
MENTAL HEALTH NEEDS OF DEPENDENT CHILDREN

Studies indicate that up to 80% of children in the dependency system have significant emotional, developmental, or behavioral needs requiring mental health services.ⁱ Screenings for developmental problems in one study showed that nearly three-quarters of children under six who were entering foster care tested in the questionable to abnormal range.ⁱⁱ The World Health Organization estimates that by 2020 childhood neuro-psychiatric disorders will increase by half to become one of the most common causes of childhood mortality.ⁱⁱⁱ While this may seem frightening, it is important to remember that most people with a mental illness are not dangerous, and mental illness is treatable with various combinations of therapy and drugs.^{iv}

Despite their disproportionate needs, most dependent children do not receive mental health care unless their situations reach a crisis point.^v Ill-informed prejudices also inform which children will receive treatment and which children's needs are overlooked. Dependent children who act out due to behavioral problems are more likely to get treatment than children with other mental health needs, as are children who have been sexually abused (children who were sexually abused are three times more likely to get mental health care than children who suffered neglect).^{vi} Children of color are the least likely to get treatment, and must show greater pathology to get referrals.^{vii} Children placed with relative caregivers are also less likely to get referrals than those in traditional foster care.^{viii} It is therefore important to ensure that each child is considered on a case-by-case basis to determine individual needs, and not to make generalizations about children's treatment needs.

As for the causes of mental illness, some mental health disorders have a biological basis; others seem to be related to traumatic life experiences.^{ix} Many practitioners see mental illness as caused by a complex interaction between inherited biological traits and life stressors.^x

The key point to remember is that it is not the job of the Program to diagnose or treat mental illness. However, it is the guardian ad litem's job to recognize when a child may need to be evaluated for treatment and to make sure that children who need evaluations obtain good ones. It is also the guardian ad litem's job to ensure that professionally recommended treatment is provided. Some key signs that a child may need to be evaluated for treatment include:

- ***Social withdrawal*** or dropping out of previously enjoyed activities, decline in academic performance, friendlessness, spending increased time alone;
- ***Depression*** including changes in sleep patterns (sleeping more or sleeping less), excessive fatigue, appetite changes, pessimism, thinking about suicide or death, increased difficulty coping with daily activities;
- ***Thought disorders*** such as illogical thinking, strange or grandiose ideas, difficulty concentrating or coping with minor issues, irrational statements, excessive suspicion or fear, peculiar word usage;
- ***Inappropriate expression of emotion*** such as indifference even in important situations, inability to cry or express joy, inappropriate laughter, excessive hostility or anger; and
- ***Inappropriate behavior*** such as hyperactivity, inactivity (or alternating between the two), sudden changes in weight, deterioration of personal hygiene, personality

changes, drug/alcohol abuse, missing school or work, forgetfulness, bizarre behavior (i.e. starrng).^{xi}

Knowing how serious and persistent dependent children's mental health needs are, it is important to have general knowledge of the most common disorders in children. Below are the mental illnesses that are the most common in the general population of children, including dependent children.

Disorders Usually First Diagnosed In Childhood^{xii}

A child may suffer from more than one disorder simultaneously (or have a "dual-diagnosis").

ANXIETY DISORDERS

Anxiety disorders are the most common childhood mental illnesses.

- **Generalized anxiety disorder** causes exaggerated and persistent stress over everyday worries.
- **Obsessive-compulsive disorder** (OCD) causes unwanted, intrusive, and repetitive thoughts and a feeling of urgent need to perform behavior.
- **Post-traumatic stress disorder** (PTSD) occurs after experiencing a traumatic event and causes the re-living of the trauma through intrusive memories and panic.
- **Phobias** include specific phobias, such as extreme fear of clowns, enclosed spaces, spiders, etc., and social phobias, such as extreme fear of public scrutiny or embarrassment.
- **Panic disorder** causes repeated extreme fear arising unexpectedly for no apparent reason and may include physical reactions like heart pounding, dizziness, or chest pain.
- **Separation anxiety** is an extreme fear relating to separating from a person to whom the child is bonded or from a place.
- **Selective mutism** is a persistent inability to talk in certain social situations.

DEPRESSIVE DISORDERS

Depressive disorders affect appetite, mood, energy, sleep, and interest. Symptoms are extreme and persistent, significantly interfering with functioning.

- **Major depressive disorder** includes five or more of the following symptoms:
 - Persistent sadness or irritability;
 - Loss of interest in activities previously enjoyed;
 - Significant change in weight or appetite;
 - Sleep changes;
 - Increased or decreased energy;
 - Feelings of worthlessness / inappropriate guilt;
 - Difficulty concentrating; or
 - Recurring thoughts of suicide or death.
- **Dysthymic disorder** is a less severe, but more long-lasting, form of depressive disorder.

- **Bipolar disorder** (manic depression) includes alternating, or cycling, between depressive symptoms and manic symptoms. Features of disruptive behavior disorders, such as attention-deficit hyperactivity disorder, may be initial signs of bipolar disorder.

ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD)

Attention-deficit hyperactivity disorder prevents a child from concentrating appropriately and from displaying appropriate behavior. It causes impulsivity and distractibility. Many children may have a form of attention-deficit disorder (ADD) without the hyperactivity component.

EATING DISORDERS

Eating disorders are not a behavioral failure; they are mental illnesses where maladaptive eating patterns virtually take over children's lives. They often lead to health complications, including kidney failure or serious heart conditions, and even death. Children with eating disorders often have other disorders, including anxiety or depressive disorders.

- **Anorexia nervosa** involves extreme reduction of food intake and concern about body shape or weight.
- **Bulimia** involves expelling food before it can be absorbed by the body.
- **Binge-eating disorder** involves repeated extreme eating beyond feelings of fullness. Binge eaters are sometimes food hoarders.

PERVASIVE DEVELOPMENTAL DISORDERS (PDDs)

Pervasive developmental disorders, such as *Autism*, *Asperger's syndrome*, *Rett's disorder*, *Childhood disintegrative disorder*, and *Pervasive developmental disorder-not otherwise specified (PDD-NOS)*, affect the child's ability to communicate, form relationships, and engage with and respond to the outside world.

SCHIZOPHRENIA

Schizophrenia symptoms usually show up in late adolescence or early adulthood, and include visual and auditory hallucinations (hearing voices), disorganized and illogical thinking, and social withdrawal.

ATTACHMENT DISORDERS

In addition to the mental illnesses prevalent in all children, children in the dependency system are at particular risk for attachment disorders. When a baby cries, an appropriate caretaker will pick up the child and address the child's needs, helping the child to develop a sense of trust and security and to develop a secure attachment to the caretaker. Children whose needs are not met consistently – especially children whose primary caretaker changes often during early childhood –

may develop attachment disorders.^{xiii} Some signs that a child may have an attachment disorder include:

- Indiscriminate affection with strangers (“promiscuous attachment”);
- Behavior that is superficially charming or engaging;
- Destructive behavior, especially self-destructive behavior;
- Poor peer relationships;
- Failure to make eye contact;
- Poor impulse control, stealing, or lying;
- Not cuddling with parents or caretakers;
- Fighting for control over everything;
- Developmental delays;
- Cruelty to animals or other children;
- Abnormal speech patterns; or
- Lacking cause-and-effect thinking.^{xiv}

OBTAINING SERVICES FOR CHILDREN WITH MENTAL HEALTH NEEDS

Any child in the dependency system is entitled to mental health services through the Department of Children and Family Services (the department).^{xv} But it is important not to overlook alternate sources for assistance. If the child’s condition is affecting his or her schooling, the child may be eligible for services through the school, and the court may order the child to be evaluated by a district school board educational needs assessment team.^{xvi}

It is crucial to remember that services should always be designed to help the child, not as punitive measures for a child’s behavior.^{xvii}

Pre-Disposition Services

Prior to the adoption of the case plan the court may order any medical, mental health, or developmental service that the child may require.^{xviii} If the child is not receiving any treatment the guardian ad litem feels is in the child’s best interests, the program attorney should file a motion requesting that such services be ordered. A sample motion is attached to this chapter.

Post-Disposition Services

The guardian ad litem should be involved in the development of the case plan^{xix}, which should include services needed for the child.^{xx} The case plan may be amended to include services for the child at any time.^{xxi} If all parties agree on the need for the amendment, the court may order the case plan amendment after receiving a memorandum of explanation.^{xxii} If there is disagreement among the parties regarding needed services for the child, a motion to amend the case plan must be filed, and the court may order the case plan amendment if competent evidence is shown regarding the need for the amendment.^{xxiii}

Psychotropic Medications

Special procedures are required before the child is administered psychotropic medications. If the child is prescribed a psychotropic medication, the Program’s psychotropic medication protocol must be strictly followed.^{xxiv} The protocol, along with a timeline and checklist, can be

found on the Guardian ad Litem Program's website. Also included with this chapter are sample motions regarding the administration of psychotropic medications to dependent children.

THE CHILD'S MENTAL HEALTH RECORDS

Recognizing the importance of protecting children's privacy interests in their mental health records, the GAL Standards of Operation (Standard 4.2) detail strict procedures to be followed regarding children's mental health records. A copy of the GAL Standards of Operation can be found on the GAL website.

RESIDENTIAL COMMITMENT

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Introduction

Dependent children in need of intensive therapeutic services may be considered for commitment to a residential treatment center. For many years children were committed to residential treatment centers without adequate due process protections. The Florida Supreme Court established these much needed protections in M.W. v. Davis, 756 So. 2d 90 (Fla. 2000) and these protections were later codified in Florida Statute § 39.407(5), Fla. Stat. (2007) and Florida Rule of Juvenile Procedure 8.350. All child advocates must be extremely familiar with this statutory provision and rule of juvenile procedure in order to competently advocate for the client. Once a child is committed to a residential treatment center, it is imperative that the child advocate carefully reviews all 30 day internal review reports and 90 day review reports to ensure the child continues to be in need of residential commitment.

Applicable Law

- Seminal cases: Parham v. J.R., 442 U.S. 584 (1979); M.W. v. Davis, 756 So. 2d 90 (Fla. 2000)
- Florida Statute § 39.407(5)
- Rule of Juvenile Procedure 8.350

Involuntary Commitment (Baker Act)

- Baker Act provision in the statute is §39.407(5)
- Criteria established in § 394.467 must be established
 - mentally ill and because of his or her mental illness:
 - refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or
 - unable to determine for himself or herself whether placement is necessary; and
 - manifestly incapable of surviving alone..., and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or
 - substantial likelihood ... inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and

- all available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.
- Different from residential commitment as a residential commitment is considered a “voluntary commitment”

Assessments for Voluntary Commitments

- Florida Statute §39.407(6)(c) and Fla.R.Juv.Pro. 8.350(a)
- Completed Before Commitment
- Notice must be provided to the parties of the assessment
- Upon Notice:
 - Court shall appoint a guardian ad litem
 - Court may appoint an attorney
- Guardian ad litem and the child’s attorney SHALL meet the child
- Evaluation completed by qualified evaluator
- Evaluation must be provided to all parties, and the guardian ad litem must have the opportunity to discuss the findings with the evaluator
- Written Findings of Evaluator
 - Child appears to have an emotional disturbance serious enough to require residential treatment
 - Child is reasonably likely to benefit from treatment
 - Child has been provided an explanation of the nature and purpose of the treatment
 - All available modalities of treatment less restrictive have been considered AND are unavailable
- The guardian ad litem SHALL file a written report indicating the guardian ad litem’s recommendation as to the child’s placement in residential treatment and the child’s wishes

Motion for Voluntary Placement Pursuant to Assessment

- Fla.R.Juv.Pro. 8.350(4)
- Motion contents:
 - Why child is suitable for placement
 - Why less restrictive alternatives are not appropriate
 - Must include findings of evaluator
 - Must state whether all parties are in agreement
- Motion must be served on all parties

Appointment of Attorney and Guardian ad Litem for Child

- If any information indicates that the child disagrees, the court shall appoint an attorney in addition to the appointment of a guardian ad litem
- Guardian ad litem must be appointed whether or not the child disagrees with the placement and the guardian ad litem must be represented by an attorney (unless the guardian ad litem is an attorney) at all proceedings regarding residential commitment.

Status Hearing on Voluntary Placement

- Must be within 48 hours – excluding weekends 8.350(a)(7)
- Must have guardian ad litem or attorney present and if hearing occurs without either, may request an additional hearing, 8.350(a)(8)

- Child shall be present at all hearings 8.350(c)
 - Excused upon finding mental or physical condition make it not in child's best interest
 - If child not present – child shall be provided opportunity to express views
- At hearing, court shall directly inquire of child if attorney not present, 8.350(a)(9)
- If everyone agrees, court “may” place child, 8.350(a)(9)

Evidentiary Hearing

- Must be held if any disagreement as to placement
- Must be held within 10 days
- Child shall be present
- Child's Attorney shall be present
- Evidence and witnesses presented
 - Department cannot rely on report alone as they must have the qualified evaluator present to provide testimony
 - Hearsay alone is insufficient, G.T. v. DCF, 935 So.2d 1245 (Fla. 1st DCA 2006)
- The court shall consider the recommendation of the guardian ad litem
- Standard of Proof – clear and convincing evidence

Court Determination

- If court determines not suitable, shall order least restrictive placement
- To find suitable for residential, the court must find:
 - Must have emotional disturbance or serious emotional disturbance
 - Child requires residential treatment
 - Child is expected to benefit from mental health treatment
 - Less restrictive alternative is unavailable

Voluntary Treatment Individualized Plans §39.407(6)(e)

- Must be developed within 10 days
- Must be explained to the child
- The guardian ad litem, the foster parents and the child must be involved in creating the plan to the maximum extent consistent with the child's treatment needs
- Must include aftercare
- Must include specific behavioral and emotional goals
- Must be provided to guardian ad litem, the child and the department

Internal Treatment Review §39.407(6)(f)

- Must occur every 30 days
- Must consider if the child is receiving benefits?
- Must consider if the child can be treated in less restrictive placement?
- Must include Discharge Plan
- Must be submitted to guardian ad litem and department
- Department must file with the Court

Court Review § 39.407(6)(g) and Fla.R.Juv.Pro. 8.350(b)

- Must occur every 3 months (90 days)
- An independent Evaluator must review and provide a report at least 72 hours before the hearing
- Court shall directly inquire of the child and if child is not present, diligently determine if child disagrees with continuing placement
- Court may also review placement at judicial review hearings
- If at any time the court determines that the child is not suitable for continued residential treatment, the court shall order the department to place the child in the least restrictive setting that is best suited to meet his or her needs
- Guardian ad litem or child's attorney can file motion at any time to review the placement

i American Academy of Child and Adolescent Psychiatry (AACAP) Policy Statement, Psychiatric Care of Children in the Foster Care System, available at <http://aacap.org>, (2001).

ii June M. Clausen, et al., Mental Health Problems of Children in Foster Care, 7 J. Child & Fam. Stud. 283, 292 (1998).

iii National Institutes of Mental Health, NIMH Brief Notes on the Mental Health of Children and Adolescents, available at www.nimh.nih.gov.

iv National Resource Center on Child Maltreatment, available at www.gocwi.org/NRCCM.

v AACAP Policy Statement, supra.

vi National Child Welfare Resource Center for Family-Centered Practice, Best Practice/Next Practice, Summer 2003

vii *Id.*

viii *Id.*

ix National CASA, The Impact of Mental Illness on Children and Families, (2002).

x *Id.*

xi National CASA, The Impact of Mental Illness on Children and Families, (2002).

xii National Institutes of Mental Health, NIMH Brief Notes on the Mental Health of Children and Adolescents, available at www.nimh.nih.gov.

xiii See, American Psychiatric Association, Position Statement: Reactive Attachment Disorder, APA Document Reference No. 200205 (2002).

xiv Keith Reber, "Children at Risk for Reactive Attachment Disorder: Assessment, Diagnosis and Treatment," Progress: Family Systems Research and Therapy, Vol. 5, 83-98 (1996), Encino, CA.

xv § 39.407, Fla. Stat. (2007).

xvi § 39.407(4)(c)

xvii See, § 39.407(12); see also, A.A. v. Rolle, 604 So. 2d 813, 818 (Fla. 1992) ("Dependent children and children in need of services are not criminals.").

xviii §§ 39.407(1) (allowing medical screenings); 39.407(2) (allowing medical treatment); 39.407(4) (allowing mental health and developmental disabilities screenings); 39.407(5) (allowing mental health and developmental disabilities treatment), Fla. Stat. (2006).

xix § 39.3011(1)(a).

xx 42 U.S.C. § 675(1)(B); § 39.6012(2).

xxi § 39.6013(2).

xxii § 39.6013(3).

xxiii § 39.6013(5).

xxiv See also, § 39.407(3)(outlining procedural requirements before a child may receive psychotropic medication).