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A FOSTER CHILD’S RIGHT TO INFORMED CONSENT: A CALL TO ADDRESS THE UNIQUE CIRCUMSTANCES OF FOSTER CHILDREN

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A FOSTER CHILD’S RIGHT TO INFORMED CONSENT: A CALL TO ADDRESS THE UNIQUE CIRCUMSTANCES OF FOSTER CHILDREN

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April 29, 2011

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I. ABSTRACT

Foster care is a term used to describe a system that provides for the needs of children who are without a family member willing or able to take care of them. Caregivers certified by the state in which the child resides will often provide for their basic needs. The Code of Federal Regulations defines foster care as a “24-hour substitute care for children outside their own homes.” How foster children may provide informed consent in medical situations is an important issue that has been largely unexplored. Children, in general, lack the competency to provide independent consent for medical decisions and procedures. However, minors placed in foster care may be more competent to make decisions for themselves than other children due to their unique, and often traumatic, childhood. This article will discuss how the issues of a historically troubled foster care system are exacerbated by the exclusion of consent rights specifically tailored for these children. This article will also analyze the status of current legal efforts and provide recommendations for addressing these areas of concern.

II. INTRODUCTION

A. Sentiments of a Foster Child

“All I want is a normal life,” Jaylin again reminds his caseworker. Jaylin is a thirteen-year-old foster care child. Within the past year he has endured the loss of his family and childhood friends, as well as the loss of an established neighborhood and familiar school setting. A substitute environment that is unfamiliar, confusing, and often scary quickly replaced any familiarity he once knew. Jaylin has lived in three foster homes (none of which felt like home to him). Numerous adults claim they are his advocates, but Jaylin perceives them as strangers who ask him personal questions that seem to inevitably lead to him being relocated once again. Even though these adults seem to agree that he had a bad mom, he still misses her very much. He cannot comprehend how life in foster care is better than living with his mom. Jaylin also feels ashamed because he knows his life is very different from his peers, who still live with their “real” parents. He never quite knows what to say when the other kids ask about his family. As a


Foster care is a generic term. States will provide a specific type of home for a child depending on the circumstances and availability. Options may include: “nonrelative foster family homes, relative foster homes (whether payments are being made or not), group homes, emergency shelters, residential facilities, and preadoptive homes”. In 2008 47% were placed in nonrelative foster family homes. Id.
foster child he has already had life experiences beyond the scope that other kids his age could understand.

Jaylin has learned that he must protect himself and adapt if he plans to survive this dramatic new lifestyle. Jaylin protects himself by keeping everyone at an arms length. He cannot risk trusting anyone and it feels as though no one trusts him either. His foster parent made a doctor appointment for him because he has been so sad and distant. Trips to the doctor are one of Jaylin’s least favorite aspects of foster care because the adults always talk as if he is not even in the room. They do not bother to ask if he wants a procedure done or even pause to ask how he feels about the choices they are discussing. It is upsetting and frustrating for him to feel like the adults that are supposed to care for him automatically assume he is not smart, just because he is a kid. They do not seem to understand how much it would mean to Jaylin to simply be acknowledged. While these facts are hypothetical, they serve to describe common attitudes of the children who find themselves in foster care.

**B. Definitions**

Individuals working within the foster care system use specialized jargon when discussing the people or agents they most frequently encounter. As the name suggests, a **foster child** is a **minor** who has been deemed a “ward” of the state.³ Ward or dependent indicates that the government provides for the child’s basic needs.⁴ The **biological parent** is the “natural . . . mother or father of the child and whose parental rights have not been terminated by a court of law.”⁵ The general population uses the generic term “parent” to describe this individual. A foster child will develop an awareness of additional parental figures. The **foster parent** is most relevant to this discussion. Foster parents are those individuals who have taken on the role of “caretaker” in regard to the child’s daily needs. Similarly, a **guardian** is anyone who has been appointed by the court to assess the child’s interests or “serves as a representative of a minor.” Some foster

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³ David M. Vukadinovich, *Minors’ Rights to Consent to Treatment: Navigating the Complexity of State Laws*, 37 J. HEALTH L. 667, 670 (Fall 2004). (“In most states a “minor” is an person under eighteen years of age”). Center for Health and Health Care in Schools, n.10: “ . . . all states except Alabama, Nebraska, and Pennsylvania recognize eighteen as the age of majority for purposes of consenting to medical treatment . . . In Alabama and Nebraska, the age of majority is nineteen and in Pennsylvania it is twenty-one”

⁴ BLACK’S LAW DICTIONARY 1720 (9th ed. 2011).

⁵ NEW YORK JURISPRUDENCE (SECOND) MALPRACTICE, § 192 (2011).

⁶ Id.
children may have even had an adoptive parent (or potential adoptive parent) in their lives. As the name indicates, an adoptive parent is a person(s) who has met the requirements to take on full legal responsibility of a child not born to them.

Finally, there are various professionals who are influential in a foster child’s life. The most prominent of these is a caseworker, who is often a social worker acting on behalf of a family service agency regulated by the state government. A Guardian Ad Litem (GAL) may also be acting on the child’s behalf. This type of guardian is similar to a general guardian, but is exclusively involved with the child’s legal interests. The GAL may be appointed to represent legal interests and best interest of the child, or serve as their legal counsel.

C. History of Foster Care

The legal system has not always been as involved with the care of abused, abandoned, neglected, or homeless children as it is today. English Poor Law is said to have shaped early ideas of foster care. These laws legalized the practice of allowing extremely poor children to be placed in homes as indentured servants. One prominent example of this was Charles Loring Brace’s “Orphan Train Movement” in the late 1800’s. At a time when extremely poor or homeless children often chose homelessness over the alternative “orphan asylums” or “almshouses”, Brace took action. The result of his action was the transfer of over 100,000

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8 SUPPORT CENTER FOR CHILD ADVOCATES, HOW TO HANDLE A CHILD ABUSE CASE: A MANUAL FOR ATTORNEYS REPRESENTING CHILDREN 6 (2007) [hereinafter CHILD ABUSE MANUAL].

9 History of Foster Care in the United States, NATIONAL FOSTER PARENT ASSOCIATION, http://nfpainc.org/content/?page=historyoffostercare, (last visited March 14, 2011). (A more extensive history as well as additional information regarding foster care can be found at the National Foster Parent Association website).

10 Id.

11 History: About Our Founder, THE CHILDREN’S AID SOCIETY, http://www.childrensaidsociety.org/about/history, (last visited March 14, 2011). (A more extensive history as well as additional information regarding foster care can be found at the Children’s Aid Society website).

12 Id. (Brace was a minister as well as the director and founder of New York’s Children’s Aid Society. He began the movement because he was concerned with the number of homeless children on the streets of New York City)
extremely poor children from New York to farms across the country. In response, individual state government became involved in the regulation of such placements. Supervision of foster parents by social agencies did not become common until the early 1900’s. Also, during this time, other systematic approaches became prevalent. The federal government began to accept and support the keeping of records, and allowing for the consideration of a child’s individual needs prior to placement, as well as inspection of family homes.

Treatment of a child, until very recently, has been considered strictly a private matter. An individual could choose to raise their child using any method they personally deemed appropriate. Child rearing techniques were not up for debate and government involvement would have been unfathomable. Today, federal laws have rapidly become one of the most prominent and accepted methods of addressing the serious issues that result in foster care placements. A few of the earliest federal responses included: Title V of the 1935 Social Security Act which included limited funds for child welfare services, 1961 Aid to Families with Dependant Children (AFDC) which allowed the use of federal funds for foster care expenses (by 1961 the program was mandatory) and the Child Abuse and Treatment Act of 1974 which was the “only federal legislation exclusively dedicated to the prevention, assessment, identification, and treatment of child abuse and neglect.” The most recent additions to federal law have been Temporary Assistance for Needy Families, which replaced AFDC and the Multiethnic Placement Act (MEPA). The 1994 version of MEPA was enacted to prevent discrimination in services that were to be provided under Title V but in 1996 was amended to delete language specifically permitting the consideration of race in placement decisions.

D. Modern Foster Care

As was the case in the 1800’s, the most common reason children become involved with the foster care system is parental inability to provide adequate care, often due to illness,
substance abuse, incarceration, or homelessness. In the most extreme circumstances, an emergency removal will be done if serious physical or sexual abuse, neglect, or extreme emotional abuse has been reported. One study completed by the Department of Health and Human Services reviewed 2,069 cases throughout 32 states and found that neglect was, overwhelmingly, the predominant reason for removal during fiscal years 2007 and 2008. Parental substance abuse, although less than half as common, ranked the second most common reason for child removal.

Forced removal is not the only method. Sometimes the biological parent or guardian will voluntarily place their child(ren) in foster care. In order to do this, an agreement will be signed granting a child welfare organization care and custody of the child(ren). Parents that resort to foster care for voluntary placement are often divorced, in a financial bind, unwed adolescent mothers, or a parent on welfare requiring hospitalization. These parents feel that they are temporarily unable to rear their child(ren).

A foster child’s case often begins with an allegation of abuse or neglect. The child welfare organization will file a petition requesting the juvenile be deemed a dependent of the court and soon after a shelter hearing is held to establish whether the allegations are true beyond a preponderance of the evidence. In order to remove the child, the “juvenile court must find proof by clear and convincing evidence that removal is necessary in order to protect the child.” An adjudication hearing will follow. During this hearing, the court will decide whether the parent has abused or neglected the child. This must be proved based on a preponderance of the evidence. Next, a sentencing hearing, or disposition hearing, will be held. At this time the

21 Id. (Please see the graph included in Appendix B for more detailed information regarding why foster care cases are initially opened)
23 Id.
25 Id. at 4
26 Id.
27 Id.
28 Id.
29 Id.
court will decide which placement option is most appropriate and will approve the case plan for service.\textsuperscript{30} All states are required to hold status review hearings every six months from the time the child is removed until they reach permanency.\textsuperscript{31} In these hearings the court will assess the progress that has been made toward the goals of the case plan.\textsuperscript{32}

At this point, the child is likely to have been placed in temporary foster care.\textsuperscript{33} Meanwhile, a special hearing will be held to determine how permanency will be achieved for the child.\textsuperscript{34} At a permanency plan hearing the goals and specific steps for achieving these goals will be articulated.\textsuperscript{35} If the court has decided that returning the child is not in the child’s best interest, they will strive to do what is possible to either terminate parental rights for adoption purposes or establish a legal guardian.\textsuperscript{36} Terminating parental rights involves a new petition to the court, as well as another set of adjudication, disposition, and review hearings. After the rights of the parent have been terminated, and if neither adoption nor guardianship is an option for the child, long-term foster care\textsuperscript{37} will be ordered.\textsuperscript{38}

During the reunification period, the foster child is not guaranteed stability within their foster care placement. A standard foster care agreement often reserves the right of the agency to remove the child upon request and the foster parent also may request removal at any time.\textsuperscript{39} The longer a child remains in foster care, the less likely they are to return to their biological parents.\textsuperscript{40}

\begin{itemize}
  \item \textsuperscript{30} \textit{Id.} at 3 (A case plan “details the specifics of out-of-home care, family services and family visitation. Restrictions on custody, supervision, and visitation are also addressed”).
  \item \textsuperscript{31} LOS ANGELES DEPARTMENT OF CHILDREN AND FAMILY SERVICES, \textit{supra} note 24.
  \item \textsuperscript{32} \textit{Id.}
  \item \textsuperscript{33} \textit{Short-Term Foster Care, ADOPTION.COM}, http://www.fosterparenting.com/foster-care/short-term-foster-care.html. “This kind of foster care is intended to provide short-term care to children whose parents may be experiencing special or emergency needs of their own. This kind of care may be given when parents lose custody during the investigation of improper care but it is fully expected that the children will return home within a week to a few months.” \textit{Id.}
  \item \textsuperscript{34} LOS ANGELES DEPARTMENT OF CHILDREN AND FAMILY SERVICES, \textit{supra} note 23.
  \item \textsuperscript{35} \textit{Id.}
  \item \textsuperscript{36} \textit{Id.}
  \item \textsuperscript{37} \textit{CHILD ABUSE MANUAL, supra} note 8, at 25.
  \item \textsuperscript{38} This document describes general foster care but often other forms of foster care will be offered. For example, in Philadelphia a child may be placed in (1) General Foster Care with an approved foster parent unrelated to the child, (2) Specialized Foster Care based on specific medical or psychological needs, (3) Treatment Foster Care if experiencing complex psychiatric or behavioral problems, (4) Group Home which is primarily for older children and teenagers, or (5) Residential Treatment facilities for children who cannot safely live in a family setting because of complex psychiatric needs. \textit{Id.}
  \item \textsuperscript{39} \textit{O.F.F.E.R.}, 431 U.S. 816 at 826.
  \item \textsuperscript{40} \textit{Id.} at 836
\end{itemize}
This description of modern foster care is intentionally general. The unique circumstances each child brings to the table or currently is involved with will alter how their case is handled.

III. BACKGROUND OF CONSENT ISSUE

Informed consent is achieved when authorization by the patient is based on complete knowledge of risks and alternatives. The acceptance and appreciation for value of such consent, however, has not come easily. In the era of the 1950’s, the role of a doctor was patriarchal in nature. It was socially unacceptable for a patient to question their doctor. Participatory decision-making between a patient and physician was frowned upon. Instead, the mentality of “doctor knows best” was the accepted norm.

By the late 1970’s, a notable difference of opinion among health care professionals began to emerge. The idea of informed consent became increasingly more popular. The development of informed consent occurred in three phases. The court system initiated the movement through multiple cases, which served to further define the law of battery. Next, judicial policies began to emphasize the disclosure of alternatives and risks. Finally, a much heavier emphasis on defining and enforcing informed consent began to be accepted. As a result, the relationship between a doctor and their patient changed dramatically.

The case of Canterbury v. Spence took place in 1972 and proved to be one of the most influential American cases involving informed consent. In this case a “youth” went to their doctor complaining of back pain. After a diagnostic procedure, the doctor recommended a laminectomy. The patient did not ask (and was not told) the details of the surgery. The

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41 BLACK’S LAW DICTIONARY supra note 4 at 346 (specific definitions for those involved with the legal and medical communities).

“For the legal profession, informed consent is defined in Model Rule of Professional Conduct 1.0(e), and a patient's knowing choice about a medical treatment or procedure, made after a physician or other healthcare provider discloses whatever information a reasonably prudent provider in the medical community would give to a patient regarding the risks involved in the proposed treatment or procedure.” Id.


44 ANNAS, supra note 42, at 3.

45 Id.

46 Id. at 232

47 Id. at 233

48 MERRIAM-WEBSTER DICTIONARY 1267 (3rd ed.-1993). (A laminectomy is a procedure where the posterior arch of a vertebra is removed).

49 FURROW, supra note 43, at 233.
patient’s mother was told that this procedure was no more dangerous than average surgeries. This was not completely accurate. After complications arose and a fall further exacerbated the issues, the youth was left in a far worse position. He sued the doctor for “negligent failure . . . to disclose a risk of serious disability inherent in the operation and negligent post-operative care . . .” The court agreed stating that a practicing physician has a duty to disclose information about a proposed treatment to patients.

Courts are now expected to respect individual autonomy. Additionally, health care professionals are expected to obtain a clear assertion that any action contemplated truly aligns with what the patient desires. The standard consent forms patients now sign, upon admission and before various procedures, reflect this societal change. Alexander Capron succinctly stated six rationales for requiring informed consent. He felt such consent was validated by a general societal desire to protect individual autonomy, protect patient’s status as a human being, avoid fraud or duress, encouraging doctors to carefully consider their decisions, foster rational decision-making by the patient, and involve the public in medicine.

Informed consent continues to be highly regarded because public policy supports clear expectations for any patient who is under the care of a medical professional. Courts within a majority of states have now defined the scope of a patient’s rights. Although most states have anywhere from ten to thirty enumerated rights, the core rights are as follows: the right to make informed decisions, the right to privacy and dignity, the right to refuse treatment, the right to emergency care, and the right to an advocate. It is clear that the once far-fetched idea of ensuring patient involvement has not only been merely accepted but has flourished and become uniformly accepted throughout the nation.

50 Id.
51 Id.
52 FURROW, supra note 42, at 240.
53 Id.
54 Id. at 230
55 Id. at 231
56 Faculty Directory, UNIVERSITY OF SOUTHERN CALIFORNIA LAW, http://lawweb.usc.edu/who/faculty/directory/contactInfo.cfm?detailID=205, (last visited April 8, 2011). (Alexander Capron is a globally-recognized expert in health policy and medical ethics. He is currently a professor of law and medicine at the University of Southern California).
57 FURROW, supra note 43, at 240.
58 ANNAS, supra note 42, at 19.
A. Consent for Minors

There are limited exceptions to the now well-established informed consent requirement. One such exception is situations where a person is found to lack competency. Formally, competency entails the “...ability to understand and appreciate the nature and consequences of a decision regarding medical treatment or foregoing life-sustaining treatment and the ability to reach and communicate an informed decision in the matter as determined by the attending physician.”59 Typically competent adults are entitled to control their own person60 but minors, in general, are thought to lack the basic maturity necessary for making such decisions.61

Ideally, parents should be the sole decision makers on behalf of their minor children. There are, however, conflicting ideas regarding parental involvement. On one extreme, circumstances may arise where failing to act or obtain necessary treatment for their child can be viewed as abuse or neglect. For example, if the life of the child is in jeopardy, most states will allow medical treatment over a parents’ refusal.62 However, if the situation is not life threatening, the court will rely on various factors, such as risk of the treatment, possibility of deferring it until the child is no longer a minor, the child’s wishes, or the basis of parental refusal.63 Ironically, parental involvement often reduces the chance that a minor will seek treatment at all.64 Controversial screenings, for pregnancy or sexually transmitted disease may be avoided if the minor knows a parent will need to be involved. This avoidance could be a reaction to an unsupportive or strained relationship between the child and parent or because of the child’s perception of the desired treatment as sensitive or controversial.65

The laws of the particular state may attempt to circumvent this issue by stipulating exceptions which require parental consent. Common exceptions to the waiver of a minor’s

59 §266.007(a).
60 ANNAS, supra note 42, at 127.
There are times when an adult will not be afforded informed consent. These include: (1) emergency situations, (2) situations where risks are well known, (3) when the patient does not want to to know specific risks or asks not to be informed, (4) a therapeutic privilege is proven to exist (physician ha objective evidence that it would lead to patient becoming so upset they are not able to make rational decisions). Id.
61 Vukadinovich, supra note 3, at 671. (An “adult” is generally defined as the converse to whoever the particular state considers a “minor.” Footnote two explained that most states view a minor as being any person under the age of eighteen; so, an adult in most states would be a person over the age of eighteen).
63 Id.
64 Vukadinovich, supra note 3, at 671.
65 Id.
consent occur when the child (1) has been emancipated,66 (2) the minor’s health concern is considered “high-risk” or, (3) if a special court order has been granted.67 Similar to requirements for adult consent, in situations where a minor is granted permission to give independent consent the medical professional must ensure the minor is mature enough to understand exactly what is being done, what the potential risks are, as well as any alternatives that must exist.68

B. Consent for Minors in Foster Care

A recent New York Times article states that the average child in foster care will change “homes” at least three times and will change schools at least seven times.69 It is easy to sympathize with how overwhelming and confusing this type of change can be for any child. In addition to the severity of losing parent(s) and a familiar school, those working with these children should be mindful that the child is also likely to feel the loss of smaller, seemingly less significant, aspects of their former life. Foster children may be mourning their previous neighborhood, places to hang out, perhaps teams or activates they were a part of or even a family pet. This sensitive situation is further exacerbated if, on top of all of this, they were subjected or exposed to physical trauma. Foster children who experience trauma have been found more likely to suffer from insomnia, night terrors, irritability, increased anxiety or nervousness, separation anxiety, fear of repetition, and even flashbacks.70

An already fragile child may be placed in a home where it is difficult to connect or relate to the adult caregiver. Foster care is intended to be a temporary option; consequently, foster parents are often told not to become attached to the children they care for.71 Worse yet, the United States Department of Health and Human Services’ Children Bureau conducted a Child Welfare Outcomes Report to Congress that cited further abuse within the foster homes.72 In 2004

66 CHILD ABUSE MANUAL, supra note 8, at 190.
   “Refers to the release of a minor from parental control … generally considered a question of fact…” The judge will usually consider the following factors: age, marital status, ability to be self-supportive, and desire to live independently.” Whether they have income and a place to live will also be considered.
67 Id. at 677 (A judge will make the determination whether the child can be released from parental control).
68 Vukadinovich, supra note 3, at 691.
70 Child Abuse Manual, supra note 8, at 94-95.
72 U.S. DEPT. OF HEALTH AND HUMAN SERVICES, supra note 20.
they reported .44% of all foster children were subject to abuse from foster parents or service providers.\footnote{73} Regardless of whether a child has been exposed to extreme trauma, a child losing their former way of life is extremely traumatic. In fact, one study of Georgia’s foster care system reports that a quarter of all foster children “suffer from post traumatic stress disorder, up to twice the rate for U.S. war veterans.”\footnote{74}

The story of DeMarcus Hysten will help to place these statistics in context. The following is an interview, conducted by National Public Radio reporter Andrea Seabrook, is a vivid presentation of what foster care was like for one child.\footnote{75}

DeMarcus Hysten is a named plaintiff in the lawsuit He has been in the foster care system since 1991, when he was 5 . . . "The Department of Human Services, they drove by the house several times, not expecting anyone to live there because the house was so abandoned-looking," Hysten recalls of life in his mother's home. The state first moved Hysten to his grandmother's house, but she didn't have utilities. Then he endured a series of 28 moves, including temporary foster placements: group homes, emergency shelters, mental health facilities and, by the time he was 16, a home for juvenile offenders — even though Hysten had not committed any crime. “I'm in there with sexual offenders, vandals, people who have assault records, stolen stuff. I'm talking about real mini-criminals — these are little criminals that I'm with," he says. The inappropriate placement and constant moves left Hysten alone and, many times, scared. He never found a permanent home. Now 20 years old and in his first year of college, he says he is still dealing with the consequences." And you know what? It feels like, because of that, there is no stability in my life now," he says. "Big trust issues — that's another thing I have a big problem with, because of all the people in my past. I've been hurt so many times — like putting all my trust into a home, putting all my trust into someone that I thought would do me right and would end up doing me wrong. (emphasis added).\footnote{76}
It is important that the professionals who have a foster child as a client make an effort to learn if that particular child, like DeMarcus, has a story that may influence their world view. Ascertaining the child’s full story will assist such professionals in understanding why a child may feel they are capable of assessing their own risks in medical situations where consent is required. “Many children involved with service agencies have suffered repeated violations of their sense of personal privacy. They have been abused by parents or relatives, or transferred from one foster care placement to another . . . Respect for confidentiality rights are particularly crucial for such children. It allows them to exert some measure of control over their world, and to develop a degree of trust in those around them.”

Unfortunately, confidentiality is not typically discussed with foster children, let alone a valid option for them.

Professionals not only possess the child’s personal information, such information (including medical records) may be openly discussed in case meetings, by a review team or within the various court hearings discussed previously. Pennsylvania state law, for example, requires that the “…court shall review a summary of the medical care provided to the foster child since the last hearing.” Under their regulations, the summary must cover specific areas. The court must be provided with information regarding the following: any emergency medical care provided, any medical or mental health treatment as well as the child’s progress regarding the treatment, any medication prescribed and the condition it was prescribed for, any diagnosis and symptoms for which the medication was prescribed, the degree to which the foster care provider has complied, any adverse reaction or side effects, any specific medical condition diagnosed or being tested for, and any activity the child should avoid or engage in.

Although the rationale and intentions of providing the court with such information may be legitimized by a general desire to ensure the child’s well being, it is clear that it also severely limits any concept of privacy the child might have had. A traditional (non-foster care) child may go to the doctor for a test, screening, or procedure and, at most, expect their parents or close friends to hear about it. A

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78 TEX. FAM. CODE ANN. § 264.509 (West 2010).
79 TEX. FAM. CODE ANN. § 266.007(a).
80 TEX. FAM. CODE ANN. § 266.007(a)(1)-(7).
foster child knows that each visit to a medical professional has the potential to be disclosed to a court room full of people whom he or she has varying levels of comfort. Additionally, the child is aware that their lawyer will always have full access to all records.\(^\text{81}\)

The life changes that a foster child endures is significant and allows a foster child to gain experience and emotions that other children their age are not yet equipped to handle. Too often a foster child must trade beneficial protections that appropriately shelter non-foster children for the ability to endure and respond to traumatic or stressful situations. Some may argue that this instability compromises a foster child’s ability to consent. However, such an arguments only serve as a blanket generality. More likely, because these children are often forced to develop heightened responsibility and life skills, they become better equipped to contribute to conversations regarding their own best interest.

The current reality is that the majority of minors in foster care, regardless of personally maturity or competence, will be unable to provide independent consent. Many foster children, even the very young, convey an adult-like feeling or sense of responsible for their own lives and welfare. A foster child who responds to unique circumstances with heightened awareness and maturity is capable of making contributions to their personal medical decisions that may prove quite valuable.

\textit{C. Rights and Positions of Various Parties Involved}

As stated, when a minor is deemed incompetent, the child’s parent or guardian consents on their behalf. However, because multiple parties are involved in the life of a foster child, it is not always clear who should provide this consent or how much weight the opinions or suggestions each of these players should receive.

If a child is in the foster care system, the rights of the their biological parent(s) may be limited or gone. Diminished rights do not reflect a lack of parental concern for their child. Despite their legal standing, the biological parent(s) are capable of having influence over the child and foster agencies, depending on the situation and degree of permitted interaction. Foster care agencies will often defer to an accepted approach or standard in situations that involve biological parents or guardians. For example, in New York City, if the biological parent has not

\(^{81}\text{CAL. FOSTERING CONNECTIONS TO SUCCESS ACT § 559 (Deering 2010) (“For the sole purpose of fulfilling his or her obligation to provide legal representation of the child, counsel for a child shall have access to all records with regard to the child maintained by a health care facility”)}.\)
had their rights terminated, agencies will defer to that parent, even if that agency technically has the ability to provide independent consent.\textsuperscript{82} One possible reason for granting extended leniency may be based on underlying criticisms that foster care is a class-based system that preys on female-headed, minority families.\textsuperscript{83} Regardless of how accurate such opinions are, this more relaxed approach is not guaranteed and certainly not used in more sensitive situations where involving the biological parent would put the child at risk. In short, the biological parent’s ability to be involved in the process is often contingent on whether their legal rights have been terminated by a court coupled with the child agency’s assessment of individual circumstances.

A foster parent’s legal rights are limited. Typically, they are afforded the ability to consent to routine medical or dental treatment for the child.\textsuperscript{84} If a dispute regarding a particular foster parent’s ability to consent arises, a court will be called to render a final judgment on the matter.\textsuperscript{85} State laws permitting court-approved exceptions are common and will also undermine independent consent. For example, in Texas, one state statute allows for other, specifically named parties or agency employees to consent.\textsuperscript{86} Additionally, the choices a foster parent makes will always be supervised by the child agency that initially certified them.

Legal ability to consent is just one of the issues with foster parents providing informed consent. A foster parent may not have been able to develop a close relationship with the child for whom they are making decisions. This is not always the fault of the foster parent. Too often these individuals, who play such an important role in the lives of foster children, are not given adequate training which will “. . . equip them to handle the often complicated demands of their role.”\textsuperscript{87} On the other hand, in every state child care agencies will provide a monthly stipend\textsuperscript{88} for foster parents will be paid for each day the child stays overnight. The rate is based on room and board and will be determined prior to placement. The stipend is expected to cover food, shelter, laundry expenses, personal items normally used by other members of the family, any activities which the family plans such as movies, amusement parks, and transportation costs. Foster children are also normally eligible for free school lunch. \textit{Id.}
the child and appropriate services to approved foster parents. Consequently, it is possible that for some the motivation for becoming a certified foster parent may be the prospect of extra income.

Under ideal circumstances, the caseworker takes an active role in the process. Caseworkers are rarely able to give each child in their caseload the amount of devotion necessary. Their desire to do so may exist but bureaucratic regulations and expectations create hurdles. Personal views of the specific caseworker also may preempt extended involvement.

Caseworkers are expected to carry an extremely high caseload. The story of DeMarcus Hysten’s experience in foster care (described previously) attests to this fact. The reporter who conducted the interview stated that the attorneys involved felt that “one reason Hysten moved so often and stayed in foster care his entire childhood is because there are not enough social workers to take care of children." The fact that there are so few caseworkers further exacerbates the overwhelming number of cases that arise daily. One reason for an insufficient number of caseworkers can be attributed to low wages. Georgia’s Department of Family and Children Services (DCFS) provides a striking example. In fiscal year 1999, DCFS was responsible for handling roughly 70,000 reports of child abuse and neglect. The caseworkers responsible for instigating each of these cases had a starting salary of $22,044.00. Additionally, some of the caseworkers studied made decisions and completed investigations relating to the life and death of children without such basic resources as a statewide information system to track children and families, cellular phones or adios to call for help, or adequate placements for children removed from their homes. Roughly 39% of these workers left their jobs within the same year, and that number jumped to 44% by fiscal year 2000. As a result of these dire circumstances, it is easy to see why a caseworker may feel helpless or undervalued and how such feelings can quickly lead to apathy.

The result of these circumstances can be devastating for the population that the caseworker is trying to protect. This strain and pressure of a caseworker that is overextended

89 Child Abuse Manual, supra note 8, at 25.
90 Bornstein, supra 69.
92 Id.
93 Id.
94 Id.
95 Id.
does not allow for a well thought out, deliberate decision-making process to occur. It is highly unlikely that under such circumstances, anyone would have the ability to perform their job well. As a result, a person can rationalize cutting corners or giving in to unethical practices for the sake of efficiency. When a social worker is unable to proficiently handle their “basic” responsibilities it is not difficult to imagine why putting effort into tasks such as resolving issues of the biological parent that initially lead to placement, striving to get the most out of periodic court reviews or even ensuring a child is in the most appropriate environment is not addressed in an ideal manner.96

Not all foster children will feel the strain of what has been described. Sometimes a child will feel extremely close to their caseworker. Strong bonds do occur between a child and a caseworker even where attention is not optimum and the situation is less than ideal. The scenario appears to be counter-intuitive but may simply reflect that a child’s caseworker is one the only individual consistently involved with the child from the initial trauma of their removal through the conclusion of their need for services.

During a recent interview former foster child Nikki Rodriguez97 was asked if she had ever personally encountered situations where foster children had expressed that they would like to provide their own consent.98 After she answered affirmatively, she provided the following example:

[When the caregiver] would take me to the doctor’s, the doctor would talk to them (not me), and then they would shove pills down my throat that I never agreed to taking . . . if I refused, I would get privileges taken away from me: phone, computer, visitation. [I was given medication for] depression, insomnia, birth control, and asthma [even though] I don’t and never did have asthma. I never wanted to take any of those things. They forced me to . . . not only did they make me take medications against my will; they also sent me bills after my 18th birthday for [the medications]!99

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97 Interview with Nicole Rodriguez, former foster child (April 11, 2011).
98 Id. (Please see Appendix D for a complete listing of interview questions).
99 Id.
It is clear that, in general, all parties involved believe they act with the best interest of the foster child in mind. However, it is also clear that certain barriers, feelings of helplessness or apathy can overshadow the ability to adequately serve these children. As a result, a foster child will be excluded from conversations, including those that involve their medical well-being.

IV. CURRENT LEGAL APPROACH

The statistics and laws of two states reveal the current legal approach regarding informed consent with foster children. California and New York were chosen based on population, overall amount of information available, and their reputation for progressive strides in children’s rights.

A. California

According to the United States Census Bureau, California is the most populated state in our nation.100 Likely related is the fact that it also has the highest number of children in foster care. According to the Adoption and Foster Care Analysis and Reporting System (AFCARS),101 in the 2009 Fiscal Year 34,826 children entered foster care, 39,226 left, and 60,198 were remaining at the end of the year.102

California law defines patient’s rights within the administration section of their social security regulations.103 The twenty-six rights enumerated closely reflect the general patient rights previously discussed. Patients’ rights serve as a foundation for the informed consent requirements, which can also be found within the administration section of their social security regulations.104 Despite California’s clarity in the overarching topics of patient rights and informed consent, none of their laws have been tailored to respond to the unique circumstances of foster children. However, the state does acknowledge specific informed consent requirements for the education and training of physicians105 as well as for health and welfare agencies

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102 Id.
103 CAL. CODE REGS. Tit. 22, § 73523 (2011).
conducting research. Implementing different requirements during education, training, or research may reflect a general understanding that adapting informed consent is sometimes necessary.

California, like most states, sets their age of majority at eighteen. This means that while a child is under eighteen, an adult will need to provide consent on their behalf. State law makes it clear that when a law applies to children in general it will apply to foster children as well. Thus, exceptions to the general consent rules apply to both groups as well. For example, California does not stipulate an age limit at all for any child seeking diagnosis or treatment related to sexual assault or pregnancy-related treatment or prevention.

When a foster child is voluntarily placed, the biological parents may have stipulated their own additional consent requirements in writing. The professionals providing mental health treatment in California are required to “... involve the minor’s parent or guardian in the treatment unless the professional providing the treatment deems it inappropriate.” A child’s legal guardian will not be able to independently consent to the following: placing child in a mental health facility, undergoing sterilization, enrolling in experimental drug trials, convulsive treatment, or undergoing psychosurgery. California’s welfare and Institutions code states that a social worker may provide authorization of performance of medical, surgical, dental, or other remedial care but should notify the parent or guardian. A foster parent’s ability to consent only extends to routine medical treatment including, but not limited to immunizations, physical exams, or x-rays.

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106 CAL. CODE REGS. Tit. 22, § 50423 (2011).
108 Id.
109 Id.
110 Id.
111 Id. (In most circumstances, the medical provider must attempt to contact the child’s parents unless there is reason to believe the parent committed the assault. In the cases of rape, sodomy, oral copulation parental notification may be required).
112 Id.
113 Id.
114 Vukadinovich, supra note 3, at 683.
115 Alliance Training, supra note 107.
116 CAL. WEL & INST CODE § 369 (Deering 2011).
117 Id.
If the parent or guardian objects to a medical procedure, California law requires that a court order be obtained.118 However, no court order will be necessary in the case of an emergency119 When health care professionals see a child, they are required to make a specific note in the child’s record stating if and when they made an attempt to contact the minor’s parent or guardian, what occurred, or if they deemed the parent or guardian inappropriate, they must note why they came to this conclusion.120

B. New York

New York is the second most populated state in our nation and, as in California, the number of children in foster care reflects this.121 According to AFCARS New York had the second highest number of foster children in care at the end of fiscal year 2009.122 12,876 foster children entered care, 13,658 left and 27,992 remained.

Many of the consent laws in New York are consistent with those found in California.123 The New York Mental Hygiene Law defines informed consent as an agreement a patient gives based on a clear understanding of their condition, the nature of purposed or alternative treatments, and risks and benefits of the proposed and alternative treatments.124 Like California, New York also sets the age of majority at 18 and, in most cases, requires the consent of the minor’s parent or guardian.125 Again, an exception would be made in the case of an emergency or pregnancy related care. New York also allows minors who are parents, married, or have been emancipated to provide their own consent.126

The most notable difference in New York law is the addition of a mature minor exception.127 This exception allows any minor who is deemed emotionally and intellectually secured enough to give informed consent regardless of whether they are living with [a] parent or guardian.128 Clearly, those who drafted this exception agreed that not allowing consent based

118 Id.
119 Id.
120 Id.
121 U.S. CENSUS BUREAU, supra note 100.
122 Id.
124 Id.
125 Id.
126 Id.
127 Id.
128 Id.
purely on age is not always justified. New York has taken a giant stride toward logical children’s rights, but again, the laws do not specifically address foster children.

C. Implementation

Anyone who has attended a single day of law school or watched legally-based television would know that even laws that appear to be the most straightforward can fall prey to gaps, loopholes, differing interpretations or the infamous “grey area.” Due to this inevitable reality, perspectives from those working in the legal field are useful in revealing how the stated laws are interpreted and followed by the professionals that are called to adhere to them. Individuals actively working with foster children in either New York or California were contacted. California Youth Connection and The Legal Aid Society of New York were kind enough to assist in the furtherance achieving a “real world” perspective. Identical questions were asked of each interview participant (please see Appendix C for this information).

The Legislative and Policy Coordinator for California Youth Connection (CYC), Chantel Johnson, offered valuable incite and opinions on both a professional and personal level. She began by explaining that CYC was initially founded by Youth Law Center. They are a non-profit organization working primarily with current foster children, ages fourteen to twenty-four, and former foster children. Ms. Johnson explained that her agency’s primary goals are to empower former foster youth and to create leadership opportunities. CYC currently exists in over 58 counties, all of which have individual chapters of foster care youth. Each year, CYC holds a statewide conference where members work together to recommend new legislation and policy development in an effort to improve the foster care system.

When asked how consent laws are carried out in their California practice, Ms. Johnson said it depends on the age of the youth, because each procedure had different categories of consent. However, it was her understanding that under almost all circumstances, the standard

129 Telephone Interview with Chantel Johnson, Legislative and Policy Coordinator, California Youth Connection (April 14, 2011).
130 Id.
131 Id.
132 Id.
133 Id.
134 Id.
135 Id.
exception for consent regulations will state, “or when developmentally appropriate.”

Ms. Johnson felt that the trend of addressing situations where a child may be deemed developmentally appropriate is relatively new and will most often come down to the judge and attorney’s discretion. For CYC, one of the most frustrating issues involving informed consent is the use of psychotropic medications. The foster children Ms. Johnson works with have expressed that they would simply like to be involved in any decision that affects them. Ms. Johnson does acknowledge that the use of psychotropic medications is a very touchy topic, often for legitimate reasons. For example, it is quite difficult for professionals to distinguish between children who would truly benefit from this type of medication, even if they do not want to, and those who should be afforded a more active role in the diagnosing process. At the root of the issue is the fact that it is against public policy to legislate parenting.

Ms. Johnson was next asked if she would share an example of a situation where a foster child felt they were unjustifiably refrained from offering informed consent. She said that as a former foster child herself, she had personally experienced how frustrating this situation often is. While she did not provide examples from her time in the foster care system, she gave a hypothetical example based on what she felt was a common occurrence. Often a child will complain that they are forced to take Ritalin when they do not feel they actually need it. These children will come to her and explain that they want to know what the alternatives were and

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136 Id.
137 Id.

The use and potential abuses of psychotropic medications, especially involving the foster care population, is a highly prevalent. One study, conducted by the University of Maryland, found that in Texas psychotropic drugs were given to foster children at a rate of at least three times more than similar children from poor families. Use of such medications is considered highly controversial because the initial prescription is given because of a child’s behavioral and emotional symptoms rather instead of the specific mental condition the medication is intended to address. Many of the sources that discussed foster children and informed consent also mentioned topic to some degree. However, the abuses of psychotropic medications is beyond the scope of this article. Id.

139 Id.
140 Id.
141 Id.
142 Id.
143 Id.
144 Id.
145 Id.
146 Id.
expressed frustration because no one seemed to take their request seriously. 147 Just as former foster child Nicole Rodriquez explained above, Ms. Johnson confirmed that often a child’s resistance to compliance is a punishment or loss of privileges. 148

Next, two individuals working for The Legal Aid Society of New York offered their perspective regarding informed consent and foster care. “The Legal Aid Society is a private, not-for-profit legal services organization, the oldest and largest in the nation, dedicated since 1876 to providing quality legal representation to low-income New Yorkers.” 149 It is dedicated to one simple but powerful belief: that no New Yorker should be denied access to justice because of poverty. 150 The Society handles 300,000 individual cases and matters annually and provides a comprehensive range of legal services in three areas: the Civil, Criminal and Juvenile Rights Practices.” 151

When asked how consent laws are carried out in their California practice, the Director of Social Work, Nanette Schrandt explained that even though agencies do possess the ability to consent in most medical situations, if the rights of the biological parent have not been terminated, it is their practice to consult with this parent about the prospective procedure. 152 She went on to explain that because law states that foster parents (or other legal guardians) can consent to minor or routine procedures, their agency will not hear about the situation unless one of the parties is upset or the potential procedure is controversial in nature. 153 The example that Ms. Schrandt felt was most common for their agency was situations where a child is in need of therapy. Specifically, she explained that teenage foster children are often skeptical to seek services from an agency located within the same building as other services they receive (such as the location of their caseworker’s office). 154 According to Ms. Schrandt, this issue seems to be more about the child’s desire to have some control in the situation, as opposed to a concern over the quality of care. 155

147 Id.
148 Id.
151 Id.
152 Telephone Interview with Gary Solomon, Director of Litigation Support & Nanette Schrandt, Director of Social Work, Legal Aid Society (April 4, 2011).
153 Id.
154 Id.
155 Id.
Like Ms. Johnson, both Ms. Schrandt and Director of Litigation Gary Solomon agreed that the most challenging and controversial consent issues stem from the administration of psychotropic medications. When asked how The Legal Aid Society handles such situations, Ms. Schrandt explained that if a child were to complain to one of their lawyers about how a medication was making them feel, the lawyer would seek an order directing the child’s agency to re-evaluate the medication.

Understandably, the professionals interviewed were not prepared to make the blanket statement that foster kids always have a higher capacity to consent, but they did recognize that not all children are at the same competency level. Mr. Solomon added that foster care children are definitely more vulnerable to “sloppy” behavior of those who may not have their well-being in mind, which he said is why it is the job of various agencies and professionals pay particular attention to these children.

V. CALL TO ACTION

A. Overarching Theories

Numerous options are available if addressing informed consent for foster children is to be taken more seriously. The most extreme response involves changing the language of the existing laws. For example, drafting additional language that requires those involved with the health care profession to assess the individual competence of any foster children they see as patients. In drafting such laws, the state interest in this area may be very persuasive. For example, in Massachusetts, courts were granted the ability to order treatment when parents refused to continue treatment at times when their child’s condition was likely to deteriorate severely. This law was justified based, in part, on the state’s interests regarding child welfare, preserving life, protecting “ethnic integrity of the medical profession,” and allowing hospitals to give the best possible care. While these interests are particular to the law Massachusetts was trying to create, similar state interests could be used to achieve results in conflicts regarding informed consent.

156 Id.
157 Id.
158 Id.
159 Telephone Interview with Gary Solomon, Director of Litigation Support & Nanette Schrandt, Director of Social Work, Legal Aid Society (April 4, 2011).
160 Vukadinovich, supra note 3, at 683.
161 Vukadinovich, supra note 3, at 685.
One way to include foster children in consent laws would be to mirror California’s reaction to sexual assault or New York’s response to HIV status. That is, such a law could take into account more than simply the age of the child when determining consent.\(^{162}\) Another example, also found within California law, takes a child’s right to be present at their court hearings very seriously.\(^{163}\) These examples serve as a reminder that incorporating children into overarching laws can be done successfully. Although no state claims to set a perfect example, perhaps a starting point in creating positive change within an agency or practice is to borrow from those who are making steps in a similar direction.

Profoundly altering the law itself may be an attractive option to certain individuals but often a less dramatic, more grassroots-level approach can also prove effective. For example, if the individuals who work most intimately with foster children (foster parents, caseworkers, guardian ad litems, and even certain health care professionals) were to take a more active role in addressing informed consent, the voice of these children will be better heard. This theory may sound unrealistic but there are a few simple approaches that would greatly increase a foster child’s feeling of responsibility and control over their own person. Ms. Johnson (who spoke on behalf of CYC) affirmed this notion. When asked what she felt is the best approach for addressing issues that involve foster care and informed consent, she responded by first affirming CYC’s progressive role in legal changes.\(^{164}\) However, she also agreed that sometimes changing the letter of the law does not have the immediate impact desired.\(^{165}\) She pointedly stated that while California has great legislation, it often is not implemented, and when it is, it takes a significant amount of time to have an impact.\(^{166}\)

**B. Suggestions**

A grassroots approach flourishes only when founded on a clear understanding of current laws and practices. Foster children will receive the best care when all parties are on the same page regarding both what the current practice is and what the ideal solution might look like. Therefore, the first step is simply to bring the topic up in daily conversation. Facilitate

\(^{162}\) LEGAL HEALTH, \textit{supra} note 123.

\(^{163}\) Telephone Interview with Chantel Johnson, Legislative and Policy Coordinator, California Youth Connection (April 14, 2011) (The law goes so far as to state that the agencies need to provide transportation and in the case that a youth is not able to attend a hearing, that hearing will be rescheduled).

\(^{164}\) \textit{Id.}

\(^{165}\) \textit{Id.}

\(^{166}\) \textit{Id.}
discussions that not only critique the current issues, but also create an environment where people are able to speak comfortably and honestly.

Another relatively simple approach is implementing the existing patient rights into profession-specific policies through “A Patient Bill of Rights.”\textsuperscript{167} Merely having such a document is not expected to create positive change. It must be made available to the affected population. Professor George Annas argues that making a Patient Bill of Rights clearly visible not only serves as a basic education for patients in hospitals or other inpatient facilities but will also lead to a sense of greater empowerment.\textsuperscript{168} In addition, the suggested Bill of Rights can be tailored to any population necessary. The example Annas provides is a “Childbearing Patient Bill of Rights.”\textsuperscript{169} By taking his lead, a “Foster Child’s Bill of Rights” may be based on the concepts professionals deem most relevant to foster children.\textsuperscript{170} This document should be placed in locations within hospitals, physician’s offices and child welfare agencies that are most frequented by foster children. This strategic placement is important in ensuring that foster children and their guardians’ notice and are given the opportunity to read the rights.

The response of the Department of Health and Human Services’ Office for Human Research Protections to violations of proper informed consent requirements provides an example of a grass-roots approach in action.\textsuperscript{171} The Colorado hospital in question responded by (1) providing training to research staff on properly obtaining and documenting informed consent, (2) conducting quality assurance reviews, (3) developing a new standard operating procedures that described how to review and report incidence of noncompliance, and finally, (4) making plans to provide education to senior institutional leaders of the importance of human subject protection and the maintenance of confidentiality. This is just one example of how a proactive approach can be used to address informed consent concerns.

After the foster child professional implements change within their own agency, the most important step, client engagement, can take place. When a professional believes their client may possess an elevated competency level they should attempt to facilitate conversation to validate their suspicion. Factors to assist assessment of competence include: the client’s ability to explain

\textsuperscript{167} ANNAS, supra note 42, at 12.
\textsuperscript{168} Id. at 14 (Please see appendix D for a complete version of the Patient Bill of Rights created by Professor Annas).
\textsuperscript{169} Id.
\textsuperscript{170} Id. at 375.
\textsuperscript{171} OHRP Determination Letters, GUIDE TO GOOD CLINICAL PRACTICE NEWSLETTER (Dept. of Health & Human Services Office for Human Research Protections), Oct. 2006, at 20.
the rationale of their decision, the professional’s assessment of how susceptible the client is to persuasion, the client’s appreciation of potential consequences or how a decision may impact others, and how consistent the decision is with long-term goals the client may have.\footnote{THOMAS D. MORGAN AND RONAL D. ROTUNDA, 2010 SELECTED STANDARDS ON PROFESSIONAL RESPONSIBILITY 63.}

Establishing competence of a foster child should be based on conclusion drawn through personal interaction with the client as well as using the assistance of other respected professionals. It is important, however, that the overall goal of giving a child a voice is not undermined by assumptions. A lawyer, for example, may inadvertently hush a child’s voice by agreeing too quickly with competency assessments of others. Jean Koh Peters, when discussing the representation of minors in child protective proceedings recommends that, “a lawyer should not accept the offhand statement that of another professional that the client cannot understand the legal matters. Indeed, of many of the issues facing children are issues intimately affecting their daily life . . . even the youngest children can understand and express ideas about issues central to their legal case.”\footnote{JEAN KOH PETERS, REPRESENTING CHILDREN IN CHILD PROTECTIVE PROCEEDINGS: ETHICAL AND PRACTICAL DIMENSIONS 367 (3rd ed. 2007).} Lawyers, in particular, are called to adhere to very strict standards set out in the Model Rules of professional ethics. Unlike the a caseworker who is subject to the polices of the agency that employees them, Model Rule 1.3 requires that all lawyers be cognizant of their workload so each client’s case can be handled with competence.\footnote{MORGAN, supra note 172, at 15.} Furthermore, Model Rule 1.14 clearly states that even in situations where a client potentially lacks capacity to make a decision regarding representation (specifically citing minority as one potential reason) the lawyer is still called to maintain a client-lawyer relationship that is as “normal” as possible.\footnote{Id. at 61. (The phrase “normal” in this context should be taken to mean the lawyer strives to treat this lower capacity individual as similarly to their other clients as possible).} The comments to this rule give the example of children as young as five or six having opinions that should be given weight within a custody hearing.\footnote{Id. at 62.} Finally, professionals should remember that empowering a child to use their voice will not occur quickly. They will often have to update their understanding of what the foster wants multiple times.\footnote{PETERS, supra note 173, at 376.}
VI. CONCLUSION

The foster care system has always faced challenges and too often is responsible for breaching serious injustices in the lives of those children it is called to protect. It can be argued that the entire system needs serious refining. There may be some truth to such a statement but often such positions quickly gain support but are unable to accomplish much because they are challenging to put into action. Instead, professionals actively working with foster children can work toward smaller, more tangible, goals. In doing their part to improve the lives of the child(ren) they encounter daily. Professionals are likely to be encouraged by small victories which, in turn, better prepares them for future challenges.

Giving a foster child a voice and advocating for their right to use that voice is one example of a small goal that any professional is capable of carrying out. When there is a medical decision to be made and a foster parent, caseworker, or other professional is required to grant informed consent, they should not forget that they are making decisions for another person and that the child, not the professional, will ultimately have to live with any consequences. Simply asking their opinion about medical situations or treatment options will go a long way in healing their general mistrust and feelings of helplessness. A child may not act like they care at the time but as the stories and statistics above reveal, the ability to have even the slightest degree of control in their lives is incredibly meaningful. Even in instances where it would be clearly unwise to grant the child independent consent, asking their opinion anyway, helping them to understand what is taking place and giving them the freedom to react without shame or punishment will go a long way in building relationships with those who are supposed to be looking out for their best interest.

Consent laws specifically tailored to the foster care population were not found in any state. As is often the case, if such laws are to be created it will take a very long time. In the meantime these children will be waiting, living their lives and forming their interpretations of the world around them. Professionals who interact with foster children need to make a personal choice to not let the children they encounter be overlooked. The issue is not simply about a single child rebelling for a juvenile sense of control. Rather it is the idea that society should allow any individual with the requisite capacity to accordingly be granted the appropriate autonomy. If a child’s experience has lead them to be wise beyond their years, the very least that can be done is acknowledging their humanity by allowing them to be heard when it comes to
their own bodies. The slogan of CYC offers the appropriate battle cry for foster children waiting for a time when they will be granted a role in informed consent. These children have every right to demand that professionals remember to do “nothing about us without us.”\(^{178}\)

VII. APPENDICES

A. *Timeline of Major Child Welfare Legislation*\(^ {179}\)

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\(^{178}\) Telephone Interview with Chantel Johnson, Legislative and Policy Coordinator, California Youth Connection (April 14, 2011).

\(^{179}\) **CHILD WELFARE LEAGUE OF AMERICA**, supra note 16.
<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
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<tbody>
<tr>
<td>1935</td>
<td>Enactment of the Social Security Act includes limited funds for child welfare services under Title V.</td>
</tr>
<tr>
<td>1958</td>
<td>Amendments to Title V require states to match federal child welfare funds if they choose to draw down funding.</td>
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<tr>
<td>1961</td>
<td>Title IV-A, the Aid to Families with Dependent Children (AFDC) entitlement, is amended to allow use of funds for foster care expenses if the child comes from an AFDC eligible family and a court determines it is in the child's best interest to be removed. State participation in the Title IV-A AFDC foster care program is made mandatory in 1969.</td>
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<tr>
<td>1969</td>
<td>Title IV-A, the Aid to Families with Dependent Children (AFDC) entitlement, is amended to allow use of funds for foster care expenses if the child comes from an AFDC eligible family and a court determines it is in the child's best interest to be removed. State participation in the Title IV-A AFDC foster care program is made mandatory in 1969.</td>
</tr>
<tr>
<td>1974</td>
<td>Child Abuse and Treatment Act is enacted. It is the only federal legislation exclusively dedicated to the prevention, assessment, identification, and treatment of child abuse and neglect.</td>
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<tr>
<td>1978</td>
<td>Indian Child Welfare Act is adopted, establishing requirements for child welfare agencies when serving Native children and families.</td>
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<tr>
<td>1980</td>
<td>Enactment of the Adoption Assistance and Child Welfare Amendments of 1980 establishes a new Title IV-E Foster Care and Adoption Assistance entitlement program.</td>
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<tr>
<td>1981</td>
<td>Congress ultimately rejects Senate legislation to create a child welfare block grant that eliminates the Title IV-E entitlement.</td>
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<tr>
<td>1985</td>
<td>Title IV-E is amended to include a new Independent Living program to assist youth that age-out of the foster care system.</td>
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<tr>
<td>1993</td>
<td>Title IV-B is amended to create a new Family Preservation and Family Support program.</td>
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<td>1994</td>
<td>Legislation is enacted that directs the U.S. Department of Health and Human Services (HHS) to create a new review of state child welfare systems. This directive ultimately creates the Child and Family Service Reviews. The legislation also authorizes child welfare waiver demonstrations.</td>
</tr>
<tr>
<td>1994</td>
<td>Multiethnic Placement Act (MEPA) is enacted to prevent discrimination in the services under Title V.</td>
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<tr>
<td>1995</td>
<td>Enactment of the Social Security Act includes limited funds for child welfare placement of children based on race, color, or national original and to facilitate the identification and recruitment of foster and adoptive parents.</td>
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B. Primary Reasons for Case Opening Graph

The Children’s Bureau Administration or Children and Families Department of Health and Human Services created the chart provided below. It is based on the average percent of primary reasons for case opening across the 2,069 cases reviewed in fiscal years 2007 and 2008\(^{180}\).

C. Interview Questions

The questions below served as a guide to facilitating discussion during interviews of individuals currently working in the foster care arena. During the interview of the former foster child questions three and four were omitted.

1. To what degree are you (or your firm or agency) involved with foster care?
2. Do you understand what is meant by the term “informed consent”?
3. Are you aware of any state laws specific to obtaining informed consent from a foster child?
4. In practice, what is done when a foster child wants or needs a medical procedure that would involve informed consent?
5. Do you feel that informed consent is an issue that the professionals involved with foster care are concerned with?

\(^{180}\) U.S. DEPT. OF HEALTH AND HUMAN SERVICES, supra note 20.
a. If yes: what do you feel are the child’s greatest frustrations?
b. If no: what do you feel are the most prominent issues? (Within patient rights)

6. Have you personally encountered situations where foster children have expressed that they would like to be able to provide their own consent?
   a. Would you be able to offer a specific instance or case example?

7. What do you feel would be the most effective approach for addressing this issue?
   a. Prompts: Redrafting legislation, A push for the professionals involved to have a more active role in the process?
   b. Why do you feel this is more realistic than other options?

8. Do you have any additional comments or questions?

D. Patient Bill of Rights\textsuperscript{181}

1. The patient has a right to all relevant information about proposed care and treatment.

2. The patient has a legal right to a clear, concise explanation in layperson’s terms of all proposed procedures, including the possibilities of any risk of mortality or serious side effects, problems related to recuperation, and probability of success, and the patient will not be subjected to any procedure without the patient’s voluntary, competent, and understanding consent. The specifics of such consent shall be set out in a written consent form and signed by the patient before the procedure is done, and the patient shall be given a copy.

3. The patient has a legal right to a clear, complete, and accurate evaluation of the patient’s condition and prognosis without treatment before being asked to consent to any test or procedure.

4. The patient has a legal right to designate another person to make health care and treatment decisions for the patient, and based on the patient’s own directions and values, in the even the patient is unable to participate in decision making.

5. The patient has a right to know the identity, professional status, and experience of all those providing service. All personnel have been instructed to introduce themselves, state their status, and explain their role in the health care of a patient. Part of this right is the right of the patient to know the identity of the physician responsible for the patient’s care.

\textsuperscript{181} ANNAS, supra note 42, at 14.
6. The patient has a legal right to prompt attention and treatment in an emergency situation.
7. The patient has a legal right not to be discriminated against in the provision of medical and nursing services on the basis or race, religion, national origin, gender, sexual orientation, or disability.
8. Any patient who does not speak English or who is hearing impaired has a legal right to have access to an interpreter.
9. The patient has a right to all the information contained in the patient’s medical record while in the health care facility, and a legal right to examine and copy the record on request, and to have their private medical information kept confidential from those not directly involved in their case, payment of their bills, or quality control.
10. The patient has a legal right to access to a consultant specialist at the patient’s request and expense.
11. The patient has a legal right to refuse any drug, test, procedure, or treatment, and to refuse to participate in educational programs.
12. The patient has a legal right to be treated with dignity.
13. We recognize the patient’s right of access to people outside the health care facility by means of visitors and the telephone. Parents may stay with their children, and relatives with patients, twenty-four hours a day, and may act as the patient advocate to help the patient exercise the rights set out in this document.
14. The patient has a legal right to leave the health care facility regardless of the patient’s physical condition or financial status, although a patient may be requested to sign a release stating that the patient is leaving against the medical judgment of the patient’s doctor or the staff.
15. The patient has a right not to be transferred to another facility unless the patient had received a complete explanation of the desirability and the need for the transfer, the other facility has accepted the patient for transfer, and the patient has agreed to the transfer. The patient has the right to a consultant’s opinion of desirability and necessity of the transfer.
16. The patient has a right to be notified of impeding discharge at least one day before it is accomplished, to a consultation by an expert on the desirability y and necessity of discharge, and to have a person of the patient’s choice notified in advance.
17. The patient has a right, regardless of the source of payment, to examine and receive an itemized and detailed explanation of the total bill for service rendered in at the health care facility. We also recognize the right of a patient to competent counseling from the facility staff to help in obtaining financial assistance from public or private sources to meet the expense of services received in the health care facility.

18. The patient has a right to timely prior notice of the termination of eligibility for payment by any third-party payer for the expense of care.

19. We recognize the right of all patients to have twenty-four-hour-a-day access to a patient rights advocate who may act on behalf of the patient to assert or protect the rights set out in this document.