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3 Meeting Minutes  
4 **NEEDS ASSESSMENT COMMITTEE**  
5 Jennifer Irwin, Chair  
6

7 April 8, 2009  
8 Cicatelli, 505 Eighth Avenue, 20<sup>th</sup> Floor  
9 10:00 am – 12:00 pm  
10

11 **Members Present:** Guillermo Garcia-Goldwyn, Lee Hildebrand, DSW,  
12 Jennifer Irwin, Rebecca Kim, Rosemary Lopez, Don McVinney, Freddy  
13 Molano, MD, Jan Carl Park, Glen Philip, Ricardo Vanegas-Plata, DDS  
14

15 **Members Absent:** Angela Aidala, PhD, Kecia Gaither, MD, Julie Lehane, PhD,  
16 Frank Machlica, Troiyle Sanon, PhD, Kate Sapadin, PhD, Roberta Scheinmann  
17 (alt. for Mary Ann Chiasson, DrPH), Robert Steptoe  
18

19 **DOHMH Staff Present:** Nina Rothschild, DrPH, Anthony Santella, DrPH, Elys  
20 Vasquez, Jessica Wahlstrom  
21

22 **Public Health Solutions Staff Present:** Derek Coursen  
23

24 **Others Present:** Felicia Carroll, Mallory Marcus, Sally Serio  
25

26 **Material Distributed:**  
27

- 28 • Agenda
- 29 • Minutes from the February 2009 and March 2009 Meetings of the Needs  
30 Assessment Committee
- 31 • Presentation by Sally Serio on Foster Care and HIV  
32

33 **Welcome/Introductions:** Jennifer Irwin welcomed participants and noted  
34 that Committee members had expressed interest in hearing about youth in the  
35 foster care system as an outgrowth of a broad interest in a variety of youth  
36 populations at elevated risk for HIV infection. Committee members will take  
37 into account what they have learned from several presentations on youth  
38 populations when they develop recommendations for the Integration of Care  
39 Committee (IOC). IOC members, in turn, will use those recommendations  
40 when they develop a guidance for NYC DOHMH as DOHMH prepares to re-

1 bid the outreach to youth service category. Committee members introduced  
2 themselves.

3  
4 **Moment of Silence:** Participants observed a moment of silence in tribute to  
5 individuals who have died in the struggle against HIV/AIDS and those who are  
6 still fighting.

7  
8 **Review of the Meeting Packet and Review of the March Minutes:** Nina  
9 Rothschild reviewed the contents of the meeting packet. Members reviewed  
10 the minutes. Guillermo Garcia-Goldwyn raised an issue regarding the  
11 minutes, stating that they do not fully reflect the conversation that transpired.  
12 He agreed to let Dr. Rothschild know about the missing content. Approval of  
13 the minutes was tabled until the next meeting.

14  
15 **Youth in Foster Care:** Sally Serio of the New York City Administration for  
16 Children's Services (ACS) gave a presentation on foster care and HIV. The  
17 full presentation is available on the Ryan White Planning Council website at  
18 [www.nyhiv.org](http://www.nyhiv.org). Some of the salient points from her talk and from the ensuing  
19 discussion are included here:

- 20  
21 • The mission of ACS is to protect the safety and well-being of New York  
22 City's children. Most of the children in the foster care system have  
23 been removed from their family homes because of abuse and neglect.  
24
- 25 • As of December 31, 2007, 98 children with HIV were in the foster care  
26 system. In 2007 and 2008, similar proportions of children living with  
27 HIV were in foster care. The vast majority of these children were  
28 perinatally infected, and many of them are aging out of the foster care  
29 system.  
30
- 31 • ACS has recently seen a small spike in the number of children under  
32 the age of two who are infected – a troubling sign, given that drugs are  
33 available to vastly diminish to likelihood of giving birth to HIV-infected  
34 children.  
35
- 36 • A lot of perinatally infected youth don't know that they are infected. In  
37 a lot of cases, grandparents take care of children whose parents die –  
38 and the grandparents know that the children are infected.  
39
- 40 • ACS's new testing policy is to recommend testing for all youth.  
41
- 42 • Some youth run away from foster care but are found. Decisions about  
43 returning these young people to the families from which they fled are  
44 made on a case-by-case basis.  
45

- 1 • Young people are generally discharged from the system on their 21<sup>st</sup>  
2 birthday. After discharge, some of these young adults go AWOL – and  
3 that may be the time when some of them who are not perinatally  
4 infected become behaviorally infected. Many of the kids who become  
5 infected know how to protect themselves but do not take the necessary  
6 steps.
- 7
- 8 • Young people who test positive are referred to specialty HIV centers  
9 such as the HEAT program at SUNY Downstate Medical Center and  
10 Montefiore Medical Center.
- 11
- 12 • When placing a child in foster care, the first choice is placement with a  
13 family (as opposed to a group home). Prospective foster parents are  
14 asked whether they would take in an HIV-infected child; those who  
15 respond in the negative would not be given a positive child. Foster  
16 parents are paid more to take an HIV-positive child.
- 17
- 18 • If a young person in foster care becomes behaviorally infected, the  
19 foster parent has to be informed. If a young person in foster care has a  
20 baby, the situation becomes very complex.
- 21
- 22 • Some agencies funded by the Administration for Children’s Services  
23 would disqualify someone who is HIV+ from being a foster parent,  
24 while others would not disqualify an infected individual. Some  
25 agencies disqualify LGBT applicants.<sup>1</sup>
- 26
- 27 • The Administration for Children’s Services encourages gays and  
28 lesbians to become foster parents.
- 29
- 30 • ACS sends some young people to places such as St. Vincent’s where  
31 religious affiliation prevents the distribution of condoms and birth  
32 control because these agencies are large and have a substantial  
33 capacity to take in children and can obtain a waiver from condom  
34 distribution requirements. Some very progressive staff at St. Vincent’s  
35 do whatever is needed to provide kids with condoms, even in the face  
36 of the no-condom policy.
- 37
- 38 • Decisions about assigning a child to one foster care agency versus  
39 another are made on a case-by-case basis: ACS makes phone calls  
40 regarding availability.
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<sup>1</sup> In response to statements about grounds for disqualification, Jan Carl Park noted that disqualifying individuals based on HIV status and/or on sexual orientation is illegal.

- ACS is about to lose 6% of its workforce and is very stretched for resources.

**Recommendations on Special Populations to the Planning Council's Integration of Care Committee:** With guidance from Ms. Irwin and Dr. Anthony Santella, Committee members began drawing upon the minutes from the Committee meetings on February 20<sup>th</sup> and March 25<sup>th</sup> to summarize highlights and begin formulating recommendations:

- The office of Juvenile Justice and Delinquency Prevention estimates that there are 1,682,900 homeless and runaway youth in the United States.
- Young people run away from home for a variety of reasons including abuse at home/domestic violence, abuse at school, alcohol or drug use (either by the teens or by their parents or both), mental illness, sexual exploitation, teen pregnancy, being orphaned, and LGBTQ status. Parent/child domestic violence issues are the primary reason why young people run away.
- Runaways who are under age 18 are referred to the Administration for Children's Services, while runaways who are over age 18 are referred to the Department of Homeless Services. This age-based referral system is problematic; the Administration for Children's services and the foster care agencies with which it contracts should be able to care for the kids until they reach 21 years of age. A precedent exists for extending the age range: some HIV programs for youth currently work with kids up until age 24.
- Organizations working with LGBTQ young people should have staff members with similar sex/gender orientations.
- Young people who receive counseling and case management services should be offered vocational/life skills training.
- The age at which young people can consent to testing for HIV should be lowered. We should make an effort to let youth know that they can test without parental consent.
- DOHMH has been pushing to change the laws regarding voluntary counseling and testing and to do away with written informed consent. For young people, however, written informed consent might be worth retaining. The Planning Council's Policy Committee should discuss consent to testing for youth.

- 1 • More money is needed for counseling and testing, mental health  
2 services, linkage to care, support services, and age- and  
3 developmentally appropriate programs.  
4
- 5 • Agencies funded under the coming RFP should be required to offer  
6 comprehensive, age-appropriate health and sex education, HIV  
7 testing, and condoms.  
8
- 9 • A special emphasis should be placed on outreach to and engagement  
10 with LGBTQ youth of color or PINS (people in need of supervision)  
11 who are transitioning out of foster care, have mental health and/or  
12 substance abuse problems, and are undocumented.  
13
- 14 • Communication between various government agencies that deal with  
15 youth populations should be increased.  
16

17 Follow-Up:

- 18
- 19 • Nina Rothschild will follow up with Dr. Freddy Molano to obtain some  
20 recommendations for transgender youth populations.  
21
- 22 • Dr. Santella will formulate a preliminary document based on the  
23 summary/recommendations, circulate it to Ms. Irwin, Mr. Park, and Dr.  
24 Rothschild, and then distribute it to the whole NA Committee for review  
25 and additional discussion at the next meeting.