

## SERVICE AND TREATMENT CONSIDERATIONS (for children)

### Physical, Mental/Developmental, and Dental Health Considerations

Infants and young children who come before the court have unique physical, mental, developmental, and dental issues that should be addressed as early as possible. The following list of questions should elicit critical information that will assist in addressing the physical, mental, and dental health needs of children in the child welfare system.

If the permanency goal is reunification, ensure that the case plan requires the parents to actively participate in the child's health services, including attending medical appointments with the child.

A number of sections of Chapter 39 describe the obligations of various entities regarding provision of health-related services to children in dependency cases. The court has a role in receiving information from the parties and in ensuring that services are provided to children as required by law. Some of those provisions are set forth here. Section 39.407(3)(f) provides, in part, that “[t]he department shall fully inform the court of the child’s medical and behavioral status as part of the social services report prepared for each judicial review hearing held for a child for whom psychotropic medication has been prescribed or provided under this subsection. As a part of the information provided to the court, the department shall furnish copies of all pertinent medical records concerning the child which have been generated since the previous hearing.” Section 39.402 provides that if a parent is unavailable or unable to consent or withholds consent and the court determines access to the records and information is necessary to provide services to the child, the court shall issue an order granting access. In addition, § 39.6241 requires for youth in Another Planned Permanent Living Arrangement that the department and guardian ad litem must provide the court with a recommended list and description of services needed by the child, such as independent living services and medical, dental, educational, or psychological referrals, and a recommended list and description of services needed by his or her caregiver.

#### Physical health.

- Ensure that the Blue Book is traveling with the child.
- Has the child received a comprehensive health assessment (i.e. early periodic screening, diagnosis and treatment, well-baby exams, newborn screenings, or annual physical) since entering foster care? If so, have all the identified needs been addressed?
- Has the treating physician conducted a review of the child’s pertinent birth and family history?

**Infants and toddlers.** 2014 DCF data show that 54.3% of the children entering the dependency system were 0-5, and 17.8% were under one year of age. These very young children who come before the court have unique physical and mental health issues and may also have developmental delays. Research documents that the best time to improve developmental outcomes is early in life when interventions are most effective and least costly. Read more about infants and toddlers in court in [\*Healthy Beginnings, Healthy Futures, A Judge’s Guide\*](#), published by the ABA, NCJFCJ, and Zero to Three.

- Ensure that a referral to the child protection team has been made in cases involving allegations of physical and/or sexual abuse.
- Ensure that children who have a history of sexual abuse receive trauma informed counseling prior to being exposed to sexual education materials.
- Are the child's immunizations complete and up-to-date for his or her age? If so, has the immunization record been filed with the court, and does the caregiver have a copy?
- Does the child have an acute or chronic health issue that needs to be addressed?
- Has the child received a hearing and vision screening since entering foster care?
- Does the child have a history of and/or has the child been assessed for allergies? Are there environmental conditions impacting the allergies?
- Has the child received a screening for lead poisoning, anemia, exposure to methamphetamine producing chemicals, or other harmful exposures?
- Has the child received routine medical check-ups and illness related visits, using a primary physician or specific wellness clinic?
- Has the child received the necessary prescriptions for medication and access to medical equipment (nebulizer, asthma pumps, etc.)?
- Based on the child's physical health needs, inquire if an assessment of the caregiver's capacity to care for the child has been conducted.
- Based on the child's physical health needs, inquire if the child's needs warrant placement in a medical foster home.

### Considerations for older youth.

Not only are adolescents in foster care more likely to become parents in their teen years, children born to teen parents are more likely to end up in foster care or have multiple caretakers throughout their childhood.

Youth in foster care initiate sexual activity at an earlier age and are 2.5 times as likely to become pregnant as their non-foster peers. They are also more likely to give birth, have subsequent pregnancies, and engage in sex with a partner who has a sexually transmitted infection.

They need:

- A **supportive relationship** with a caring adult who is skilled in communicating effectively about intimate issues. This has been shown to be the single most important factor in preventing teen pregnancies.
- Comprehensive, accurate **information** from reliable sources. Evidence-based sex education programs should be utilized whenever possible.
- A vision and **motivation** for a bright future.

- Has the youth received developmentally appropriate information regarding the Human Papillomavirus (HPV) vaccine? The HPV vaccine can be administered to girls as young as age 9 but is mostly commonly administered to girls/women 11 to 26 years of age.

- Has the youth received a family planning consultation that included abstinence education as well as available methods of birth control?
- Has the youth received developmentally appropriate sexual health education that included instruction in interpersonal relationships and communication skills, reproductive health, prevention of sexually transmitted diseases, and prevention of physical and sexual abuse?

**SOURCE:**

“When You Decide: A Judge’s Guide to Pregnancy Prevention Among Foster Youth.” (<https://thenationalcampaign.org/resource/when-you-decide?display=grid>) - Technical assistance brief created by the National Council of Juvenile and Family Court Judges and the National Campaign to Prevent Teen and Unplanned Pregnancy.

**Mental / Developmental / Emotional Health**

- If applicable, inquire what the comprehensive behavioral health assessment says about the child’s development and mental health needs.
- Inquire if the child has been referred to or is currently receiving counseling.
- Does the child have any mental health issues that impair his or her ability to learn, interact appropriately, or attend school regularly? If yes, what is this mental health issue, and how is it being addressed?
- When ordering a psychological evaluation or similar evaluation, clearly state the court’s expectations and ensure that these directives are included in the order. Require prompt action and ensure that all critical case information is provided to the evaluator.
- Is the child currently being prescribed any psychotropic medications? If yes, which medications have been prescribed, and has consent been obtained?
- Inquire if the child’s need for medication has clearly been explained to him or her and the caregiver.
- Based on the child’s mental health needs, inquire if an assessment of the caregiver’s capacity to care for the child has been conducted.
- If the child has been previously hospitalized for a mental health issue, ensure that the case worker has obtained all records from the hospitalization.
- Inquire if the child’s mental health needs warrant placement in a medical foster home.
- Ages 0-3: The early intervention for children under three is known as Part C of the Individuals with Disabilities Education Act (IDEA), which in Florida is Early Steps in Children’s Medical Services. This program offers free developmental screening, evaluations and treatment statewide. Federal law requires the screening to occur within 45 days of the date the referral is issued and entitles children to needed services (physical, occupational and speech therapy, counseling, nursing services, transportation) provided through insurance, Medicaid, or otherwise at no cost to the family.
- School age: The early intervention for children ages 3-5 is Part B of the IDEA, which is known as The Florida Diagnostic and Learning Resources System (FDLRS), offering free diagnostic and instructional supports mostly for school age children.

- Ensure that children ages 0-5 receive developmental screenings that emphasize social and emotional development. If delays or deficits are determined, ensure that the appropriate referrals are made.
- Inquire if the child was exposed to harmful substances, including alcohol, prenatally. For children who were substance exposed, ensure that they are referred for developmental screenings and assessments that address exposure to substances and identify interventions.
- Does the child have a diagnosis of a developmental delay or disability?
- Is the child receiving services from the Agency for Persons with Disabilities (APD) or on a wait list for such services if the child has a developmental disability?
- Does the child have an Individualized Education Plan (IEP)? If yes, what is the noted disability on the IEP? Ensure that the case worker has a copy of the most recent IEP and that it has been filed with the courts.
- If indicated, will the parent and child be referred for an evidence-based parenting program that includes observable, real-time parent child interactions to practice and acquire new skills?
- If applicable, inquire if the adolescent has been screened, and if indicated, received an assessment for substance abuse related issues. If indicated by the assessment, has the youth been referred for treatment services? Is there a possibility of a co-occurring disorder, and if so, is the child in integrated treatment? (The best form of treatment for co-occurring disorders is what is known as integrated treatment. As the name implies, the patient receives treatment for both mental illness and substance abuse from the same clinician or from a team of clinicians.)

#### **Dental health.**

- Has the child received a dental examination since entering foster care?
- Has the child received routine check-ups/cleanings (including accommodations for children with special needs), fillings, and other preventive treatment?
- Does the child have dental needs that extend beyond preventive care? If yes, how are the needs being addressed?
- Ensure that the case worker or caregiver has instructed the child on the proper way to brush and floss.
- Is the child receiving fluoride or fluoride treatments on a regular basis?
- Inquire if the child's next dental examination has been scheduled.
- Have the child and the caregiver been educated on the importance of good oral health?

#### **Children and trauma.**

The court and the service providers should ensure that treatment is gender specific and uses the principles of trauma-informed care. Trauma-informed care recognizes the impact past trauma has on a child's life, as well as the potential triggers and vulnerabilities of these trauma survivors. The care should be supportive and not exacerbate the symptoms.

Judges should use professionals who are experienced in using validated trauma screening tools such as the Trauma Symptom Checklist for Children, the Trauma Symptom Checklist for

Young Children, and the Child Sexual Behavior Inventory. Judges should maintain a list of trained trauma professionals who use evidence-based treatments.

Child Traumatic Stress Reactions By Age Group (from the National Child Traumatic Stress Network, Justice System Consortium, *Helping Traumatized Children: Tips for Judges* <http://www.nctsnet.org/sites/default/files/assets/pdfs/JudgesFactSheet.pdf>)

Age Group	Common Traumatic Stress Reactions
Young children (Birth - 5 years)	<ul style="list-style-type: none"><li>• Withdrawal and passivity</li><li>• Exaggerated startle response</li><li>• Aggressive outbursts</li><li>• Sleep difficulties (including night terrors)</li><li>• Separation anxiety</li><li>• Fear of new situations</li><li>• Difficulty assessing threats and finding protection (especially in cases where a parent or caretaker was aggressor)</li><li>• Regression to previous behaviors (e.g., baby talk, bed-wetting, crying)</li></ul>
School-age children (6 - 12 years)	<ul style="list-style-type: none"><li>• Abrupt and unpredictable shifts between withdrawn and aggressive behaviors</li><li>• Social isolation and withdrawal (may be an attempt to avoid further trauma or reminders of past trauma)</li><li>• Sleep disturbances that interfere with daytime concentration and attention</li><li>• Preoccupation with the traumatic experiences(s)</li><li>• Intense, specific fears related to the traumatic event(s)</li></ul>
Adolescents (13 - 18 years)	<ul style="list-style-type: none"><li>• Increased risk taking (substance abuse, truancy, risky sexual behaviors)</li><li>• Heightened sensitivity to perceived threats (may respond to seemingly neutral stimuli with aggression or hostility)</li><li>• Social isolation (belief that they are unique and alone in their pain)</li><li>• Withdrawal and emotional numbing</li><li>• Low self-esteem (may manifest as a sense of helplessness or hopelessness)</li></ul>

**Trauma resources for judges.**

***Bench card for the trauma-informed judge:*** (developed by by the National Child Traumatic Stress Network and the National Council of Juvenile and Family Court Judges)

[http://www.nctsn.org/sites/default/files/assets/pdfs/judge\\_bench\\_cards\\_final.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/judge_bench_cards_final.pdf)

***Family Court Tool Kit: Trauma and Child Development:*** (developed by the Florida Supreme Court Steering Committee on Families and Children in the Courts)

<http://flcourts.org/resources-and-services/court-improvement/judicial-toolkits/family-court-toolkit/>

## **Common types of mental illnesses/disorders in children. (from the National Alliance on Mental Illness)**

Attention-Deficit/Hyperactivity Disorder (ADHD) affects an estimated three to five percent of school-age children. ADHD is an illness characterized by inattention, hyperactivity, and impulsivity. Symptoms may include some or all of the following: failure to pay close attention to details or make careless mistakes in schoolwork, work, or other activities; difficulty sustaining attention to tasks or leisure activities; forgetful in daily activities, easily distracted; feeling of restlessness; excessive talking; and difficulty waiting their turn. Common treatments include medication and behavioral therapy.

Autism Spectrum Disorders (ASDs) are complex developmental disorders of brain function. Each disorder can affect a child's ability through signs of impaired social interaction, problems with verbal and nonverbal communication, and unusual or severely limited activities and interest. Symptoms usually occur during the first three years of life. Signs include lack of or delay in spoken language; repetitive use of language and/or motor mannerisms; little or no eye contact; lack of interest in peer relationships; lack of spontaneous or make-believe play; persistent fixation on parts of objects; does not smile. There is no cure for ASDs, but with appropriate early interventions, a child may improve social development and reduce undesirable behaviors. Treatment consists of therapies or interventions designed to remedy specific symptoms in each individual and educational, behavioral, and medical interventions.

Anxiety Disorders are the most common mental illnesses in America. They cause people to feel excessively frightened, distressed, and uneasy during situations in which most others would not experience these symptoms. The most common anxiety disorders are:

- **Panic Disorder** - Sudden feelings of terror that strike repeatedly and without warning, causing panic attacks. Children and adolescents may experience unrealistic worry, self-consciousness, and tension.
- **Obsessive-Compulsive Disorder (OCD)** - Repeated, intrusive, and unwanted thoughts and/or rituals that seem impossible to control.
- **Post-Traumatic Stress Disorder (PTSD)** - Occurs after experiencing a trauma such as abuse, natural disasters, or extreme violence. Symptoms include nightmares, flashbacks, numbing of emotions, depression, anger, irritability, distraction, and startling easily.
- **Phobia** - A disabling and irrational fear of something that really poses little or no actual danger. Common symptoms for children and adolescents with "social" phobia are hypersensitivity to criticism, difficulty being assertive, and low self-esteem.
- **Generalized Anxiety Disorder** - Chronic, exaggerated worry about everyday, routine life events and activities. Children and adolescents usually anticipate the worst and often complain of fatigue, tension, headaches, and nausea.

Depression is found in about two percent of school-aged children and about eight percent of adolescents. A family history of mood disorders and stressful life events increase the risk of depression. Signs include feeling persistently sad, talking about suicide or being better off dead, becoming suddenly much more irritable, having a marked deterioration in school or home functioning, isolation, and substance abuse. Possible treatment options include psychotherapy and medication.