

# Working Together

## HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

NYS Office of Children and Family Services

### Chapter One

## Initial Evaluation of Child's Health

Certain initial medical activities are required and/or recommended when a child is placed in foster care. This is the time to gather as much medical history as possible on the child and family and to begin a comprehensive evaluation of the child's medical, dental, mental health, developmental, and substance abuse needs. The initial health evaluation should result in a comprehensive needs/problem list and plan of care that addresses all of the child's identified health needs.

Whether a child in placement continues on medications previously prescribed or continues a relationship with a specialized practitioner (or needs a referral to one) are crucial decisions. Health care coordination plays a vital role in seeing that (a) all necessary health-related services are provided in the specified time frames; (b) the caregiver supports the medical plan for the child; (c) information is shared appropriately among professionals involved in the child's care; and (d) the child's parents are involved in the planning and treatment (*see Chapter 4, Health Care Coordination*).



Sections in this chapter include:

Chart: Health Services Time Frames

1. Initial screening
2. Information gathering
3. Comprehensive health evaluation
  - Initial medical assessment
  - Initial dental assessment
  - Initial mental health assessment
  - Initial developmental assessment
  - Initial substance abuse assessment
4. HIV risk assessment
5. Follow-up health evaluation
6. Child abuse and neglect health evaluation
7. Resources

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### Health Services Time Frames

The chart below outlines the time frames for initial health activities, to be completed within 60 days of placement. The column labeled Mandated indicates whether an activity is required. The “M” in the time frame column indicates that the activity is required within a mandated time frame. Initial health activities include:

- Immediate screening of the child’s medical condition, including assessment for child abuse/neglect.
- Immediate efforts to obtain medical consent.
- Immediate attention to HIV risk assessment.
- Comprehensive health evaluation: A series of five assessments provides a complete picture of the child’s health needs and is the basis for developing a comprehensive problem list and plan of care.
- Follow-up health evaluation that incorporates information from the five initial assessments.
- Ongoing efforts to obtain child’s medical records and document medical activities.

#### INITIAL HEALTH SERVICES TIME FRAMES

| Time Frame       | Activity   | Mandated | Who Performs   |
|------------------|--|----------|--|
| 24 Hours         | Initial screening/screening for abuse/neglect  |          | Health practitioner (preferred) or caseworker/health staff |
| 5 Days <b>M</b>  | Initial determination of capacity to consent for HIV risk assessment & testing   | <b>X</b> | Caseworker or designated staff                             |
| 5 Days <b>M</b>  | Initial HIV risk assessment for child without capacity to consent  | <b>X</b> | Caseworker or designated staff                             |
| 10 Days <b>M</b> | Request consent for release of medical records & treatment   | <b>X</b> | Caseworker or health staff                                 |
| 30 Days <b>M</b> | Initial medical assessment   | <b>X</b> | Health practitioner  |
| 30 Days <b>M</b> | Initial dental assessment  | <b>X</b> | Health practitioner  |
| 30 Days          | Initial mental health assessment   | <b>X</b> | Mental health practitioner                                 |
| 30 Days <b>M</b> | HIV risk assessment for child with possible capacity to consent  | <b>X</b> | Caseworker or designated staff                             |
| 30 Days <b>M</b> | Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection                           | <b>X</b> | Caseworker or health staff                                 |
| 45 Days          | Initial developmental assessment   | <b>X</b> | Health practitioner  |
| 45 Days          | Initial substance abuse assessment   |          | Health practitioner  |
| 60 Days          | Follow-up health evaluation  |          | Health practitioner  |
| 60 Days <b>M</b> | Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent & assessed to be at risk of HIV infection | <b>X</b> | Caseworker or health staff                                 |
| 60 Days <b>M</b> | Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing                                       | <b>X</b> | Caseworker or health staff                                 |

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### 1 Initial Screening

Each child entering foster care should receive a health screening within 24 hours of placement. The purpose is to observe the child and gather information to identify active health problems and needs for immediate care and to continue medications, if any. Use of a screening checklist can help identify and document:

- Signs of abuse or neglect. (If trauma is present, seek immediate medical attention.)
- Active medical/psychiatric problems: obvious illnesses, injuries, or disabilities.
- Current medications, if any.
- Allergies to food, medication, and environment (e.g., pets, pollen).
- Upcoming medical appointments.
- Need for eyeglasses, hearing aids, or other durable medical equipment (e.g., prosthetic devices).
- For an infant: delivery history (e.g., where, when, how, toxicology screen, complications).

*(See Appendix A for a sample Admission Screening Interview tool.)*

It is recommended that a qualified health care practitioner (RN, LPN, physician, nurse practitioner, or physician's assistant) conduct the screening. A caseworker trained to use the screening tool may also conduct the screening, if necessary. If the screening identifies an active health problem and need for immediate care, follow your agency's procedures to address this need. *Emergency rooms should not be used for routine screening.*

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## 2 Information Gathering

At the time of placement, make every effort to obtain the child's complete medical history. Try to obtain information from the birth parents, the child (if appropriate), health care providers, other service providers (e.g., school nurse, day care center), and existing medical records (*see Chapter 8, Maintaining Health Records*). Whenever possible, the caseworker should gather medical information at the time of the child's removal from the home.

(*See Appendix A for sample Health History Interview With Family form and a Medical Review of Systems form, which can guide staff in obtaining a more thorough health history on the child from a family member or caregiver.*)



### Health Care Coordination Activities

To prepare for the initial health assessments, gather the following information on the child's medical history:

- Prior and current illnesses and behavioral health concerns.
- Immunization history (*see next page*).
- Medications (prescription and over-the-counter).
- Allergies (food, medication, and environmental).
- Results of diagnostic tests and assessments, including developmental and psychological tests.
- Results of laboratory tests (including HIV antibody screening).
- Family history of hereditary conditions or diseases.
- Details of pregnancy, labor, and delivery (for children age 5 and under, and as available for other children).
- Results of the infant's Newborn Screening (*see Chapter 3 Newborn Screening Program*)
- Names and addresses of the child's health and medical provider(s), with details of illnesses, accidents, and previous hospitalizations, including psychiatric hospitalizations.
- Durable medical equipment/adaptive devices currently used or required by the child (e.g., wheelchair, feeding pump, glasses).
- Needed follow-up or ongoing treatment for active problems.

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### Immunization History

To prevent children from receiving additional, unnecessary immunizations when they enter foster care, it is important to obtain all documentation of previous immunizations and maintain an updated list in the child's health file. There are generally four sources where staff can obtain the child's immunization history: the health care practitioner, the family, the child's school, and the New York State Immunization Information System or the Citywide Immunization Registry.

- Ask the birth parent or guardian to identify the provider or clinic where the child received immunizations, and send a request for copies of the records.
- Obtain a copy of immunization cards or documentation that the birth parent or guardian has received from the provider.
- Obtain a copy of immunization records from the school for school-age children.

#### New York State Immunization Information System

The New York State Immunization Information System (NYSIIS) was created in response to legislation requiring health care providers to report all immunizations administered to persons less than 19 years of age beginning January 1, 2008. If the child receives a vaccine after that date, all past immunizations must also be recorded in NYSIIS. When a child receives a vaccination at a location outside of New York City, information should be entered into NYSIIS.

Authorized users of NYSIIS include health care providers, schools, and commissioners of local social services districts. (*Note: NYSIIS is not yet fully implemented.*) The health care provider at the Initial Medical Assessment can also search NYSIIS for records. The system can accommodate different addresses and different names under which the child may be known. If you have obtained documentation of immunizations that have not yet been entered into NYSIIS, ask the provider to record them in NYSIIS. You may contact the NYSIIS team at 518-473-2839.

#### Citywide Immunization Registry

When a child receives an immunization at a location in New York City, the information must be entered into the Citywide Immunization Registry (CIR). The Administration for Children's Services (ACS) is authorized to access information from the CIR, as are voluntary foster care agencies. Agencies that provide health services in New York City are required to report immunizations to the CIR. You may contact the CIR at 212-676-2323 or online at: <http://www.nyc.gov/html/doh/html/cir/index.html>.

The NYSIIS and CIR systems will soon be able to exchange information freely. (*See section 7, Resources, for the NYS and NYC Recommended Childhood Immunization Schedule.*)

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### Consent

Request consent for release of medical records and consent for routine medical treatment from the birth parent or guardian within 10 days of the child's placement in foster care<sup>1</sup> (*see Chapter 6, Medical Consents*).

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<sup>1</sup> 18 NYCRR 441.22(d).

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### 3 Comprehensive Health Evaluation

To develop a full understanding of a child's health, a comprehensive health evaluation comprising five assessments should take place within certain time periods after the child's entry into foster care. These include:

- Medical assessment (within 30 days)
  - Dental assessment (within 30 days)
  - Mental health assessment (within 30 days)
  - Developmental assessment (within 45 days)
  - Substance abuse assessment (within 45 days)
- The Office of Children and Family Services (OCFS) recommends that a full comprehensive health evaluation as described in this chapter be completed for each child in foster care. Footnote citations to a law or regulation indicate that an activity or component is *required* and provide the legal or regulatory source for the requirement. Use of the term “should” indicates that an activity is recommended by OCFS but is not required by law or regulation.**

Assessments and services for children in foster care are described here as falling into five domains: medical, dental, mental health, developmental, and substance abuse. This model recognizes that there are multiple aspects of wellness for children in care. The descriptions of each assessment provide guidance on the components involved and the considerations to be taken into account by the health provider. Though there are five assessment domains, there need not be five different clinicians. Some providers are well qualified to conduct more than one assessment. For example, a pediatrician will routinely assess the developmental status as well as physical health of an infant.



#### Health Care Coordination Activities

The following staff activities are provided to support the completion and needed follow up for the health assessments:<sup>2</sup>

- Scheduling the examination for the child or helping the foster parent schedule it within the required time frame.
- Offering to provide or arrange for transportation as needed.<sup>3</sup>
- Providing the practitioner with the child's available medical history at the time of the exam or as soon as possible thereafter.

<sup>2</sup> 90 ADM-21 Foster Care: Medical Services for Children in Foster Care.

<sup>3</sup> 18 NYCRR 441.22(j)(2).

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- Making sure that the practitioner is familiar with the requirements of a comprehensive examination for children in foster care.
- Following up to make sure that the examination is completed and appropriate actions are taken, including filling prescriptions.
- Making sure that the results of the initial medical assessment and any referrals for follow-up care are filed in the medical section of the child's Uniform Case Record (UCR)<sup>4</sup> or Family Assessment Service Plan (FASP) and documented electronically, as required.

### Initial Medical Assessment

Each child entering foster care must receive an initial medical assessment within 30 days of placement.<sup>5</sup> If it is documented that the child has had such an assessment within 90 days before placement, and the results are available, the examination does not need to be repeated unless medically indicated or if there are allegations of abuse or maltreatment that require medical attention. In this case, obtain a copy of the assessment to determine if appropriate treatment and follow-up have occurred for identified issues.

Practitioners providing this assessment may include:

- Physicians
- Nurse practitioners
- Physician assistants

The qualified practitioner should be experienced in providing comprehensive primary care for infants, children, and adolescents in foster care.

Institutional regulations require – and quality practice would dictate – that all providers be licensed, certified, and registered in New York State to practice their profession.<sup>6</sup>

### Medical Home

When feasible, children should receive all of their health care, including routine preventive, acute illness, and chronic illness, from the same provider while in foster care. In this model of care, every child has an established, ongoing relationship with a primary health care provider, so that health problems can be identified, treated, and documented early to improve outcomes and reduce the likelihood of disease, disability, and hospitalization. Health providers outside the medical home should consult with the primary care provider and share their findings (with appropriate consent) to facilitate comprehensive, coordinated care. This is particularly important when the child is referred to subspecialists for diagnostic evaluations and/or treatment, and when services are ordered in other

<sup>4</sup> 18 NYCRR 441.22(k) and 428.3(b)(4)(ii).

<sup>5</sup> 18 NYCRR 441.22(c)(1) (“comprehensive medical examination”).

<sup>6</sup> 18 NYCRR 442.18.

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settings (e.g., occupational or speech/language therapy).<sup>7</sup> The medical home provides continuity of health care despite any changes in placement.

The initial medical assessment provides the opportunity to establish a “medical home” with one primary care provider who is familiar with the child’s needs from placement to discharge and beyond. In the interest of maintaining a medical home, talk to the practitioner about continuing to follow the child and keeping a complete record of the child’s medical history and referrals.

A medical home is not a building, house, or hospital, but rather an approach to providing health care services in a high-quality and cost-effective manner. Children and their families who have a medical home receive the care they need from a pediatrician or physician (pediatric health care professional) whom they trust. The pediatric health care professionals and parents [or other caregivers] act as partners in a medical home to identify and access all the medical and non-medical services needed to help children and their families achieve their maximum potential. The American Academy of Pediatrics believes that all children should have a medical home where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. (*American Academy of Pediatrics*)

### Components of Medical Assessment

The initial medical assessment<sup>8</sup> must include (1) a medical and developmental history; (2) a physical examination by a qualified medical professional; (3) screening tests; (4) preventive services; and (5) development of a problem list and treatment plan.

1. Medical history – building on the information from the initial screening, if available:
  - Identify past providers and seek records.<sup>9</sup>
  - Obtain information from parent or guardian whenever possible.
  - Obtain immunization records.
  - Review all available medical information.
  - Obtain developmental history
    - Birth family history of developmental problems.
    - History of psychosocial issues prior to placement.
    - Previous developmental assessments and treatments, if any.

Having this information at hand will be helpful for the primary care provider when conducting the initial medical assessment.

2. Complete unclothed physical examination in accordance with current recommended medical practice, taking into account the age, environmental background, and development of the child.

The examination must include observation for child abuse and neglect, which, if suspected, must

<sup>7</sup> EPSDT/CTHP *Provider Manual for Child Health Plus A (Medicaid)* (2005), p. 19.

<sup>8</sup> 18 NYCRR 441.22(c)(2).

<sup>9</sup> 18 NYCRR 441.22(e).

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be reported to the State Central Register of Child Abuse and Maltreatment (*see section 6, Child Abuse and Neglect Health Evaluation*). The exam must also include observation for dental problems in children under 3 years old and referral to a dentist if problems are found.

3. Screening tests appropriate for age, identified risks, and identified conditions:
  - Laboratory and sensory screening appropriate for age per the American Academy of Pediatrics (AAP) including appropriate vision, hearing, and dental screening.
    - Urinalysis.<sup>10</sup>
    - If AAP recommends “risk assessment to be performed, with appropriate action to follow, if positive,” the tests referenced should be conducted for all adolescents entering foster care during the initial medical assessment (e.g., cholesterol and lipids).
  - Screening for lead poisoning, anemia, tuberculosis, HIV, and hepatitis B exposure due to higher risk status of children in foster care.
  - Special screening tests for children with specific medical conditions or risks such as HIV, fetal alcohol syndrome, sickle cell disease, diabetes, or seizures, consistent with current standards for primary care of the particular condition that is present in the child.
4. Preventive services, such as immunizations, health education, and anticipatory guidance appropriate for the child’s age.
5. Development of a problem list and treatment plan.

### Additional Time Frames for the Medical Assessment

A comprehensive medical assessment must be completed within 30 days after a child returns to foster care following discharge, trial discharge, or absence without consent that lasted more than 90 days.<sup>11</sup> At the discretion of the agency, the examination may be completed if there are concerns about a child’s health when:

- The child returns to care *within* 90 days following discharge, trial discharge, or absence from care without consent.
- The child is transferred to the care of another agency, and the receiving agency determines that a comprehensive medical examination may be necessary to help formulate the child’s service plan.<sup>12</sup>
- There are allegations of abuse or maltreatment.
- There are concerns that the child has been involved with alcohol, drugs, or sexual activity during an absence without consent.

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<sup>10</sup> 18 NYCRR 508.8(b)(9).

<sup>11</sup> 18 NYCRR 441.22(c)(3).

<sup>12</sup> 18 NYCRR 441.22(c)(4).

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### Initial Dental Assessment

An initial dental assessment must be conducted within 30 days of placement.<sup>13</sup> If it is documented that the child has had such an assessment within 90 days before placement, and the results are available, the assessment does not need to be repeated unless medically indicated. In this case, obtain a copy of the assessment to determine if appropriate treatment and follow-up have occurred for identified issues.

The assessment includes:

- Dental history and screening.
- For children under age 3, referral for dental care when a medical provider finds problems upon examining the child's mouth.
- For children age 3 and older, diagnostic examination by a dentist.<sup>14</sup> [*Note: NYC Administration for Children's Services (ACS) requires an exam by a dentist at age 2.*]

The following is recommended:

- Dental x-rays as indicated for diagnostic examination.
- Routine prophylaxis consistent with current dental practice for age:
  - Cleaning
  - Topical fluoride
  - Oral hygiene instruction to the child and caregiver
- Sealants on permanent molars.
- Dental problem list and treatment plan.
- Referral to a dentist and establishment of a dental home is recommended no later than 6 months after the first tooth erupts, or by 12 months of age, whichever comes first. This practice allows the dentist to assess risk and recommend interventions. It also provides an opportunity for the dentist to intervene in the oral hygiene habits of the primary caregivers to reduce the risk of colonization of the infant by the bacteria that cause tooth decay.

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<sup>13</sup> 18 NYCRR 441.22(c)(2)(vii).

<sup>14</sup> 18 NYCRR 441.22(f)(2)(viii).

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### Initial Mental Health Assessment

The initial mental health assessment must be conducted for children age 3 and older. It is recommended that this be completed within 30 days of placement. Although not explicitly required in NYS OCFS regulations, Early Periodic Screening, Diagnosis and Treatment (EPSDT) requires an assessment of mental health development for all Medicaid eligible children,<sup>15</sup> and AAP recommends a psychosocial/behavioral assessment at each checkup.<sup>16</sup> OCFS regulations specify that psychiatric and psychological services must be made available appropriate to the needs of children in foster care.<sup>17</sup>

The assessment includes (1) a mental health assessment conducted by a qualified mental health professional; (2) development of a mental health needs list; (3) list of child's strengths; and (4) development of a mental health treatment plan.



#### Health Care Coordination Activities

Before the mental health assessment takes place, you can help further the process by gathering records on the child's past mental health issues, diagnoses, and treatment, if any. After the assessment is completed, you will be involved in supporting the child's mental health treatment plan, including working with the child's caregivers, birth parents, and service providers. It is a good idea to arrange for mental health providers to share appointment information with you to better monitor attendance at appointments.

Practitioners providing the assessment may include:

- Physicians experienced in providing mental health services:
  - Developmental/behavioral pediatricians for children under age 5.
  - Child and adolescent psychiatrists or general psychiatrists with experience in the care of children and adolescents.
- Licensed clinical psychologists with training and/or experience with emotional problems of children and adolescents.
- Nurse practitioners with certification in child and adolescent psychiatry.
- Certified psychiatric clinical nurse specialists.
- Licensed clinical social workers (LCSWs) or licensed master social workers (LMSWs) with

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<sup>15</sup> EPSDT 5123.2A.

<sup>16</sup> <http://practice.aap.org/content.aspx?aid=1599>.

<sup>17</sup> 18 NYCRR 441.15.

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training and/or experience with the emotional problems of children and adolescents.

**Note:** LMSWs may only provide clinical social work services under supervision.

### Components of Mental Health Assessment

The purpose of the mental health assessment is to obtain a complete picture of the child who has just been placed in foster care and to identify any emotional and behavioral needs, issues, or problems or risk thereof arising from the child's situation. Most children in foster care have experienced multiple traumas such as abuse or neglect, witnessing domestic violence, or parental absence due to mental illness or substance abuse. Factors such as removal from the home, separation from parents and siblings, changing schools, and changing foster homes can also place additional stress on the child's emotional stability.

The practitioner derives this picture by obtaining the child's history, interviewing the child, caregivers, and birth parents and completing the following assessment components. It may take more than one interview to obtain the needed information and determine if the child has a mental health disorder or need for treatment.

1. Mental health/psychiatric history – obtained by interviewing the child, family, and caregivers, covering the following information:
  - Identifying information
  - Past psychiatric history
  - Past and current psychiatric medications
  - Identification of individual strengths/assets
  - Identification of individual deficits/liabilities
  - Developmental history
  - School history, including reports and assessments
  - Family history
  - Social and behavioral history
  - Medical history (including results of initial medical assessment and prenatal exposure to alcohol or drugs)
  - History of drug/alcohol use by the child
  - Trauma and abuse history
2. Mental status examination – accomplished by interviewing the child and examining the child's appearance, behavior, feeling (affect and mood), perception, thinking, and orientation to time, place, and person.
3. Assess the circumstances of placement, family life events, and traumatic events, and observe for signs and symptoms:
  - Risks for suicide, self-mutilating behaviors, and/or violence
  - Substance exposure, misuse, abuse, and addiction
  - Maltreatment, including physical, sexual, emotional abuse and neglect
  - Risk of placement disruption
  
  - Risky sexual behavior

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- Risk of antisocial behavior
- 4. If clinically indicated, completion of diagnostic screening and assessment tools (behavior, mood, etc.) (*see section 7, Resources, for a list of assessment tools*).
- 5. If clinically indicated, perform psychological testing
- 6. Identification of mental health symptoms and/or diagnosis that must be addressed (*see Chapter 2, Preventive and Ongoing Health Care, for information on the DSM-IV-TR Manual*).
- 7. Mental health treatment plan for the child's identified needs, consisting of treatment goals, treatment objectives, and treatment methods/interventions/services (types, frequency, specific providers).

### Guidance for Caregivers

You have an important role in helping foster parents or childcare staff understand the mental health needs of the child placed in their care. If information regarding the trauma experienced by the child and any mental health symptoms or diagnosis are known at the time of placement, discuss these with the caregivers so that they can be more aware of the child's needs. As the child becomes more comfortable in the placement setting, he or she may begin to exhibit certain different behaviors. This is a critical time to support caregivers and provide practical guidance and training to address these changes. Caregivers should be aware of this possibility, make note of the child's behavior, and pass the information on to the person conducting the mental health assessment. It is important to realize that the child may be reacting to feelings of separation, loss, or rejection, and his or her behavior may be more a reflection of the situation than an indicator of a genuine mental illness.

Some of the behaviors that caregivers should be alert to are:

- Angry outbursts.
- Excessive sadness and crying.
- Withdrawal.
- Lying or stealing.
- Defiance.
- Unusual eating habits, such as hoarding food or loss of appetite.
- Sleep disturbances.
- Sexual acting out, such as seductive behaviors toward caregivers.
- Change in behavior at school, including truancy.

Please note that if the child appears to be in crisis, immediate referral to the mental health provider should be made. If a foster parent identifies a child in crisis, he/she should contact the caseworker immediately.

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### Initial Developmental Assessment

An initial developmental assessment must be conducted for children entering foster care. It is recommended that this be completed within 45 days of placement. Although not explicitly required in NYS OCFS regulations, EPSDT requires a developmental assessment for all Medicaid eligible children,<sup>18</sup> and regulations require a developmental history.<sup>19</sup>

The assessment includes (1) a developmental history; (2) a clinical assessment; and (3) an individual service plan.

The purpose of the initial developmental assessment is to examine the child's growth and development in relation to his or her age and expected milestones. Adequate knowledge about a child's development supports better placement, custody, and treatment decisions. Many children in foster care have not grown up in an environment that supports the achievement of developmental milestones. Negative environmental conditions, including lack of stimulation, child abuse, or violence within the family, impact and may impair brain development, particularly in very young children.

Practitioners providing this component may include:

- Professionals with formal training and experience evaluating child development appropriate to the age of the child (*see above section on mental health assessment*).
- The same professional performing the medical examination if appropriately qualified.

### Components of Developmental Assessment

The components of a developmental assessment include:<sup>20</sup>

1. A developmental history – obtained by interviewing the child, family, and caregivers, covering the following information:
  - Age at which developmental milestones were achieved (e.g., age when child first walked or talked)
  - Results of previous developmental and educational assessments
  - Medical history (including results of initial medical assessment)
  - History of prenatal exposure to alcohol or drugs, including the type of substance, amount, and when during pregnancy exposure occurred
  - History of trauma, abuse, and neglect
  - Quality of the child's important relationships prior to placement
2. A clinical assessment of:

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<sup>18</sup> EPSDT 5123.2A.1.

<sup>19</sup> 18 NYCRR 441.22(c)(2).

<sup>20</sup> *Pediatrics*, 106(5) (November 2000), 1145-1150.

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- Gross motor skills
- Fine motor skills
- Cognition
- Expressive and receptive language
- Self-help abilities
- Emotional well-being
- Coping skills
- Relationships to persons
- Adequacy of caregiver's parenting skills
- Behaviors

Assessment tools vary according to the child's age, developmental stage, and previous history. Measures used should be standardized and validated.

2. Creation of a developmental treatment plan (individual service plan) for identified needs, consisting of treatment goals; treatment objectives; and treatment methods, interventions, and services including types, frequency, and specific providers.

### Initial Substance Abuse Assessment

An initial substance abuse assessment should take place within 45 days of placement for children age 13 and older, and younger if indicated. Although not explicitly required in NYS OCFS regulation,<sup>21</sup> the OCFS health services guidelines recommend this assessment be considered for children age 10 and older, as either an independent activity or a component of the mental health assessment. Standards for services to Medicaid eligible adolescents require an assessment of psychosocial adjustment, including use of drugs, alcohol, and tobacco.

The purpose of the assessment is to determine whether the child is currently using drugs, alcohol, or tobacco or is at risk of using them. A thorough assessment also considers substance use in the child's family.

**Note:** "Substance" or "drug" includes all alcohol and chemicals, including prescribed pharmaceuticals, improperly used either by inhalation, smoking, ingestion, or injection.

Practitioners providing this component may include:

- Qualified health professionals with adolescent development and addiction training and experience.
- Certified alcohol and substance abuse counselors (CASAC) practicing in an approved work setting.<sup>22</sup>
- Psychologists with MSWs with adolescent development and addiction training and experience.

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<sup>21</sup> 18 NYCRR 508.8(b)(4)(iii).

<sup>22</sup> 14 NYCRR 853.3(b).

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- LCSWs or LMSWs with adolescent development and addiction training and experience.

The assessment should be consistent with current standards of care for adolescent substance abuse assessments (*see section 7, Resources, for Screening and Assessing Adolescents for Substance Use Disorders*). The American Academy of Pediatrics (AAP) and the New York State Office of Alcohol and Substance Abuse Services (OASAS) recommend the use of the “CRAFFT” substance abuse screening instrument, which is developmentally appropriate for adolescents, and which provides a practical means of quickly identifying youth in this age group who will need more comprehensive assessment or referral to substance abuse treatment specialists (*see section 7, Resources*).

Based on the assessment and any identified problems, a treatment plan will be developed that includes recommendations for counseling and other services for the child and family.

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### 4 HIV Risk Assessment

Children entering foster care must be assessed for their risk of HIV exposure, capacity to consent to an HIV test, and HIV testing history.<sup>23</sup> Each child entering foster care must be assessed within five business days of entry into care to determine, based on the child's developmental stage and cognitive abilities, whether it is possible that the child may have the capacity to consent to HIV-related testing.

If it is determined that there is no possibility that the child has the capacity to consent, then within five business days of the child's entry into care the authorized agency also must complete an initial assessment of the child's risk for HIV infection.

If it is determined that there may be a possibility that the child has capacity to consent, then within 30 business days of the child's entry into care, the authorized agency must: initiate discussions and counseling with the child based on the child's developmental stage and cognitive abilities regarding the behaviors that create a risk for HIV infection and the importance of reducing and preventing such behaviors; complete an assessment of the child's risk for HIV infection; and determine whether the child has the capacity to consent to HIV-related testing.

The risk assessment must be performed by designated staff who are trained in HIV risk assessment, able to assess a child's capacity to consent, and familiar with the special HIV confidentiality requirements.

*(See Chapter 3, Special Health Care Services, for information on HIV-related assessment and services and Chapter 6, Medical Consents, for information on capacity to consent.)*

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<sup>23</sup> 18 NYCRR 441.22(b); 97 ADM-15 Foster Care: Assessment of Foster Children for Capacity to Consent and HIV Risk; Counseling of Adolescents; Legal Consent for HIV Testing; Documentation and Disclosure.

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### 5 Follow-Up Health Evaluation

A follow-up health evaluation with the primary care provider should take place when all assessments are completed, approximately 60 days after the child's entry into care.

Activities of the follow-up health evaluation include, at a minimum:

- Continue to update immunizations for age.
- Review results of all assessments and laboratory and other screening tests.
- Review new information emerging during placement (e.g., mental health issues, substance abuse) and update the treatment plan accordingly.
- Review compliance with appointments to make sure all planned follow-up has occurred.
- Plan continuing care.
- Review compliance with treatment recommendations, including medication.



#### Health Care Coordination Activities

Make sure that the medical home (primary care provider) has received the results of each initial assessment. The follow-up health evaluation provides an opportunity for the primary care provider to review the child's strengths and needs as identified in the initial assessments and develop an overall plan of care for the child. Communicate this plan to the child's treatment team and all specialty providers.

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### 6 Child Abuse and Neglect Health Evaluation

A child abuse and neglect health evaluation is a medical examination conducted by a health care practitioner for the purpose of identifying, documenting, and treating any signs and/or symptoms of abuse or neglect. This evaluation may be integrated into an initial or routine physical or mental health exam. It may also be a separate activity at any time that suspicions of abuse or neglect arise. A thorough evaluation addresses both the physical and emotional aspects of the child's well being. Medically, the child will need treatment for injuries and other physical complaints. Just as important is the identification and treatment of the functional and emotional consequences of abuse or neglect. This should include referrals to skilled mental health providers. All health care providers involved in the child's treatment plan should know when the child's needs are related to suspected abuse or neglect, and the plan must address these needs.

Health care practitioners as well as caseworkers and caregivers need to be vigilant in observing the child for signs of abuse and neglect. Identification and documentation of child abuse and neglect should be an ongoing activity that begins with the initial screening (within 24 hours of placement) and must be a part of every medical contact.

If there is reasonable cause to suspect abuse or maltreatment, an immediate call should be made to the State Central Register of Child Abuse and Maltreatment (SCR). Keep in mind that caseworkers, childcare staff, and licensed health professionals are mandated reporters under state law.<sup>24</sup> The telephone number for reporting suspected abuse and maltreatment to the SCR for mandated reporters is 1-800-635-1522, and the number for the general public is 1-800-342-3720.

All in-depth interviews related to abuse or neglect, especially sexual abuse, should be conducted by qualified and experienced professionals. It is not the role of the foster parents or caregivers to take on this task.

#### Time Frames

A child abuse and neglect evaluation should take place:

- Prior to or within 24 hours of placement.
- At the initial medical assessment.<sup>25</sup>
- At periodic health visits.<sup>26</sup>
- Immediately, when specific indicators of abuse or neglect are present.

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<sup>24</sup> SSL Article 6, Title 6, 413-415.

<sup>25</sup> 18 NYCRR 441.22(c)(2).

<sup>26</sup> 18 NYCRR 441.22(f)(2).

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- Within 24 - 48 hours of return when a child returns from trial discharge or has been absent without leave (AWOL).
- Within 24 - 48 hours before discharge.

### Time Frames for a Sexual Abuse Evaluation

The timing of a sexual abuse health evaluation depends on when the suspected abuse occurred. If the sexual abuse occurred more than four days prior to the disclosure, it is more important to have the examination conducted in a child-friendly, non-threatening environment than to adhere to strict time frames for seeking the medical evaluation. The assessment and interview process should begin immediately and medical attention sought as soon thereafter as possible and appropriate. If there are suspicions that a caregiver or someone with regular access to the child is the abuser, immediate action must be taken to protect the child regardless of when the abuse occurred. Involve child protective services as appropriate.

A medical exam should take place:

- On the same day if the sexual abuse occurred within the past 96 hours (4 days).
- On the same day if there is vaginal or rectal bleeding, pain, or signs of sexual trauma.
- If the sexual abuse took place more than 96 hours ago, seek the advice of a clinician as needed to determine the urgency of a medical examination on an individual basis. Examples of situations where an immediate exam may be indicated include: the child has vaginal discharge or there is suspicion of a sexually transmitted disease or pregnancy; the child lives in the same house as another child who has been sexually abused; or the child has specific behavioral or physical indicators of sex abuse.

The professional conducting the health evaluation should be trained and experienced in child abuse and child sexual abuse issues. Whether conducted by an individual or a child abuse team, the evaluation should be comprehensive to avoid multiple interviews and examinations, which may increase the trauma for the child. It is recommended that a sexual abuse evaluation take place within a multidisciplinary child abuse team (MDT) or Child Advocacy Center (CAC) (*see section 7, Resources*). If no MDT/CAC is available, a qualified medical professional should conduct the evaluation.

The Child Abuse Evaluation and Treatment for Medical Providers website is a comprehensive source for child abuse information that offers tools and resources with which to diagnose and manage child and adolescent abuse victims: <http://www.childabusemd.com/index.shtml>. Another valuable reference tool for medical practitioners is the Child and Adolescent Sexual Offense Medical Protocol. For an updated version of the protocol, contact the NYS Department of Health's Rape Crisis Program at 518 474-3664. The New York State Children's Justice Task Force Forensic Interviewing Best Practices protocol referenced in the box below is available on the OCFS Intranet at: <http://ocfs.state.nyenet/dps/pdf/NYSCJTFForensicInterviewBestPractice.pdf>.

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### Components of Child Abuse and Neglect Health Evaluation

A medical evaluation for child abuse and neglect should include the following:

1. Interview with the child that is developmentally appropriate, sensitive, and completed in an unbiased and truth seeking manner. The New York State Children's Justice Task Force Forensic Interviewing Best Practices Guidelines are recommended, although not required. With an allegation of sexual abuse, the interviewer also seeks to identify signs and symptoms of child sexual abuse, including but not limited to: nightmares, sexual knowledge inappropriate for the child's age, and sexualized behaviors inappropriate for his/her age (*see Chapter 3, Special Health Care Services, for information on child sexual abusers*).
2. Thorough directed physical examination: observation of verbal and nonverbal behaviors, affect, growth parameters (height, weight), skin, nails, hair, mouth, extremities, genitalia, anus.
3. Documentation, including detailed narrative, sketches, and photographs.
4. Imaging and laboratory studies as clinically indicated: If signs of physical abuse are present, a skeletal survey (x-ray) should be done to identify old and new fractures (e.g., a very young child with injuries in various stages of healing).



### Health Care Coordination Activities

If your county does not have a Child Advocacy Center, identify and use health care practitioners who are experienced and trained in conducting a child abuse and neglect evaluation. Encourage them to reference guidance documents such as the ones noted above. To support a coordinated approach to child abuse and neglect in your local department of social services (LDSS) or voluntary agency, establish a multidisciplinary child abuse team if one is not already present.

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### 7 Resources

#### Medical Home

<http://www.medicalhomeinfo.org/>

The National Center of Medical Home Initiatives for Children with Special Needs is a site sponsored by the American Academy of Pediatrics.

#### Medical Information Sites

##### Fetal Alcohol Spectrum Disorders (FASD)

Any amount of alcohol use by the mother during pregnancy can cause an FASD. Children with an FASD may also be diagnosed with a mental health disorder, have developmental delays and learning problems. Identification of brain damage caused by FASD will assist service providers and schools in implementing effective interventions.

Diagnosis of Fetal Alcohol Syndrome (FAS):

[http://www.cdc.gov/ncbddd/fas/documents/FAS\\_guidelines\\_accessible.pdf](http://www.cdc.gov/ncbddd/fas/documents/FAS_guidelines_accessible.pdf)

New York State: <http://www.oasas.state.ny.us/fasd/index.cfm> (includes additional links)

##### Sickle Cell Disease

The Sickle Cell Information Center: <http://www.scinfo.org/> (includes additional links)

##### Autism Spectrum Disorders

Center for Autism and Related Disabilities: <http://www.albany.edu/psy/autism/autism.html>

National Institute of Mental Health: <http://www.nimh.nih.gov/health/publications/autism/complete-publication.shtml>

#### Immunization Schedule

See the following page for the New York State and New York City Recommended Childhood Immunization Schedule. Check the following website at least once a year for updates to the schedule: [http://www.health.state.ny.us/prevention/immunization/childhood\\_and\\_adolescent.htm](http://www.health.state.ny.us/prevention/immunization/childhood_and_adolescent.htm)

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### New York State Recommended Childhood and Adolescent Immunization Schedule

A check ✓ means that this is the earliest and best time for your child to be immunized. If your child misses the "best time" for vaccination, he or she should still be immunized as quickly as possible. Ask your doctor about getting your child caught up.

| Vaccine against:                          | Age   |           |          |            |             |   |   |  |
|---|-------|-----------|----------|------------|-------------|---|---|--|
|   | Birth | 2 months  | 4 months | 6 months   | 12 months   | 18-24 months  | 4-6 years   | 11-12 years  |
| Hepatitis A                               |       |           |          |            | ✓           | ✓   |   |  |
| Hepatitis B                               | ✓     | ✓ 1-4 mo. |          | ✓ 6-18 mo. |             |   |   |  |
| Diphtheria, Tetanus, Pertussis (DTaP)     |       | ✓         | ✓        | ✓          | ✓ 12-18 mo. |   | ✓   |  |
| Haemophilus influenzae type b (Hib)       |       | ✓         | ✓        | ✓          | ✓ 12-15 mo. |   |   |  |
| Polio (IPV)                               |       | ✓         | ✓        | ✓ 6-18 mo. |             |   | ✓   |  |
| Pneumococcal Disease (PCV7) <sup>1</sup>  |       | ✓         | ✓        | ✓          | ✓ 12-15 mo. | Ask your doctor if your child 2 years old or older should get vaccinated with PPV23. <sup>1</sup> |   |  |
| Measles, Mumps, Rubella (MMR)             |       |           |          |            | ✓ 12-15 mo. |   | ✓   |  |
| Varicella (Chickenpox)                    |       |           |          |            | ✓ 12-15 mo. |   | ✓   | A second catch-up dose is recommended for any child who has had only one dose. |
| Rotavirus                                 |       | ✓         |          | ✓          |             |   |   |  |
| Tetanus, Diphtheria, Pertussis (Tdap)     |       |           |          |            |             |   |   | ✓ 11-18 yrs.   |
| Meningococcal Disease (MCV4) <sup>2</sup> |       |           |          |            |             | Ask your doctor if your child 7 years old or older should get vaccinated with MCV4. <sup>2</sup>  |   | ✓  |
| Human Papillomavirus (HPV)                |       |           |          |            |             |   |   | ✓ <sup>3</sup>   |
| Influenza                                 |       |           |          |            |             |   | Recommended yearly for all children aged 6 months and older. Ask your doctor if your child should receive one or two doses. |  |

<sup>1</sup> PCV7 = Pneumococcal Conjugate Vaccine; PPV23 = Pneumococcal Polysaccharide Vaccine

<sup>2</sup> MCV4 = Meningococcal Conjugate Vaccine

<sup>3</sup> The HPV vaccine is given through a series of three shots over a 6-month period.

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### Mental Health Assessment Tools

#### Voice-Diagnostic Interview Schedule for Children (V-DISC)

V-DISC is a comprehensive, structured interview that uses DSM-IV criteria to screen for more than twenty mental health disorders as well as suicidal ideation found in children and adolescents. The V-DISC is a self-administered test. For more information:

Columbia University - <http://www.promotementalhealth.org/overview.htm>

NYS DPCA: <http://dpca.state.ny.us/technology.htm>

On the following page is a list of instruments used to assess children and adolescents in New York State Office of Mental Health children's programs.

**Note:** Many assessment instruments exist, but not all are valid and reliable. Some are expensive and require training, while others are available at no charge and do not require training. Any tools used for mental health assessment warrant close scrutiny. Please remember that tools are only one aspect of a mental health assessment. Mental health practitioners need to involve the birth family, if possible, the foster family, and schools, along with direct observation.

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### INSTRUMENTS USED TO ASSESS CHILDREN AND ADOLESCENTS IN NYS-OMH CHILDREN'S PROGRAMS

June 2003

| Assessment Instrument   | Children's Programs   | Results of Instrument   | Completed By                      |
|---|---|---|-----------------------------------|
| <b>ASI</b> Adolescent Symptom Inventory - Stonybrook, Ages 13-18 years            | Inpatient (Sagamore CPC)  | DSM Diagnosis;<br>Symptom Clusters                                  | Parent<br>Teacher                 |
| <b>CAFAS</b> Child & Adolescent Functional Assessment Scale                       | Kids Oneida (Oneida County)<br>SPOA* (1 County)   | Level of Functioning;<br>Symptom/Problem Clusters                   | Trained Rater                     |
| <b>CANS-MH</b> Child and Adolescent Needs and Strengths - Mental Health           | NYS-OMH Study (statewide)<br>Kids Oneida<br>SPOAs* (most Counties)                          | Level of Functioning;<br>Level of Need;<br>Symptom/Problem Clusters | Trained Rater                     |
| <b>C-DISC</b> Computer Voice - Diagnostic Interview Schedule for Children         | Inpatient (Sagamore CPC)<br>School Support III (NYC, 6 sites)                               | DSM Diagnosis<br>Symptom Clusters                                   | Youth                             |
| <b>CSI</b> Child Symptom Inventory - Stonybrook, Ages 6-12 years                  | Inpatient (Sagamore CPC)  | DSM Diagnosis<br>Symptom Cluster                                    | Parent<br>Teacher                 |
| <b>SACA</b> Service Assessments for Children and Adolescents                      | FFT (Functional Family Therapy, 11 teams, 5 locations)                                      | History of Service Use  | Trained rater (interviews parent) |
| <b>SDQ</b> Strengths and Difficulties Questionnaire                               | FFT (Functional Family Therapy, 11 teams, 5 locations)<br>School Support III (NYC, 6 sites) | Level of Need;<br>Symptom/Problem Clusters                          | Parent<br>Youth                   |
| <b>YI</b> Youth Inventory - Stonybrook, 13-18 years                               | Inpatient (Sagamore CPC)  | DSM Diagnosis;<br>Symptom Clusters                                  | Youth                             |
| <b>YDQ</b> Youth Outcome Questionnaire  | FFT (Functional Family Therapy, 11 teams, 5 locations)                                      | Outcomes  | Parent<br>Youth                   |
| <b>YSBI</b> Youth Symptom Behavior Inventory, Child/Adolescent Measurement System | FFT (Functional Family Therapy, 11 teams, 5 locations)                                      | Level of Need;<br>Symptom/Problem Clusters                          | Parent<br>Youth                   |

\* Single Point of Access.

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### Developmental Assessment Tools

**Ages and Stages Questionnaires** (ASQ and ASQ SE, 1991) are a series of questionnaires that screen and monitor a child's development between 4 months and 5 years of age. The *Ages & Stages Questionnaires® (ASQ): A Parent-Completed, Child-Monitoring System, Second Edition*, is a comprehensive developmental screening tool designed to find out if the child is on track or if he or she should receive a more in-depth assessment to determine the need for specialized services. Developmental areas screened by this measure include: communication, gross motor, fine motor, problem solving, and personal-social; plus self-regulation, compliance, language, adaptive behaviors, autonomy, affect, and interaction with people. The website is <http://www.agesandstages.com/asq/index.html>.

**Battelle Developmental Inventory**, Second Edition (BDI-2, 2005) is designed for use with children between birth and 7 years, 11 months. The assessment can be given up to three times a year, and is available in Spanish. There is both a screening version and an assessment version. The domains covered in the scale include: personal social, adaptive, motor, communication, cognitive.

**Bayley Scales of Infant and Toddler Development**, Third Edition (Bayley-III) can be used to measure development and developmental delays in very young children (ages 1- 42 months). This instrument includes assessment scales for adaptive behavior, cognitive functioning, social-emotional growth, language, and motor skills. Three scales are administered with child interaction, and two with parent questionnaires. The Bayley can be used as a screening tool, a tool to monitor growth or to identify developmental delays, and to determine the need for further in-depth assessment.

The **Prescreening Developmental Questionnaire** (PDQ-II, 1998) has been developed to help parents quickly identify whether their children need further assessment. The PDQ-II is a pre-screening consisting of 91 parent questions. The questionnaires are divided by age range (0 to 9 months, 9 to 24 months, 2 to 4 years, and 4 to 6 years). The website is <http://www.denverii.com/>.

### Measures of Adaptive Behavior

**Adaptive behaviors** are everyday living skills such as walking, talking, getting dressed, going to school, going to work, preparing a meal, cleaning the house, etc. They are skills that a person learns in the process of adapting to his/her surroundings. Since adaptive behaviors are for the most part developmental, it is possible to describe a person's adaptive behavior as an age-equivalent score. An average five-year-old, for example, would be expected to have adaptive behavior similar to that of other five-year-olds. The purpose of measuring adaptive and maladaptive behavior is usually either for diagnosis or for program planning. The diagnosis of mental retardation, for example, requires deficits in both cognitive ability *and* adaptive behavior, occurring before age 18. Adaptive behavior assessment is also used to determine the type and amount of special assistance that people with disabilities may need. This assistance might be in the form of home-based support services for infants and children and their families, special education and vocational training for young people, and supported work or special living arrangements such as personal care attendants, group homes, or nursing homes for adults. Adaptive behavior assessments are often used in preschool and special education programs for determining eligibility, program planning, and assessing outcomes.

**The Adaptive Behavior Assessment Systems**, Second Edition (ABAS II, 2003) is a norm-referenced tool designed to assess the adaptive skills in individuals from birth to 89 years of age

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using 1999-2000 census data. The tool measures the following skill areas: communication, community use, functional academics, home living, health and safety, leisure, self-care, self-direction, social, and work (optional). This measure is a comprehensive tool that assists in the diagnosis and classification of disabilities and medical/clinical disorders, the identification of strengths and weaknesses, service needs for treatment and intervention, and evaluation.

**The Comprehensive Test of Adaptive Behavior-Revised** (CTAB, 2000) is an adaptive behavior assessment measure to precisely evaluate the adaptive abilities of an individual who has a disability from birth. It provides descriptive and prescriptive information for ages 0 to 60 years. It assesses an individual's self-help skills, home living skills, independent living skills, social skills, sensory and motor skills, language concepts, and academic skills.

**Vineland Adaptive Behavior Scales, Second Edition** (VABS-II) is an assessment designed for use to evaluate personal and social skills of children and adults from birth to age 90. It can be used to identify and develop interventions for individuals with a cognitive disability, autism spectrum disorders, attention deficit hyperactivity disorder (ADHD), brain injury, or dementia/Alzheimer's disease. The assessment provides information for developing educational and treatment plans. The item contents reflect tasks and daily living skills that are related to current societal expectations. The content and scales are organized within a three-domain structure (communication, daily living, and socialization) that corresponds to the three broad domains of adaptive functioning recognized by the American Association of Mental Retardation (AAMR, 2002): conceptual, practical, and social. In addition, the assessment includes a motor skills domain and a maladaptive behavior index.

The following document, *Eligibility Assessment Guidelines for B2H Referrals*, provides eligibility guidelines for anyone seeking services through the Office of Mental Retardation and Developmental Disabilities (OMRDD) system and for the Bridges to Health Waiver Program (*see Chapter 3, Special Health Care Services*).

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NYS Office of Mental Retardation & Developmental Disabilities

## Putting People First

### Eligibility Assessment Guidelines for B2H Referrals

A psychological assessment designed to make a differential diagnosis of some form of developmental disability (DD), for inclusion in an OMRDD eligibility packet, must address the key elements of a DD diagnosis. These elements are:

- A. Date of onset (prior to 22 years of age),
- B. Disorder that is **neurologically based** (affects brain and/or spinal cord),
- C. The disorder produces significant adaptive behavior deficits currently and prior to the age of 22,
- D. The condition will last indefinitely.

#### **A. Date of Onset**

1) All developmental disabilities must involve a condition that is **neurologically based** and impacts the person **prior to the age of 22**, and therefore, diagnosis of such a disability requires that a psychologist obtain and present information pertaining to this developmental period. If the person being referred is older than 22, the complete referral packet must include documents supporting the presence of the disability prior to 22. If the person is younger than 22, the psychological must **describe present findings and what has been reported through examination and interview that supports the posited disorder**. For example, for a diagnosis of Autism to be supported, specific descriptions of impaired social relationships, language delay, and stereotypic/compulsive behaviors currently and in childhood, i.e., 2 – 5 years old, must be included to support the diagnosis. If the psychologist examines a person whose circumstance precludes obtaining developmental history, the clinician must state that no history can be obtained, and they must state their judgment regarding the date of onset. They must also address the possibility that events occurring between the age of 22 and the present age could or could not have produced the present deficits.

2) It is possible for a neurological disorder to be present prior to the age of 22, but not produce significant adaptive behavior deficits until after that age. For example, if a seizure disorder is present prior to the age of 22 but relatively well controlled with medication, it may be that the person is developing relatively normally. However, if in their late 20's or 30's the person's seizure disorder significantly worsens, and at that time they present with significant adaptive behavior deficits, they are not considered developmentally disabled.

#### **B. Neurological Disorder**

Aside from the neurologically based disorders that are known by many professionals to be the basis for developmental disabilities (for example, mental retardation, Autism, Cerebral Palsy), there are many obscure conditions that may have to be researched to ensure that they are indeed, neurologically based and not orthopedic or muscular in nature. Evidence of the neurological basis of the disorder is required. However, some non-neurological disorders, for example, osteogenesis imperfecta, may evolve into neurological disorders. If this progression or regression is the basis of the neurological

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disorder that supports a developmental disability diagnosis, a physician must establish this through a consult. It must be reported that the previously non-neurological disorder is now having neurological effects, and these effects have caused significant adaptive behavior deficits prior to the age of 22. Note that psychiatric disorders (depression, anxiety, schizophrenia, bipolar disorder, etc.) are never considered a basis for making a diagnosis of developmental disability even though they may produce similar symptoms at times, and even though most experts agree that anomalies of brain chemistry or structure are the basis of many of these disorders.

### **C. Adaptive Behavior Deficits**

All developmental disabilities must be diagnosed on the basis of the present and past existence of significant adaptive behavior deficits. Regardless of the documented deficits that existed prior to the age of 22, if these deficits no longer exist the person cannot be diagnosed with a developmental disability. Conversely, if significant adaptive behavior deficits are currently present but there is no indication that such deficits existed prior to 22, the person cannot be diagnosed with a developmental disability. A standardized assessment of adaptive behavior must be included in the psychological report\*. Standard scores of each domain must be reported. Age equivalents are not acceptable in place of standard scores. The instrument used for this purpose must be comprehensive, must be normed on an appropriate population, and must be reasonably current such that the normative sample still represents the current population. Assessments of adaptive behavior must be completed with a proper informant. A proper informant is usually a family member or someone who lives with the person. Children under 18 years of age may not be used. In the absence of a family member or someone living with the person, other knowledgeable people are acceptable as informants as long as the lack of availability of anyone else is addressed in the report. On occasion, individuals are assessed who have lived in such isolation much of their lives that there is no proper informant at all. In such cases, this must be stated in the psychological.

\*(OMRDD allows a DDSO to make an exception and not require a formal scale of adaptive behavior for an individual with an IQ below 60. However, "best practices" strongly support inclusion of an adaptive behavior scale for all individuals being referred for eligibility, and failure to do so could result in a request for this to be performed subsequently if the DDSO believes this is needed for a proper determination.)

### **Examples of Appropriate Adaptive Behavior Scales**

- Vineland II Adaptive Behavior Scales
- ABAS (Adaptive Behavior Assessment System)

### **D. Course of Condition**

Some neurological disorders may respond to treatments that significantly reduce the deleterious effects of the condition and prevent the condition from producing the significant adaptive behavior deficits that accompany a developmental disability. For example, treatment of ADHD with medication can have a profound influence on attention and behavior such that a child with ADHD can develop almost normally.

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Similarly, early intervention including speech therapy, PT, and OT can lead to significant improvements in children with PDD NOS or learning disabilities. The psychological report that uses such diagnoses as the basis of a developmental disability must address the likelihood that the condition will last indefinitely even if provided with conventional medical and other treatments. Traumatic brain injuries also present unique assessment issues that must be addressed in the psychological report, particularly in the determination of whether or not the person will likely regain sufficient brain function over time or continue to present with significant adaptive behavior deficits.

### **Cognitive Functioning**

***Mental retardation*** is the only developmental disability that must be diagnosed on the basis of both ***adaptive behavior*** deficits and ***cognitive limitations***. ***A diagnosis of mental retardation therefore absolutely requires the results of an IQ test.*** Nevertheless, OMRDD strongly advises that all eligibility examinations include an IQ test to ensure a proper eligibility determination even if the presenting diagnosis is not mental retardation. The selection of an IQ test must be based on the age and individual needs of each person. However, instruments that are not comprehensive (i.e., the Cognistat, WASI or Slosson) are never accepted. Except for the non-standardized use of the Bayley Scales for individuals with IQ's in the Severe or Profound range of mental retardation, tests may never be translated from English into the person's primary language even if the examiner is fluent in that language.

- **For children whose only language or preferred language is not English, or for nonverbal or deaf children**, the performance items of the Wechsler scales or Stanford-Binet must be used in combination with a language-free instrument such as the \*Leiter-R or C-TONI.
- **For Spanish speaking children**, the new Spanish WISC is acceptable, and if used, obviates the need for use of a language-free instrument.
- **For children and adults whose intellectual functioning is too low for measurement by age-appropriate standardized instruments**, an infant scale should be administered, such as the Bayley III. An IQ and level of mental retardation must still be reported, even if it is an estimate.
- **For children and adults who are extremely difficult to test due to non-compliance, hyperactivity, or inattention**, but who are likely to have IQ's above the Profound or Severe range, it is expected that clinicians will make repeated attempts to obtain a valid test protocol. The Bayley Scales are not to be used in such situations. If these attempts are unsuccessful, the clinician is expected to complete a report with clear statements regarding the difficulties they encountered in attempting to test the individual, and to state any estimate of functioning level they can make with support for their statements. The DDSO eligibility committee will have the discretion to accept the report as submitted and to make their determination with the materials submitted or to request another testing session.
- **For most other children, ages 6 - 16**, the WISC IV or Stanford-Binet V are acceptable instruments.
- **For non-English speaking, deaf, or nonverbal adults**, the performance items of the Wechsler scales or Stanford-Binet must be used in combination with a

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language-free instrument such as the \*Leiter-R or C-TONI in order to determine intellectual functioning.

- **For most other adults**, the WAIS III or Stanford-Binet V are acceptable instruments.

### **Narrative**

Psychological test reports for differential diagnosis and eligibility determination must provide a cogent analysis of past and present test data and history. The purpose of the report is to provide a diagnosis and to support this diagnosis. Therefore, large variations in IQ scores over time, the effects of emotional disturbance or attention on testing, a gross discrepancy between adaptive functioning and measured IQ, peculiar patterns of adaptive functioning, etc. must be addressed in the narrative so that the diagnosis is properly supported.

### **\*Special Testing Considerations**

The **Leiter-R** is an instrument designed for testing people who are nonverbal, do not speak English, or who are deaf. The publisher of the Leiter-R addresses the use of their instrument to diagnose mental retardation in children specifically. They note that “some attempt to measure the client’s skills in these (verbal/communication) areas (e.g., in the client’s native language) should be pursued to supplement the Leiter-R.” However, since the translation of test items into another language does not produce results that can be interpreted via a normative sample, OMRDD has instead emphasized obtaining results of the nonverbal portion of the Wechsler Scales and Stanford-Binet V to supplement the results of the Leiter-R. Except in the case of the Bayley III Scales, OMRDD will not include results of translated tests in its review.

The **Bayley III** is an instrument designed to test infants and toddlers up to the age of 42 months. Although the Bayley III Scales include some verbal items, OMRDD recommends and expects that this instrument be administered in a non-standardized manner for consumers of any age who are too low functioning (and who may lack language) as to make administration of age-appropriate instruments impossible. Therefore, it is not expected that the administration of the Bayley will result in a protocol according to the guidelines of the publisher. Indeed, items may be translated into another language, or it may be necessary to query caregivers as to whether or not the consumer has ever demonstrated the skill being rated if the consumer cannot cooperate for an actual test item. Its use is simply to allow the examiner to make some valid statements regarding the estimated mental age and likely functioning level of the consumer.

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### Substance Abuse Resources

Screening and Assessing Adolescents For Substance Use Disorders  
*Treatment Improvement Protocol (TIP) Series 31*  
(available from: <http://ncadi.samhsa.gov/>. Enter “TIP 31” into Search.)

Excerpts from Chapter 3, Comprehensive Assessment of Adolescents for Referral and Treatment:

Comprehensive assessment follows a positive screening for a substance use disorder and may lead to long-term intervention efforts such as treatment. Screening procedures identify that a youth may have a significant substance use problem. The comprehensive assessment confirms the presence of a problem and helps illuminate other problems connected with the adolescent's substance use disorder. Comprehensive information can be used to develop an appropriate set of interventions.

Listed below are the domains that should be assessed to arrive at an accurate picture of the adolescent's needs or problems:

- History of use of substances, including over-the-counter and prescription drugs, tobacco, and inhalants – the history notes age of first use; frequency, length, and pattern of use; mode of ingestion; treatment history; and signs and symptoms of substance use disorders, including loss of control, preoccupation, and social and legal consequences.
- Strengths and resources to build on, including self-esteem, family, other community supports, coping skills, and motivation for treatment.
- Medical health history and physical examination, noting, for example, previous illnesses, ulcers or other gastrointestinal symptoms, chronic fatigue, recurring fever or weight loss, nutritional status, recurrent nosebleeds, infectious diseases, medical trauma, and pregnancies.
- Sexual history, including sexual orientation, sexual activity, sexual abuse, sexually transmitted diseases (STDs), and STD/HIV risk behavior status (e.g., past or present use of injecting drugs, past or present practice of unsafe sex, selling sex for drugs or food).
- Developmental issues, including possible presence of attention deficit disorders, learning problems, and influences of traumatic events (such as physical or sexual abuse).
- Mental health history, with a focus on depression, suicidal ideation or attempts, attention-deficit disorders, anxiety disorders, and behavioral disorders, as well as details about prior evaluation and treatment for mental health problems.
- Family history (including parents, guardians, and extended family) of substance use, mental and physical health problems and treatment, chronic illnesses, incarceration or illegal activity, child management concerns, and the family's ethnic and socioeconomic background and degree of acculturation. (The description of the home environment should note substandard housing, homelessness, proportion of time the young person spends in shelters or on the streets, and any pattern of running away from home. Issues regarding the youth's history of child abuse or neglect,

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involvement with the child welfare agency, and foster care placements are also key considerations. The family's strengths should be noted as they will be important in intervention efforts.)

- School history, including academic and behavioral performance, and attendance problems.
- Vocational history, including paid and volunteer work.
- Peer relationships, interpersonal skills, gang involvement, and neighborhood environment.
- Juvenile justice involvement and delinquency, including types and incidence of behavior and attitudes toward that behavior.
- Leisure-time activities, including recreational activities, hobbies, and interests.

### CRAFFT Substance Abuse Screening Instrument

Recommended by the American Academy of Pediatrics in its Alcohol Use and Abuse: A Pediatric Concern. See <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;108/1/185>.

| CRAFFT—Questions to Identify Adolescents With Alcohol Abuse Problems* <sup>27</sup> |   |
|---|---|
| C   | Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? |
| R   | Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?                                       |
| A   | Do you ever use alcohol or drugs while you are by yourself, or ALONE?   |
| F   | Do you ever FORGET things you did while using alcohol or drugs?   |
| F   | Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?                          |
| T   | Have you ever gotten into TROUBLE while you were using alcohol or drugs?  |

\* Two or more "yes" answers suggest that the adolescent has a serious problem with alcohol or drug abuse.

**Note:** The DAST and MAST are listed below as examples of screening tools.

#### Drug Abuse Screening Test (DAST)

<http://counsellingresource.com/quizzes/drug-abuse/index.html>

The purpose of the DAST is to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs; and to yield a quantitative index score of the degree of problems related to drug use and misuse. This 20-item instrument may

<sup>27</sup> J.R. Knight, L.A. Shrier, T.D. Bravender, M. Farrell, J. Vander Bilt, H.J. Shaffer. "A new brief screen for adolescent substance abuse," *Archives of Pediatrics & Adolescent Medicine*, 153 (1999), pp. 591-596.

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be given in either a self-report or in a structured interview format. DAST obtains no information on alcohol use, the type of drugs used, or the frequency or duration of drug use.

Michigan Alcohol Screening Test (MAST)

<http://alcoholism.about.com/od/tests/a/mast.htm>

## Child Abuse and Neglect Resources

New York State Child Advocacy Resource  
and Consultation Center (CARCC)

320 Schermerhorn Street

Brooklyn, NY 11217

718-330-5455

866-313-3013 toll free

718-330-5462 fax

<http://www.nyscarcc.org>

Established in 1996 as a program of Safe Horizon, CARCC's mission is to work with Multidisciplinary Teams and Child Advocacy Centers throughout New York State to promote and enhance multidisciplinary responses to child sexual abuse and child fatality reviews (*see website for a list of centers*). This approach maximizes the strength of all disciplines involved in child abuse investigations and minimizes the trauma to child victims. The Center is committed to building on existing resources to benefit multidisciplinary efforts across New York State and to providing services tailored to the needs of each community they serve. CARCC provides periodic regional trainings throughout the year. The New York State Children's Alliance (NYSCA), formed in 1997, is composed of multidisciplinary team coordinators and Child Advocacy Center directors. Contact CARCC to obtain a copy of the NYS Children's Justice Task Force Forensic Interviewing Best Practices protocol. It can also be downloaded from the OCFS Intranet at <http://ocfs.state.nyenet/dps/pdf/NYSCJTFForensicInterviewBestPractice.pdf>.

Child Abuse Evaluation and Treatment for Medical Providers

<http://www.childabusemd.com/index.shtml>

The above website is an online resource for medical providers who do not have a background or expertise in child abuse pediatrics and are striving to develop best practice standards for their patient care setting. It was developed under the direction of Dr. Ann Botash at SUNY Upstate Medical University.

Child Abuse Medical Provider Program (CHAMP)

<http://www.champprogram.com/default.asp>

CHAMP's goal is to improve the New York State medical response to suspected child abuse by improving the examination, treatment, documentation, community referral, and management of suspected child abuse cases.

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American Professional Society on the Abuse of Children

<http://www.apsac.org/mc/page.do>

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The American Professional Society on the Abuse of Children (APSAC) is a membership organization for professionals who work in child abuse and neglect. Its mission is to improve the quality of practice provided by professionals who work in child abuse and neglect through:

- Providing professional education that promotes effective, culturally sensitive, and interdisciplinary approaches to the identification, intervention, treatment, and prevention of child abuse and neglect.
- Promoting research and practice guidelines to inform all forms of professional practice in child maltreatment.

Resources include the website, a quarterly newsletter, a quarterly peer-reviewed scientific journal, guidelines (handbook) on child maltreatment, an annual colloquium, training seminars, and state chapters for state-level training and networking.

Child Welfare Information Gateway

<http://www.childwelfare.gov/aboutus.cfm>

Child Welfare Information Gateway promotes the safety, permanency, and well-being of children and families by connecting child welfare, adoption and related professionals as well as concerned citizens to timely, essential information.