Docket No. 00-3195

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

JOHN DOE; MARY DOE,

Appellants

v.

COUNTY OF CENTRE, PA; CHILDREN & YOUTH SERVICES OF CENTRE COUNTY; BOARD OF COMMISSIONERS OF THE COUNTY OF CENTRE; TERRY WATSON, individually and in his official capacity as the Director of Centre County Office of Children and Youth Services; CAROL SMITH, individually and in her official capacity as the Assistant Director Administrator of the Centre County Office of Children and Youth Services; LISA RICE, individually and in her official capacity as a Foster Home Specialist of the Centre County Office of Children and Youth Services,

Appellees.

On Appeal from the United States District Court
for the Middle District of Pennsylvania

BRIEF OF *AMICI CURIAE* AMERICAN PUBLIC HEALTH ASSOCIATION; AIDS ALLIANCE FOR CHILDREN, YOUTH AND FAMILIES; AIDS LAW PROJECT OF PENNSYLVANIA; ALLIANCE FOR CHILDREN'S RIGHTS; LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.; THE JUVENILE LAW CENTER; LAWYERS FOR CHILDREN, INC.; LEGAL AID FOR CHILDREN/PITTSBURGH; THE LEGAL AID SOCIETY OF NEW YORK/JUVENILE RIGHTS DIVISION; NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS; NATIONAL CENTER FOR YOUTH LAW; THE SUPPORT CENTER FOR CHILD ADVOCATES; THE YOUTH LAW CENTER; AND THE ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS IN SUPPORT OF APPELLANTS JOHN AND MARY DOE

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IDENTITY AND INTEREST OF THE *AMICI CURIAE*

This *amici curiae* brief is submitted on behalf of the American Public Health Association; AIDS Alliance for Children, Youth and Families; AIDS Law Project of Pennsylvania; Alliance for Children's Rights; Lambda Legal Defense and Education Fund, Inc.; the Juvenile Law Center; Lawyers for Children, Inc.; Legal Aid for Children/Pittsburgh; the Legal Aid Society of New York/Juvenile Rights Division; National Alliance of State and Territorial AIDS Directors; National Center for Youth Law; the Support Center for Child Advocates; the Youth Law Center; and the Association of Maternal and Child Health Programs in support of the appellants John and Mary Doe and of reversal of the district court's grant of summary judgment.[1] Each *amicus* organization has authorized Lambda Legal Defense and Education Fund, Inc., through its attorneys, to submit this brief on their behalf.

The district court's decision endorses assumptions about HIV, and generalizations about the propensity of foster children to engage in assaultive behavior, as a substitute for the American with Disabilities Act's (ADA) mandated individualized assessment on which exclusions from publicly-operated programs

[1] Statements of Identity and Interest for each of the *amicus* organizations are included in *Amici* Appendix A (attached).

must be based. *Amici* believe that the district court's analysis not only reduces the placement options for children with special needs, but also could insulate from challenge virtually any discrimination against persons with HIV in employment, health care, education, and other aspects of community life.

SUMMARY OF ARGUMENT

The decision below defies controlling Supreme Court guidance on how the court should have determined whether the Does' parenting of a child with AIDS poses a sufficiently significant risk to justify their exclusion from Centre County's ("the County") foster care program. The district court endorsed the County's reliance on a subjective, generalized summary of the experience of foster children with sexual abuse as a proxy for an objective determination of whether AJB, the Does' adopted child with AIDS, would pose a direct threat to a child who is placed with them. This approach is at clear odds with the prevailing view of medical, public health and child welfare professionals on how to assess and manage HIV infected children, and reflects an abdication of the County's responsibility to conduct the objective and individualized assessment of risk which the ADA and the Rehabilitation Act of 1973 require.

ARGUMENT

I. THE DISTRICT COURT'S ANALYSIS CANNOT BE SQUARED WITH THE SUPREME COURT'S TREATMENT OF SIGNIFICANT RISK UNDER *ARLINE* AND *BRAGDON*.

A. Neither *Arline* Nor *Bragdon* Contemplate Reliance on Subjective Presumptions for Determining When the Risk of HIV Transmission is Significant.

In this case, the district court endorsed the County's argument that children with HIV must be segregated from other children because any individual foster child, regardless of age or actual behavioral history, conceivably may engage in activities which pose a risk of HIV infection. The district court concluded that the inevitable inability to guarantee the complete absence of any risk of HIV transmission — "the existence of this uncertainty" — is sufficient to justify automatic separation or exclusion of those living with HIV. *Doe v. County of Centre*, 80 F. Supp. 2d 437, 443 (M.D. Pa. 2000) ("Doe II").

The district court ignored the irrational aspects of the County's policy, including its willingness to waive the policy if a biological parent consents to the child's placement in a home with an HIV positive person. It effectively held that any theoretically supportable theory of transmission will justify a "direct threat" finding, concluding that the risk of HIV transmission is "substantial" despite a complete absence of evidence that it ever had occurred. *See Doe v. County of*

Centre, 60 F. Supp. 2d 417, 429-30 (M.D. Pa. 1999) ("Doe I"). The basis of this holding was the court's reliance on unscientific "statistical evidence" on abuse compiled by a County employee, not on evidence of risk-taking behavior by AJB or on a careful assessment of any individual foster child whose behavior would cause a significant risk to materialize. *Doe II*, 80 F. Supp. 2d at 441. This reformulation of the significant risk test conflicts with the Supreme Court's rulings in *School Bd. of Nassau County v. Arline*, 480 U.S. 273 (1987), and *Bragdon v. Abbott*, 524 U.S. 624 (1998).

In *Arline*, the Supreme Court held that the Rehabilitation Act of 1973 prohibits the exclusion of individuals with infectious disease unless it is documented by *objective* evidence that the disease poses a significant risk to the health or safety of others.[2] Similarly, the ADA provides a defense to a discrimination claim when the plaintiff "pose[s] a direct threat to the health or safety of other[s]." 42 U.S.C. § 12113(b) (Title I); 42 U.S.C. § 12182(b)(3) (Title III).

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[2] *Arline* established that assessments of "significant risk" must take into account science-based judgments about "'(a) the nature of the risk, (how the disease is transmitted), (b) the duration of the risk (how long is the carrier infectious), (c) the severity of the risk (what is the potential harm to third parties) and (d) the probabilities the disease will be transmitted and will cause varying degrees of harm.'" 480 U.S. at 288 (citation omitted).

Under the ADA, a "direct threat" is "a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices, or procedures or by the provision of auxiliary aids or services" by a public accommodation, 42 U.S.C. § 12182(b)(3). As this Court noted in *Bragdon v. Abbott*, 524 U.S. at 649, the ADA's significant risk standard was intended by Congress to be identical to the standard delineated in *Arline*.[3]

In *Bragdon*, a dentist had refused routine treatment to a patient with HIV on the belief that she posed a risk of infecting him. In addressing whether the patient posed a "direct threat to the health or safety of others," the Court made explicit one of *Arline's* fundamental assumptions: "Because few, if any, activities in life are risk-free, *Arline* and the ADA do not ask whether a risk exists, but whether it is significant." 524 U.S. at 649 (citation omitted). The Court held that an inquiry into whether an HIV positive individual poses a significant risk to another must

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[3] The House of Representative's Judiciary Committee Report states:

> *. . . a decision [may not] be based on speculation about the risk or harm to others. Decisions are not permitted to be based on generalizations about the disability but rather must be based on the facts of an individual case . . .* The purpose of creating the "direct threat" standard is to eliminate exclusions which are not based on objective evidence about the individual involved.

H.R. Rep. No. 101-485 (1990), reprinted in 1990 U.S.C.C.A.N. 445 (emphasis added).

"assess the level of risk," *id.* at 651-52, and consider the "statistical likelihood" of transmission. *Id.* at 652.

After a careful analysis of the record evidence on the possibility that HIV would be transmitted in the course of providing dental care, the Supreme Court remanded the case so that risk calculations could be performed with rigor and scientific integrity, without reference to subjective, non-specific notions of risk. 524 U.S. at 649, 655. Dr. Bragdon's evidence of possible transmission of HIV to seven dental workers fell short of the proof of "significant risk" that the Court demanded. *Id*. at 654. The Supreme Court's direction to assess the level of risk, and its remand order, would have been wholly superfluous if mere proof of a theoretically recognized risk of fatality were enough to establish a direct threat.

It is not enough that, in this case, the County asserts that it is acting reasonably to safeguard children. Neither is it sufficient that it compiled, as "proof" of a factual underpinning for its policy, anecdotal information about the experience of foster children generally with sexual abuse prior to their coming into its care. This Court, in a recent explanation of the importance of an individualized inquiry when determining the qualifications of a person with HIV in an employment context, has indicated it will require much more. Under the ADA, even "reasonable mistakes" about the threat of harm individuals with HIV pose to

others will result in liability for a defendant, who has the burden to "educate itself about the varying nature of impairment and to make individualized determinations" about affected individuals. *Taylor v. Pathmark Stores, Inc.*, 177 F.3d 180, 192-93 (3rd Cir. 1999).

Even reliance on a trained professional for a decision to exclude someone with HIV will not pass muster if the professional fails to base the decision on objective, scientifically sound data that addresses the individuals in question, as *Holiday v. City of Chattanooga,* 206 F.3d 637 (6th Cir. 2000) demonstrates. Holiday was a police officer candidate whose conditional job offer was revoked after he revealed during his pre-employment physical examination that he is HIV positive. After Holiday disclosed that he is HIV positive, the city's examining physician noted Holiday's anemia, swollen lymph nodes and HIV infection, and concluded that he was not physically qualified for police work. The city explained that Holiday's HIV status rendered him a direct threat to others because of the possibility of blood-to-blood contact during police work. *Id.* at 641.[4] The district court granted the city's motion for summary judgment, reasoning that "[t]he City had a right to reasonably rely on [its physician's] expert medical opinion when the

[4] On appeal, the city abandoned its direct threat defense, and claimed that Holiday's HIV status played no role in its decision to withdraw its offer of employment to him. *Id.* at 641.

City made the decision to withdraw its conditional offer of employment to Holiday." *Id*. at 643.

The Sixth Circuit Court of Appeals disagreed. Reversing the grant of summary judgment, the Court of Appeals concluded that the district court erred in accepting the city physician's report "as dispositive evidence of Holiday's alleged inability to serve as a police officer, where . . . there is no indication that the physician conducted the individualized inquiry mandated by the ADA . . . ." *Id*. The Court of Appeals found the doctor's recommendation to be both "unsupported by any concrete medical findings . . . [and] at odds with the objective evidence on record." *Id*. at 645. For this reason, the Court concluded, the district court "erred in holding that the City had the right to rely on [its physician's] unsubstantiated and cursory medical opinion, and in treating the physician's opinion as having settled the question of whether Holiday was qualified for the job." *Id*.

In this case, the County has employed an "assessment" that does not even rise to the level of the inquiries that this and other federal appellate courts have rejected. Eschewing any serious attempt at ensuring that its policy in fact reflected current medical and behavioral science, the County failed to consult independent experts in the treatment of HIV or child welfare. It also ignored, as discussed below, the very state and national guidelines that should have informed it in the

first place. In what seems a transparent attempt to justify its discriminatory treatment of the Does, the County instead relied on in-house staff with undocumented credentials to construct a wholly unscientific, unsupported and ultimately irrelevant set of "statistics" on the abuse histories among children in foster care; used these statistics as support for the hypothesis that these children are disproportionately predisposed to sexual assault; and then relied on these suppositions as a bridge to its conclusion that AJB, by virtue of his having AIDS, poses a direct threat to any foster child placed in his home.

Other courts of appeal confronting the charged issues of HIV or children's safety have refused to allow generalized assumptions about potential risks to substitute for the objective standard that guards against the even greater risk of discriminatory stereotypes in such contexts. *Rizzo v. Children's World Learning Centers, Inc.*, 84 F.3d 758 (5th Cir. 1996), for example, reversed a district court's ruling allowing a school's decision to remove a hearing-impaired employee from her school van driving responsibilities on the basis that she might not hear a choking child in the back of the bus. While concluding that any risk of harm to children "will greatly impact the consideration of '[t]he nature and severity of the potential harm,'" *id.* at 758, the Fifth Circuit held that the lower court had not properly considered whether the harm in question was significantly likely to occur.

Id. In *Martinez v. School Board,* 861 F.2d 1502 (11th Cir. 1988) the Eleventh Circuit held that segregated schooling of a mentally retarded child with AIDS was not justified, concluding that the trial court's finding of a "remote theoretical possibility" of HIV transmission "does not rise to the 'significant' risk level that is required for [the child] to be excluded from the regular . . . classroom." *Id.* at 1506. *See also Doe v. Dekalb County Sch. Dist.*, 145 F.3d 1441 (11th Cir. 1998) (citing *Martinez* and remanding case of an HIV positive teacher of children with behavioral disorders who was fired based on the fear that children might bite him and become infected).

B. The District Court's Reformulation of the Significant Risk Test Ignores Fundamental Public Health Principles, Contrary to the Supreme Court's Instructions in *Arline* and *Bragdon.*

In *Arline* the Court noted that "[f]ew aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness," 480 U.S. at 284 (footnote omitted), and that "[t]he [Rehabilitation] Act is carefully structured to replace such reflexive reactions to actual or perceived handicaps with actions based on reasoned and medically sound judgments." *Id*. at 284-85. *Bragdon* forged a further link between the federal mandate against disability discrimination and the practice of public health, holding that only judgments about risk based on "objective, scientific information" will receive deference. 524 U.S. at 649. In

evaluating risk, "the views of public health authorities, such as the U.S. Public Health Service, CDC, and the National Institutes of Health, are of special weight and authority." *Id*. at 650 (citation omitted).

Public health practice recognizes, as this Court observed in Bragdon, that "few, if any, activities in life are risk-free," 524 U.S. at 649. The science of public health fundamentally is focused on regulating risks, not by striving to eliminate remote or theoretical risks, but by using the best available scientific evidence to identify and mitigate those risks that are both serious and most likely to occur. *See* James G. Hodge, Jr., *Implementing Modern Public Health Goals Through Government: An Examination of New Federalism and Public Health Law*, 14 J. Contemp. H. L. & Policy 93, 110 n.83 (1997). By focusing on risks that are objectively significant, sound public health policy substitutes rational risk assessment for the misunderstanding and fear that often distorts thinking about, and reaction to, infectious diseases and other risks posed by modern society. Leonard H. Glantz et al., *Risky Business: Setting Public Health Policy for HIV-Infected Health Care Professionals*, 70 Milbank Quarterly 43, 56-57 (1992).

The County's policy reflects the frequency with which the lay public's assessments of health risks widely diverge from those of scientists:

> Lay perceptions of risk may be highly personalized, dwelling on whether the threat is voluntary or inescapable, exotic or familiar, fair or unfair, and memorable or forgettable. Consequently, the lay public may give disproportionate attention to relatively low risks such as . . . HIV transmission from physician to patient . . . .
> . . .
> [U]nless law lays the foundation for rational, scientific risk assessment, public health determinations are likely to remain hostage to moral confrontations, overstated fears of contagion . . . , and political responses to sensationalized health threats.

Lawrence O. Gostin, *Public Health Law: A Review*, 2 Current Issues in Public Health 205, 210 (1996).

A determination that an infected individual poses a significant risk of infecting others should be based on evidence of "behavior by [the] carrier which has been demonstrated epidemiologically to transmit" the pathogen, or other evidence that the infected individual is substantially likely to transmit the disease to others. Lawrence O. Gostin et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 Colum. L. Rev. 59, 114-15, n.230 (1999) (hereafter "Gostin et al."). The assessment of risk also should "preclud[e] the treatment of merely theoretical risks of death as 'significant' simply because the consequence, although unlikely, is severe." Gostin et al., at 121 n. 252.

Contrary to these principles, the district court based its conclusion that HIV positive children always pose a significant risk to HIV negative children in foster

care on assumptions about theoretical risks that lack adequate empirical foundation. Relying on the County's subjective, unscientific assessments on the risk of sexual assault, the lower court held that such behavior might occur in any situation involving foster children, regardless of the particular individuals involved. Under this type of reasoning any individual, regardless of age, conduct or character, is subject to discriminatory treatment simply for having the HIV virus, as disproving the possibility that unidentified third parties will initiate risk-taking behavior is not objectively possible.

The policy statement of the American Academy of Pediatrics, ("AAP") Committee on Pediatric AIDS and Committee on Infectious Diseases, on HIV transmission in schools, child care, medical settings, the home and the community,[5] is instructive as a more reasonable approach. The policy recognizes that "HIV-infected. . . children are nurtured at home or in foster homes, cared for in child care centers, educated in schools, and participate in community activities."[6] The recommendations of the AAP focus on proper education regarding standard precautions for caregivers of HIV positive children, expressly

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[5] *See* American Academy of Pediatrics, *Issues Related to Human Immunodeficiency Virus Transmission in Schools, Child Care, Medical Settings, the Home, and Community*, 104(2) Pediatrics 318 (1999).

[6] *Id*. at 318.

stating that "children known to be HIV-infected should be managed the same as healthy children."[7] Not surprisingly, the Centers for Disease Control and Prevention (CDC) policy statement, which notes that there is no evidence that HIV transmission ever has occurred in school or out-of-home child care settings, reflects the AAP's statement and cites it several times.[8]

II. THE COUNTY'S POLICY ON HIV POSITIVE CHILDREN IS AT ODDS WITH THE PREVAILING POLICIES OF LOCAL AND NATIONAL CHILD WELFARE ORGANIZATIONS.

Another important marker in assessing the extent to which a disability-related policy is reasoned and objective rather than discriminatory is the extent to which the policy at issue reflects the approach of the majority of those in the same profession. The core issue in this case is whether placing HIV negative foster children with HIV positive children is, *per se*, a direct threat to the HIV negative

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[7] *Id*. at 323.

[8] *See* Centers for Disease Control, Medical Issues Related to Caring for Human Immunodeficiency Virus-Infected Children In and Out of the Home (1993). The risk of HIV transmission from the type of ordinary contact that is common among children in households, schools, day-care centers and other out-of-home child care settings is extremely small. *Id.* at 3. No cases of HIV transmission in out-of-home child care settings have been reported. *Id.* at 5. No cases of HIV transmission in school have been reported and current epidemiologic data do not justify excluding children with HIV infection from school or isolating them in school to protect others. *Id.* at 5. Children with HIV infection deserve the same rights to health care, privacy, education and social interactions that other children enjoy. *Id.* at 7.

child such that policies relying on case-by-case individualized determinations rather than blanket segregation of infected from uninfected children are dispensable.[9] The policies of child welfare agencies which explicitly address HIV indicate that the standard practice is to rely on an individualized assessment in each and every case that involves a child with HIV or AIDS rather than a *per se* bar on placing HIV negative foster children with HIV positive children.

A key indication that the County's policy is far afield of mainstream practice is that it does not follow the guidelines drafted by the very state officials who supervise CYS.[10] Pennsylvania's Office of Children, Youth and Families ("OCYF") has produced a draft policy addressing services to youth affected by

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[9] Although this particular case is about certification of the Does to care for other than HIV positive children, the County's policy and the Court's reasoning and holding necessarily have much broader implications regarding placement and services to *all* foster children. The policy, read literally, produces a variety of types of segregation, i.e., that no HIV positive children ever can be placed in homes where there are other than HIV positive children; that HIV positive children can be placed only in homes where other people who are HIV positive reside; that an otherwise qualified foster family can serve only as a placement for HIV positive children if one of the parents has HIV; and, perhaps most ludicrously, that siblings must be separated for placement unless all share the same HIV serostatus.

[10] Child welfare in Pennsylvania is county-run and state supervised. *See* 62 P.S. §§1-704, 708; *Comm'r, Dep't of Public Welfare v. Harambee, Inc.*, 346 A.2d 594 (Pa. Comwlth. 1975).

HIV and circulated it to the counties.[11] Although it was never formally enacted and therefore is not binding on the counties, it is what the state provides to counties who request guidance.[12] The policy explicitly states that, "HIV positive children should not be segregated in day care facilities, foster homes, group homes, residential placements, or institutions based on their HIV status alone."[13]

In its August, 1999 decision denying the Does' motion for a preliminary injunction, the district court accepted as true defendants' representations that "Centre County CYS did a thorough investigation of other infectious disease policies throughout the Commonwealth of Pennsylvania before enacting its own policy." *Doe I*, 60 F. Supp. 2d at 422. Had the County in fact contacted officials in Philadelphia, which has the highest concentration of AIDS cases in the state[14] and consequently the most experience in dealing with the issue in its foster care program, it would have found a reasonable policy diametrically opposed to its

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[11] *See* DEPARTMENT OF PUBLIC WELFARE, COMMONWEALTH OF PENNSYLVANIA, CHILDREN, YOUTH AND FAMILIES BULLETIN, HIV/AIDS POLICY, *Amici* App. at B-1 to B-11.

[12] *See id.*, *Amici* App. at B-1.

[13] *Id., Amici* App. at B-10.

[14] According to the Pennsylvania Department of Health's Bureau of Communicable Diseases, as of March 31, 2000 there were 12,761 diagnosed cases of AIDS, while the total number of cases in Centre County was 87. BUREAU OF COMMUNICABLE DISEASES, PENNSYLVANIA DEP'T OF HEALTH, AIDS STATISTICAL SUMMARY 11, CUMULATIVE AIDS CASES (2000), *Amici* App. at I-1.

own. Consistent with the recommendations of the state OCYF, the Philadelphia Children and Youth Division of the Dept. of Human Services has an extensive non-discrimination policy protecting both children and foster parents who are HIV positive, and directing that all "placement decisions are made on an individual basis" with the "primary consideration [being] the potential caregiver's ability to meet the child's individual and particular needs."[15]

Even a cursory look at the policies of other states in the Third Circuit demonstrates that the County's policy runs counter to the mainstream of state child welfare policy. In Delaware and New Jersey, *per se* prohibitions on placement of HIV positive children with HIV negative children are not the standard practice. Delaware's policy states, for example: "Except where the presence or risk of communicable disease presents specialized care needs, the presence or risk of communicable diseases should not be the mitigating factor in the placement decision."[16] New Jersey's HIV placement policy is similar, stating: "Siblings and children of any age may be placed together in the same household, unless a

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[15] CHILDREN AND YOUTH DIVISION, PHILADELPHIA DEP'T OF HUMAN SERVICES, POLICY MANUAL §§ 1010, 5200, 5201, *Amici* App. At C-1, C-4.

[16] THE DEP'T OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES, STATE OF DELAWARE, POLICY AND PROCEDURE MANUAL #103 (1988), *Amici* App. at D-7.

physician advises otherwise . . . ."[17]

Both states' policies also stress the need for an in-depth, individualized assessment in each placement case. Delaware enumerates the following list of factors to be considered when deciding on placements for an HIV positive child or any child with a communicable disease: "the behavior, neurologic development, physical condition of the child, the skills and services available in the placement setting, and the anticipated types of interaction with others in the placement setting."[18] In like fashion, New Jersey's policy manual states that the following points are to be considered: "age of child, behavior of child, degree of symptomatology and accompanying level of care the child requires, age and behavior of other children in the home, ability of the caregiver to meet the child's physical and emotional needs, and benefits of having the child in a family versus a hospital setting."[19] Lastly, the states explicitly provide that these decisions should

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[17] NEW JERSEY DIVISION OF YOUTH AND FAMILY SERVICES, FIELD OPERATIONS CASEWORK POLICY AND PROCEDURES MANUAL §1502.10 (1999), *Amici* App. at E-3.

[18] THE DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES, *supra* note 16, *Amici* App. at D-7.

[19] NEW JERSEY DIVISION OF YOUTH AND FAMILY SERVICES, *supra* note 17, *Amici* App. at E-2.

be made by a team of professionals.[20] A review of other states' policies demonstrates that those in the Third Circuit represent the mainstream of positions on this issue.[21]

Finally, the County's policy ignores applicable guidelines of the national professional organization which provides leadership on the very issues raised in this case. The Child Welfare League of America ("CWLA"), a national advocacy organization and a recognized authority on child welfare policy, has published specific recommendations regarding service provision to HIV infected children and their families in both the foster care[22] and the residential group care settings.[23] The CWLA states that there is "*no medical reason for children with HIV infection*

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[20] The suggested lists include the child's protective case manager and their supervisor, the child's treating physician or a pediatric physician, someone from the department of public health, the child's parent, the child, the child's advocate and the potential caregiver. *See Amici* App. at D-8; E-2.

[21] *See, e.g.,* DEP'T OF CHILDREN AND FAMILIES, STATE OF CONNECTICUT, POLICY MANUAL (1997-98), *Amici* App. at F-1 to F-9; DEP'T OF SOCIAL SERVICES, COMMONWEALTH OF MASSACHUSETTS, POLICY #89-003 (1995), *Amici* App. at G-1 to G-2. Indeed, *amici* have uncovered no other parallel child welfare policy that requires separation of HIV negative from HIV positive foster children.

[22] CHILD WELFARE LEAGUE OF AMERICA, MEETING THE CHALLENGE OF HIV INFECTION IN FAMILY FOSTER CARE (1991) (hereinafter "MEETING THE CHALLENGE"), excerpted in *Amici* App. at H-1 to H-6.

[23] CHILD WELFARE LEAGUE OF AMERICA, SERVING HIV-INFECTED CHILDREN, YOUTH, AND THEIR FAMILIES: A GUIDE FOR RESIDENTIAL GROUP CARE PROVIDERS (1989) (hereinafter "SERVING HIV-INFECTED CHILDREN"), excerpted in *Amici* App. at H-7 to H-12.

not to be placed with each other, or with other noninfected children. . ."[24] The CWLA explicitly states that, in foster care, "decisions about placement must never be based solely on the presence of known or suspected HIV infection."[25] The CWLA goes further to make clear that, "[t]here is no reason to preclude the placement of an HIV-infected child in a group care setting with noninfected children unless medically or behaviorally indicated."[26]

Despite its representations, the County never produced a single policy or authority from any professional organization that supports the one it adopted. Lacking any basis in established, mainstream guidelines of county, state or national child welfare organizations, the policy instead relies on inflated fears of HIV as a proxy for individually assessing each child and potential foster family on the basis of factors, such as actual behavior or age, that are relevant to placement decisions. It is, therefore, the clearest form of disability-based discrimination.

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[24] MEETING THE CHALLENGE, *supra* note 22, at 21, *Amici* App. at H-5.

[25] *Id.* at 18, *Amici* App. at H-2.

[26] SERVING HIV-INFECTED CHILDREN, *supra* note 23, at 29, *Amici* App. at H-8 ("Recommendations and decisions about the HIV-infected child's/family's service plan should be based on a case-by-case comprehensive review by the agency's multidisciplinary team that includes both social work and medical consultation.").

III. THE COUNTY'S POLICY DOES NOT PROTECT THE INTERESTS OF CHILDREN IN ITS CARE

The County maintains that its policy has the effect of preventing HIV transmission to foster children in its care and reflects its mandate pursuant to the Adoption and Safe Families Act ("ASFA") to ensure their safety.[27] However, its policy does nothing to advance the goal of ensuring the safety of all children in its care.

The County put forth, and the district court accepted, essentially one seriously flawed piece of "evidence" that HIV positive children are a direct threat to HIV negative foster children: that it believed that 15 children in their care had engaged in some kind of "sexual abuse" with other children. *Doe II*, 80 F. Supp. 2d at 441. With no further information even on what the County considers a sexual assault,[28] let alone on the individual characteristics of the children

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[27] Centre County officials, as the district court recognized — like those in Philadelphia County and the states of Pennsylvania, Delaware and New Jersey — are mandated under the Adoption and Safe Families Act ("ASFA") to provide safe placements for children. *Doe I*, 60 F. Supp. 2d at 422; *see* 42 U.S.C. §671. Only Centre County attempts to accomplish this goal by enacting *per se* bars as a substitute for the individualized assessments the ADA requires.

[28] The County's representations fail to describe what acts are included in their definition of sexual abuse. While a grave issue in itself, not every act of sexual abuse represents even a theoretical risk of HIV transmission. Pennsylvania's criminal code illustrates the point. By statute, sexual assault can include forcible sexual intercourse as well as indecent contact and indecent exposure. *See* 18 Pa. C. S. §§ 3121-3127. The latter two are sex offenses but would pose no risk of

purportedly involved, this "data" was extrapolated to the conclusion that foster children as a class are more prone to aggressive, inappropriate, sexually predatory behavior than other children. *See Doe I*, 60 F. Supp. 2d at 29. The district court found that this alleged propensity, coupled with a generalized inability of child welfare officials to predict exactly when, and in whom, this propensity will manifest itself, requires child welfare officials to assume the worst case scenario in any placement decisions involving children with HIV. *See id.* at 428-29.

This reasoning is illogical and pretextual; it begs the question of why the County is able to place *any* foster children in *any* home where there are *any* other children. Certainly the County does not contend that it is concerned about sexually predatory behavior only when there is a risk of HIV transmission. If, as the County alleges, foster children as a class are unpredictable sexual predators, then it could not responsibly be placing them in homes where other children reside. This clearly is not the County's policy.

The County acknowledges that it is responsible under the ASFA to provide children with safe placements and posits that homes where HIV is present are, *per se*, not safe. Curiously, the County also provides for a waiver of its infectious disease policy, whereby a biological parent may consent to the placement of his or

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HIV transmission.

her child in a foster home where someone with HIV resides. If, as the County insists, the policy is necessary for the protection of children in its care, the existence of a waiver would be a violation of the agency's mandate to provide safe placements.[29]

The contradiction inherent in the waiver policy is enormous: the County is mandated to provide safe placements, yet if those alleged to have abused or neglected a child in the first place consent to the child's *not* being placed in a safe place, then CYS is released from its obligation under the federal law. Consideration of a parallel hypothetical makes plain how completely counterintuitive and pretextual the waiver policy is. For example, the County would correctly find that a home where an adult sex offender resides is, *per se*, an unsafe placement for a child; but the County would never, as a matter of policy, provide for a waiver of appropriate placement considerations to allow placement of a child with a sex offender — as of course they should not. The ASFA provides

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[29] The ASFA requires states to develop for each child in its care "a plan for assuring that the child receives safe and proper care. . ." and directs that "each child [have] a case plan designed to achieve placement in a safe setting that is the least restrictive (most family like) and most appropriate setting available. . . consistent with the best interest and special needs of the child. . ." *See* 42 U.S.C. § 675(1)(B),(5)(A). Nowhere in the statute is there a provision that authorizes either the parent or the state to waive these or any requirements with respect to the safety of children in foster care. *See* 42 U.S.C. § 671 *et seq.*

the County no authority to "waive" its statutory responsibility to ensure the safe placement of children.[30]

When Congress adopted the Abandoned Infants Assistance Act of 1988, it made specific findings addressing the lack of adequate foster homes willing to care for medically fragile and drug-exposed children and infants, and noted the particular difficulty of finding placements for them. *See* 42 U.S.C. § 670(2). Adopting a policy that effectively reduces the already limited number of qualified adults willing to care for children with special needs, and even can require the separation of siblings who are HIV serodiscordant, the County undermines the very statutory mandate that governs it.

CONCLUSION

The grant of summary judgment for Centre County should be reversed.

Respectfully Submitted,

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Colleen Sullivan
Lambda Legal Defense and Education Fund, Inc.
Counsel for Amici

Dated: May 22, 2000

[30] *See supra* note 28, 42 U.S.C. § 671 *et seq.*

APPENDIX

APPENDIX CONTENTS

STATEMENTS OF IDENTITY AND INTEREST OF THE *AMICI CURIAE*

The American Public Health Association ("APHA") is a national organization devoted to the promotion and protection of personal and environmental health. Founded in 1872, APHA is the largest public health organization in the world, representing over 50,000 public health professionals. It represents all disciplines and specialties in public health. APHA supports the goal of equalization of opportunities for mentally and physically disabled persons in every facet of life.

AIDS Alliance for Children, Youth & Families is a non-profit organization founded in 1994 to help respond to the unique concerns of HIV positive and at-risk children, youth, women and families and their service providers. AIDS Policy Center conducts policy research, education and advocacy on a broad range of HIV/AIDS prevention, care and research issues. Organizational members include over 350 community-based agencies in 27 states, the District of Columbia and Puerto Rico. Individual members include young people, women and family members throughout the United States. Many of AIDS Policy Center's members provide or receive services funded by Title IV of the Ryan White CARE Act.

The AIDS Law Project of Pennsylvania ("ALPP") is a non-profit, public interest law firm providing legal services to persons in Pennsylvania who are affected by the AIDS epidemic. Through either direct representation or its attorney referral panel, ALPP advocates for clients throughout the state who, because of AIDS, are subjected to discrimination in accessing services, goods, programs, housing, and employment. ALPP believes that the district court's decision elevates the AIDS status of a small child to a *per se* direct threat under the ADA. ALPP is particularly concerned that the decision in this case may serve as the basis to deny children with AIDS equal access to public accommodations and also may promote segregation in residential placement solely on the basis of HIV status.

The Alliance for Children's Rights is Los Angeles' only free legal services, information clearinghouse, and social service referral organization devoted solely to helping children in poverty. The Alliance's mission is to provide impoverished children with free legal representation and appropriate social service referrals. Since its founding in 1992, the Alliance has helped more than 20,000 children in Los Angeles County. The Alliance currently serves over 4,700 children each year. Among the children the Alliance helps are: children who need adoptive families, children who are in the foster care system or about to leave foster care as young

adults, children who need health care coverage and services, children infected or affected by HIV or AIDS, children who have learning or developmental disabilities, children with mental illness, severe behavioral disorders, or mental retardation, and children who are homeless or runaways. The Alliance strives to help disadvantaged children receive the support and services they need to become healthy, productive adults.

Lambda Legal Defense and Education Fund, Inc. ("Lambda") is a national non-profit public interest legal organization dedicated to the civil rights of lesbians, gay men and people with HIV/AIDS through impact litigation, education and public policy work. Founded in 1973, Lambda is the oldest and largest legal organization addressing these concerns. In 1983, Lambda filed the nation's first AIDS discrimination case. Lambda has appeared as counsel or *amicus curiae* in scores of cases in state and federal courts on behalf of people living with HIV or other disabilities, including, in part, *Albertsons, Inc. v. Hallie Kirkingburg,* 119 S. Ct. 2162 (1999); *Cleveland v. Policy Management Systems, Inc.,* 119 S. Ct. 1597 (1999); *Bragdon v. Abbott,* 118 S. Ct. 2196 (1998); *Doe & Smith v. Mutual of Omaha Insurance Co.*, 179 F.3d 557 (1999), *cert denied* 120 S. Ct. 845 (2000); *School Bd. for Nassau Cty. v. Arline*, 107 S. Ct. 1123 (1987); *Chalk v. U.S. District Court* 814 F.2d 701 (9th Cir. 1988); *Raytheon v. Fair Emp. & Housing*

Comm'n, 212 Cal. App. 3d 1242 (1989); *McGann v. H&H Music Co.,* 946 F.2d 401 (5th Cir. 1991); *Gonzales v. Garner Food Services, Inc.*, 89 F.3d 1523 (11th Cir. 1996), *cert. denied, Wood v. Garner Food Services, Inc.*, 117 S. Ct. 1822 (1997); and *Mason Tenders Dist. Council Welfare Fund v. Donaghey*, Civ. Action No. 93-1154, 1993 WL 596313, 2 A.D. Cases 1745 (S.D.N.Y. Nov. 19, 1993). Lambda is particularly familiar with the unique barriers confronting persons with HIV and other stigmatized disabilities who attempt to secure fair access to publicly available services and programs.

The Juvenile Law Center ("JLC") is a private, non-profit public interest law firm that has represented children since 1975 in cases involving Pennsylvania's child welfare, juvenile justice, mental health and public health systems. JLC has worked to ensure, *inter alia*, that children's constitutional and statutory rights are rigorously enforced throughout these systems. JLC's publications are used by attorneys, judges, and child welfare professionals across the Commonwealth. They include A Guide to Judicial Decisions Affecting Dependent Children: A Pennsylvania Judicial Deskbook (Third Edition); Child Abuse and the Law (Fifth Edition), and the Children's Rights Chronicle (a bi-monthly newsletter). JLC has participated as *amicus curiae* in the Pennsylvania Supreme and Superior Courts and the United States Supreme Court, as well as this Court.

Founded in 1984, Lawyers for Children, Inc. ("LFC") is dedicated to protecting the rights of individual children in foster care in New York City and compelling system wide reform of the foster care bureaucracy. Every child we represent receives free legal and social work services in cases involving foster care, abuse, neglect, termination of parental rights, custody and visitation. Our attorneys and social workers collaborate on every case to reduce the time a child must spend in foster care by vigorously advocating for court ordered plans that achieve permanency for children by safely returning them to their families or speeding their adoptions. We insure that when a child is placed in foster care, their temporary home provides them with the safety, comfort, and support that every child needs. In addition to providing individual representation to over 4000 children a year, LFC's special projects include: The Child Sexual Abuse Evaluation and Education Project; state and federal impact litigation; legal rights handbooks for children in foster case; and a child centered handbook on prevention and treatment of sexual abuse.

Legal Aid for Children/Pittsburgh is a non-profit agency founded and incorporated in 1908 as the Legal Aid Society of Pittsburgh. The mission of the agency and of our twelve attorneys is to provide and facilitate high quality legal representation and advocacy assistance to children who are abused or neglected or

otherwise at risk. Legal Aid For Children serves 5,000 abused, neglected and at-risk children each year, many of whom live in foster and group homes. Our efforts ensure that the most appropriate services are in place to protect children from future harm, with the ultimate goal of providing a safe and permanent home for every child.

The Legal Aid Society is the nation's largest and oldest provider of legal services to poor people. Since its founding in 1962, the Juvenile Rights Division ("JRD") has provided comprehensive representation as law guardians to the overwhelming majority of children who appear before the New York City Family Court in child abuse and neglect, termination of parental rights, Persons in Need of Supervision, juvenile delinquency, and other proceedings affecting children's rights and welfare. Last year, our attorneys and social workers represented more than 40,000 children, many of whom are or have been in foster care. In addition to advocating on behalf of individual children in the Family Court, JRD's attorneys work for systemic improvement through policy and legislative advocacy, and major litigation in state and federal courts.

The National Alliance of State and Territorial AIDS Directors ("NASTAD") represents the nation's chief health agency staff who have programmatic responsibility for administering AIDS health care, prevention, education, and

supportive services funded by state and federal governments. NASTAD seeks to promote a more effective national, state, and local response to the HIV/AIDS epidemic and has considerable expertise in identifying community needs and responding to the challenges of the HIV epidemic nationwide. As an organization whose focus is on preventing the occurrence of HIV and providing health services to those who are infected, NASTAD is deeply concerned that bias and stigma toward people living with HIV disease undermines public health practice and efforts to prevent HIV transmission. In the present case, NASTAD believes that the foster care policy of Centre County discriminates against people with HIV by denying them equal access to participation in the foster care system on the unfounded basis that HIV-positive individuals always pose a threat to HIV-negative individuals in such circumstances. As an organization of public health officials concerned with human services and the welfare of minors, NASTAD also expresses its concern about larger issues relating to the foster care system raised by this case. In particular, NASTAD wishes to underscore the necessity for systems to assure the safety and security of foster children from physical, sexual, psychological, and other forms of abuse.

The National Center for Youth Law ("NCYL") based in Oakland, California, engages in litigation, legislative and administrative advocacy, and policy

development on behalf of low-income children, adolescents, and their families. NCYL also provides technical assistance, training and publications to attorneys, health and social service providers, and other child-serving professionals on legal issues affecting low-income children and youth. NCYL's work includes advocacy to improve state foster care and child protection systems, and to ensure adequate access to health care and public benefits for low-income children and youth with disabilities and chronic illnesses, including HIV positive children and youth.

The Support Center for Child Advocates provides legal assistance and social advocacy to abused and neglected children in Philadelphia. For all the children committed to the Support Center's care, lawyers and social workers advocate to ensure safety and permanency, as well as access to health care, education and justice. Systematically, the Support Center promotes collaborative, multi-disciplinary casework and solutions to recurrent problems in the child welfare system. For the community, the Support Center provides educational programs to increase public awareness about the effects of and ways to prevent child abuse. Respected for diligent and effective advocacy, Support Center attorneys and social workers move public systems to deliver entitled services and private systems to open their doors to needy children and their families.

The Youth Law Center ("YLC") is a non-profit, public interest law office that

advocates for the interests of children and youth in state custody. YLC staff have also provided research, training, and technical assistance to legal professionals, public officials and service providers in every state on legal issues relating to children in out-of-home care. In its child welfare work, YLC has emphasized the right of every child to a stable and permanent home with loving caretakers. As part of that work, YLC strives to maximize the use of appropriate, family-like settings for children in foster care, and to prevent the application of arbitrary standards that result in unnecessarily decreasing the pool of appropriate foster homes.

The Association of Maternal and Child Health Programs ("AMCHP") is a national non-profit organization that represents state public health leaders and others working to improve the health of women of reproductive age, children and youth, including those with special health care needs, and their families. It actively promotes and advances national and state program and policies, and advocates Congress and other policy makers for maternal and child health needs and programs. AMCHP serves as a source of ideas and in-depth knowledge in key public health areas including reproductive health, adolescent and school health, teen pregnancy prevention, HIV, tobacco control and smoking cessation, immunization, children with special health care needs, and perinatal and women's

health. AMCHP has published several HIV-related studies and reports.