



LEJ Policy Brief

December 2010

Is Hawai'i a Good Parent?

Systemic Failures in Providing Critical Services to Foster Youth in Hawai'i

HAWAII APPLESEED CENTER for LAW AND ECONOMIC JUSTICE

P.O. BOX 37952 HONOLULU, HAWAII 96837-0952

tel. (808) 587-7605 web: www.hiappleseed.org





Acknowledgements

Lawyers for Equal Justice would like to thank the following individuals who assisted in the development of this report:

Substantial contributions to the research and drafting of this paper were made by Rebecca Wolitz, LEJ Summer Law Clerk 2010 from Yale Law School

Twenty Guardian ad Litema who participated in these interviews for their time, concern, and candid responses

Daniel Pollard and Nalani Fujimori-Kaina for their assistance in identifying persons familiar with the foster care system as potential interviewees for research required to complete the report

We hope that this report is informative and helps stimulate advocacy efforts directed at improving the lives of Hawai'i's youth in foster care.





Introduction

Children in foster care often come from difficult pasts and have uncertain futures. Lacking alternatives, they are dependent upon government agencies to provide them with crucial services. Such services are not only necessary to promote and safeguard the current health and wellbeing of these children, but also to ensure that they have adequate support to become well adjusted, flourishing adults.

For several years some children's advocates in Hawai'i have claimed that a variety of services required by youth in foster care were not being properly provided by the Department of Human Services (DHS) and/or the Department of Health (DOH). In particular, Lawyers for Equal Justice (LEJ) had been told that the provision of mental health services was an area in need of dramatic improvement. Recognizing the significant effect inadequate services would have on Hawai'i's youth in foster care, LEJ decided to acquire more information on the provision of services with the goal of identifying systemic weaknesses. Depending upon these results and further research, LEJ may decide at a future date to initiate advocacy efforts including possible litigation to strengthen the child welfare system.

During the months of June and July 2010, LEJ contacted 26 community members possessing direct experience with and knowledge of youth in foster care and their ability to access and receive government services. These individuals were predominantly guardians ad litem (GALs), however, a few were voluntary guardians ad litem (VGALs) or foster parents (also called resource parents); one was a social worker. The Executive Director of LEJ, Victor Geminiani, in conjunction with Danny Pollard from the Honolulu office of the Legal Aid Society of Hawai'i generated the contact list. Contacts were either affiliated with Legal Aid Society of





Hawai'i or professional associates. The decision to focus primarily on GALs was motivated by a desire to speak with an accessible group of professionals that would be able to provide a wide range of potentially unbiased information. Information was gathered through relatively unstructured, informal conversations providing interviewees with the opportunity to reflect upon their experiences, and share their thoughts about particular cases or overarching issues.

Of the 26 individuals contacted, 20, or seventy-seven percent (77%), were available for interviews. Interviews were predominantly conducted in person or over the phone, though a few participants submitted email responses. The experience of interviewed GALs ranged from less than 1 year to more than 20. Their number of current foster care cases ranged from 0 to 37. While most interviewees were based in Oahu, 3 were from Big Island (representing both Kona and Hilo), 3 were from Maui, and 2 were from Kauai.

This report is divided into four parts. Parts A and B summarize the results of these interviews. Part C discusses the negative impact of delayed and inadequate services on youth in foster care. Part D presents a brief discussion of the federal laws governing issues raised by interviewees and makes suggestions for further research. To respect the confidentiality of individuals interviewed for this project, identifying citations have been redacted.



Part A

What are the most prominent problems interfering with access to mental health services for youth in foster care?

This section of the report summarizes the most prominent issues identified by interviewees that interfere with access to mental health services by youth in foster care. Despite the diversity of geographic location and work experience, interviewees consistently raised concerns about: social workers, delays, quality, kind, and availability of care, transportation and convenience.

1. Social Workers

A majority of interviewees, sixty-five percent (65%), reported either dissatisfaction with social workers or expressed concern that social workers were overextended and therefore unable, sometimes through no fault of their own, to accomplish everything that their jobs demand. Comments were on a spectrum. Some felt that, “Social workers are overworked, but good.” Others remarked: “Social workers are terrible.” “Only 2% of social workers do a good job.” A few, when asked about their interactions with social workers, said that they had no problems to report.

Those expressing dissatisfaction with social workers were most concerned about the following:

- Required referrals not being made.
- Referrals not being made in a timely manner.
- Legally mandated timelines for follow-ups and visits not observed.
- A lack of awareness on behalf of social workers of all the services available to youth in foster care.
- Increased pressure on GALs to be more aggressive advocates and pick up the slack for social workers.
- Social worker apathy about their employment.

- Social workers potentially actively causing harm, for example, by refusing to implement a therapist's treatment regime.
- Budgets cuts resulting in social worker aversion to calling and participating in team meetings.

Interviewees repeatedly emphasized that social workers are gatekeepers to accessing mental health services. “Who your social worker is, is key.” As facilitators and coordinators, social workers are often responsible for making referrals and appointments, arranging transportation, and interfacing between different government agencies or other members of the foster child's team. Failure to facilitate or coordinate effectively was cited as causing delays and ultimately affecting access to government services.

The issue of psychiatric evaluations repeatedly arose. According to interviewees, only social workers can place requests for initial psychiatric evaluations. The timing of this request is critical because DOH will not provide a child in foster care with mental health services until DOH receives the results of this initial evaluation. Delays in placing the referral negatively affect youth who are in need of care. It also causes a ripple effect of delays because the system is not necessarily well functioning further down the line. Similar concerns were raised regarding other kinds of referrals.

Despite deep frustration with individual social workers, many interviewees were at pains to point out that budget cuts likely play a significant role in social workers being unable to perform their jobs properly. Reduced funding and staffing has forced social workers to take on an increased caseload. One GAL estimated that each social worker is now responsible for double the amount of cases. Under such circumstances, “It is inevitable that some things fall between the cracks.” The work that social workers do is very important for adequate access to and provision of mental health services for youth in foster care. If their jobs are not done

properly, however, for whatever reason, the mental health of youth in foster care will likely suffer the consequences.

2. Delays

Sixty-five percent (65%) of interviewees expressed concern about unnecessary and harmful delays in the provision of mental health services for youth in foster care. LEJ was repeatedly told that getting mental health services for foster kids is “slow.” As one GAL puts it, “You can’t get it when you need it. You need something tomorrow, it takes six months.” Delays were reported as interfering with the timely provision of appropriate services at multiple stages:

- Getting initial psychiatric evaluations.
- Receiving the results of those evaluations.
- Making a diagnosis about what kind of therapy is needed.
- Forcing a child to start with least level of services and slowly ratchet up until the appropriate level is reached.

While delays occurred at multiple stages in the provision of services, the most significant challenge is often just getting a child into therapy. As mentioned earlier, DOH will not provide services until it has the results of a child’s psychiatric evaluation. On Oahu, an interviewee reported that it took nine months to get a child into therapy. Others on Oahu indicated that it could take four or five months just to get a determination that therapy is needed. On Maui, LEJ was told that it usually takes more than a month to get a psychiatric evaluation. Big Island GALs reported a six-month wait for initial psychiatric evaluations; the contractor in charge of evaluations, Kapiolani Child Protection Center, has been backed up and DHS has not remedied the situation.

These delays are harmful to youth in foster care and those with whom they interact. One GAL, for example, spoke about a child who needed therapy. In the 3-5 month interim while

waiting for therapy, the child began manifesting sexually inappropriate behavior toward others. These incidents could have been avoided, in the GAL's opinion, if this child had been in therapy.

Once a child is in therapy, interviewees expressed concern about whether the mental health services being provided were appropriate for the child's needs. Interviewees observed a "one-size fits all" approach to mental health care, with all youth being provided the lowest level of mental health services possible. If the initial service plan does not work, the type and amount of services are changed slowly until the youth's needs are met. This was generally viewed as counterproductive and a waste of time and energy. Delaying appropriate, individualized services because it is easier to provide one type of service to all children and hope that it works, is harmful and unnecessary. Such delays can, say some GALs, exacerbate children's mental health conditions, making youth in foster care worse off than they otherwise would or should be.

Delays contributing to mental health issues, but derivatively related to the provision of mental health services themselves were also described. There was a general expression of concern about the timely and appropriate placement of youth in foster care. GALs reported that such delays resulted both in youth in foster care being bounced around from one placement to another and children languishing in a particular placement far beyond the time that they were supposed to have been moved. Either situation is less than ideal. In the opinion of interviewees, however, constantly changing placements is particularly damaging to the mental health of youth in foster care.¹ Placement stability is so important to the well-being of youth in foster care that the federal government measures state performance on placement stability in the Federal Child and Family Services Reviews (CFSR). The federal standard for the first round of CFSRs was

¹ A study that interviewed foster children about effects on their mental health supports these observations; iterative uprooting interferes with the ability and desire to forge positive connections and relationships. See Caroline R. Ellermann, *Influences on the Mental Health of Children Placed in Foster Care*, 30 Fam. Community Health, S23, S25-S28 (2007).

that “of all children who have been in foster care for less than 12 months from the time of the latest removal from the home, 86.7% or more should have had no more than 2 placement settings.”²

This uprooting furthermore interferes with the provision of mental health services. One GAL remarked that repeated moving interferes with “establishing a good physician-patient relationship necessary for progress.” It also “disrupts the continuity of care to have to constantly start over.” Another GAL importantly noted that the bouncing around because of delays in finding an appropriate placement is contraindicated for children with mental health issues like autism who require stability.

3. Quality, Kind, and Availability of Services and Providers

Sixty percent (60%) of interviewees were concerned about the quality or kind of mental health services being provided to youth in foster care. Additionally, thirty percent (30%) felt that there were not enough available providers and fifteen percent (15%) expressed concern about children with severe mental health issues being forced to pursue treatment on the mainland due to a lack of on-island facilities.

Some GALs expressed concern about the quality of the care given by mental health care providers. They felt that the mental health care received was not very good. Several also expressed concerns about DOH cutting off services prematurely, thus negatively impacting the overall quality of care. As soon as progress is made “they want to cut you off.” Noting that the emotional wellbeing of children and adolescents can be volatile, one GAL observed that this

² See, e.g., Children’s Bureau/ACF/DHHS, *General findings from the federal child and family services review* (2004) <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/genfindings04/ch1.htm> (last visited December 2, 2010); Children’s Bureau/ACF/DHHS, *Chapter IV: Achieving Outcomes Related to Placement Stability and Appropriate Placements for Young Children in Foster Care*, Child Welfare Outcomes (2003) <http://www.acf.hhs.gov/programs/cb/pubs/cwo03/chapters/chapterfour2003.htm>, last visited December 2, 2010)

practice is short sighted. Just because progress has been made one week, does not mean that it will necessarily be sustained over subsequent weeks. DOH mental health care coordinators, furthermore, were often perceived in a negative light. “It’s as if someone takes them aside and tells them to provide as few services as possible or try to get someone else to be responsible.” Interviewees also complained that agency employees say “no” too frequently and refuse creativity in overcoming barriers to providing services. GALs attributed this behavior to budget cuts. Several interviewees had experiences where they were told a service could not be provided because there was no funding.

Most interviewees, however, raised concerns about the kind of services available to youth in foster care. One interviewee observed that it is harder to get therapy for children who are not high end, but who nevertheless are having a hard time coping with separation from parents or siblings. Twenty-five percent (25%) of interviewees spoke in particular about the predicament of “in-between” cases. Examples of in-between cases included those suffering from mild mental retardation (MMR) and autism. According to GALs that were interviewed, youth in foster care with MMR, for example, have a very hard time getting services because the Mental Health Division of DOH considers the individual to have too low an IQ to qualify for their services and the Developmental Disability Division considers the individual’s IQ to be too high. One GAL interviewed told LEJ about a teenager with MMR who needs 24-hour supervision, but does not qualify for services under Support for Emotional and Behavioral Development because of the nature of the individual’s condition. In another case, a teenager with Asperger’s, a form of autism, has been bounced around between shelters because there are no appropriate homes set up to deal with this condition. The various government agencies involved (DHS, DOH, and DOE)

pass the responsibility for providing this child with services amongst themselves, ultimately rendering the receipt of services delayed or inaccessible.

GALs also expressed dissatisfaction with the kind and number of residential care facilities and services available to youth in foster care. Like the child with Asperger's, youth in foster care who are very high end or no longer acute but still struggling with significant mental health issues often lack appropriate placements. According to one interviewee, the "highest end kids get sent to the mainland, to places where it would be very hard for a kid from Hawai'i to go, like Colorado." This is because there either is not an appropriate facility or placement in Hawai'i, or because the facility that would have been utilized is at capacity. Concern was also reported about children who are no longer acute. It was said that few options exist for youth in foster care who need significant residential care but no longer qualify for facilities treating acute cases.

In addition to a deficit of certain kinds of facilities, interviewees, particularly from neighbor islands, were very concerned about a lack of providers. Providers are particularly scarce for youth in foster care living in remote or rural parts of an island. This can be a major stumbling block for children in need of mental health services. One GAL described a case on Big Island where there was only one specialist that could provide the therapy needed by a foster child. The child and doctor had a strained relationship. The child dropped out of therapy, but had nowhere else to go. Consequently, the foster child never received the needed therapy.

4. Transportation and Convenience

A lack of providers often dovetails with the barriers created by the lack of transportation. Forty-five percent (45%) of interviewees cited transportation as being a major interference with

the provision of mental health services. While GALs on Oahu also raised this issue, those interviewed from neighbor islands frequently cited transportation as being one of the most significant interferences with access to mental health services by youth in foster care. Because local providers are scarce in rural areas, youth in foster care (and foster parents) often have to travel great distances to access therapy or other mental health services.

GALs said that DHS and in turn its contractors are responsible for providing transportation. Due to budget cuts, however, those responsible seldom provide transportation service in practice. One primary service program on the Big Island, for example, provides many kinds of services including transportation. The demand for services, however, outstrips the ability of this contractor to fulfill its obligations. Significant delays of multiple months have resulted. The transportation burden then falls on foster parents who are often unable or unwilling to routinely make a two or three hour roundtrip trek, on neighbor islands, for weekly therapy appointments. Though foster parents might be able to receive extra payments for transporting youth in foster care themselves, interviewees thought that DHS does not do an adequate job of educating foster parents about this possibility. This situation has, for many youth in foster care, rendered crucial mental health services inaccessible.

The problem of transportation is more generally an issue of convenience. In that vein, many GALs also lamented the availability of convenient mental health appointments for youth in foster care. After-school therapy appointments are hard to obtain. The situation of choosing between missing school or missing a therapy session is less than ideal—particularly when school may be the only constant in a foster child's life.

Part B

What other problems exist with the foster care system in general or provision of services in particular?

Interviewees raised three important additional issues that either constituted a small minority or did not fit squarely under the umbrella of access to mental health services. Lean foster parent training, a lack of education about mental health services available to youth in foster care, and inadequate transitional services for children aging out of the system were cited by interviewees as additional problems with the foster care system.

1. Resource Family Training

One interviewee expressed deep concern about the criteria for becoming a foster parent, and the process by which foster parents are trained. According to this individual, “Training for foster parents keeps getting cut back. It is now only nine hours of face time training. The rest is computerized.” It was also noted by the interviewee that, “Hawai`i is only one of two states that does not require continuing training to foster parents.” This scaling back of training was viewed as a deep disservice to youth in foster care.

2. Education About Services

Twenty percent (20%) of interviewees raised concerns about a general lack of education regarding what services are available as well as agency procedures for eligibility and receipt of services. Many GALs felt that DHS and DOH do not adequately educate children, parents, foster parents, and professionals about available resources. LEJ was told, for example, about the

predicament of teenagers approaching their 18th birthdays. “Kids don’t know what services are available to them...to help their transition and their future.” Acronyms were said to be numerous and confusing, administrative procedures opaque. Interviewees felt as though they need to be especially zealous advocates because they work within a broken system. A lack of comprehensive education about how the system works and what services the system provides, can make this situation that much more challenging to navigate.

3. Transitional Services for Children Aging Out

Twenty-five percent (25%) of interviewees expressed discomfort with how teenagers age out of the foster care system. As one individual expressed it “Kids reach their 18th birthday and are told ‘Congratulations you’re 18 and now you’re homeless.’” This interviewee described getting calls from kids whose foster parents told them to be out of the house within days following their 18th birthdays.

GALs observed that how a teenager fared earlier in life was a good indicator of how he/she would transition out of the system into adulthood. They also noted that a child’s last placement and foster parents could have great negative or positive influence on this process.

Anecdotes about kids aging out, however, were generally grim. The most vulnerable of youth in foster care, those with significant mental health or other issues, often have rough transitions. GALs frequently fear that these kids are at increased risk for either ending up homeless or in jail. In terms of services available to youth in foster care aging out of the system, interviewees discussed youth circles and some transitional programs offered by Hale Kipa. Interviewees, however, were uncertain as to what services government agencies in particular

must provide, by law, for these teenagers. There was simply concern and consensus that the needs of this population desperately require more robust attention.

Part C

What is the impact of delayed services on youth in foster care?

Delays in providing needed services to youth in foster care violate state and federal laws and create extensive and unnecessary liability for Hawai'i. More importantly, delays in providing medical care, mental health services, education, and appropriate temporary homes hurt children.

Numerous studies have shown that prompt attention to the needs of traumatized children helps to mitigate the long-term consequences of the trauma. Every child who is taken away from a parent experiences the trauma of separation and loss; the trauma of adjusting to a new home, routine, people, foods, and possibly school. Regardless of the benefits of changes in their lives, major changes are traumatic for children unless they have protective factors in place to help them deal with the change. Protective factors might include having a known, caring adult who can explain to the child what is happening, moving cherished belongings such as a blanket or teddy bear to a new home with the child, and placing children with siblings. Additional protective factors might include maintaining connections with friends and relatives, keeping the child in the same school, not disrupting medical treatment, and providing counseling or other therapeutic services.

The Child Welfare League of America (CWLA), the American Academy of Pediatrics (AAP), and the American Academy of Child and Adolescent Psychiatry (AACAP) all

recommend that every child entering foster care should receive a complete medical screening when placed into foster care and a comprehensive physical and mental health assessment within a month of being placed into foster care. Youth in foster care should receive ongoing health services at more frequent intervals than children who are not in foster care.³ Each of these organizations has put forward standards which outline the need for a systematic, coordinated approach to the delivery of health services to meet children's ongoing health needs.⁴ The health needs of youth in foster care are of such concern to the AAP that the organization has created a web site, Health Foster Care America, specifically to provide standards and information about the needs of youth in foster care, with special guidance on the needs of specific subgroups of youth in foster care.⁵ Three distinct subgroups of youth in foster care have specialized needs.

1. Very young children

Hawai'i knows how critical it is to address the needs of very young children in foster care: Hawai'i has a Zero to Three specialty court that was created precisely because of the long-term benefits of quickly and appropriately addressing the unique needs of children younger than 36 months. Much research has been conducted on the needs of young children who have been abused and neglected and on the lasting effects of maltreatment at a young age.⁶ Younger children are more likely to experience negative long-term consequences from maltreatment.

³ See, e.g., American Academy of Pediatrics Committee on Children with Disabilities, *Care Coordination: Integrating Health and Related Systems of Care for Children with Special Health Care Needs*, Pediatrics, Vol. 104, No. 4, 978 (1999).

⁴ CWLA and AAP, *Standards for Health Care Services for Children in Out-of-Home Care* (1998, revised 2007); AAP, *Fostering Health: Health Care for Children and Adolescents in Foster Care* (2004), *Developmental Issues for Young Children in Foster Care* (2000), *Health Care of Young Children in Foster Care* (2002); AACAP, *Psychiatric Care of Children in the Foster Care System* (2001), *Foster Care Mental Health Values* (2002), and *Screening and Assessment of Children in Foster Care* (2003).

⁵ Healthy Foster Care America, <http://www.aap.org/fostercare/index.html> (last visited December 2, 2010).

⁶ See, e.g., Chrystal Wiggins, et. al, *Literature Review: Developmental Problems of Maltreated Children and Early Intervention Options for Maltreated Children*, ZERO TO THREE (April 2007), available at <http://aspe.hhs.gov/hsp/07/Children-CPS/litrev/index.htm>.

Research has also shown, however, that supportive services for young children can minimize the negative effects, if the services are appropriate and provided in a timely manner.⁷

2. Children with special needs

Children in foster care have a higher prevalence of medical and mental health needs than the general population of children. The U.S. Government Accountability Office told Congress that “80% [of children in foster care] are estimated to have significant health care needs, including chronic health conditions, developmental concerns, and mental health needs.”⁸

Children with developmental delays can make great strides in their development when specialized services are provided when they are very young. One of the keys to ameliorating the negative effects of maltreatment and maximizing children’s healthy development is early identification of development delays. Congress has recognized the benefits of early intervention services: the Child Abuse Prevention and Treatment Act of 1974,⁹ amended by the Keeping Children and Families Safe Act of 2003,¹⁰ requires states to screen every child under the age of three who has a substantiated case of maltreatment. States must have a plan for screening these children and, for children with identified physical or mental conditions that are likely to result in a developmental delay and children with existing developmental delays, for referring them to the state’s services provided under Part C of the Individuals with Disabilities Education Act.¹¹ Identification alone is not enough: appropriate and timely services must be provided.

⁷ *Id.*

⁸ U.S. Government Accountability Office, *Foster Care: State Practices for Assessing Health Needs, Facilitating Service Delivery, and Monitoring Children’s Care* (GAO-09-26), February 2009, at 1.

⁹ P. L. 93-247.

¹⁰ P. L. 108-36.

¹¹ P. L. 91-230, 20 U.S.C.A. § 1431 *et. seq.*

All children in foster care who have developmental delays and special medical and mental health needs, regardless of their age, need to have those needs addressed immediately. DHS is required to have complete, current information about the child's health needs, including medical conditions and prescriptions the child is taking. If children are already receiving therapies and/or medications, DHS must ensure that there are no interruptions in these services. Resource families must be provided with enough information to properly care for the child's needs. If medications, eyeglasses, inhalers, etc., do not come into care with the child, prescriptions must be filled. An example of a preventable incident is a child with chronic asthma entering care without her daily anti-inflammatory medication. If she is placed in a home with animals and without her asthma medication, the trip she ends up taking to the emergency room because of a full-blown asthma attack is not merely foreseeable, but avoidable.

Children who are traumatized demonstrate a variety of troubling behaviors. It is the job of adults to help children deal with strong feelings and to teach children how to manage such behaviors in ways that are not destructive to the child and those around the child. When feelings are not addressed and supportive factors are not put in place for children, negative behaviors and dysfunctional relationships can become further entrenched. Children in foster care have been harmed; it is the responsibility of the state to do no further harm to these children and to try to mitigate the impact of the maltreatment. Delaying treatment and not providing protective factors as soon as children enter care is harmful and irresponsible and leads to higher needs among these children as they get older.

3. *Older youth*

Older youth who are in foster care face the difficulties of being a victim of abuse or neglect and dealing with an imperfect government system charged with their care on top of the typical difficulties associated with adolescence. Most teenagers struggle with one or more of the following: physical, hormonal, and emotional changes of puberty; identity development; peer relationships and peer pressure; school and extracurricular activities; and preparation for adulthood. Brain development is not complete until age 23-25; even youth who appear exceptionally mature do not have the same executive functioning as adults—the prefrontal cortex, the part of the brain that manages impulse control and helps people understand and evaluate the consequences of behavior, is not fully developed.¹² Because the frontal regions of their brains, where goal-oriented rational thinking occurs, are not fully developed, adolescents' decision-making occurs more often in the amygdala region, where emotional centers are located.¹³ The experiences that led to placement in foster care and the experience of being in foster care itself can affect brain development, the intensity of emotions, the feelings that are experienced, and the ways that youth handle the feelings. Supportive services can help youth manage their feelings in non-destructive ways, which contributes to appropriate decision-making, enhanced self-esteem and a positive identity—all of which are protective factors to help the youth successfully mature to adulthood.

One of the primary tasks of adolescence is identity development and youth in foster care need special attention as they master this task. Minimizing changes in schools and communities, allowing teens to engage in as many “typical” activities as possible, maintaining relationships

¹² See, e.g., Giedd, J., Blumenthal, et. al, *Brain development during childhood and adolescence: A longitudinal MRI study*, *Nature Neuroscience*, 2 (10), 861 (1999) and Beatrice Luna, Ph.D., *Brain and Cognitive Processes Underlying Cognitive Control of Behavior in Adolescence*, University of Pittsburgh, Oct. 2005.

¹³ See, e.g., Paul Thompson, Ph.D., *Time-Lapse Imaging Tracks Brain Maturation from Ages 5 to 20*, National Institutes of Mental Health, and the University of California Los Angeles, May 2004.

with siblings and extended family, including teens in decision-making about their lives, and providing mental health services, are all ways that adults caring for youth can help these youth during and after their stays in foster care. Youth in foster care must also receive appropriate, meaningful services to help prepare them for adulthood. Specifically independent living services, required by the John H. Chaffee Foster Care Independence Act of 1999, are provided

To help these children make the transition to self-sufficiency by providing services such as assistance in obtaining a high school diploma, career exploration, vocational training, job placement and retention, training in daily living skills, training in budgeting and financial management skills, substance abuse prevention, and preventive health activities (including smoking avoidance, nutrition education, and pregnancy prevention).¹⁴

In Hawai'i, independent living services are provided to youth in foster care beginning at age 12.¹⁵ Teenagers should be involved in planning and implementing their independent living plans and must be informed about the services and resources that are available to them during and after foster care. Before youth emancipate out of foster care, they need to have an individualized transition plan that addresses all the needs of the young person, including health, housing, education, and employment.

Part D

What federal laws govern these issues and might be a source for future investigation into, and potential litigation over, agency compliance?

Interviews with community members, as documented in Part A and B of this paper, have revealed that the foster care system's ability to provide services to children faces multiple systemic failures. Whether litigation is an appropriate remedy will depend, in part, on the

¹⁴ 42. U.S.C.A. § 677(a)(1).

¹⁵ See, e.g., http://hawaii.gov/dhs/protection/social_services/child_welfare/ILP.

relevant statutes. It is beyond the scope of this study to provide comprehensive legal analysis of federal statutes and case law governing the provision of mental health and other services by DHS and DOH. However, brief review of some of the relevant statutes indicates a great deal of promise for generating claims based upon some of the issues raised by interviewees. Continued investigation into these sources will reveal whether DHS and DOH operate in compliance with federal law.

1. Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272), as amended by the Adoption and Safe Families Act of 1997 (P.L. 105-89) and the Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351).

In order to receive federal funding to support Hawai`i's child welfare system, Hawai`i must comply with federal laws including the Adoption Assistance and Child Welfare Act, the Adoption and Safe Families Act, and the Fostering Connections to Success and Increasing Adoptions Act (FCSIAA), all of which are codified in Title IV of the Social Security Act, "Grants to States for Aid and Services to Needy Families with Children and for Child-Welfare Services." Promulgating regulations are found at 45 C.F.R. Parts 1355-1357.

Interviewees' concerns about social workers having too many cases, not making referrals in a timely manner, and not complying with legally mandated timelines should be examined in light of the federal requirements for case planning and case management.

Hawai`i is required to develop and implement written case plans for each child in foster care in a timely manner and to review the case plans according to the time line set out in state statute.¹⁶ Case plans must include specific information about the child's situation, including health and

¹⁶ 42 U.S.C. § 671(a)(16), 42 U.S.C. § 675(5).

education needs.¹⁷ Hawai`i must provide services that protect the safety and health of children in foster care and must ensure that foster parents are adequately prepared to provide for the needs of the child.¹⁸ Caseworkers must visit youth in foster care at least once a month and the visit must be “well-planned and focused on issues pertinent to case planning and service delivery to ensure the safety, permanency, and well-being of the children.”¹⁹

The most recently passed federal child welfare law, FCSIAA, added new requirements to the list of actions states must take to meet the health and education needs of youth in foster care. To better address the health care needs of youth in foster care, states have to develop, in consultation with health care experts including pediatricians, a plan for the “oversight and coordination of health care services for any child in a foster care placement, which shall ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs.”²⁰ The state plan must address the monitoring and treatment of identified health needs of children, the updating and sharing of medical information, “steps to ensure continuity of health care services,” and “the oversight of prescription medicines.”²¹ Hawai`i’s plan must also “include an outline of (i) a schedule for initial and follow-up health screenings that meet reasonable standards of medical practice.”²²

FCSIAA addressed the educational needs of youth in foster care by requiring each child’s case plan to include “a plan for ensuring the educational stability of the child while in foster care,” to consider the child’s educational needs and current educational setting when deciding where to place the child, and, “if remaining in [the child’s current] school is not in the best

¹⁷ 42 U.S.C. § 675(1).

¹⁸ 42 U.S.C. § 671(a)(24).

¹⁹ 42 U.S.C. § 622(b)(17).

²⁰ 42 U.S.C. § 622(b)(15)(A), emphasis added.

²¹ 42 U.S.C. § 622(b)(15)(A)(ii)-(v).

²² 42 U.S.C. § 622(b)(15)(A)(i).

interests of the child,” to work with state and local education agencies to immediately enroll the child in a new school.²³ FCSIAA also now requires states to assure the federal government that every school-aged child in foster care is enrolled in school or a home-school or independent study program unless a medical condition prohibits the child from participating.²⁴

Each child’s case plan must include documentation about how the state is meeting the child’s health and educational needs. The case plans must include

- the most recent information available regarding--
- (i) the names and addresses of the child's health and educational providers;
- (ii) the child's grade level performance;
- (iii) the child's school record;
- (iv) a record of the child's immunizations;
- (v) the child's known medical problems;
- (vi) the child's medications; and
- (vii) any other relevant health and education information concerning the child determined to be appropriate by the State agency.²⁵

Another area on which the FCSIAA focuses is youth aging out of foster care. Many studies have shown that youth aging out of foster care have much higher rates of early, unwed pregnancy; incarceration; homelessness; unemployment; and mental health needs.²⁶ One purpose of the FCSIAA is to change some of those statistics. FCSIAA allows states to elect to allow youth to remain in foster care until they turn 21 years old, if the youth are in some type of education or employment program, are employed at least 80 hours a month, or are unable to participate in these activities because of a documented medical condition.²⁷

²³ 42 U.S.C. § 675(1)(G).

²⁴ 42 U.S.C. § 671(a)(30).

²⁵ 42 U.S.C. § 675(1)(C).

²⁶ See e.g., *Time for Reform: Aging Out and On Their Own*, The Pew Charitable Trusts and the Jim Casey Youth Opportunities Initiative (2007), available at <http://www.jimcaseyyouth.org/time-reform-aging-out-and-their-own-0> and Ira Culter, *Cost Avoidance: Bolstering the Economic Case for Investing in Youth Aging Out of Foster Care* (2009), available at <http://www.jimcaseyyouth.org/cost-avoidance-bolstering-economic-case-investing-youth-aging-out-foster-care-0>.

²⁷ 42 U.S.C. § 675(8)(B)(iii)-(iv).

FCSIAA requires specific steps to be taken when youth are about to age out of foster care. Within 90 days before the youth ages out of care, the state agency must assist the youth

in developing a transition plan that... includes specific options on housing, health insurance, education, local opportunities for mentors and continuing support services, and work force supports and employment services, includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions....²⁸

Finally, FCSIAA extends eligibility for the Chafee Foster Care Independent Living Program services to children who were in foster care before age 16 but exit care after turning 16 to kinship guardian placements or to adoption. Access to Chafee education and training vouchers is also extended to youth who exit care after age 16 to a kinship guardianship placement (youth who exit to adoption were already eligible).²⁹

These federal requirements are codified in Hawai'i law in the Child Protective Act, HRS § 587A-1 et. seq. Further exploration of Hawai'i state laws and the Hawai'i Constitution are needed to determine what causes of action may be available under state law. The right of youth in foster care to bring § 1983 claims to challenge violations of federal child welfare laws is clearly established in case law.

2. Early and Periodic Screening, Diagnostic, and Treatment Services under Medicaid

Medicaid Act, 42 U.S.C.S. § 1396d(r) (LexisNexis 2010), is commonly referred to as EPSDT (early and periodic screening, diagnostic, and treatment services). Services provided under EPSDT are available to all eligible youths up to the age of 21. It is unclear whether states may be able to set their local program's age limit lower.³⁰ At least one court has written that the

²⁸ 42 U.S.C. § 675(5)(H).

²⁹ 42 U.S.C. § 677(a)(7) and § 677(i)(2).

³⁰ 42 U.S.C.S. §§ 1396d(a)(4)(B), (a)(i).

age limit of 21 is federally mandated for all states. “Thus, California, like all other states participating in Medicaid, is required to provide EPSDT care to eligible children under the age of 21.”³¹

States must make all services listed under § 1396d(a) available to all those eligible for EPSDT, including services that would be otherwise optional for states to provide.³² Medicaid also includes a promptness provision. State Medicaid plans must “provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals.”³³ This provision has been interpreted as rendering delays in the provision of services actionable.³⁴

Delays were one of the most significant issues reported by interviewees; Hawai`i’s youth in foster care face severe and chronic delays in accessing mental health and other services. 42 U.S.C. § 1396a(8) may provide the basis for an actionable claim. Consequently, a thorough investigation of Ninth Circuit and Federal District Court of Hawai`i case law surrounding this provision is strongly suggested.

³¹ *Katie A. v. Los Angeles County*, 481 F.3d 1150, 1154 (9th Cir. 2007).

³² *Id.*

³³ 42 U.S.C.S. § 1396a(8) (LexisNexis 2010).

³⁴ *See, e.g., Rosie D. v. Romney*, 410 F. Supp. 2d 18, 52 (D. Mass. 2006) (noting that defendant agencies “failed to perform their statutory obligation to furnish these medical services with ‘reasonable promptness’”).

Conclusion

Interviews with GALs and other community members make clear that Hawai'i's foster care system has significant problems that negatively impact children in the child welfare system. The provision of mental health and other services by DHS and DOH is in critical need of attention and improvement. Youth in foster care are not getting the crucial services that they need, when they need them. As suggested by Part D of this report, federal laws exist to protect against several of the foster care system's problems reported by interviewees.