diuretics to lose weight.

• Severely distorted body image.

• Body mass index (weight/height) below the fifth percentile.

DENTAL AND ORAL HEALTH

The 1997 National Survey of America's Families, which provided information on 100,000 children and adults, found that nationally nearly 30 percent of low-income children three years of age and older received no dental care and 60 percent did not receive the recommended levels of care.

The survey focused on low-income populations, and found that youth between 13 and 17 years of age have the highest rate of unmet dental needs of any children.

When adolescents experience oral diseases and disorders, their dental health may trigger problems with self-esteem and self-image. Poor dental health in adolescents may discourage social interaction and lead to stress and depression.

As the gateway to the body:

• The mouth reflects what is happening deep inside the body.

• The mouth may show signs of nutritional deficiencies.
ORAL HEALTH FACT

Tooth decay is currently the single most common chronic childhood disease—five times more common than asthma and seven times more common than hay fever.


- The mouth may serve as an early warning system for diseases such as HIV infection and other immune system problems.

  Some of the common oral diseases and disorders:
  
  - Cavities.
  
  - An acute periodontal infection common to adolescents under stress.
  
  - Cold sores.
  
  - Chronic facial pain conditions.
  
  - Malocclusion.

What Is the Effect of Poor Dental Health on Teens?

Some oral diseases and disorders may interfere with breathing, eating, swallowing and speaking.

What Dental Services are Mandated?

States are required by federal law to provide dental care to all Medicaid-eligible children.

The children are to receive:

- Annual dental screening and follow-up.

- Prophylaxis examination and fluoride treatments.

- All necessary emergency, preventive and restorative services.

In addition, Medicaid’s EPSDT law requires screening and follow-up treatment for dental problems for all Medicaid-eligible youth in Title IV-E foster care, and for youth covered by most insurance expansion programs.

What are the Barriers to Proper Dental Care?

- Lack of knowledge about or low priority given to meeting recommended dental standards.

- Lack of access to providers who accept Medicaid or expansion program patients.
Lack of means to pay for care.

Frequent changes of placement for children in care.

TEENS WITH DISABILITIES

The critical issue for teens with physical, mental or developmental disabilities often is the unavailability of high-quality and effective services. Most conditions have been present for many years and may not have received adequate or consistent treatment or rehabilitative services. Some conditions remain the same as the child moves through adolescence. However, others may change in their severity or in the effect that the conditions have upon other areas of adolescent development.

Whether the condition remains the same or not, it is often difficult to obtain comprehensive records regarding the appropriateness of services provided and their effectiveness. At times, the adolescent may receive services from the medical community, the school system, and the child welfare system without consistent case management to ensure that no services slip through the cracks.

Special education services, to the extent that the services are health-related (e.g., psychological, speech-audiology, counseling, physical and occupational therapy, medical care), may be financed by Medicaid even though the services are provided at the school.

SPECIAL EDUCATION

The incidence of learning disabilities in children in care is so high that many experts believe every child under court supervision should receive an educational assessment. Many adolescents in care move to new schools each time there is a change in their placement. Often their school records are not readily available.

DENTAL CARE

An investigation by the U.S. Government Accounting Office in 2000 found:

- Twenty-five percent of all children have untreated tooth decay.

- Eighty percent of those are from low-income and other high-risk groups.

- Pain and infection from tooth decay causes almost 12 times the “restricted activity days”—including loss of school time—among poor children, compared to higher income children.
SURROGATE PARENTS FOR CHILDREN IN FOSTER CARE AND JUVENILE DETENTION

IDEA requires the appointment of a surrogate parent for educational purposes for all children who are placed away from their families, where the parents cannot be found or the parental rights have been terminated.

Most school districts have developed certification programs for surrogate parents.

If a child requires special education, the court should inquire whether a surrogate parent has been identified or whether the birth parents are involved in the educational planning.

Who is Eligible for Special Education Services?

Students who have a documented learning disability, or emotional or physical disabilities that affect the student’s ability to learn without specialized instruction or accommodations, are eligible for special education services.

What is Legally Required When a Child is Believed to Need Special Education Services?

Every child is entitled to a free and appropriate education. If screening uncovers impairment of hearing, speech, language or eyesight, orthopedic issues, learning disabilities, mental retardation, emotional disturbance, or brain injury that affects the child's ability to learn, a referral for an educational assessment is required. The educational assessment is the first step in developing an Individualized Education Plan (IEP) as authorized under IDEA.

The IEP

Comprehensive multidisciplinary educational assessments are provided free by public school systems, upon request.

Among the IEP assessments:

- Educational Evaluations: Testing determines whether the teen has educational disabilities in areas such as math or reading.

- Psychological Evaluations: Testing determines whether the child has emotional impairments that affect his ability to maximize academic training.

- Physical Examinations: Testing for hearing, vision, and motor skills may be required depending upon the areas of weakness presented by the child or areas noticed by others (birth parent, foster parent, social worker, teacher) that affect the teen’s ability to maximize educational services.
Once the assessments are completed, a meeting is held with members of the school system, the child, and his parent or surrogate parent. At the meeting the teen’s IEP is developed and agreed to—or rejected—by the parent or surrogate parent.

The IEP must be updated annually.

**Does IDEA Include Transitional Services?**

IDEA provides services to children with special needs beyond high school. Through “transition services” IDEA can support additional education, vocational training, employment, and even independent living. 20 USC sec.1401(3). The IEP required under IDEA must describe the transition services that will be provided to youth 16 years and older. 42 USC 1414(d)(1)(A)(vii)(I) & (II).
Child Welfare League of America

Checklist of Needed Services for Children in Foster Care

- Immediate eligibility for services.
- 7 day/week, 24 hour/day availability of emergency services.
- Community-based services.
- Culturally competent services including language capacity that reflects consumer’s primary language.
- Initial health screening appropriate to the child’s circumstances and agency concerns at the time the child enters foster care (within 24 hours).
- Comprehensive, multidisciplinary health, mental health and developmental assessment within one month of child’s placement.
- Screening tests for common medical conditions such as anemia, lead poisoning, etc., and risk assessments and screening tests for specialized conditions including HIV and in utero drug exposure if indicated.
- Developmental and mental health evaluations on a regular schedule.
- Immunizations.
- Comprehensive dental services including relief of pain and infection, restoration of teeth, and maintenance of dental health.
- Follow-up diagnostic and treatment services for all conditions and problems identified in the health assessment and developmental and mental health evaluations.
- Covered costs of hearing aids, eyeglasses, and other equipment.
- Ongoing primary and preventive health care services including reassessments at a minimum every 6 months.
- Access to appropriate specialty and subspecialty care.
- Case management designating one individual or center to be responsible for coordinating all aspects of the health care of foster children including a plan to meet the child’s health care needs and identification of responsibilities and recommendations for follow-up care. Case management services must include assistance with scheduling appointments and transportation.
- Coordinated medical and psychosocial record keeping.
Addressing Well-being One Case at a Time

Upon evidence that health care due to a teen has not been provided, the court should direct the child welfare agency to fulfill its duties to ensure that the teen’s well-being needs are met.

In fact, it can be argued that failure to provide and document the health care and health needs of each adolescent in foster care provides the basis for a court finding that the agency did not make reasonable efforts to achieve the permanency goal or alternate plan for the teen.

To assist judges, attorneys, and agency workers in complying with ASFA and meeting the health needs of all adolescents under court supervision, the following checklists are offered for monitoring adolescent well-being.

GENERAL QUESTIONS

- Who does the teen consider significant in his life (e.g., parents, teachers, relatives, siblings, other adults)?

- Does the teen have a faith community? How frequently is the teen involved? How is the teen involved in the faith community?
THE LAWS

The obligations of the state to provide comprehensive health care to teens in foster care and independent living programs springs from:

- The Foster Care Independence Act of 1999, P.L. 106-169; 42 U.S.C. 677 et seq; 42 U.S.C. 1396 (a) and (d); 42 U.S.C. 673 (b).


- Does the teen have special needs that will affect the passage from adolescence to adulthood?

- How many placements has the teen had since entry into foster care?

- What is the teen’s current placement (e.g., family foster home, group home, detention, residential treatment)?

- Is the teen eligible for Medicaid?

- Does the agency have any information regarding the health history of the adolescent’s birth family? Has this information been provided to the teen’s primary physician? Is there a family history of diabetes, high blood pressure, cancer, mental illness, substance use/abuse, developmental disabilities, and so forth? Is the family history documented in the case plan?

PHYSICAL HEALTH—MEDICAL CARE

- Has the agency provided information regarding the results of the most recent physical examination provided to the adolescent?

- Are the teen’s immunizations current? Is the immunization record attached or reflected in the case plan?

- When was the adolescent’s last physical examination? By whom? Where?

- Is the adolescent being seen by the doctor for the first time, or is the physician her regular primary care physician?

- What tests were given, and do any results indicate follow-up is required? By whom? When?

- Does the adolescent have any of the following chronic conditions?
  - Asthma
  - Diabetes
  - High cholesterol
- Acute and chronic urinary tract infections
- Headaches
- Cerebral palsy
- Seizures
- HIV/AIDS
- Tuberculosis
- Hepatitis
- Scabies
- Immunization deficits
- Eczema
- Vision problems
- Genetic disorders
- Allergies
- Developmental delays
- Iron deficiency with and without anemia
- Dental caries
- Intestinal parasites
- Obesity
- Lactose intolerance
- Juvenile rheumatoid arthritis
- Lupus
- Hearing loss

- Does the adolescent have any medical conditions that require monitoring, medication, or other treatment by a specialist on a regular basis?

**WHAT IS EPSDT?**

Medicaid is the gateway through which eligible teens are assured access to Early and Periodic Screening, Diagnostics and Treatment (EPSDT) and follow-up health care.

Teens can obtain comprehensive health care that encompasses mental health, substance abuse treatment, special education, reproductive health care and counseling, nutrition and dental care, basic preventive health care, and follow-up treatment for acute and chronic illness and disability.
MAKING REASONABLE EFFORTS UNDER ASFA

Upon evidence that health care due to a teen has not been provided or documented in the record, the court should consider directing the child welfare agency to fulfill its duties to assure that the teen’s health needs are met.

It can be argued that the agency's failure to provide and document the health care and unmet health needs of children in foster care may be a basis for a finding that the agency has failed to make reasonable efforts to achieve the permanency goal or plan for the child.

- What is the treatment plan for any identified medical condition(s)?
- When was the medical condition identified?
- Are medications prescribed for the adolescent? What are they? Are they available consistently?
- How frequently must the adolescent see the specialist for these conditions?
- Do the medical conditions affect the adolescent’s educational program, placement, social involvement, or emotional development?
- Does the adolescent understand his medical condition and any limitations or requirements due to the condition?
- Who participates or accompanies the adolescent to medical appointments?

The Adolescent’s View:

- How does the teen view the care he is receiving?
- Does he feel comfortable asking questions of the medical staff? If not, why?
- What would make him feel more comfortable when following up on medical care?

SEXUAL AND REPRODUCTIVE HEALTH

- Does the adolescent's history include any indications of sexual abuse or sexual assault?
- Has the adolescent received sex education instruction? Where? When? By whom?
- Has the adolescent been informed of the services available related to sexual health and well-being?
• Does the adolescent engage in high-risk activities that increase vulnerability to sexually transmitted diseases and HIV/AIDS?

• Has the adolescent been tested for sexually transmitted diseases based on risk status?

• Has the adolescent been tested for HIV/AIDS based upon risk status?

• Have all requirements related to informed consent and confidentiality been met?

• Is the adolescent pregnant?

• Does the adolescent receive prenatal care? Where? How frequently? How does the teen get to appointments?

• Does the adolescent have any conditions that pose a risk during pregnancy (high blood pressure, diabetes, seizure disorder, auto-immune disease, HIV/AIDS)?

• Does the adolescent receive post-natal care? Where? How frequently?

The Adolescent’s View:

• Is the adolescent interested in receiving information regarding sexual health and well-being?

• Has the information been provided?

• Did the adolescent understand the information provided? Was it useful?

WHAT DOES EPSDT REQUIRE?

• Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) requires comprehensive screening for health problems and follow-up care for identified problems.

• The term “medically necessary” is used to describe the treatment to be provided, but the term is not defined in the statute.

• “Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.” [42 CFR sec. 440.230(b)]

• Besides physical health, the basic EPSDT components for recipients of Medicaid who are 0–18 years of age (or 21 by state option), include:

  • Dental
  • Vision
  • Hearing
  • Reproductive counseling
  • Mental health care
  • Treatment for substance abuse

MENTAL HEALTH

• Has the teen had problems in this review period with any of the following:
  — Depression
  — Declining school grades
BARRIERS TO EPSDT COMPLIANCE

Even though the Medicaid law provides comprehensive health services for children and adolescents, there are a number of potential hurdles to the delivery of health care for teens in foster care:

- Lack of adequate notice that EPSDT services are available.

- In some states comprehensive EPSDT and follow-up services are not fully available despite the law.

- There may be arguments about whether certain kinds of follow-up care are "medically necessary."

- Certain services like mental health and substance abuse treatment may be "carved out" of the basic HMO package and the teen may not know how to access them.

- Reproductive health care may not be as extensive as needed by an individual teen.

- Case management and transportation services, which are required under EPSDT, may not be available to the teen.

- Chronic melancholy
- Family dysfunction
- History of physical or sexual abuse
- Alcohol use/abuse
- Drug use/abuse
- Previous suicide attempt
- Suicidal plans

- Has there been an evaluation to determine whether the problems should be addressed through mental health intervention?
  
  - Mental health screen
  - Psychiatric evaluation
  - Psychological evaluation

- What is the teen's diagnosis?

  - **Axis I:** Clinical Disorders
    Includes: Motor Skills Disorder, Pervasive Developmental Skills Disorder, Attention Deficit & Disruptive Disorders, Tic Disorders, Learning Disorder, Separation Anxiety Disorder, Cognitive Disorders (i.e., Dementia, Delirium), Mental Disorders Due to General Medical Conditions, Eating Disorders, Substance-Related Disorders, Schizophrenia and other Psychotic Disorders, Mood Disorders, Anxiety Disorders, Somatoform Disorders and other disorders.

  - **Axis II:** Personality Disorders and Mental Retardation.

  - **Axis III:** General Medical Conditions
    General medical conditions that are related to the mental health diagnoses on Axis I and II.

  - **Axis IV:** Psychosocial and Environmental Problems
    Includes things such as family issues, abuse and neglect, and school problems.
— **Axis V:** Global Assessment of Functioning (GAF)
  Psychiatrists and psychologists use a rating scale to assess how well the individual is able to function in his or her environment.

• What is the treatment plan?
  — Focus.
  — Treatment process: Talk therapy, behavior modification, group therapy, family therapy, and so forth.
  — Length of the plan or the next treatment plan review date.

• Is there a need for parental or caregiver involvement in the therapeutic process? If yes, have the parents or caregivers been notified? Will they participate?

• Has therapy been arranged?
  — Frequency.
  — Location in relation to adolescent's residence.

• Who will provide the therapy?
  — Psychiatrist
  — Psychologist
  — Clinical social worker
  — Counselor

• Has psychotropic medication been prescribed? Who is the psychiatrist monitoring the medication? Frequency and method (e.g., blood levels)? Who is responsible for ensuring that prescriptions are filled in a timely fashion?

• If the teen has developmental, physical or cognitive impairments, does the clinician have the skill to work with the teen?
WHAT IF THE TEEN IS NOT ELIGIBLE FOR MEDICAID OR THE SERVICES ARE NOT COVERED?

- Free emergency services are available through "public" hospitals that receive Hill Burton funds under The Hospital Survey and Construction Act of 1946, 42 U.S.C. sec. 291 et seq. Low cost follow-up treatment for youth in the public hospital’s catchment area may also be available.

- Excellent care for pregnant teens and their children may be available at low cost in clinics and through programs (for example, “Healthy Start”) funded for that purpose through a Maternal and Child Health Services Block Grant to the State under Title V of the Social Security Act, 42 USC sec. 701 et seq. (1992).

- Food supplements that provide infants, mothers, and pregnant teens with basics for well-balanced meals are available through the Women, Infants and Children Supplemental Food Program (WIC) under the Child Nutrition Act, 42 U.S.C. sec. 1786 (1992).

- Does the therapist speak the teen’s primary language?

- Is the therapist competent to address the cultural issues that may arise for the adolescent?

- If the teen is not open to therapy, are other services (e.g., specialized mentors, church-related programs) available to provide support and an outlet to address the adolescent’s behavioral and emotional issues?

- Does the teen receive supportive psychological or counseling services at school?
  - Are these services defined in the teen’s IEP?
  - What level of services is the teen receiving?
  - Are the services being provided in compliance with the current IEP?
  - Who provides the services?

- What is the therapeutic approach of the mental health professional assigned to the case?

- Has the therapist provided a written statement of issues to be addressed over the next three to six months and a statement of progress made toward addressing the issues for each review hearing?

- Is the therapeutic plan included in the teen’s case plan?

- Has the adolescent been hospitalized for evaluation and treatment? When? Where?

- Are genetic testing or neurological evaluation indicated in this case? Have the evaluations been completed? What were the results?

Service Delivery

- How frequently should the teen receive services based upon the evaluation(s)?

- How frequent are the sessions?
• If there is a difference between the recommendation and the actual service frequency, what is the reason for the difference?

**Access**

• Who, if anyone, accompanies the teen to the sessions?

• How does the teen get to the sessions (public transportation, agency transportation, caretaker or facility)?

• Where are the sessions held? Is the environment appropriate to meet the adolescent’s needs?

**The Adolescent’s View:**

• Is there anyone whom the teen would like to include in the therapeutic process?

• Does the teen understand her diagnosis?

• Has the teen been involved in the development of the treatment plan?

• Does the teen think the therapy or other mental health services are useful? Why or why not?

• If the teen does not attend the sessions, what reasons does he give? Has anyone talked with the teen to determine the effectiveness of the therapy?

• Are the teen’s views of the usefulness of the therapeutic services outlined in the case plan?

• What are the teen’s views regarding medication?

**SUBSTANCE USE/ABUSE**

• Does the adolescent present behaviors that indicate screening and assessment for substance use/abuse is necessary?

• What are the results of the screening and assessment?

• What are the recommendations for treatment (i.e., inpatient, outpatient)? Where?

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**WHAT IF..., CONT’D**

• Many states also have waiver and demonstration programs financed by funds from the U.S. Department of Health and Human Services that improve outreach to services for populations that are at high risk for health problems.

• Some courts have forensic psychiatry available for youth with critical mental health problems, and immediate assessment and referral for treatment can be made.
STANDARDS OF PRACTICE ARE KEY

Many health care standards have been incorporated into Medicaid laws. The EPSDT law bases the schedule for medical appointments on:

...intervals which meet reasonable standards of medical and dental practice....

42 U.S.C. sec.1396d(a)

Among the standards that are accepted and should be used in providing health care to adolescents under court supervision:

The American Medical Association’s Guidelines for Adolescent Preventive Services (GAPS).

Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, sponsored by Maternal and Child Health Bureau, Medicaid Bureau and Centers for Medicare and Medicaid Services under the U.S. Department of Health and Human Services.

Policy Compendium on Reproductive Health Issues Affecting Adolescents, compiled by the American Medical Association.

- What organization/agency will provide the treatment services? Will the organization/agency provide reports to the court? If not, is a court order necessary?
- What are the aftercare recommendations for the adolescent, including school placement and type of living arrangement?
- Does the adolescent have a dual diagnosis (substance use/abuse and a mental health diagnosis such as depression)?
- What is the recommended course of treatment for the dual diagnosis (e.g., inpatient, outpatient)?
- Is medication recommended? What medication? Who will monitor?
- Who will be the primary clinician handling the case?
  - Psychiatrist
  - Psychologist
  - Clinical social worker
  - Drug treatment counselor

The Adolescent’s View:

- Is the teen willing to participate in drug treatment (either as an inpatient or outpatient)?
- Is the teen willing to consider medication if recommended?
- Does the teen understand his diagnosis?
- Does the teen agree to participate in—and follow—the treatment plan?
- Did the teen participate in the development of the treatment plan?
- Does the teen agree with the terms of the treatment plan?
- Does the teen agree to participate in an inpatient/residential program if one is recommended?
NUTRITION

- Has the teen displayed risk factors that indicate nutritional deficiency, such as unhealthy skin and hair, wasted muscles or mental confusion, and weight loss or gain?

- Is the adolescent involved in any organized sports or other physical activity?

- Has the teen received the recommended evaluations of diet, nutritional history, weight, physical history, and sexual and physical maturation?

- For those who have been diagnosed with eating disorders or poor eating habits such as bulimia, anorexia, or obesity, have they received the proper treatment they are entitled to?

The Adolescent’s View:

- What does the adolescent say about her diet?

- Is the adolescent willing to work with appropriate professionals to address nutritional issues?

- What does the teen believe he needs to effectively address the nutritional concerns (e.g., taking classes, eating meals at home, learning to cook)?

DENTAL HEALTH

- Does the teen have any obvious dental health problems that affect the adolescent socially or physically?

- Has the teen received comprehensive and routine dental care over a 12-month period?

- Does the teen receive dental services from the same provider each time?

- Does the teen have access to the appropriate tools to ensure dental hygiene between visits (e.g., toothbrushes, dental floss, fluoride rinses)?

STANDARDS... CONT’D

The Diagnostic and Statistical Manual of Mental Disorders, developed by the American Psychiatric Association.
• Does the teen require any specialized dental services, such as surgery or orthodontics?

**The Adolescent’s View:**

• Are there any problems with dental services that he wishes to have addressed?

• Are the services that are provided explained and understandable to her?

**TEENS WITH DISABILITIES**

• Is the adolescent receiving special education services? Where? Is the IEP current?

• Who is responsible for case management for the adolescent?

• What services are recommended by health care providers?

• Are the services being provided? By whom? What is the frequency of services compared to the level of services recommended?

• Does the adolescent have the appropriate equipment to assist in his day-to-day habilitation?

• Would the adolescent benefit from other devices to improve her ability to function?

• What services are to be provided by the school system?

• Does the adolescent have all equipment and supplies necessary to effectively benefit from the school program?

• Has a transition plan been developed for the adolescent’s transfer from child welfare to an adult protective system? At what age must the transfer be made? When should the process begin?
SPECIAL EDUCATION

- Are school attendance records included in the case plan?
- Are the adolescent’s report cards or progress reports included in the case plan?
- Does the case plan include a copy of the current IEP if the adolescent is eligible for special education services?

Services

- Are tutoring services needed? In what subjects? What is the goal to be accomplished through the tutoring process (e.g., increase grade performance, increase level of functioning, provide homework support)?
- Has a vocational assessment been completed if the adolescent is 16 or older, or at whatever age is set for such assessments in the jurisdiction? What are the results of the assessment? What is the transition plan for the adolescent based upon the results of the assessment? Are the results included in the treatment plan?
- Depending upon the functioning level of the adolescent, have referrals been made to the agency that provides services to adults who are developmentally disabled, mentally ill, or mentally retarded? When will the referral be acted upon?
- Is the training, development or education plan included in the adolescent’s case or independence/emancipation plan?

The Adolescent’s View:

- What is the adolescent’s view of his future and the role of education in achieving his goals? Are his views and concerns reflected in the case plan?
- Did the adolescent participate in meetings regarding educational services or transition services to adult systems for the developmentally disabled, mentally ill, or mentally retarded?
- Did the adolescent participate in the IEP meeting and sign the IEP?
- Is the adolescent aware of the results of the vocational assessment? What are his views of the results?
- What are the adolescent's views about the transition services that have been discussed with him?

**ACCESS TO MEDICAL SERVICES**

- Are services to be provided under a state expansion health program (S-CHIP) or Social Security Disability and Medicare?
- Is the teen IV-E eligible and receiving Medicaid or S-CHIP?
- If the teen is not eligible for services, what options have been explored to provide needed health services?
- Did the adolescent receive notice of screening opportunities under EPSDT? How? When?
- Was there a diagnosis? In what areas?
- Did follow-up treatment occur based upon the recommendations of the health care professionals involved?
- Are there service gaps that should be addressed by the court (e.g., access to funds to purchase adaptive equipment, upgrade wheelchairs)?
- Are there service providers available to provide services using the financing available?
Mandatory and Optional Title XIX Medicaid Services

- Inpatient hospital services (other than in an institution for mental disease)
- Outpatient hospital services
- Rural health clinic
- Rural health clinic services
- Federally qualified health center services
- Laboratory and x-ray services
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals < age 21
- Family planning services and supplies
- Physicians services
- Medical and surgical services of a dentist
- Medical or remedial care provided by licensed practitioners and recognized by state law
- Home health care
- Private duty nursing
- Clinic services
- Dental services
- Physical therapy and related services
- Prescription drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Other diagnostic, screening, preventive, or rehabilitative services recommended by a physician or other practitioner of the healing arts
- Intermediate care facility services for the mentally retarded
- Inpatient psychiatric hospital services for individuals < age 21
- Nurse midwife services
- Hospice care
- Case management
- Respiratory care
- Pediatric or family nurse practitioner services
- Community supported living arrangements
- Personal care services
- Primary care case management services
- Other medical care and remedial care recognized under state law and specified by the Secretary of Health and Human Services

Source: 42 U.S.C. sec 1396d(a). For adults some of these services are mandatory while others are optional; but for individuals under age 21, all services must be available if medically necessary pursuant to the requirements for EPSDT, 42 U.S.C. sec. 1396d(r)(5). Services limited to individuals age 21 or older have been omitted from the list. Adolescents in Public Health Insurance Programs: Medicaid and CHIP, Authors Abigail English, Madlyn Monreale & Amy Stinnett, Center for Adolescent Health and Law (1999), p.62.
The Final Transition

The original Independent Living Initiative became law in 1986. It did not provide continuing support for those young adults who required assistance after emancipation, including extension of health care services after the age of 18. For more than a decade, Independent Living Programs were to provide supportive, training, and employment services to youth between the ages of 16 and 18.

It is important to note that the Foster Care Independence Act of 1999 extends service eligibility to young adults in care and those who have aged out or otherwise achieved their permanency goal after the age of 15. [The Foster Care Independence Act of 1999, Public Law 106-169, 42 United States Code 677 et seq.; also amending 42 United States Code 1396a and 1396d; 42 United States Code 673b.]

Therefore, older youth who are adopted, return home, or remain with caretakers under custodial or guardianship arrangements are eligible for the first time for employment, education and life skills assistance.

Judges, attorneys, and social workers are charged with monitoring the effectiveness of each adolescent’s case plan that should include the emancipation plan. The process is dynamic and requires the participation of all significant persons in the young adult’s life. To be successful, the plan must be assessed and reassessed at regular intervals to ensure progress toward meeting each adolescent’s needs for stability at the time of emancipation.

PART IV:
THE ROAD TO EMANCIPATION

There is a presumption that at the age of 18 young adults in foster care are somehow magically prepared to take on the world armed with viable housing, employment, education, health care, and parenting abilities.

To more realistically move toward a successful transition, experts now focus on developing INTERDEPENDENCE skills in adolescents and young adults before they age out of the child welfare system. The focus is on the development of skills that will allow young adults to care and advocate for themselves while remaining connected to family, former caregivers and their communities.

This section provides information to help plan and monitor healthy transitions to adulthood:

- The Journey Toward Emancipation
- Planning Early for Transition
- Developing the Emancipation Plan
- Monitoring Well-being
FOCUSBING ON COLLABORATION AND TRAINING

The Foster Care Independence Act of 1999 requires:

- Each state must develop a plan for the Independent Living Program, and these plans must be filed with the federal government each year.

- States coordinate Independent Living activities with other state and federally funded programs for youth, abstinence education programs, local housing programs, programs for disabled youth, and school-to-work programs through local high schools or employment services agencies.

- Funds are to be set aside to train adoptive and foster parents, group-home workers and case managers to address the issues confronting adolescents preparing for emancipation.

PLANNING EARLY FOR TRANSITION

The Independent Living Act of 1999 does not include a minimum age of eligibility to receive Chafee Independent Living Program services. Prior to the 1999 Act, services were only available to youth between the ages of 16 and 18. Today, states must begin providing services to youth at any age or stage of development that is appropriate to meet the long-term needs of the adolescent.

As in all areas of development, individuals advance at their own pace. Young adults between the ages of 18 and 21 often are not ready to live on their own. Many require the opportunity to return home when they encounter social, financial, or housing problems. Some may have special needs that affect the pace and nature of their growth toward responsible adulthood.

For young adults who have been under court supervision, there may not be a home to return to. These young adults may have special emotional or developmental needs that affect their ability to move rapidly into responsible adults.

Research shows that despite long periods away from family, many young adults under court supervision reconnect with parents, siblings and other relatives in an unplanned manner as they move toward emancipation. On the other hand, some move from the foster care system to an adult protection system including the criminal justice system. Others find themselves homeless.

The Foster Care Independence Living Act of 1999 requires states to provide "bridge" services to young adults until the age of 21. Financial incentives are provided to states that provide comprehensive services, and the states must provide information to begin determining the strategies that work to bring adolescents in foster care successfully into adulthood.

Each adolescent must have a written independence or emancipation plan that outlines all of the services that are designed to ensure a successful transition to adulthood, and indicates who or what agencies will provide the services and time frames for completion of each phase of the plan.
Very little research has been conducted since early in the program’s development. Since 1997, The National Child Welfare Resource Center for Organizational Improvement at the University of Southern Maine and the National Resource Center for Youth Services at the University of Oklahoma have been working under an Anne E. Casey Foundation grant to conduct research on Independent Living Program services. These researchers make it clear that that they do not believe they are in a position to define best practices; rather, they provide suggested practices based upon their survey of programs across the United States.

Among the suggestions to policy makers and practitioners:

- Assist youth in identifying a mentor, relative or staff member who can provide ongoing support after the youth’s discharge from care.

- Assist youth in establishing, reestablishing or working through redefining their relationships with family members before discharge from care.

- Expand life skills training to provide greater focus on vocational training, computer training, driver’s education, and long-term academic planning targeted toward post-secondary education.

- Provide youth who are struggling educationally and who do not plan to pursue post-secondary education with the educational support necessary to complete a high school decree or General Education Development (GED) certification.

- Complete and review life-skills assessments with youth.

- Provide “real world” opportunities for youth to practice life skills.

**SETTING STANDARDS**

In 1989, the Child Welfare League of America developed *Standards for Independent Living*, and these standards have been incorporated into the Chafee Independent Living Program.

Among the standards are:

- Independent Living Planning requires a written plan.

- Youth should be involved in the planning process.

- The planning should begin as early as possible.

- Planning for emancipation or independence requires realistic time frames that take into account the lack of family stability for youth in out-of-home-care.

- Youth may require post-emancipation services.

- Foster parents and social workers must be available and willing to support and to serve as role models for youth.

- Biological families should be included in the planning process as much as possible.
RISKS IN TRANSITION

Research presents a clear picture of life after emancipation for many young men and women who age out of foster care. The findings of a 1991 Westat study of youth in foster care who were interviewed some 2.5 to 4 years after their cases closed are illustrative:

- 46 percent of the young adults had not finished high school.
- 40 percent were dependent upon some form of public assistance or Medicaid.
- 51 percent of those interviewed were unemployed.
- 42 percent had given birth or fathered a child.
- 38 percent were diagnosed as emotionally disturbed.
- 50 percent reported using illegal drugs after discharge from foster care.
- 25 percent reported having problems with the law.


DEVELOPING THE EMANCIPATION PLAN

Preparing for emancipation requires consistent monitoring of the adolescent's progress toward meeting the emancipation plan. It is imperative that the young person, and all significant adults in the young adult's life, are involved in the process. Who should be involved?

- The adolescent or young adult.
- Parents, other relatives or former foster parents who the adolescent identifies as important in planning for the future.
- The Guardian ad litem or attorney for the adolescent.
- A teacher or counselor involved in the adolescent’s education.
- If the adolescent has disabilities, a representative of the agency that the young person will transition to for services once the youth is no longer in the child welfare system.
- The assigned agency worker responsible for managing the adolescent's case.
- The worker assigned to the case from the Independent Living Program.
- Any other persons the youth determines are an important and appropriate participants in transition planning.

How is the plan developed?

It is critical that youth become leaders in the development and implementation of their emancipation plans. The ability to define goals, research options, and model after adults who are positive and significant in the youth's life will provide opportunities for the development of self-esteem and success as the youth moves toward emancipation.

Those who consistently participate in the planning process also have a greater sense of their own responsibility for their
development and the choices they make. They also learn to adjust their plan when barriers surface.

Through the planning process they learn to work with others in fashioning their future. Adolescents have the opportunity to improve their communication abilities, and their social and interpersonal relationships with peers and adults through the planning and implementation processes.

What must be included in the plan?

The law requires that each Independent Living Program include the following services:

- Education or training
- Employment
- Daily living skills
- Appropriate housing

Other suggested services include:

- Mentoring to provide youth in care with the role models needed to transition to adulthood.
- Assistance in maintaining or reestablishing connections with foster parents and relatives where appropriate.
- Legal services should be available when a need arises.

Each youth's written plan should include these services tailored to the abilities, needs and status of each adolescent.

Step 1: Education and Employment Assistance

All adolescents require consistent encouragement to compete and excel in high school, higher education, or vocational training. Direction and assistance are needed to gain practical experience in the world of work. In addition, education and employment planning require consistent exposure to options.

Adolescents in the child welfare system or the juvenile justice system need even more encouragement and assistance to
SERVICES
The following services are among the services available under the Chafee Independent Living Program:

- Assistance in obtaining a high school diploma.
- Career exploration, vocational training, job training and employment services.
- Training in daily life skills, budgeting, and money management.
- Substance abuse prevention.
- Preventive health care including smoking prevention, pregnancy prevention, and nutrition education.
- Preparation for post-secondary education.
- Mentors and interaction with other adults.
- Employment, financial, housing, counseling, education, and other appropriate supports and services for young adults ages 18 to 21 who were formerly in foster care.

complete high school because they are frequently behind academically and socially due to frequent placement changes or the circumstances that lead to their court involvement.

Research shows that they are more likely to drop out of school and are less likely to complete the GED. Meanwhile, the lack of an education limits their employment possibilities, leaving these youth at even greater risk for homelessness and poverty.

Planning must begin early to maximize benefits and ensure timely and substantial progress before emancipation. Judges, attorneys, and social workers must monitor each adolescent's progress toward completion of high school and post-graduation training or education. Judges, attorneys and social workers must monitor the youth's exposure to job opportunities and assist the young persons in determining whether those jobs provide career opportunities that will allow them to support themselves after emancipation.

Young adults also require guidance to explore vocational, educational and employment options based upon their interests and aptitudes.

The Role of Assessments
Vocational assessments and referrals to appropriate programs through the school system or the agencies responsible for workforce development are viable avenues to help the youth understand the importance of completing high school and providing training courses that are appropriate.

Each adolescent's emancipation plan should also address any special needs that would affect the youth's education or vocational training.

If vocational training, employment assistance and high school graduation can not be attained before emancipation, the emancipation plan should include a clear statement of the resources that will be available to the young adult after court supervision ends or Independent Living Program services are no longer available.
Step II: Daily Living Skills

Generally, youth learn basic daily living skills by practicing them in the home environment:

- One learns to cook by helping mom or dad in the kitchen.
- One learns to keep the home clean by having regular chores or responsibilities in the home.
- One learns to shop and manage money by assisting with the shopping and managing an allowance.

However, youth under court supervision may not be placed in settings that afford an opportunity to acquire these skills. To provide some training in daily living skills, most Independent Living Programs provide classes that cover the following topics:

- Budgeting and money management.
- Parenting and sexual responsibility.
- Effective communication.
- Health and hygiene.
- Safety.

In addition, many school programs provide instruction in these areas. However, the training provided in the classroom setting often assumes that the principles learned will be practiced in the home environment. Experts agree that adolescents need the opportunity to apply the classroom training in their daily lives if training is to be effective.

Step III: Housing and Other Transitional Services

Housing can be a difficult service to secure for young adults aging out of care. Many landlords are not willing to risk renting to 18- to 21-year-olds with no housing references or employment history. Often youths do not have enough income to qualify for an apartment in most urban areas.

Many youth return to family members for housing assistance once they have aged out of foster care. However, many more run the risk of homelessness soon after their emancipation.

SERVICES CONT’D

- Room and board for young adults who left foster care at age 18 and required additional services to age 21.

because they have no family ties that can offer consistent housing or financial assistance to stave off homelessness.

The Chafee Independent Living Program allows states to provide room and board assistance to youth who have aged out of foster care at ages 18 to 21.

Housing Assistance is also available through the U.S. Department of Housing and Urban Development are special programs to assist 18- to 21-year-olds for 18 months as they age out of foster care.

**MONITORING WELL-BEING**

The following questions should be addressed in the emancipation plan and monitored throughout the transition process:

- What is the current living arrangement for the adolescent? Group home? Foster home? With parent(s) or other relatives?
- Does the adolescent have any special needs that must be addressed in developing daily living skills?
- Does the adolescent have a developmental delay or mental illness that will allow continued placement through an adult protection system? Can the current foster parents qualify as caretakers under the adult protection system?
- If the adolescent plans to remain with a long-term foster parent after emancipation, what resources will be available to her to assist in her support?
- Is the adolescent a parent? Does the adolescent have physical custody of the child? Does the adolescent pay child support? Does the adolescent have visitation with the child? Will issues of child support and custody need to be resolved before the adolescent is emancipated?
- Does the adolescent have any issues that may require legal assistance? Who will provide the services? Has the adolescent been informed and made familiar with the contact for legal services?
Does the adolescent have a birth certificate and social security card? Has she received instruction on how to replace these documents if they are lost or stolen?

**Education**

- When will the adolescent complete high school? From what school? Will the adolescent receive a high school diploma or certificate of completion?

- If the adolescent will not complete high school, will he seek a GED? When will he begin the course work? What will be the completion date? When will he take the examination?

- Has the adolescent received a vocational assessment? What were the results?

- What career or vocational opportunities is the adolescent interested in pursuing? What programs would be appropriate?

- Has the adolescent been counseled regarding available training opportunities in his areas of strength? Have timeframes been set for completing any prerequisites before enrollment in a training program? What are the prerequisites? What agency will be responsible for providing training opportunities? Should other agencies be involved?

- Is the adolescent interested in pursuing a college education? Has the adolescent received assistance in preparing for the college entrance examinations?

- What college is the adolescent interested in attending? When would she begin? Would her education be completed prior to emancipation? What financial assistance will be available to her after emancipation?

**Employment**

- Has the adolescent ever been employed? Where? What was the rate of pay?

- What employment opportunities are currently available to the adolescent? Number of hours each week? Rate of pay?
• Are employment mentoring services available to the adolescent through the Independent Living Program, vocational training program, or college and university services?

**Life Skills**

• Is there a written plan that outlines what daily living skills (e.g., cooking, cleaning, laundry, shopping) will be mastered by the adolescent within each case review period? Does the plan outline who is responsible for guiding and monitoring progress in this area?

• When will the adolescent be provided drivers’ training? If no training is to be provided, why not?

• Has the adolescent participated in a life skills evaluation or inventory? When? What instrument? What were the results? Were the results reviewed with the adolescent?

• What services are needed based upon the evaluation or inventory? Who will provide the services? Based upon the assessment, how long will the services be necessary? When will a reassessment be conducted?

• If needed, have referrals been made to adult systems that can provide services to the adolescent? Is the adolescent eligible for rehabilitative services through an adult protection system?

**Financial Issues**

• Is there a written financial plan to ensure sound saving strategies between ages 14 to 21? What is the plan? Does it detail who will make contributions, how frequently, and how much will be saved from jobs the adolescent secures?

• Does the adolescent have a bank account (e.g., savings, checking)? Where? Who monitors status of the account?

• Is the adolescent eligible for Social Security Disability Income payments? Has the application been submitted?

• Does the adolescent have any financial resources available to her after emancipation (e.g., survivor social security benefits
accrued while in care, inheritance, settlements from law suits)? Will the financial resources affect her ability to continue to receive Chafee Independent Living Program services after emancipation?

- Does the adolescent have the capacity to manage money, or will assistance be necessary after emancipation? Will formal assistance be needed through the court (guardianship or conservatorship) or through an adult protection system?

**Health**

- Has the adolescent received training in accessing health care? Does she know who her primary care physician is and how to contact the doctor?

- Does the young adult understand any medical or mental health issues that currently exist? Does the young adult understand the treatment requirements?

- Is the adolescent eligible for Medicaid? Does he have a Medicaid card or other proof of health coverage? What steps must be taken to apply for or receive the card?

- What steps have been taken to help the young adult manage existing medical, dental and mental health needs?

- Was the young adult given information regarding health care financing options once he is no longer eligible for Medicaid?

- Was the young adult given medical history information prior to emancipation?

**Housing**

- Has the agency worker or independent living counselor assisted the adolescent in determining how much money will be needed each month and year to live after emancipation?

- Will the adolescent be ready to move into an apartment and manage her own living environment before emancipation? What will be used to measure her readiness for apartment living?
• What are the adolescent’s views and feelings regarding apartment living? Is the adolescent open to sharing housing costs with a roommate? Can the adolescent identify a person to share housing costs?

• What are the adolescent’s views regarding the housing plan?

• What housing assistance will be provided to the adolescent as he moves toward emancipation?

• On what date will the adolescent be responsible for paying housing expenses without assistance?

• Does the adolescent or young adult have a relationship with anyone who might serve as a roommate during the transition period?

• Are there any relatives with whom a shared living arrangement would be appropriate and supportive for the adolescent?

• Does the adolescent have any special needs that would require specialized housing arrangements through an adult protection system?

• Should the adolescent be referred for subsidized housing services? Is the young person eligible for short-term housing assistance under HUD programs? How will the youth access the programs?

• Has the young adult been provided with a list of community resources to assist with medical care, housing, mental health and employment before emancipation?

After Emancipation

• Does the young adult know what services are provided under the Chafee Independent Living Program? Has the young adult been provided addresses and phone numbers of agencies that can provide services?

• Does the young adult know whom to contact for assistance after emancipation?
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PART IV: THE ROAD TO EMANCIPATION


Appendix A

THE LAW

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES

42 USC SECTION 1396D(R)

The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services—
   (A) which are provided—
      (i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines and
      (ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and
   (B) which shall at a minimum include—
      (i) a comprehensive health and developmental history (including assessment of both physical and mental health development),
      (ii) a comprehensive unclothed physical exam,
      (iii) appropriate immunizations (according to the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines) according to age and health history,
      (iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and
      (v) health education (including anticipatory guidance).
(2) **Vision services**—
(A) which are provided—
(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) **Dental services**—
(A) which are provided—
(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and
(ii) at such other intervals, indicates as medically necessary, to determine the existence of a suspected illness or condition; and

(4) **Hearing services**—
(A) which are provided—
(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) **Such other necessary health care, diagnostic services, treatment, and other measures**
described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this subchapter shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services.
42 CFR Sec. 441.56

Required Activities

(a) Informing. The agency must—

(1) Provide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals (or their families) about the EPSDT program.

(2) Using clear and nontechnical language, provide information about the following—
   (i) the benefits of preventive health care;
   (ii) the services available under the EPSDT program and where and how to obtain those services;
   (iii) that the services provided under the EPSDT program are without cost to eligible individuals under 18 years of age, and if the agency chooses, to those 18 or older, up to age 21, except for any enrollment fee, premium, or similar charge that may be imposed on medically needy recipients; and (iv) that necessary transportation and scheduling assistance described in sec. 441.62 of this subpart is available to the EPSDT eligible individual upon request.

(3) Effectively inform those individuals who are blind or deaf, or who cannot read or understand the English language.
Appendix B

A REFERENCE GUIDE TO
PROFESSIONAL HEALTH STANDARDS

The American Medical Association (AMA) has published
*Guidelines for Adolescent Preventive Services* (GAPS).

**GAPS**

Although framed as recommendations, the AMA’s *Guidelines for Adolescent Preventive Services* (GAPS), Arthur B. Elster M.D. and Naomi J. Zuznets, Ph.D. Editors, are substantive and direct. They have been systematically implemented in many school and clinical settings. The AMA has developed GAPS training for health care providers. The AMA recognizes that one use of GAPS is as a standard of care. It should be understood that GAPS is a minimum standard of preventive care applicable to all youth, and that more intensive health services are needed by at-risk youth in foster care.

**GAPS provides 24 recommendations for preventive health care in four general areas:**

- Health care delivery
- Health guidance
- Screening
- Immunizations

**Topics include:**

- Diet
- Psychosexual adjustment
- Hypertension
• Use of tobacco, alcohol, and drugs
• Depression
• Suicide
• Sexual and emotional abuse
• Learning problems
• Infectious diseases

The full text of GAPS recommendations can be found on the web at http://www.amaassn.org/ama/pub/category/2279.html.

Several agencies of the Department of Health and Human Services have developed Bright Futures, a series of publications that describe best practices for assessing teen health.

Bright Futures

Bright Futures is the popular name for Guidelines for Health Supervision of Infants, Children and Adolescents, Morris Green, M.D. Editor. It is sponsored by the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services, as well as the Medicaid Bureau and the Health Care Financing Administration. Bright Futures analyzes health needs from three different points of development: early, middle, and late adolescence.

Bright Futures gives descriptions that are informative for non-medical professionals. The descriptions are placed in the context of an adolescent’s actual development (physical, sexual, cognitive, social, and emotional). There are also narrative descriptions of normal adolescent development and areas of vulnerability. There are reader-friendly charts that can be taken in at a glance. Finally, there are descriptions of what should occur during a physical examination, a list of the additional screening procedures for high-risk youth, and a list of immunizations that must be up-to-date. For example, in early adolescence, all youth should be screened for age-appropriate development, scoliosis, acne, dental anomalies, evidence of abuse, sexual maturity, and reproductive issues. There should be up-to-date immunizations for Hepatitis B, Measles, Mumps, Rubella, Tetanus, and Diphtheria. In addition, risk factors for certain diseases and impairments are described, and the screening that should follow if they are present. That might require screening for vision, hearing, (but note that these are required EPSDT screenings) TB, blood pressure, hemoglobin, hyperlipidemia, sexually transmitted diseases (STDs), HIV, and behavior problems.
Bright Futures advises additional screening procedures if a problem is uncovered or if a teen confides a concern. Given the vulnerability of the foster care population, most of the additional screenings are appropriate.

For example, vision is to be tested “if adolescent is not tested at school or reports problems.” Hearing is to be screened “if adolescent is exposed to loud noises regularly.” STDs are to be screened “for sexually active adolescents.” HIV screening is to occur “if the adolescent asks to be tested,” or if certain risk factors are present such as “sex in exchange for drugs or money,” or for males “sex with other males.”

However, Bright Futures does not offer guidance to the physician to consider nutrition, mental health, or special education. Therefore the best use of Bright Futures for a teen covered by Medicaid, or Medicaid-expansion, would be to support the EPSDT law. For youth covered by an alternative insurance program, Bright Futures could be used in combination with GAPS and Guidelines for Health Supervision III to describe how Federal government policy, combined with standards developed by professional medical organizations, supports a holistic and comprehensive approach to teen health.

The American Academy of Pediatrics has published Guidelines for Health Supervision III, which provides clinical guidance for physicians.

Guidelines for Health Supervision III

The American Academy of Pediatrics has published clinical guidance for physicians that describes the health assessment, physical examination, developmental observation, tests, immunizations, and guidance that should be delivered at different stages of adolescent development. The Guidelines do not go beyond the approaches in GAPS and Bright Futures. Instead, the Guidelines are aimed directly at primary care physicians; they succinctly state what tests are to be performed and what questions are to be asked of the teen. Its guidance is tailored to developmental stages, separately covering years 10–11, 12–13, 14–15, 16–17, and 18–19.

Guidelines for Health Supervision III may be useful in examining the pediatrician as a witness. The inquiry is whether the witness follows the Guidelines. The Guidelines also provide support for GAPS and Bright Futures in that they do not contradict any position in the other documents. Finally, the Guidelines demonstrate that the American Academy of Pediatrics stands shoulder to shoulder with the AMA on issues important to foster children.
The American Psychiatric Association has published standards for diagnosis of cognitive, behavioral, and emotional disorders in the *Diagnostic and Statistical Manual-IV-TR* (DSM IV-TR).

The *Diagnostic and Statistical Manual of Mental Disorders, Text Revision, 4th Edition* (known as DSM-IV-TR)

This manual is the standard reference for all mental health professionals in the United States. The DSM-IV-TR classifies mental illnesses and behavioral disorders. While not primarily focused on adolescent issues, it does refer to teens and distinguishes the application of adult diagnoses to adolescents. Diagnoses in mental health evaluation reports submitted to the court should be based on the DSM-IV classification. The diagnostic classifications and multiaxial assessments are described in plain English. Diagnoses are grouped in such categories as “Substance-Related Disorders” and “Schizophrenia and other Psychotic Disorders.”

Psychiatric and psychological reports usually offer a provisional diagnosis, often identifying it by number and assigning the diagnosis to either Axis I or Axis II of the five axes, which provide an assessment of whether the person has a clinical disorder (Axis I), personality or developmental disorder (Axis II), the status of the person's physical health (Axis III), statement of psychosocial and environmental problems (Axis IV), and the person's overall functioning (Axis V). Diagnoses are thoroughly explained in the text of the DSM-IV-TR, listing the combination of factors that must be present to make any finding. These descriptions can help judges, lawyers, and other advocates who are trying to determine the adequacy of an evaluation.

The Federal government has published the results of its studies on advances in assessment and treatment in *Mental Health: A Report of the Surgeon General, Chapter 3.*

*Mental Health: A Report of the Surgeon General*

Other Sources

For youth with significant illnesses, standards of care have been developed by Federal organizations such as the National Institutes of Health and the Centers for Disease Control and Prevention. On-line resources often are the most up-to-date for standards of care in today's rapidly evolving areas of medical treatment. Check the website at http://www.cdc.gov for information about standards on STD diagnosis and treatment; Tuberculosis testing and treatment; Pelvic Inflammatory Disease; HIV counseling, testing, and risk assessment and reduction counseling; Health Resources and Service Administration (HRSA); and the HIV/AIDS Treatment and Information Service (HIV/ATIS). Check the website at http://www.hvatis.org for the latest HIV Treatment Guidelines for Adults and Adolescents.
# Appendix C

SCHIP AND MEDICAID CONTACT INFORMATION FOR ALL 50 STATES AND THE DISTRICT OF COLUMBIA

The INSURE KIDS NOW! national toll-free hotline (1-877-KIDS-NOW/1-877-543-7669) can also connect you to your state for SCHIP and Medicaid information and applications. All 800, 877, and 888 phone numbers are toll-free.

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<td>All Kids</td>
<td>Medicaid 888-373-KIDS (888-373-5437) 800-362-1504</td>
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<td>California Healthy Families/Medi-Cal 800-880-5305</td>
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<td>Colorado CHP+ (Child Health Plan Plus) Medicaid 800-359-1991 800-221-3943</td>
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<td>PeachCare for Kids Medicaid 877-GA-PEACH (877-427-3224) 800-246-2757</td>
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<td>Children's Health Insurance Program Medicaid 800-926-2588 888-239-8463</td>
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<td>NC Health Choice</td>
<td>800-367-2229</td>
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<td>North Dakota</td>
<td>Healthy Steps Program</td>
<td>888-222-2542</td>
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<td>Ohio</td>
<td>Healthy Start</td>
<td>800-324-8680</td>
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<td>Oklahoma</td>
<td>SoonerCare</td>
<td>800-987-7767</td>
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<td>Medicaid</td>
<td>800-522-0310</td>
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<td>Oregon</td>
<td>Oregon Health Plan</td>
<td>800-359-9517</td>
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<td>Medicaid</td>
<td>800-943-9249</td>
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<td>Pennsylvania</td>
<td>Children’s Health Insurance Program</td>
<td>800-986-KIDS</td>
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<td>(800-986-5437)</td>
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<td>Rhode Island</td>
<td>RIteCare</td>
<td>800-346-1004 (English)</td>
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<td>800-299-8444 (Spanish)</td>
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<td>South Carolina</td>
<td>Partners For Healthy Children</td>
<td>888-549-0820</td>
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<td>Child Health Insurance Program</td>
<td>Call your local department of social services office for assistance.</td>
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<td>Medicaid</td>
<td>800-452-7691</td>
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<td>Tennessee</td>
<td>TennCare</td>
<td>800-669-1851 (English)</td>
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<td>800-258-7568 (Spanish)</td>
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<td>Utah</td>
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<td>Vermont</td>
<td>Dr. Dynasaur</td>
<td>800-250-8427</td>
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<td>877-VA-CMSIP</td>
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<td>West Virginia</td>
<td>WV Children’s Health Insurance Prgrm</td>
<td>888-WV-FAMILY</td>
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<td>Wisconsin</td>
<td>BadgerCare</td>
<td>800-362-3002</td>
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<td>Wyoming Kid Care</td>
<td>888-996-8786</td>
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<td>Medicaid</td>
<td>800-251-1269</td>
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<td>For more information, contact</td>
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<td>Alexandra Yoffie at 202-942-0336 or e-mail</td>
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<td><a href="mailto:schip@cwla.org">schip@cwla.org</a>.</td>
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Index

A
abortion 26
abused and neglected youth 2, 4, 6, 7, 13
Adoption and Safe Families Act (ASFA) 5, 7, 19, 20, 41, 42, 4420, 46
American Academy of Pediatrics 5, 25
American Correctional Standards for Accrediting Juvenile Facilities 19
American Medical Association 26
American Nurses Association 26
American Psychiatric Association 31
American Public Health Association 26
Anne E. Casey Foundation 59
anorexia nervosa 28, 33, 35

B
behavioral development 9, 17
birth control 17
birth families, relatives 41, 57, 58, 60, 61, 64, 68
budgeting and money management 62, 63
bulimia 28, 33, 35

C
case plans 20, 21, 31, 48, 49, 53, 57-62, 66
see also emancipation plans
Casey Family Programs 16
Centers for Disease Control and Prevention (CDC) 17, 18
Chafee Independent Living Program 59, 62, 63, 64, 67, 68
Child Welfare League of America 4, 6, 7, 40, 19, 28, 30, 59
chronic conditions 42-43
cognitive development 10
Committee on Pediatric AIDS, American Academy of Pediatrics July 2000 25
common medical conditions found in the foster care population 22
common medical conditions found in the juvenile justice population 23
community 2, 3, 4, 12, 14, 16, 18, 22, 37, 40, 55, 68
confidentiality 25, 26, 31, 45
Court Appointed Special Advocates (CASA) 2
Cultural issues 16, 52
see also ethnic identity, racial identity

daily living skills,
see life skills
dating 11
dental 3, 4, 5, 7, 40, 43, 45, 50, 51-52, 55, 67
developing a sense of identity 13, 14-16
DSM-IV 28
E

eating disorders 28, 32, 33
see also bulimia and anorexia nervosa
education 65-66, 69
educational assessment 38
educational evaluation 38
emancipation 61, 64-65
emancipation plans 57-62, 66
see also case plans
emotional development 13
emotional growth 9, 11, 13
employment 1, 12, 39, 57, 58, 61, 62, 63, 64, 65, 66, 68,
etnic identity 16
ethnic identity testing 16

G

gay and lesbian adolescents 14-15
General Education Development (GED) 59, 65
growth spurt 9

H

hygiene 52, 63
hearing 3, 4, 7, 13, 43, 40, 45, 48
high blood pressure 32, 33
high cholesterol 33
high-risk behavior 12, 13, 17, 40
HIV/AIDS 4, 18, 25-27, 36, 40, 45, 43
Homeless, homelessness 25, 58, 62, 63, 64
housing 57-58, 61-64, 67-68

I

immunizations 21
Independent Living Act of 1999 58, 61

Individualized Education Plan (IEP) 38-39, 48, 53-54
Individuals with Disabilities Education Act (IDEA) 30, 38-39
informed consent 25, 26, 45
initial screening 22, 28

J

Juveniles 6-7, 19, 23-25
Juvenile detention 4, 5, 6, 14, 19, 23, 25, 38, 42
Juvenile justice 2, 5, 6, 7, 14, 24, 25, 29, 61

L

language 38, 40, 48
learning disabilities 6, 13, 14, 37, 38
legal services 61
life skills 57, 59, 66

M

Mandatory and Optional Title XIX Medicaid Services 55
Medicaid 6, 7, 19, 25, 26, 29, 30, 36, 37, 42, 43, 45, 46, 48, 50, 54, 55, 60, 61
medical care 19, 21, 33, 37, 42, 45, 55, 68
medical histories 22
mental health 3, 7, 29, 30, 31, 34, 40, 42, 45, 46, 48, 49, 50, 67, 68
mental health diagnostic standards 28
mental illness 29-30
mentor, mentoring 59, 61, 62, 66
moral development 10
N
National Association of Social Workers 26
National Child Welfare Resource Center for Organizational Improvement 59
National Foster Care Awareness Project (NFCAP) 63
National Longitudinal Study of Adolescent Health 3
National Resource Center for Youth Services at the University of Oklahoma 59
National Survey of America’s Families 35
neglected and abused youth  
see abused and neglected youth
nutrition 32, 43, 48, 51, 55, 62

O
obesity 32-34, 43, 51
oral health 35-36

P
parenting 1, 57
permanency 5, 21, 41, 44, 57
Personal Responsibility and Work Opportunities Reconciliation Act of 1996 42
physical development 9
physical health 4, 32, 41, 42, 45
pregnancy 17, 24, 26, 27
preventive care 22, 33
privacy 26-27
psychological evaluation 38, 46
puberty 9-10

R
racial identity 16
see also ethnic identity, cultural issues
racial identity testing 16
reasonable efforts 7, 21, 41, 44
reproductive health care 26, 46
risk taking 2, 17, 31
risks in transition 60

S
safety 5, 7, 20, 63
State Children’s Health Insurance Program (S-CHIP) 26, 30, 54
school failure and drop out 18
self-concept 13-15
self-esteem 11-14, 35
sex education 24
sexual and reproductive health 19, 24-27, 44-45
sexual development 24
sexual identity 14-15
sexual orientation 14-15
sexual responsibility 63
sexually transmitted diseases (STDs) 14, 18, 45
social development 9, 11, 12
Social Security Act 19, 20, 42
social security 54, 65, 66
special education 19, 37-38, 433, 52, 53
Standards for Independent Living 59
standards of practice 40, 50-51
substance use and abuse 17, 18, 25, 31, 45, 43, 49
suicide 15, 31, 46
Surgeon General’s Report on Nutrition and Health 32
surrogate parents 38
INDEX

T

teen and work 12
teen with disabilities 3, 6, 13-14, 37-38, 41, 52, 60
termination of parental rights 32
therapy 37, 47-49, 55
Title IV-E foster care 5, 20-21, 24-25, 29, 36, 39
transitional services 39, 44, 63
treatment plan 29, 44, 47, 49-50, 53
tuberculosis 5, 22-23, 43

U

U.S. Department of Health and Human Services Center for Substance Abuse Treatment 31
U.S. Department of Health and Human Services, Administration for Children and Families 1, 13, 49
U.S. Department of Housing and Urban Development (HUD) 68

V

violence 18, 30
vision 3, 4, 43, 45, 38
vocational 53-54, 59, 61, 62, 65, 66

W

weight-related orthopedic problems 33
well-being 19, 41, 68
Westat study 1991 60
Health for Teens in Care, A Judge’s Guide

ASFA meets Medicaid law

The Medicaid Early and Periodic Screening, Diagnostic, and Treatment law, 42 USC sec. 1396d(c), requires comprehensive health care for Medicaid-eligible youth. Meanwhile, the Adoption and Safe Families Act (ASFA) has changed the focus of child welfare agencies and the courts to permanency for children who have been removed from their homes while emphasizing “well-being” and “safety” for all children under the court’s jurisdiction. The Foster Care Independence Act of 1999 has provided additional opportunities for assistance and support as adolescents move toward emancipation.

*Health for Teens in Care* is designed to help judges, attorneys, and social workers ensure that the monitoring of safety and well-being of adolescents includes comprehensive health care screenings; and the diagnosis and treatment of physical, dental, nutritional, and emotional health issues on a consistent basis.

To achieve compliance with ASFA, Medicaid, and the Foster Care Independence Act of 1999:

- Should the judge question the agency worker regarding the health issues presented in their cases?
- Should the information regarding medical, dental, nutritional, psychological/behavioral, sexual development/activity be available to the court in mandated court reports?
- Should updated health information be included in each teen’s case plan?
- Should the court inquire regarding these issues during the hearing?
- Should the judge consider entering a finding that the agency has not made reasonable efforts to achieve permanency if health and education issues have not been adequately addressed by the agency?
- Should the judge monitor the progress of the adolescent’s transition to independence or emancipation?

*Health for Teens in Care* will help you answer these questions and more.