INDIANA

CENTER FOR URBAN POLICY AND THE ENVIRONMENT OCTOBER 2004

Improvements in State Foster Care System Would Aid Children with Special Needs

According to the Indiana Family Social Service Administration, there were 28,428 cases of child abuse and neglect substantiated in the state in 2003, and approximately 7,700 children were in foster care.[1] Most foster children are victims of abuse and neglect, and they are far more likely than other children to suffer from disabilities and significant medical problems. Sullivan and Knutson (2000) showed that children with an identified disability are 3.4 times more likely to be maltreated. (The rate of children with disabilities in foster care may be even higher than reported because nationally and locally, there is no uniform system to record the numbers.[2])

When children enter foster care, the state has an obligation to provide measures to remedy damage caused by direct abuse or neglect. Failure to do so obviates the reason for the intervention taken by the social agency. Because of this obligation and the high proportion of children with special needs in foster care, it is important to examine the issues that uniquely affect these children. Improvements in the system can potentially help all children in state care.

Indiana legislators and child services agencies are currently working to update the child protection system and address the medical and social needs of children who are under state supervision. In 2003, the Indiana General Assembly created the Indiana Commission on Abused and Neglected Children and Their Families (Commission). This Commission is chaired by Dean Michael Patchner of the Indiana University School of Social Work and includes representatives from all facets of the child protective system. The creation of this task force was an important step toward improving the current system. The task force presented their report in August 2004 to representatives from the Indiana House and Senate and Governor Kernan, and included 32 recommendations for improving Indiana's child protection system.

This issue brief examines some of the concerns that most significantly affect children under state supervision or care who have disabilities or special medical needs. These children have unique needs in three broad areas: medical care, educational needs, and caregiver/caseworker training.

Continued on page 3

This issue brief is the first in a series that the Center for Urban Policy and the Environment will produce jointly with other centers at Indiana University–Purdue University Indianapolis. This report was developed in cooperation with the William S.and Christine S.Hall Center for Law and Health.

Please see page 7 for more information about the William S.and Christine S.Hall Center for Law and Health.

Reforms Could Prevent Many Tragedies

Incidents in the news have demonstrated that states sometimes fail children in foster care. No state has a perfect foster care system, but the improvements described in this issue brief and those recommended by the Indiana Commission on Abused and Neglected Children and Their Families might have prevented the tragedies described in the following three cases.

New Jersey: In 2003, a man thought he heard an animal digging through his garbage, and instead, he found a ravenous 45-pound 19-year-old boy foraging for food. The boy was one of six children who had been adopted by a couple who were collecting $400 a month from the state of New Jersey for each adopted child. Authorities subsequently charged the couple with aggravated assault and child endangerment. caseworker who visited the home 38 times had not reported problems, and the adoptive parents claimed that the boy and three other emaciated younger boys had eating disorders that had predated their placement with the family. The boys were placed with other families and within four months, each had gained between 15 to 33 pounds and grown in height from 1.5 to 6.5 inches.[1,2]

A Midwestern Community: A state child welfare department sent a one-year-old girl who needed constant medical attention for ongoing epileptic seizures to a foster home that the state knew was inadequate. A caseworker who supervised the home had called the home "marginal," and recommended that it be used only for short-term temporary placements. Later, the child's caseworker reported that the foster parents were not bringing the child to her scheduled medical appointments. But again, the child welfare department did not respond. Finally after more than two years and pressure from the child's physician, the state found a new foster home for the child. By this time, the child, now three and one-half years old, had received no treatment for her epilepsy and had developed additional medical problems. Even after the state registered an official finding of abuse against the home for neglect of this child, the agency continued to use the foster home as a placement for other abused and neglected children.[3]

Florida: In 2002, the public was outraged when the media reported that 5-year-old Rilya Wilson had been missing from her foster home for more than a year before anyone noticed. The Florida Department of Children and Families said that the caseworker filed false reports of monthly visits with the child and the DCF supervisor failed to review the case. The foster mother, who had twice been convicted of fraud and theft, asserted that the child had been taken from her care a year before by a woman claiming to be a DCF worker.

Subsequently, ABC news reporters discovered that hundreds of children have been "lost" by Florida's child-welfare system. In response, attorneys filed a lawsuit against the state, citing details about problems that include failure to visit foster children and placements in abusive foster homes.

It appears that most of the "lost children" in Florida are teenagers who chronically cycle in and out of the state's foster-care system. In May 2004, ABC News quoted Dr. George Rahaim of the Department of Children and Families who said there should be no confusion about the inadequacies in Florida's foster-care system. "It has gotten worse over time," Rahaim said in a videotaped deposition. "It is worse now, in my opinion, than it ever has been."[4]

[1] CBSNews.com. (2003, October 28). *NJ's Starving Kids Horror Story*. Accessed from www.cbsnews.com/stories/2003/10/28/eveningnews/main580586.shtml

[2] CBSNews.com (2004, May 5). *N.J. Starved-Kids Couple Indicted*. Accessed from www.cbsnews.com/stories/2003/09/30/national/main575794.shtml

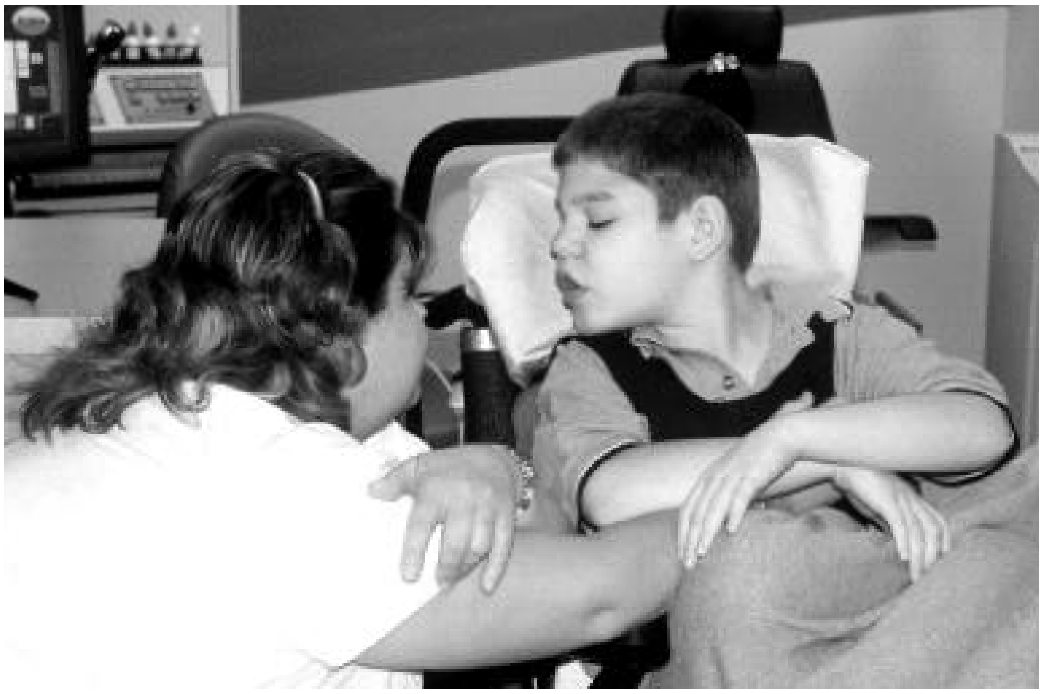
[3] Michael B. Mushlin, (1988). *Unsafe Havens: The Case for Constitutional Protection of Foster Children from Abuse and Neglect*, 23 HARV. C.R.– C.L.L.REV. 199, 199-200.

[4] Brian Ross. (2004, May 16). *The Lost Children: Fla. Official Says Hundreds of Foster Kids Have Been Lost*. Accessed September 22, 2004 from ABC News Web site from http://abcnews.go.com/sections/GMA/GoodMorningAmerica/gma020516FlaLostKids.html)

Continued from page 1

Consistency of medical care helps children with special needs

Children with special medical needs or developmental disabilities benefit from a *medical home,* a primary pediatrician or family practitioner who can follow the child as long as the child is in state care. A medical home physician would provide consistent monitoring of a child's health and developmental needs even if placement changes are necessary. Changes in environment may cause a subtle difference in a child's health or mental status that may not be recognized by new caregivers who do not know the child well. A consistent medical care provider can monitor the child for physical and psychological changes and help transfer important information to new foster parents. All children in long-term placement, not just those with special needs, would benefit from consistent medical care.[3]



Indiana currently has some provisions in place for medical continuity. Under Indiana law, the foster child should have a "medical passport." The medical passport program requires that:

- the state or county division must maintain a record of medical care given to the child,
- the division must assist the provider in providing appropriate care to the child,
- foster parents are allowed to authorize routine and emergency medical care for their foster child, and
- forms are given to the provider to submit to the county office.[4]
- Children must have the passport with them until they are either returned to their natural parents, adopted, or placed in another permanent plan.[5]

While the medical passport does respond to one concern regarding continuity of care, the transfer of medical records, it does not provide for an assessment of the child with medical difficulties. With the medical passport, a new doctor (provider) receives information about the child's past medical care as well as the former doctor's recommendations for future care. In addition, the records are kept by the office that oversees the child's placement in state care. However, the system still does not provide for some important subtleties of medical care for children with special medical needs. The medical passport fails to address that a new doctor may not understand the intricacies of that particular child's behavior, especially if the child is not verbal and cannot express feelings or fears. The passport program takes care of major changes in a child's psychological or physical state that a former doctor may mention in the reports, but it does not cover changes that a new doctor would miss due to unfamiliarity with a child. A medical home model paired with the medical passport would address both of these concerns.

However, barriers to implementation of a medical home do exist. Foster parents may have difficulty traveling to the medical home physician if a child is later placed in a different part of town from the original placement. Additionally, a foster parent may have an existing relationship with a pediatrician or family practitioner and prefer to use that doctor. The burden also may be greater on caseworkers to ensure that each child with a disability or special medical need has been assigned a medical home.

In addition, some children not originally identified as having a special need may be identified later. The caseworker would then have to be responsible for implementation later in the process.

Early medical evaluations help identify children with special needs

To determine the immediate medical and psychological needs of children entering foster care, each child should receive an initial medical and developmental evaluation as soon as possible after entering state care.[6] In addition, the American Academy of Pediatrics (AAP) recommends a second more comprehensive medical evaluation within 30 days of placement in foster care.[7] The AAP recommends that, at a minimum, the comprehensive evaluation should include an assessment of these areas:

- gross motor skills,
- fine motor skills,
- cognition,
- speech and language function,
- self-help abilities,
- emotional well-being,
- coping skills,
- relationship to persons,
- adequacy of caregiver's skills, and
- behaviors.[8]

Completed evaluations can serve as a tool in planning appropriate care and placement for children.

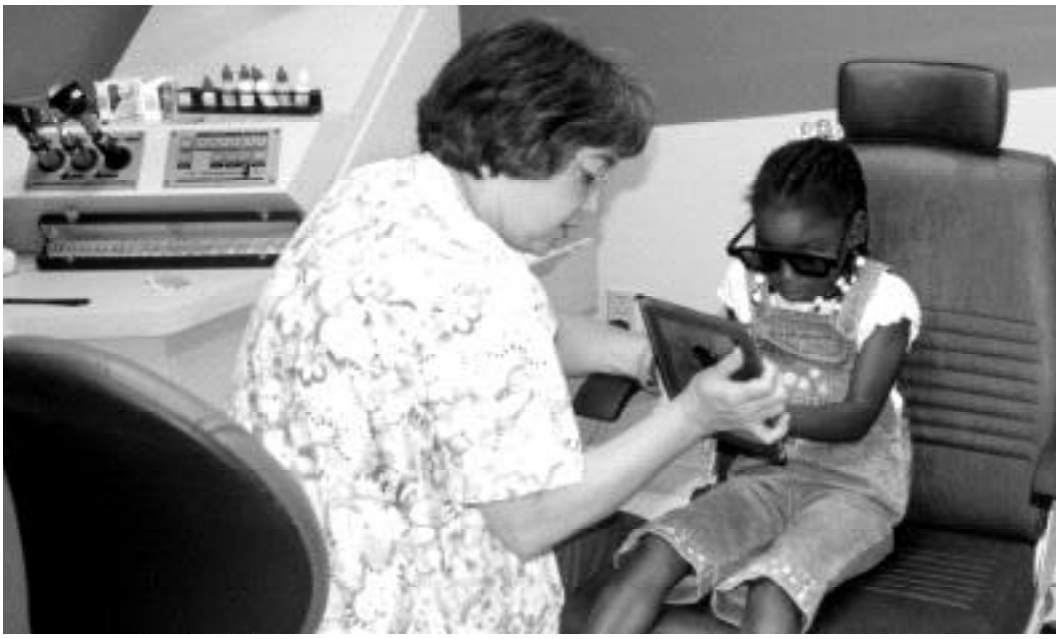
Child placement agencies already are obliged to provide physical exams when children enter their care, but a uniform requirement of a physical examination upon removal from the home would be beneficial.[9] Potential barriers include the cost of the evaluations, cost of monitoring to ensure that these exams occur, additional cost of services that may be recommended as a result of these exams, and additional burdens on foster parents. Once special needs are identified, a system to ensure provision of appropriate care is necessary.

Early intervention services can help alleviate developmental issues

It has long been recognized that a child's brain develops most rapidly from birth to age three or four.[10] Circumstances such as neglect that force a young child to miss the nurturing and stimuli necessary to form good relationships and the ability to adapt to new surroundings are detrimental to long-term health.[11]

New primary caretakers often have not been involved in the early care of their foster child and may lack the experience needed to understand how the child is progressing, especially if they have assumed the care of one of the many children in foster care who have special needs.

It would be useful if children age birth to three could be referred for evaluation to the state early intervention program (First Steps) under the Individuals with Disabilities Education Act.[12] Some of these children will be found to have no need for services, but a minimal evaluation can be reassuring to various representatives of the legal system and the original family. If a child has had



sufficient emotional or physical trauma to result in foster care placement, the child's risk for developmental issues is serious enough by itself to reasonably justify referral. Indiana's First Steps program allows for children at risk for disabilities to be referred under certain circumstances.[13]

Barriers to implementation of the First Steps referral would be cost of services, foster parent hardship, potential overutilization of

the First Steps services, and the cost of monitoring to ensure that services take place. Cost of services may be the greatest and most obvious barrier. Unfortunately, the ultimate cost of not finding (and treating) children with medical, psychological, or developmental problems is far more costly to the state and the children involved. Without automatic evaluations, some children who need early treatment will not be found, and the chance to help these children during the crucial early years when the brain is rapidly developing would be lost. It is likely that this recommendation will require additional study and cost/benefit analysis.

Educational and medical surrogates should be assigned at time of placement

Educational and medical surrogates can be appointed to ensure that a child has access to educational programming and immediate evaluations when needed.

Educational surrogates

If there is any question as to who the educational surrogate may be, delays may occur in education that could severely disadvantage the child. While the current Indiana Administrative Code does not allow a judge or court to assign an educational surrogate, it does allow such an appointment by a public agency (defined as a public school corporation, a community agency, a program operated by the state Department of Health, the Indiana schools for the blind or deaf, or a program operated by the Department of Correction[14]). The court can, however, bring attention to the need for an educational surrogate to be appointed.

Officials in the school system can work closely with the court system if the proper person for an educational surrogate is apparent at the time of placement, which is not always the case. The delays that occur in the current system for assignment of an educational surrogate are too costly to ignore. A change in the appointment process that is allowable within the regulatory system may prove very helpful to children in this situation.

Medical surrogates

Under the medical passport program, the foster care provider is empowered to make medical decisions for the child.[15] The current system does not consider the possibility that a biological parent may be able to fulfill this role in some circumstances. Unfortunately, if there is any ambiguity as to who the decision-maker should be, there may be delays in services for the child. The court should consider this question at the time of placement

to ensure that everyone is clear regarding this issue and to avoid possible delays.

A requirement that surrogates be appointed at the time of placement would create an additional burden for a busy court system. The appointment of educational surrogates at the time of placement is complicated by a regulatory scheme that requires specific entities to appoint the surrogate.[16] Also, the best person to assume the role of surrogate may not be apparent at the time of the initial placement. However, the delays in treatment or educational services that can accompany the current system may create a high enough cost to justify changes.

Training in child development better prepares foster parents

When foster care providers are not well trained in child development, they are less able to recognize whether a child needs special care. Training would also better prepare foster parents to respond to some behaviors associated with placement changes. Foster parents currently have access to some training in child development, but a required comprehensive course in typical development and warning signs of atypical development would benefit foster parents and the children.

Implementation of this training would involve additional costs to the system and additional burdens to potential foster parents. It also may create more "red tape" for certifying agencies.

Caseworkers benefit from additional training in disabilities and medical needs

Since caseworkers work with many children who have disabilities and special medical needs, the caseworkers need a solid understanding of the issues involved to make informed decisions about the child's removal from the biological home and placement in an appropriate foster home. Caseworkers would benefit from education about special medical issues and normal and abnormal child development. In addition, basic medical terminology and direct training with medical professionals would help them understand the medical charts of children with complex medical needs and disabilities.

This training would cost additional state dollars and place more stress on already overtaxed caseworkers by demanding more of their time. The cost and time would need to be weighed against the potential benefits of the training.

Training foster parents and caseworkers about the special education process can be helpful

The special education system is complex and can be difficult to navigate. It may be beneficial for both caseworkers and foster parents to receive training on the basics of the system. It would be helpful for caseworkers to understand the foster parent's role in the special education system. This would help caseworkers make appropriate decisions about the type of home in which to place a particular child. It also is useful for foster parents to have this knowledge as they help guide the child through the school system.

This program also has barriers to implementation: it requires additional cost for training, and it places an additional burden on foster parents and caseworkers, people whose time is already at a premium.

Some of the Commission's recommendations will help children with disabilities

The 32 recommendations in the Commission's report[17] include suggestions that would help not only the overall system, but specifically address some of the needs of children with disabilities and special medical needs. These recommendations include:

- Foster parents and caseworkers should receive specific training in overserved populations, including children with disabilities (Recommendations 4 and 21). Recommendation 4 specifically suggests that caseworkers receive "[t]raining in childhood disabilities, including information on how to interview disabled children, and on how to work with families who care for children with disabilities."[17]
- A call for licensing boards to require child welfare training for professionals in areas traditionally interacting with children in the system (Recommendation 22). Training in areas of overrepresentation in the system is suggested, with a specific call for training in the area of disabilities.
- Expanding the availability of community support services to all children in the system, including services prior to a child being placed out of the home. (Recommendation 16).
- A recommendation (20) that the state provide Medicaid waiver services to all families of children with disabilities. Medicaid waivers provide home and community supports to families of persons with disabilities and special needs. The state currently provides these services as the budget allows, but the Commission observed that thousands of families are unable to receive community services through this program due to long waiting lists.[18] With increased provision of services, perhaps some of the disproportionate representation of children with disabilities in the foster care system can be mitigated.

Conclusion

As the state considers its rules and regulations based on the Commission's report, it is also time to ensure that children with disabilities and special needs receive the care they need. It will be important to weigh the costs and benefits of different programs to determine what would be in the best interest of Indiana's children.

Endnotes

[1] Eunice Trotter, State Bills Parents for Foster Care, *Indianapolis Star*, May 2,2004, *available at* www.indystar.com/articles/8/143103-5508-P.html

[2] *IN FOCUS: The Risk and Prevention of Maltreatment of Children with Disabilities* , U.S. Department of Health and Human Services , Administration for Children and Families, *available at* http://nccanch.acf.hhs.gov/pubs/prevenres/focus.cfm (last modified Feb. 2001).

[3] AMERICAN ACADEMY OF PEDIATRICS, *DEVELOPMENTAL ISSUES FOR YOUNG CHILDREN IN FOSTER CARE, POLICY STATEMENT* (2000).[hereinafter AAP].

[4] Ind. Code Ann.§ 12-17-9 (West 2004).

[5] Ind. Code Ann.§ 12-17-11 (West 2004).

[6] Peter A.Gorski, Deborah Ann Borchers, Danette Glassy, Pamela High,et al, *Health Care of Young Children in Foster Care*, 3/1/02 PEDIATRICS 536 (2002);AAP *supra* note 3.

[7] AAP, *supra* note 3.

[8] AAP, *supra* note 3.

[9] Ind. Admin. Code tit.470 r. 3-2-11 (2004).

[10] American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care, Developmental Issues for Young Children in Foster Care (policy statement),106 *Pediatrics* 5.

[11] Peter A.Gorski, Deborah Ann Borchers, Danette Glassy, Pamela High,et al.,Health Care of Young Children in Foster Care, *Pediatrics* 536 (2002).

[12] Jennifer R.Meiselman Titus, *Adding Insult to Injury: California's Cruel Indifference to the Developmental Needs of Abused and Neglected Children from Birth to Three*, 39 CAL. W. L.REV. 115,116 (2002).

[13] Ind. Code Ann.§12-17-15-4(b) (West 2004)."(b) This term may also include, under rules adopted by the division,individuals from birth through two (2) years of life and who are at risk of having substantial developmental delays if early intervention services are not provided."

[14] Ind. Admin. Code tit.511 r. 7-24-2(c) (2004).

[15] Ind. Code Ann.§ 12-17-11-2 (West 2004).

[16] Indiana Commission on Abused and Neglected Children and Their Families, *Child Welfare in Indiana:A System in Crisis* (Aug. 15,2004) [hereinafter Abused and Neglected Children].

[17] Abused and Neglected Children, *supra* note 16 at 10.

[18] Abused and Neglected Children, *supra* note 16 at 26.

William S.and Christine S.Hall Center for Law and Health

The Center for Urban Policy and the Environment is pleased to produce this issue brief in cooperation with the William S.and Christine S.Hall Center for Law and Health at Indiana University School of Law - Indianapolis.

The William S.and Christine S.Hall Center for Law and Health was established in 1987 to conduct legal and empirical research on health law issues in Indiana and the nation;interpret health law issues for the bar, government, and the healthcare community; and expand the curriculum and teaching of health law at the law school.

Located in downtown Indianapolis, the Center is near several major pharmaceutical firms, many of the state's leading medical centers, health insurers, health law firms, and the health agencies of state government. The Center's proximity to these institutions has enabled it to become a major contributor to state and national health law and policy development. The Center is also located on the same campus as the Indiana University Medical Center, Indiana University's health professions schools, and the Indiana University Bioethics Center, resulting in excellent opportunities for interdisciplinary research on health law and policy issues.

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Indiana's Future: Identifying Choices and Supporting Action to Improve Communities

Indiana Counties

This project, funded by an award of general support from Lilly Endowment, Inc., builds on the Center's research to increase understanding of Indiana. The Center's faculty and staff work to identify choices that can be made by households, governments, businesses, and nonprofit organizations to improve our quality of life. Our goal is to understand the people, economics, problems, and opportunities in Indiana, and to help decision makers understand the impacts of policy decisions. The Center also works to mobilize energy to accomplish these goals.

One way the Center works to achieve its goals is through joint efforts with other centers at Indiana University–Purdue University Indianapolis. This report, produced with the William S. and Christine S. Hall Center for Law and Health, addresses the need for improvements in Indiana's foster care system.

The Center for Urban Policy and the Environment is part of the School of Public and Environmental Affairs at Indiana University–Purdue University Indianapolis. An electronic copy of this document and other information about community issues can be accessed via the Center Web site (www.urbancenter.iupui.edu). For more information, visit the Center Web site or contact the Center at 317-261-3000.

Authors: Heather McCabe, JD, MSW, assistant director for projects, and **Kathryn Fox**, research assistant, William S. and Christine S. Hall Center for Law and Health; **Marilyn Michael Yurk**, editor, and **Margie Roe,** photographer and designer, Center for Urban Policy and the Environment, School of Public and Environmental Affairs, Indiana University–Purdue University Indianapolis

CENTER FOR URBAN POLICY AND THE ENVIRONMENT

342 North Senate Avenue
Indianapolis, IN 46204-1708
www.urbancenter.iupui.edu

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