

CENTERS FOR DISEASE CONTROL



MORBIDITY AND MORTALITY WEEKLY REPORT

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Current Trends

Education and Foster Care of Children Infected with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus

The information and recommendations contained in this document were developed and compiled by CDC in consultation with individuals appointed by their organizations to represent the Conference of State and Territorial Epidemiologists, the Association of State and Territorial Health Officers, the National Association of County Health Officers, the Division of Maternal and Child Health (Health Resources and Services Administration), the National Association for Elementary School Principals, the National Association of State School Nurse Consultants, the National Congress of Parents and Teachers, and the Children's Aid Society. The consultants also included the mother of a child with acquired immunodeficiency syndrome (AIDS), a legal advisor to a state education department, and several pediatricians who are experts in the field of pediatric AIDS. This document is made available to assist state and local health and education departments in developing guidelines for their particular situations and locations.

These recommendations apply to all children known to be infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV). This includes children with AIDS as defined for reporting purposes (Table 1); children who are diagnosed by their physicians as having an illness due to infection with HTLV-III/LAV but who do not meet the case definition; and children who are asymptomatic but have virologic or serologic evidence of infection with HTLV-III/LAV. These recommendations do not apply to siblings of infected children unless they are also infected.

BACKGROUND

The Scope of the Problem. As of August 20, 1985, 183 of the 12,599 reported cases of AIDS in the United States were among children under 18 years of age. This number is expected to double in the next year. Children with AIDS have been reported from 23 states, the District of Columbia, and Puerto Rico, with 75% residing in New York, California, Florida, and New Jersey.

The 183 AIDS patients reported to CDC represent only the most severe form of HTLV-III/LAV infection, i.e., those children who develop opportunistic infections or malignancies (Table 1). As in adults with HTLV-III/LAV infection, many infected children may have milder illness or may be asymptomatic.

Legal Issues. Among the legal issues to be considered in forming guidelines for the education and foster care of HTLV-III/LAV-infected children are the civil rights aspects of public

*HTLV-III/LAV — Continued***TABLE 1. Provisional case definition for acquired immunodeficiency syndrome (AIDS) surveillance of children**

For the limited purposes of epidemiologic surveillance, CDC defines a case of pediatric acquired immunodeficiency syndrome (AIDS) as a child who has had:

1. A reliably diagnosed disease at least moderately indicative of underlying cellular immunodeficiency, and
2. No known cause of underlying cellular immunodeficiency or any other reduced resistance reported to be associated with that disease.

The diseases accepted as sufficiently indicative of underlying cellular immunodeficiency are the same as those used in defining AIDS in adults. In the absence of these opportunistic diseases, a histologically confirmed diagnosis of chronic lymphoid interstitial pneumonitis will be considered indicative of AIDS unless test(s) for HTLV-III/LAV are negative. Congenital infections, e.g., toxoplasmosis or herpes simplex virus infection in the first month after birth or cytomegalovirus infection in the first 6 months after birth must be excluded.

Specific conditions that must be excluded in a child are:

1. Primary immunodeficiency diseases—severe combined immunodeficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome, ataxia-telangiectasia, graft versus host disease, neutropenia, neutrophil function abnormality, agammaglobulinemia, or hypogammaglobulinemia with raised IgM.
2. Secondary immunodeficiency associated with immunosuppressive therapy, lymphoreticular malignancy, or starvation.

school attendance, the protections for handicapped children under 20 U.S.C. 1401 et seq. and 29 U.S.C. 794, the confidentiality of a student's school record under state laws and under 20 U.S.C. 1232g, and employee right-to-know statutes for public employees in some states.

Confidentiality Issues. The diagnosis of AIDS or associated illnesses evokes much fear from others in contact with the patient and may evoke suspicion of life styles that may not be acceptable to some persons. Parents of HTLV-III/LAV-infected children should be aware of the potential for social isolation should the child's condition become known to others in the care or educational setting. School, day-care, and social service personnel and others involved in educating and caring for these children should be sensitive to the need for confidentiality and the right to privacy in these cases.

ASSESSMENT OF RISKS

Risk Factors for Acquiring HTLV-III/LAV Infection and Transmission. In adults and adolescents, HTLV-III/LAV is transmitted primarily through sexual contact (homosexual or heterosexual) and through parenteral exposure to infected blood or blood products. HTLV-III/LAV has been isolated from blood, semen, saliva, and tears but transmission has not been documented from saliva and tears. Adults at increased risk for acquiring HTLV-III/LAV include homosexual/bisexual men, intravenous drug abusers, persons transfused with contaminated blood or blood products, and sexual contacts of persons with HTLV-III/LAV infection or in groups at increased risk for infection.

The majority of infected children acquire the virus from their infected mothers in the perinatal period (1-4). In utero or intrapartum transmission are likely, and one child reported from Australia apparently acquired the virus postnatally, possibly from ingestion of breast milk (5). Children may also become infected through transfusion of blood or blood products that contain the virus. Seventy percent of the pediatric cases reported to CDC occurred among children whose parent had AIDS or was a member of a group at increased risk of acquiring HTLV-III/LAV infection; 20% of the cases occurred among children who had received blood or blood products; and for 10%, investigations are incomplete.

HTLV-III/LAV - Continued

Risk of Transmission in the School, Day-Care or Foster-Care Setting. None of the identified cases of HTLV-III/LAV infection in the United States are known to have been transmitted in the school, day-care, or foster-care setting or through other casual person-to-person contact. Other than the sexual partners of HTLV-III/LAV-infected patients and infants born to infected mothers, none of the family members of the over 12,000 AIDS patients reported to CDC have been reported to have AIDS. Six studies of family members of patients with HTLV-III/LAV infection have failed to demonstrate HTLV-III/LAV transmission to adults who were not sexual contacts of the infected patients or to older children who were not likely at risk from perinatal transmission (6-11).

Based on current evidence, casual person-to-person contact as would occur among schoolchildren appears to pose no risk. However, studies of the risk of transmission through contact between younger children and neurologically handicapped children who lack control of their body secretions are very limited. Based on experience with other communicable diseases, a theoretical potential for transmission would be greatest among these children. It should be emphasized that any theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes to blood and possibly other body fluids of an infected person.

Risks to the Child with HTLV-III/LAV Infection. HTLV-III/LAV infection may result in immunodeficiency. Such children may have a greater risk of encountering infectious agents in a school or day-care setting than at home. Foster homes with multiple children may also increase the risk. In addition, younger children and neurologically handicapped children who may display behaviors such as mouthing of toys would be expected to be at greater risk for acquiring infections. Immunodepressed children are also at greater risk of suffering severe complications from such infections as chickenpox, cytomegalovirus, tuberculosis, herpes simplex, and measles. Assessment of the risk to the immunodepressed child is best made by the child's physician who is aware of the child's immune status. The risk of acquiring some infections, such as chickenpox, may be reduced by prompt use of specific immune globulin following a known exposure.

RECOMMENDATIONS

1. Decisions regarding the type of educational and care setting for HTLV-III/LAV-infected children should be based on the behavior, neurologic development, and physical condition of the child and the expected type of interaction with others in that setting. These decisions are best made using the team approach including the child's physician, public health personnel, the child's parent or guardian, and personnel associated with the proposed care or educational setting. In each case, risks and benefits to both the infected child and to others in the setting should be weighed.
2. For most infected school-aged children, the benefits of an unrestricted setting would outweigh the risks of their acquiring potentially harmful infections in the setting and the apparent nonexistent risk of transmission of HTLV-III/LAV. These children should be allowed to attend school and after-school day-care and to be placed in a foster home in an unrestricted setting.
3. For the infected preschool-aged child and for some neurologically handicapped children who lack control of their body secretions or who display behavior, such as biting, and those children who have uncoverable, oozing lesions, a more restricted environment is advisable until more is known about transmission in these settings. Children infected with HTLV-III/LAV should be cared for and educated in settings that minimize exposure of other children to blood or body fluids.

HTLV-III/LAV -- Continued

4. Care involving exposure to the infected child's body fluids and excrement, such as feeding and diaper changing, should be performed by persons who are aware of the child's HTLV-III/LAV infection and the modes of possible transmission. In any setting involving an HTLV-III/LAV-infected person, good handwashing after exposure to blood and body fluids and before caring for another child should be observed, and gloves should be worn if open lesions are present on the caretaker's hands. Any open lesions on the infected person should also be covered.
5. Because other infections in addition to HTLV-III/LAV can be present in blood or body fluids, all schools and day-care facilities, regardless of whether children with HTLV-III/LAV infection are attending, should adopt routine procedures for handling blood or body fluids. Soiled surfaces should be promptly cleaned with disinfectants, such as household bleach (diluted 1 part bleach to 10 parts water). Disposable towels or tissues should be used whenever possible, and mops should be rinsed in the disinfectant. Those who are cleaning should avoid exposure of open skin lesions or mucous membranes to the blood or body fluids.
6. The hygienic practices of children with HTLV-III/LAV infection may improve as the child matures. Alternatively, the hygienic practices may deteriorate if the child's condition worsens. Evaluation to assess the need for a restricted environment should be performed regularly.
7. Physicians caring for children born to mothers with AIDS or at increased risk of acquiring HTLV-III/LAV infection should consider testing the children for evidence of HTLV-III/LAV infection for medical reasons. For example, vaccination of infected children with live virus vaccines, such as the measles-mumps-rubella vaccine (MMR), may be hazardous. These children also need to be followed closely for problems with growth and development and given prompt and aggressive therapy for infections and exposure to potentially lethal infections, such as varicella. In the event that an antiviral agent or other therapy for HTLV-III/LAV infection becomes available, these children should be considered for such therapy. Knowledge that a child is infected will allow parents and other caretakers to take precautions when exposed to the blood and body fluids of the child.
8. Adoption and foster-care agencies should consider adding HTLV-III/LAV screening to their routine medical evaluations of children at increased risk of infection before placement in the foster or adoptive home; since these parents must make decisions regarding the medical care of the child and must consider the possible social and psychological effects on their families.
9. Mandatory screening as a condition for school entry is not warranted based on available data.
10. Persons involved in the care and education of HTLV-III/LAV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept at a minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase (e.g., bleeding injury).
11. All educational and public health departments, regardless of whether HTLV-III/LAV-infected children are involved, are strongly encouraged to inform parents, children, and educators regarding HTLV-III/LAV and its transmission. Such education would greatly assist efforts to provide the best care and education for infected children while minimizing the risk of transmission to others.

*HTLV-III/LAV - Continued**References*

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*Perspectives in Disease Prevention and Health Promotion***Status of the 1990 Physical Fitness and Exercise Objectives**

Eleven of the U.S. Public Health Service's 1990 Objectives for the Nation concern physical fitness and exercise (1). When the objectives were developed in 1980, less baseline information was available for physical fitness and exercise than for most other areas. During the ensuing 5 years, considerable progress has been made toward clarifying the relationship between physical activity and health and in collecting previously unavailable information about the activity levels of children and adults. Several of the objectives are likely to be achieved by 1990 (Table 2). Nevertheless, much remains to be learned and most segments of society would benefit from increased levels of physical activity. The following is a brief summary of the current status of the 1990 objectives on physical fitness and exercise.

HEALTH EFFECTS

The established beneficial effects of physical activity on health include reduced risk of coronary heart disease (CHD), desirable weight control, and reduced symptoms of anxiety and mild to moderate depression (2-4). Beneficial effects on the prevention and control of hypertension, diabetes, osteoporosis, and certain psychiatric and psychologic conditions appear likely but are less firmly established (2,4). The temporarily increased risk of sudden death during vigorous physical activity is outweighed by the overall reduced risk of CHD from habitual vigorous activity (2). Information about the incidence of musculoskeletal injuries and other possible adverse effects is not available (5).

New Conservatory Children's Theatre Company
Zephyr Theatre Complex
Lower Level
25 Van Ness
San Francisco, CA 94102

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The San Francisco New Conservatory Children's Theatre Company and The Federal Centers for Disease Control Present...



GET REAL!

Questions and answers:

What is GET REAL?

GET REAL! is a play that seeks to encourage development of self-esteem and a sense of individual responsibility, dealing with AIDS prevention within this context. Children ages 9-12 have heard many frightening things about AIDS, often without being able to ask questions. GET REAL! employs fast, funny vignettes to emphasize self-esteem and individual responsibility while addressing AIDS issues in a fun adventure-type format. With this presentation we hope to shape children's attitudes about AIDS prevention so that they will engage in safe behavior and be encouraged to make positive choices when they become older. All performances are followed by a question and answer session with the company.

Written by: Doug Holsclaw

How did GET REAL! come about?

Script development began at the New Conservatory Children's Theatre Company during the Summer of 1989 with a four week series of workshops involving a group of 9-12 year olds. Both playwright and director were committed to approaching the subject matter from the perspective of the play's target audience. A five-month-long writing and staged reading process guided by youth, parents, educators, health care professionals and San Francisco AIDS Foundation representatives resulted in the world premiere of GET REAL! on January 26, 1990.

GET REAL!

Directed by: Ed Decker

A play about kids, choices & well-being

AIDS -- The Facts

The World Health Organization reports that well over 225,000 people have died of AIDS. Progress is being made in the area of AIDS treatment, but no cure has yet been found. AIDS, however, is preventable. One thing that scientists and doctors do know about the disease is that it can strike anyone. Young people are especially vulnerable. They need information about AIDS presented in a way that they can accept and understand. Dry medical facts droned out in a lecture hall are not the answer.

Encouraged by the success of its teen AIDS education play, *The Inner Circle* by Patricia Loughrey (now in its third year of touring around the globe), The New Conservatory commissioned noted Bay Area playwright, Doug Holsclaw, to write *GET REAL!* The play marks the second phase of The New Conservatory's AIDS Theatre in Education Program and has been partially funded by a major grant from the Federal Centers for Disease Control.



From *GET REAL!* (The Pre-Teen Asteroid Ninja Bunnies Sketch.)

How can I find out about scheduling a performance of GET REAL?

Call or write The New Conservatory Children's Theatre Company in San Francisco for more information. The *GET REAL!* California tour is already in progress and has played to legislators at the State Capitol in Sacramento and to classes throughout Northern California.

Designated by the Federal Centers for Disease Control to be a national model, the production of *GET REAL!* provides students and educators with a unique opportunity to address AIDS prevention issues in a live, accessible, and engaging theatrical format. A study guide is included as part of the production.

GET REAL! by Doug Holsclaw was originally produced and developed at The New Conservatory Children's Theatre Company.
Artistic Director: Ed Decker

For More Information Contact:

Ed Decker/Executive Director
New Conservatory Children's Theatre Company
Zephyr Theatre Complex
Lower Level
25 Van Ness
San Francisco, CA 94102
Phone: (415) 861-4914

Photos by Lois Tema
Brochure design by RML Graphics



February 15, 1991

Dear Mr. Chuck Frutchey,

You and your colleagues are cordially invited to attend The New Conservatory Children's Theatre Company's 5 week matinee program of Get Real a play about kids, choices and well-being by Doug Holsclaw.

All performances for this limited San Francisco engagement are held at 25 Van Ness Lower Lobby in Zephyr Theatre One. Performances are sponsored by the Federal Centers For Disease Control- dates and times are as follows:

Tuesday, February 19 at 11am
Thursday, February 21 at 1pm
Tuesday, February 26 at 11am
Thursday, February 28 at 11am
Tuesday, March 5 at 11am
Thursday, March 7 at 11am
Tuesday, March 12 at 11am
Thursday, March 14 at 1pm
Tuesday, March 19 at 11am

The performance lasts approximately 60 minutes.

To reserve your complimentary seating please call 861-4914.

Thank you,

ED

Ed Decker
Executive Director
The New Conservatory

Executive Director: Ed Decker
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STATEMENT
HOUSE OF REPRESENTATIVES

SELECT COMMITTEE ON CHILDREN,
YOUTH AND FAMILIES

HEARING.

AIDS AND YOUNG CHILDREN: EMERGING ISSUES

FEBRUARY 21, 1987

BERKELEY, CALIFORNIA.

Presented By:

Jean McIntosh, MSW
County of Los Angeles
Department of Children's Services

Good Morning Representative Miller and distinguished Committee Members.

I am Jean McIntosh, Assistant Director of the Los Angeles County Department of Children's Services. Our Department is responsible for carrying out the Title IV-B Child Welfare Services and Title IV-E Foster Care Maintenance Payments and Adoption Assistance Programs initiated by P.L. 96-272, the Adoptions Assistance and Child Welfare Act of 1980. The Department serves 43,000 abused and neglected children at any point in time; 29,000 of these youngsters are dependents of the Juvenile Court with 20,000 in foster care.

We applaud the Committee's concern about this very important issue and thank you for including us in this discussion.

My statements today will focus on how the dependent care system will be stressed by children with AIDS:

- The increased severity of abused and neglected children coming into the Child Welfare system - the impact of drug abuse and sexual molestation.
- Activities at the local level to begin to address issues of young children with AIDS.
- The resource implications and specialized care needed in both the Child Welfare and Foster Care programs.

CHILDREN AT RISK: GREATER NUMBERS, MORE HARM

The past five years have seen a major increase in the allegations of child abuse and neglect. This reflects mandated child abuse reporting statutes and community awareness and attention. In conjunction with the growth in reported incidences, the severity of cases has also increased. The child welfare/foster care system has seen a dramatic increase in the numbers of high risk children needing child protective services. Incidences of substance abuse and sexual molestation are of particular concern.

CHILD WELFARE/DRUG ABUSE INTERACTION

Of primary importance to child welfare advocates is the correlation between AIDS, drug abuse, and sexual molestation. Comparable to other human service agencies, child welfare has seen the unfortunate increase in drug-related incidents which endanger children. Our Juvenile Court intake statistics on dependency petitions demonstrate this pattern. A petition is a legal document submitted to the Juvenile Court by the children's services worker containing allegations to show why a minor should be declared a dependent child of the Juvenile Court. The goal of initiating Juvenile Court actions is to protect the child. Our 1981-1986 data on petition requests

demonstrate the alarming increase in allegations of substance abuse: this includes drug withdrawal/ingestion by young children as well as debilitating drug use by a child's parents.

- * Excessive drug use by a parent:
 - 1981 - 241 cases
 - 1986 - 2,857 cases; a 1100% increase
- * Drug ingestion of minor or infant in drug withdrawal:
 - 1981 - 132 cases
 - 1986 - 1,363 cases; a 933% increase

In 1981, substance abuse related referrals represented 4.09% of the total 9,133 petitions filed.

In 1986, substance abuse related referrals represented 21% of the total 20,096 petition filed.

Of particular concern is the increase in these petitions between 1985 and 1986. Parental drug abuse increased by 60%. Drug ingestion by a minor increased by 69% in the same one year period. This demonstrates that substance abuse is expanding not only on a cumulative basis, but also on a geometric basis!

Our Board of Supervisors has recognized the growing problem of substance abused infants and has instructed our Chief Administrative Office to coordinate the efforts of County Departments to develop recommendations and activities to address this problem. This includes a media campaign, development of protocols on maternal substance use and neonatal drug withdrawal and coordination of efforts among our local law enforcement agencies and the Departments of Health Services and Children's Services.

Problem

Pregnant women who use drugs present an enormous national problem. Hospitals, Departments of Social Services and law enforcement are seeing an increasing number of infants who are born under the influence or addicted to drugs. Drugs involved include PCP, heroin, cocaine and other illegal drugs. Often, mothers use more than one drug. Newborns whose parents are prostitutes and/or intravenous drug abusers are at a high risk of being seropositive and contracting AIDS.

Effects of Drug Use

There are many harmful effects of prenatal drug exposure.

These infants have special needs that require special care.

- Infants born to substance abusing women characteristically are premature, poorly nourished and neurologically abnormal as a result of their drug exposure.
- Mental retardation and seizure disorders are now well-recognized complications of fetal drug and alcohol exposure.
- Other problems include sleeping and feeding disorders, vomiting, diarrhea, tremors, high-pitched crying and excessive movements; increased risk of Sudden Infant Death Syndrome (SIDS).

The follow-up studies of these children have shown poor growth and developmental delays. When they enter school, they are almost sure to have learning problems.

Investigation and Protection

The Department of Children's Services (DCS) is working with county-wide law enforcement agencies to develop procedures that will trigger an immediate investigation

of children living at the home of an arrested drug suspect.

We have an Emergency Response Command Post to respond to referrals 24 hours a day, seven days a week. It is designed to provide an immediate investigation by a CSW after normal department working hours. CSWs are housed at six law enforcement stations throughout Los Angeles County.

We support, and work with law enforcement toward, the goal of referring drug cases where there is a suspicion that drug activity has endangered children residing in the home. We have also emphasized with law enforcement that whenever their officers have questions concerning the safety of a child in a drug case, they should refer the case to DCS for evaluation, even if the children are not taken into temporary custody.

Permanency Planning

Infants are generally placed with relatives or foster parents until parents are able to provide safe care. Mother/child residential treatment centers are few and needed.

Parents' participation in a drug treatment program is considered essential. Feedback from treatment programs is essential for monitoring progress. Drug use must be controlled before other parenting issues are addressed. Frequent and unannounced home calls are made.

Because of their tender age and consequent high risk, infants and toddlers needing protection due to drug abuse situations are often placed in foster care. Nationally, recruitment of foster families for pre-school children is becoming more and more difficult due to social and financial considerations. Compounding this trend is the fact that those foster parents we do recruit are often afraid to care for such medically fragile children. Now, we are facing the alarming possibility that a significant proportion of these children are at risk to AIDS. It is not hard to imagine that potential foster parents may move away from caring for these vulnerable children to protect their own families!

We are already beginning to see greater numbers of high risk infants and toddlers going into government-run shelters and private sector congregate care facilities. For example, the Los Angeles County shelter for abused and neglected children had an average daily population of nine children under the age of five (5) in November 1982.

In November, 1986, the average number of children in our shelter's nursery was 90!

Equally disturbing is the fact that young children are increasingly being placed in group homes rather than in foster families. The number of foster family spaces for infants and toddlers has remained approximately even at 7,800 over the past six years, while the number of spaces for these little ones in group homes and institutions has increased from 70 in 1980 to 170 now - with at least 64 more spaces opening in three new facilities by April 1987.

It is clear that current trends in foster care may show young children more often placed in group homes and institutions. Given what we know about the social and physical isolation that is attendant to AIDS and even AIDS-Related Complex (ARC), young children so afflicted may have significantly reduced hope for foster placement with a nurturing family. Not only will the social costs be great; the fiscal ramifications for the foster care system are enormous.

Because of the debilitating effects drug abuse has on parents, these children may not return home and may be freed for adoption. However, potential adoptive parents

are now expressing reluctance to adopt these children because of the "timebomb" medical unknowns these children potentially represent. As the tie between maternal drug use and pediatric AIDS becomes more pronounced, the chances of adoption - or even placement with relatives - may decrease significantly.

The child welfare system may then be confronted with a growing number of "legal orphans" - despite our best permanency planning efforts. Unfortunately, I am afraid we are just beginning to understand the potential magnitude of pediatric AIDS

- on children and their families
- on foster care resources
- on medical resources

SEXUAL ABUSE AND AIDS

Referrals of children who are the victims of sexual molestation have also increased since the enactment of P.L. 96-272. In 1981 there were 1,361 sexual abuse petitions filed in Juvenile Court. In 1986 there were 3,778 such cases; a 178% increase.

Given what we know of the linkage between sexual contact and AIDS, children who are victims of sexual abuse would seem to be at higher risk of contracting AIDS or ARC. Unfortunately, child welfare professionals may soon be confronted with young children who are not only traumatized by the sexual abuse they have experienced, but also by medical (even life-threatening) realities they may face later in childhood and adolescence.

TEEN PREGNANCY AND AIDS

As we know all too well, teen pregnancy is increasing nationally at a disturbing rate. Teens, then, present two potentially critical problems when we think about AIDS:

- adolescence is a time of sexual awakening and can include sexual experimentation. To the extent that AIDS is linked to numbers of sexual contacts, teens - especially those who are disturbed and alienated from their families - may be at higher risk of contracting the disease;
- pregnant teens may compound the problem by being at risk to AIDS/ARC themselves and by having a baby similarly afflicted.

Many teens in the dependency care system today may face these problems. As caretakers, what is our responsibility to educate them about the risk of AIDS? Are we in child welfare going to have sufficient foster care and medical resources to meet the needs?

LOS ANGELES COUNTY, CHILD WELFARE, AND AIDS

In response to community concerns on the implications of AIDS, our Department has developed protocols and policies to anticipate AIDS cases, as there is no AIDS crisis in the Child Welfare system - yet.

The Los Angeles County Department of Health Services AIDS Report for December 31, 1986, shows that of the 2,559 cases reported, only 15 are pediatric. The incidence of pediatric AIDS has always been, and currently remains, very low in Los Angeles County. The children at greatest risk are those who received blood or blood products transfusions prior to March 1985, and infants born to mothers who engage in risk behavior including prostitution and intravenous drug abuse. As AIDS appears to be expanding in the general population, our Department has taken a comprehensive planning approach to anticipate problems in dealing with this volatile issue.

Although the placement numbers are small, AIDS or AIDS Related Complex (ARC) impacts our Department in three ways:

- * It affects some of the children we serve.
- * It affects our foster care providers, and
- * It affects our social work staff in their professional capacities and their personal concerns.

Protocols have been developed to provide staff with factual information about:

- * how AIDS is and is not transmitted
- * confidentiality requirements
- * personal and environmental hygiene procedures, which may be shared with foster care providers
- * AIDS testing
- * uniform policy and procedures for the placement of children with AIDS, ARC and positive AIDS virus (HIV) tests, and,
- * AIDS resources for counseling, education, and support groups.

Overall goals of our AIDS policy are to:

- * Provide appropriate placement settings for children with AIDS or ARC;
- * Assure that no children in placement, Departmental staff, or foster care providers are at risk because of co-placement or contact with a child with AIDS; and to
- * Educate staff and foster care providers how to accomplish those two goals.

Children who have AIDS or ARC but who are well enough to be in a foster care setting should be placed with the smallest possible child population. This is for their own sake, to limit their exposure of the viruses and germs of other children.

We also recommend that no more than one child with AIDS or ARC be placed in any foster/group home at any given time.

- * This is to protect the ill child; and
- * To limit the stress on the caretaker, as caring for a child with a possibly fatal illness is physically and emotionally draining.

Children who test positive to the AIDS antibody but do not have AIDS or ARC do not require special placement procedures, but confidentiality requirements and hygiene procedures are to be followed. Our Department of Health Services staff are available to counsel and train foster care providers who are willing to care for children with AIDS and ARC.

TRAINING

- The Department is working to develop a pool of foster parents specifically trained to deal with substance abuse babies. Recruitment is targeted on health services professionals.
- We are working with the Augustus Hawkins Mental Health Center and King/Drew Medical Center to expand substance abuse training for foster parents.
- We are also working with UCLA on a Federal grant to jointly train foster parents and public health nurses to care for infants exposed prenatally to drugs.
- Our Staff Development Section has incorporated substance abuse training into our ongoing in-service training program for line children's services workers and foster parents.

FOSTER CARE PAYMENTS

- Because of the severity of the problems faced by drug addicted infants and the need for ongoing supervision, a "specialized" care increment is added to the payment rate for these infants.

- Our basic foster care monthly payment for children ages infant - four years is \$294.00. We have added an additional \$261.00 to bring the payment to a total of \$555.00 per month.

RESOURCE IMPLICATIONS: CAN P.L. 96-272 BE FULLY IMPLEMENTED?

These difficult problems demand more sophisticated service programs, foster parenting, and specialized group care. Los Angeles County recommends creative funding approaches focused to maximize existing resources and increase development of specialized service programs to reflect the increased severity of cases.

The increased volume of calls, combined with the increased severity of referral allegations, have demonstrated a critical "gap" in our child protection system - the availability of pre-placement preventive services.

Because the primary concern of P.L. 96-272 is to protect the child while preserving the family unit whenever possible, the cornerstone of successful implementation rests with our ability to provide an appropriate array of supportive services to strengthen the family's ability to safely care

for the child. We believe it is essential that we analyze the problems our system has in meeting this goal. The increased severity of cases provides an obligation to review service needs and to take a fresh look at the gaps in our system in an effort to build an effective support network for families and children at-risk. Specialized needs such as treatment for AIDS, drug-addicted infants and victims of sexual abuse need to be supported and developed. Congress needs to recognize changes in society and in the composition of the children served by P.L. 96-272.

As we explore ways to institute such programs, the Department is reaching out to the private sector and is developing an approach which recognizes that the community shares in the responsibility of protecting its children. We are forging service relationships, trying to streamline our referral system, and we are implementing pilot projects to try different intervention strategies. In order to make P.L. 96-272 work, we need additional funding for ancillary services which can help a family improve their ability to raise children in a safe environment. For us in Los Angeles County, counseling, home-based services, and respite care will make that difference.

Priority attention should be given to the availability of emergency shelter care and appropriate placement resources for adolescents, infants, substance abused infants and hard-to-place children. If children must go into foster care, foster family homes should be readily available. Group home and institutional placements - however appropriate for certain children should not be the sole placement option.

The development of appropriate placement resources for the 1980s requires coordinated action at the Federal and State levels among the social services, developmental services, mental health and health programs. The increased complexity of cases entering the child welfare system is demonstrating the multiplicity of problems that cut across categorical funding streams. The new realities of the 1980s also require the child welfare system to concentrate on improving interactions with these agencies and their local counterparts, as well as with law enforcement.

Congress should initiate review of the child welfare and foster care system to strengthen the system established by P.L. 96-272. Issues needing attention include foster parent training, recruitment, licensing support and rate-setting. Particularly important is the availability and funding for emergency shelter care and appropriate placement resources.

We are approaching a difficult and demanding future as we confront the many problems of children and AIDS. Let's not be foolish and think that the window of opportunity will open sometime in the future. The opportunity is here; for the welfare of endangered children, let's seize it.

APPENDIX

The Board of Supervisors in Los Angeles County has adopted the following legislative policy guidelines developed by the Department of Health Services in response to concerns identified in our community on AIDS.

POLICY GUIDELINE: AIDS AND AIDS-RELATED COMPLEX

Favor legislation that increases eligibility and state and federal reimbursement for health care to AIDS-related Human Immunodeficiency Virus (HIV) patients.

ISSUE STATEMENT:

AIDS is probably the greatest public health threat of the 20th Century. In Los Angeles County from November 1985 to June 1986, 634 cases have been reported averaging approximately 80 cases per month. Approximately 56% of reported cases are already dead. Hospitalization costs for AIDS patients are now covered under the Medi-Cal (Medicaid) Program. There are many individuals, however, who are being admitted to county hospitals, who do not fall under the definition of AIDS. They suffer from AIDS-Related Complex (ARC) and are not covered by the Medi-Cal Program. ARC is a term with various interpretations but it usually means antibody positivity with specific clinical symptoms or illnesses short of the Federal Centers for Disease Control (CDC) definition of AIDS.

There is a need at both the state and federal levels to base eligibility for funding on the totality of the AIDS-related infection which is presently being referred to as Human Immunodeficiency Virus or HIV. Eligibility for services for HIV patients would allow counties to be reimbursed under Medi-Cal and Medicare not only for individuals with AIDS as defined by the CDC, but also for services to individuals from the point of HIV infection.

POLICY GUIDELINE: AIDS-RELATED COMPLEX - MEDICAID (MEDI-CAL)
ELIGIBILITY

Provide that a diagnosis of an AIDS-Related Complex (ARC) in an individual shall create a presumption of disability for the purpose of determining eligibility for Medi-Cal.

ISSUE STATEMENT:

Existing state law provides for presumptive disability due to an AIDS diagnosis. In addition, AIDS is recognized under the federal Social Security presumptive disability criteria. However, there is no presumptive disability due to AIDS-Related Complex (ARC) under state or federal law.

The County Department of Health Services estimates that county facilities provide care for 20% to 25% of all AIDS and ARC patients receiving hospital care. The cost of treating these patients is high because of their longer than average hospital stays, need for psycho-social support services and other factors.

This legislative proposal could result in additional federal and state financial assistance to counties to help offset the costs of health care to AIDS and ARC patients.

POLICY GUIDELINE: AIDS - WAITING PERIOD FOR MEDICARE
ELIGIBILITY

Favor legislation that would eliminate the 24-month waiting period for Medicare eligibility when Social Security disability is based on AIDS.

ISSUE STATEMENT:

Existing federal law requires an individual to be in receipt of Social Security disability for 24 continuous months before he/she is eligible for Medicare. AIDS is recognized under the Federal Social Security presumptive disability criteria.

Data estimates compiled by the Centers for Disease Control indicate that California has a disproportionately high percentage of AIDS patients, reported at approximately 23% of the total AIDS patients nationwide.

Existing law provides for the presumption of disability for the purpose of determining eligibility for Social Security. However, once AIDS has been diagnosed, the short survival span often precludes AIDS victims from ever obtaining Medicare coverage because they die before 24-month waiting period elapses, even though they have qualified for Social Security disability.

This legislative proposal would enable an individual diagnosed with AIDS and eligible for Social Security disability to, in addition, immediately qualify for Medicare, thereby providing faster financial assistance to offset the cost of health care.

POLICY GUIDELINE: AIDS-RELATED COMPLEX - MEDI-CAL
REIMBURSEMENT RATE

SUMMARY:

Establish a pilot program to determine the appropriate level of Medicare and Medi-Cal reimbursement rates for treatment of Human Immunodeficiency Virus (HIV) patients and expand Medi-Cal coverage to provide alternative modes of post-acute care.

ISSUE STATEMENT:

Existing federal law authorizes Medicare after two years of disability for persons diagnosed with AIDS, as defined by the Centers for Disease Control. State law authorizes presumptive disability based on an AIDS diagnosis for Medi-Cal assistance. It also specifies the services qualified for assistance under the Medi-Cal program of which most are inpatient services. Reimbursement for outpatient services is very low. In addition, reimbursement for alternative modes of care such as in-home medical services and hospice care is limited. Acute hospital care costs significantly more than the alternatives of home health, skilled nursing and hospice care.

This legislative proposal to establish a pilot project would provide a basis for determining the extent to which additional state and federal financial assistance to counties is necessary to help offset the cost of providing care to AIDS and ARC patients and would provide for a better determination of the use of alternative and less costly modes of care.

A Timely Book on an Important Subject

Children and the AIDS Virus

A BOOK FOR CHILDREN, PARENTS, AND TEACHERS

Written and illustrated with 30 black-and-white photographs by
ROSMARIE HAUSHERR

Since the first case was reported in the United States in 1981, an estimated 85,000 Americans have contacted AIDS. More than half have died from it. The Center for Disease Control estimates that 1.5 million Americans now carry the virus. That is one in every 165 people. A growing number of the victims are children.

As Rosmarie Hausherr explains in *Children and the AIDS Virus*, many children, particularly hemophiliacs, acquired the virus from tainted blood received in blood transfusions. Prior to early 1985, blood collected at blood banks was not screened for the Human Immunodeficiency Virus, or HIV. Although this threat has now been contained, the number of infected children continues to climb since infants of infected mothers are born with the disease.

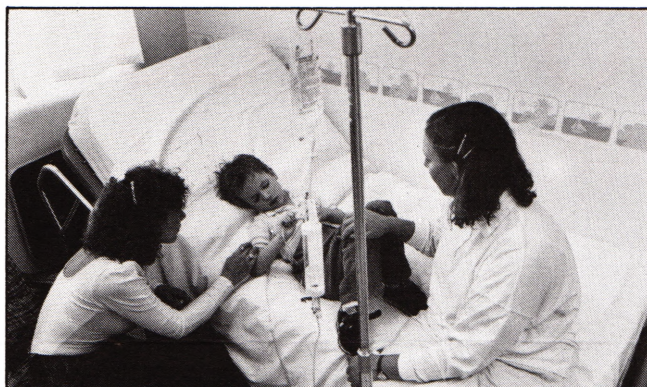
In her book, Ms. Hausherr addresses children in grades 1-5 as well as their parents and teachers. She describes our body's immune system before discussing the human immunodeficiency virus (HIV) that causes AIDS. Ms. Hausherr tells the true stories of Jonathan, a five-year-old in Denver who received the HIV from a blood transfusion, and Celeste, a ten-year-old in New York who was born to a mother with AIDS. Both children are doing well and attend school. The author stresses that it is safe for them and for non-infected children to go to class and enjoy other activities together.

Accompanied by thirty black-and-white photographs, Ms. Hausherr's text is clear and concise in describing the way AIDS can and cannot be contacted. Her book effectively allays fears and enhances the understanding of this grim subject for the increasing numbers of children and their parents who know young victims in their schools and neighborhoods. The book concludes with a realistic



yet hopeful look at the worldwide search for vaccines and drugs to conquer AIDS. Also included is an extensive bibliography of AIDS education resources and service organizations available for further information.

Rosmarie Hausherr interviewed dozens of health care experts, parents, teachers, and children all over the country in preparing this book and is donating part of the royalties to two organizations that help children with AIDS.



PRAISE FROM PARENTS, EDUCATORS AND DOCTORS

"Here is a much-awaited book introducing the story of AIDS to schoolchildren. It will throw a more compassionate light on our youngest AIDS patients and their families, who are too often ignored."

— Arye Rubinstein, M.D.
Dept. of Pediatrics and Immunology
Albert Einstein College of Medicine
Bronx, New York

"Both as a parent and as a physician, I am aware that a proper understanding of AIDS is essential for us to deal sensitively and safely with this disease. Ms. Hausherr's book offers an excellent vehicle to bring the complexities of AIDS into focus for both the young reader and the parent."

— Carol Martinez Weber, M.D.
Dept. of Community Medicine
St. Vincent's Hospital and Medical Center of NY
New York, New York

"An outstanding resource for parents to explain to their children how AIDS is transmitted to reassure them that they cannot get AIDS by being near a person who has AIDS."

— Geri Brooks, Ph.D.
Director of Children with HIV/AIDS
Center of Attitudinal Healing
Tiburon, California

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