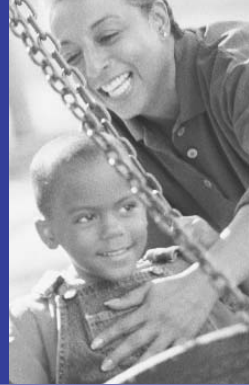




MEETING THE Health Care Needs of Children in the Foster Care System



S I T E V I S I T R E P O R T

Foster Care Pediatrics

Department of Health
Monroe County, NY

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THE INFORMATION PROVIDED IN THIS PUBLICATION IS THE RESULT of a 3-year project conducted by the Georgetown University Child Development Center to identify and describe promising approaches for meeting the health care needs of children in the foster care system. In response to a national search for promising approaches, information was collected on over 100 different approaches. Multiple publications representing the findings of the study are available.



Georgetown University
Child Development Center



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Overview of the Approach

Foster Care Pediatrics is a full service primary care pediatric clinic dedicated to providing comprehensive medical services to children in foster care in Monroe County, New York. Foster Care Pediatrics operates under the auspices of Monroe County Department of Health (DoH) in collaboration with Monroe County Department of Social Services (DSS). Both agencies are committed to the well being of children in foster care and to providing the best possible health care services. Foster Care Pediatrics is funded through Medicaid in addition to receiving financial support from the Department of Health. The mission of Foster Care Pediatrics is to provide:

- comprehensive, high quality primary health care to children in foster care;
- coordination of health care services;
- support and education for foster families and casework staff;
- advocacy; and
- development of collaborative efforts to enhance wellness.

Since 1990, Foster Care Pediatrics has served about 90% of the children who are living in foster family care in the county. The medical team is composed of pediatricians, pediatric nurse practitioners, nurses, a social worker, and clerical staff. The program averages 4,000 visits per year. The clinic provides primary care services on site. In addition, Foster Care Pediatrics offers developmental screenings conducted by a developmental pediatrician, on-site assessment of sexual and physical abuse cases, and a careful monitoring of children receiving psychotropic medications. Comprehensive developmental, mental health, and other consultations are obtained from the community and tertiary care centers. Foster Care Pediatrics provides night and weekend coverage through contracts with a group of nurses who provide triage services and assistance to families.

Background and Context

Monroe County, New York, is home to Rochester, the third largest city in the state. The county is actually comprised of 19 towns, 10 villages and the City of Rochester, and has a combined population of 750,000. The geographic area is largely urban, with some mixed suburban and rural areas. Foster Care Pediatrics is currently housed in a county building that includes offices for the Department of Health (DoH) and Department of Social Services (DSS).

Child Welfare System

The Department of Social Services in Monroe County has regulatory responsibility for the safety, permanency and well-being of all children in custody, including oversight of their physical and mental health needs. The majority of children in foster care in Monroe County (85%) are placed under the direct auspices of DSS. Approximately 15% of children in the county are in the care of five private child welfare agencies, referred to in the state as voluntary agencies.

Population of Children in Care

As of September 2000, there were approximately 1200 children in foster care in Monroe County. This figure does not include children in relative placements, unless the relatives are certified foster parents. About 600-700 new children enter foster care each year in Monroe County. Of these cases, approximately 50% are discharged within 90 days, either returning home or to a relative placement. Among the remaining 50%, some 60-70% of foster children are eventually freed for adoption, while the rest are reunified or discharged to an independent living situation. Of the children currently in care, 46% are African American, 21% are Caucasian, 7.5% are Hispanic, 4% are inter-racial, and 21.2% are of unspecified or unknown backgrounds.

Health Care Issues for Children in Foster Care

Monroe County provides managed care Medicaid for its entitled citizens. However, children entering the foster care system are switched to fee-for-services Medicaid.

In addition to the physical problems that are commonly seen among children in foster care, mental health issues and developmental concerns are very common. They include: post-traumatic stress disorder, attachment disorders, conduct disorders, attention deficit hyperactivity disorder, sexual acting out, substance abuse among adolescents, bedwetting, fetal alcohol effects, and mental retardation.

Barriers identified to providing health care services for this population include lack of access to previous medical records, issues of consent (negotiating who has the authority to sign for what), and problems when children transition (communicating with providers so that children don't experience a disruption in services). There is also a need for comprehensive mental health assessments so that children can begin receiving mental health treatment without long delays upon entering care.

Implementation of the Approach

Rationale for Implementation

For the past 40 years, Monroe County has had a medical clinic that served the health care needs of children in foster care. This clinic was part of DoH's well baby clinic, and operated about four hours a week. About 10 years ago, while Dr. Moira Szilagyi (current medical director of Foster Care Pediatrics) was rotating through the clinic, she noticed that the complex health care needs of children were not being met in this setting, and no care coordination was being provided. She communicated her concerns to the directors of DoH and DSS, with the goal of improving the health care of children in foster care. A task force comprised of Dr. Szilagyi, the deputy director of DSS, a pediatric nurse practitioner, and the director of an inner city pediatric health center was formed to identify potential models for providing medical services for children in foster care. The models identified included creation of a centralized clinic, contracting out with major medical centers and utilizing nurses and clerical staff to collect information, or leaving the service the way it was and adding a nurse and clerk to collect information. After several meetings and discussion, the consensus of the task force was that it would be most cost-effective to implement an on-site centralized clinic that would provide:

- organized medical care (a medical home);
- adequate preventive medicine to insure the well being of children in foster care and to reduce the number of hospitalizations and emergency room visits;
- opportunity for communication between the responsible agencies;
- support and education to foster parents and health workers; and
- quality assurance.

Initial Implementation

Foster Care Pediatrics began with a small team consisting of a part time medical director, a full time nurse practitioner, 2 half time nurses, and a clerk. The clinic consisted of two examining rooms and served about 200 children. Between 1990 and 1997, the clinic gradually expanded in terms of the number of children served. The deputy director of DSS was satisfied with the centralized clinic model and felt that DSS had a better understanding of medical issues for children who were seen at the clinic. In 1997, the decision was made to require that all children in foster family care receive their care from Foster Care Pediatrics. As a result, the clinical team was expanded and the clinic was given a larger space.

Funding the Approach

When a child enters the foster care system in Monroe County, he or she is enrolled in fee-for-service Medicaid, even if the child was previously enrolled in the County's Medicaid managed care program. Foster Care Pediatrics becomes the medical home for the child. The clinic is funded through Medicaid in addition to receiving financial support from Monroe County DoH. The clinic averages about 4,000 patient visits per year. Medicaid reimburses Foster Care Pediatrics at a rate of \$106 per visit. A list of children served is communicated between Foster Care Pediatrics, DSS and DoH. The actual cost of a clinic visit is currently \$190, so the remainder of costs not covered by Medicaid are absorbed by DoH. Direct costs for the clinic are about \$675,000 per year.

Management and Staffing

The health team in Foster Care Pediatrics is currently composed of the following:

- Medical director/pediatrician
- Pediatrician (part time)
- Nurse practitioner/program manager (part time)
- Nurse practitioner (32-36 hours per week)
- 3 Nurses (full time)
- 2 Clerks (full time)
- Health aide (full time)
- Social worker (half time)

The clerical staff, health aide, nurses and pediatricians are employees of DoH. The nurse practitioners and the social worker are contract employees, which provides DoH with additional hiring flexibility. The staff roles and responsibilities are outlined below.

Medical Director

- Supervision of the health team
- Serving as the administrative link to DSS
- Working with the program manager to run the clinic and supervise special projects
- Supervision of medical residents who rotate through the clinic
- Conducting rounds at the hospital to see hospitalized children and children in chronic care facilities

Pediatricians and Nurse Practitioners

- Assessment, diagnosis, and triage
- Child abuse and neglect evaluations
- Routine preventive healthcare
- Education of foster parents about behavior management, child development, etc.
- Treatment, prescription of medications, and referral for mental health evaluation (after consultation with the DSS supervisor)
- Periodic checks of medications and sometimes behavior (every 2-3 months)
- Follow-up with DSS and community agencies

Nurses

- Telephone triage for Foster Care Pediatrics
- Nursing assessment on every child who is being seen in the clinic
- Blood draws and other technical duties
- Implementation of the HIV protocol (a risk assessment tool)

In addition to their routine nursing duties, each nurse works on a special project:

- One nurse serves as the liaison to the mental health demonstration project being conducted through Strong Memorial Hospital (described in a later section of this report)
- One nurse is in charge of quality assurance (e.g., follow up on vaccines, follow up on psychotropic medications)
- One nurse is in charge of implementing the clinic's HIV protocol

Social worker

Upon receiving a referral from the physician or nurse practitioner, the social worker:

- Assesses the child's needs
- Contacts schools, caseworkers, others involved in the child's case
- Provides support and education to foster parents
- Makes clinical assessments, then works with the DSS caseworker to determine who will make the referral if needed
- Sees children during therapists' vacations (not to conduct therapy) as an interim plan for continued support to the child

For night and weekend coverage, the clinic utilizes the local pediatric nurse on-call telephone service. The on-call nurse faxes a summary of calls received to the clinic, and one of the clinic nurses is responsible for follow-up. The pediatrician backs up the telephone triage service.

Components of the Approach

Primary Care at Foster Care Pediatrics

Whenever a child enters the foster care system in Monroe County, a member of the DSS Intake Team attempts to interview the child's biological family to obtain medical and family history and appropriate consent forms. These forms are sent to Foster Care Pediatrics. Frequently, medical and family histories are not available and consent forms have not been signed by the biological parents. Foster families in Monroe County are informed that children in foster care receive their medical services from Foster Care Pediatrics and are asked to make an appointment with the clinic. Foster parents are expected to accompany children to all appointments. Monroe County has a transportation van to assist in transportation to the clinic.

As a general rule, Foster Care Pediatrics is expected to see every child within 30 days of placement in foster care. At this time they receive a comprehensive evaluation followed by a routine two-month follow-up. Newborns and hospitalized children are seen within 2 or 3 days following their discharge from the hospital. Children who are acutely ill are seen immediately. After the initial assessment process, children receive their routine primary care at the clinic according to an enhanced well-child schedule, and also receive treatment for acute or chronic illnesses. The clinic's medical director is notified of any children who are admitted to the hospital or who go to the emergency room. Following any medical evaluation at Foster Care Pediatrics, a special form summarizing the medical findings, medication changes, treatment, plan, immunizations, and referrals is completed by the medical provider (pediatrician or nurse practitioner) and sent to the DSS caseworker.

Access to Specialty Services

Because all children in the foster care system in Monroe County are placed on fee-for-services Medicaid, specialty services are obtained with few difficulties from teaching hospitals (Strong Memorial Hospital), non-teaching hospitals, and private specialists in the community. The fact that Foster Care Pediatrics is a known entity in the community facilitates access to specialty services. For example, the clinic provides referrals for developmental services in the community, and it was reported that the clinic facilitates requests for early intervention (EI) evaluations. Some difficulties are encountered in securing pediatric ear, nose, and throat and orthopedic services. Dental services, including orthodontics, are typically obtained through the local dental school.

Access to Mental Health Services

In the past, DSS viewed mental health referrals as the caseworker's responsibility. Thus, the clinic focused on physical health care, while DSS caseworkers and supervisors dealt with mental health issues. However, continued dialogue between pediatric and casework administrative staff led to the conclusion that children would be served better by a holistic approach to care.

Five years ago, the clinic was able to obtain the services of a half-time social worker through a contract between DoH and Family Services of Rochester. The role of the social worker is to serve as a liaison between caseworkers, Foster Care Pediatrics, and mental health treatment providers. The social worker

is notified when a caseworker, clinic physician or nurse practitioner feels there is a need for mental health assessment or counseling services. The social worker does not provide these services directly, but obtains them from providers in the community. She may also do some coordination with schools and teachers, and provide support and education to foster parents around mental health issues. Because of some confusion that emerged with respect to the roles of DSS and Foster Care Pediatrics around mental health referrals, a set of procedures was formalized in writing.

Due to a shortage of mental health providers in the community willing to accept Medicaid, the social worker was often limited to referring children to community mental health centers for assessments. At times, several months could pass before a child was seen for an assessment. Both DSS and the medical director of Foster Care Pediatrics considered it essential for children to receive mental health assessments as soon as possible after entering care. As a result, the county recently initiated the demonstration project (described below) aimed at obtaining assessments for all children coming into care.

Foster Care Mental Health Demonstration Project

Several years ago, the Medical Director of Foster Care Pediatrics received a CATCH grant from the American Academy of Pediatrics to examine gaps and overlaps in the system with respect to mental health services for foster children. From that grant, a booklet was developed that highlighted the gaps, and some funds from the Office of Mental Health were obtained to organize a task force. Gaps in the system that the task force wanted to address included the problem of consent, the need for timely mental health assessments when children come into care, and the need for a preventative (rather than crisis-oriented) mental health approach.

The task force released an RFP for the conduct of mental health evaluations for children entering care. All 6 mental health provider agencies in the county responded. After review of the responses, it was determined that Strong Memorial Hospital would assess 80% of children entering care and Unity Health System would assess 20% of children entering care. Ultimately, Strong Memorial Hospital assumed responsibility for 100% of children entering care.

As part of the project, every child entering care receives a comprehensive mental health assessment, typically within 60 days of entry. The cost of the mental health assessments is billed to Medicaid (the true cost that Strong incurs for an assessment exceeds the reimbursement rate and is absorbed by the hospital). In general, young children have one assessment session and older children have two sessions. The foster family is given a feedback session, and this is also available for biological parents. Following the assessment, two reports are generated. A full report is sent to the DSS worker and Foster Care Pediatrics. A modified report with recommendations is sent to the foster family (findings, recommendations, safety issues, etc.).

Collaboration Across Systems

Interface between Foster Care Pediatrics and DSS

Communication regarding the health of children in foster care is maintained at various levels between Foster Care Pediatrics and DSS. There is ongoing communication between the medical director of Foster Care Pediatrics and administrators at DSS, and DoH. Following any medical evaluation at Foster Care Pediatrics, a special form summarizing the medical findings, medication changes, treatment, plan, immunizations, and referrals is completed by the medical provider (pediatrician or nurse practitioner)

and sent to the child's caseworker at DSS. Communication also takes place between the social worker at Foster Care Pediatrics and DSS caseworkers around mental health needs to determine who will make a mental health referral. In addition, one of the nursing staff at Foster Care Pediatrics conducts follow-up for all children referred for mental health assessments.

DSS staff felt that benefits of the clinic included help they received with medically fragile children on their caseload, advice on foster parents' capacity to deal with children's health issues, and advocacy for better care. Frequently and upon the request of DSS caseworkers, the clinic's medical director provides written reports for caseworkers to take to court regarding medical issues for certain children. Overall, communication was cited as one of the most crucial factors in determining whether the relationship between DSS and Foster Care Pediatrics was working effectively. One problem raised was the fact that DSS did not have a dedicated staff member to function solely as a liaison to Foster Care Pediatrics. This would help to ensure ongoing communication between DSS and the clinic around every case.

The Judiciary System and CASA

Recently, the court system in Monroe County has begun to address how health care issues impact court decisions. The county's chief judge has mandated that judges ask 10 health questions when children come into court. These questions were developed by New York's Permanent Judicial Commission on Justice for Children, and are available as a "Checklist for the Healthy Development of Foster Children" at <http://www.courts.state.ny.us/pjcc/>.

The Monroe County Court Appointed Special Advocates (CASA) program is also trying to examine health issues more routinely in its work. Typically, CASA volunteers need to obtain consent before talking with a child's medical providers, but their court order states that they are allowed to talk to staff from the Foster Care Pediatrics clinic. CASA workers often contact the clinic to help determine what a child needs, to obtain clarification on health issues, to ask for a referral, or to ask the clinic to see the child. CASA workers have an easier time obtaining information on children who utilize the clinic, because the clinic maintains records on what other services a child has received. The CASA program has also adopted the checklist developed by the Permanent Judicial Commission, and has expanded the checklist into a more comprehensive form with additional questions. The form is designed to summarize pertinent health information about the child, covering physical health, medications, mental health, education, domestic violence, physical/sexual abuse, basic needs, visitation, placement, and permanency issues. CASA staff felt that focusing on health issues helps them to advocate for needed services for children and to better leverage resources from the community. They also felt that children who do not receive services through the Foster Care Pediatrics clinic (for example, children in relative placements) do not have access to the same level of services and follow-up care as those who use the clinic.

Training and Education

Foster Care Pediatrics is involved in providing both formal and informal education around health issues to a range of stakeholders involved in the lives of children in foster care. Formal training for foster parents is conducted twice a year, as well as training for new foster parents. Informal education takes place when families visit the clinic or receive consultation from clinic staff. The nursing staff sometimes refers foster parents to other organizations that conduct formal training on specific topics, e.g., asthma education. Training around health care issues is part of the ongoing training for DSS child welfare staff. Health care providers in training, such as medical students, fellows, residents and pediatric nurse practitioner

students frequently rotate through the clinic. This opportunity benefits the field in general, because the providers will have a better understanding of the health care issues for children in foster care when they move on to other settings. As mentioned in the previous section, there is also a considerable amount of back and forth education between Foster Care Pediatrics and the judicial system in Monroe County.

Family Involvement

Foster Care Pediatrics attempts to actively engage foster families in the process of obtaining health care for the children in their care. However, there is little involvement of biological and extended families. The clinic's medical director would like to offer foster parent support groups, as well as teen support groups for youth in foster care to connect with one another. Since the time of the site visit, the clinic has reinstated a highly successful foster parent mentoring program that had lost its funding. This program has resulted in improved communication between foster parents and caseworkers.

Cultural Issues

Cultural issues represent an ongoing challenge for Foster Care Pediatrics. Currently, the staff does not reflect the ethnic and racial background of the population served, and there are no Spanish-speaking staff members. The clinic also does not have a staff member who can sign for children and families with deafness, though DSS staff noted that the clinic has obtained a sign language interpreter when needed. DSS staff mentioned that some adolescents do not want to receive services from a clinic that is associated with being in foster care, and some seek out their own providers. As a result of this issue, Foster Care Pediatrics will be changing its name in the near future.

Caseworkers from some of the voluntary agencies in the county serving primarily African American and Hispanic families are opposed to mandating that foster parents bring children in their care to the clinic. They feel that families want to use providers in their own communities, and that they would like their foster children to be able to see the same providers as other children in the family. Being singled out as having to go to a clinic only for foster children was raised as a self-esteem issue for some children. Because of these issues, use of the clinic by foster children in the care of voluntary agencies, as opposed to those in the direct care of DSS, was described as being hit or miss. Some barriers could be addressed by having a more diverse staff at the clinic, having more flexible evening and weekend hours for foster parents who work, or having satellite clinics in different communities. Staff from the voluntary agencies did mention that a benefit of having families utilize the clinic was the records maintained by the clinic. Otherwise, they tend to have no health information when children come into the care of their agency.

Future Directions

The following plans are being discussed with respect to future directions for Foster Care Pediatrics and health care issues for children in foster care:

- Moving the clinic to a building downtown with more space and more staff
- Appointing a DSS liaison for the clinic
- Continued work on enhancing the integration of health and mental health services
- Providing more developmental services
- Providing more education and training for foster parents
- Providing more dental services (by either placing a dental suite in the new clinic location or improving the reimbursement rate for private providers)
- Restarting a support group for foster parents, foster to foster family support, and a teen support group for children in foster care

Summary of Learnings from the Site Visit

Benefits of a Centralized, On-Site Pediatric Clinic

- Close communication between the health care team and DSS workers (facilitated by having the clinic co-located in the building that houses DSS workers); DSS staff can drop in at the clinic if they need information or health care issues explained; also written communications are provided to DSS (visit information sheet, subsidy letters, medical summaries)
- Medical staff specialized in foster care
- Improved care coordination and continuity of care—a medical home for children in foster care
- Centralized location where all medical records are maintained
- Reduction in emergency room visits
- Clinic is a known entity in the community and may have faster response to referrals
- Foster parents can meet with social workers and medical staff at the same location, promoting ongoing contact with the health care providers
- Clinic serves as an educational resource for families, caseworkers, and others involved in the foster care system
- Medical staff can provide information to aid in decisions made by the court

Disadvantages of a Centralized, On-Site Clinic

- Some families are inconvenienced by having to travel longer distances to the clinic; some prefer more choices of providers, or want to use providers in their own community
- Families may want all of their children, regardless of whether they are foster children, to be able to utilize the same providers (however, this might result in a change of providers whenever a child moved to a different foster home)
- Older children and adolescents may feel stigmatized about receiving medical care at a clinic for children in foster care
- Confusion for children who identify the clinic as being in the same building as where visits with their biological parents take place
- Working all of the time with children who have been abused or neglected can be overwhelming for clinic staff and there is a need for mental health services and stress-relief

Strengths and Essential Elements of the Foster Care Pediatrics Approach

- The clinic's medical director is very committed to the well-being of children in foster care and a strong advocate for their needs
- Children in foster care are viewed as being the responsibility of the whole county, not just DSS; DSS and the clinic function as allies in advocating for quality health care services; communication between the partners is essential

- Support of the Commissioner of the Department of Health
- Commitment to educating the community of providers about the health care issues for children in foster care
- The clinic takes a holistic approach to health, understanding that physical and mental health are related; the clinic takes into account behavioral health issues of the whole family, and can make recommendations for when respite is needed
- The clinic’s nurses and other staff members are very supportive of each other, which helps in relieving the stress encountered in their jobs
- Availability of an on-call system for night and weekend coverage; foster parents are comfortable speaking to the nurses who staff the on-call system
- Commitment to finding ways of better addressing the mental health needs of children in care
- Positive relationship between the court system, CASA, and Foster Care Pediatrics

Challenges

- Difficulties in accessing children’s previous medical records
- Difficulties in securing consent from biological parents for treatment, evaluation for early intervention services, and prescription of psychotropic medications (this has been addressed by developing a general medical consent form covering all of these areas)
- Maintaining adequate communication between the medical providers and caseworkers (lack of a specified liaison between Foster Care Pediatrics and DSS)
- Lack of resources, space, and staffing (need more exam rooms, a community nurse to conduct home visits, more nurses to ensure that all referrals are followed up)
- Lack of mental health providers in the community who accept Medicaid and high turnover among providers

Recommendations and Advice for Other States and Communities

- Communication is the most important thing—institutionalize a system of communication between the health care providers and child welfare providers
- Make sure that people at each level work things out with each other (e.g., DSS Director and DoH director must communicate, nurses and caseworkers must communicate, etc.)
- Provide ongoing education regarding each others’ roles, and understand that the caseworker is the ultimate case manager
- Seek out health care providers (through teaching hospitals, medical societies, etc.) who have an interest in and are willing to serve a high-risk pediatric population; providers need to understand the special issues for children in foster care, need to be efficient and compassionate, and need to understand the workings of the child welfare agency
- To build a health care team, start with a devoted MD or RN and form a core team to spearhead the efforts
- Start with one piece of the system and keep adding to it—you can’t get everything done at the same time
- Make the clinic as family friendly as possible; consider access issues such as transportation and parking

Appendix A: Foster Care Pediatrics

Site Visit Interviews Conducted

Foster Care Pediatrics

- Medical Director
- Nurses
- Social Worker

Department of Health

- Director

Department of Social Services

- DSS Administrator
- Caseworkers
- Supervisors

County Voluntary Agency

- Caseworker
- Supervisor

County Court System

- CASA Workers
- Clerk of Court

University of Rochester, Strong Behavioral Health

- Clinical Psychologist

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