Conference Paper

Special Needs and Child Welfare: Healing the Child

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Abstract: *Passage of the Adoption and Safe Families Act of 1997 has placed the child at the center of the child welfare system. Courts bear the ultimate responsibility for the safety and well-being of these children, including those with disabilities. Findings from the Child and Family Service Reviews, however, indicate less-than-optimal conformity in a number of states regarding the physical and mental well-being of children. A multidisciplinary approach involving jurisprudence, science, and financing is required to bring about better compliance. Collaboration among legal, medical, dental, and child advocacy organizations is necessary for healing children in the welfare system to become a national imperative. (Pediatr Dent 2007;29:143-5)*

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US juvenile courts are often the places of last resort for children and families when everyone else has failed them. The courts are typically their last chance for help. Stories of impoverishment, emotional deprivation, and cumulative disadvantage flood these courtrooms, and human suffering appears to be everywhere.

Compared with children in the general population from the same socioeconomic background, children in the child welfare system have much higher rates of serious emotional and behavioral problems, chronic physical disabilities, birth defects, and developmental delays.[1] It is imperative that these children and their families leave the courts' jurisdiction on the way to healing and with some hope. How can the tragedy that involuntarily brings them into our courts be turned into an opportunity to help them?[2]

Since the passage of the Adoption and Safe Families Act of 1997 (ASFA), the child has been the center of the child welfare system. The health and safety of the child are the paramount concerns of the dependency judge. This was a revolutionary change in the law governing child welfare cases. Before ASFA, reunification, almost at any cost, was the paramount duty of the court. Now, promoting the child's health and safety must be in the forefront of every decision by the court. ASFA requires the court to be much more hands-on in the management of the cases and requires periodic reviews by the court of each case every 6 months. The court bears the ultimate responsibility for the safety, well-being and permanency of children in the child welfare system.

Promoting and measuring the physical and mental well-being of children in the child welfare system continue to be major challenges. ASFA regulations require the court to ensure that the physical and mental health needs of dependent children are met. In fact, every state is audited by the federal government (DHHS) to determine compliance with ASFA. In reporting the well-being findings of the Child and Family Service Reviews (CFSR), there is no reported data on compliance with the dental health needs of the children. Essentially, the dental needs of these children are virtually ignored.

Findings from the CFSR regarding physical and mental health outcomes for children

Only one state was determined to be in substantial conformity on the CFSR outcome that addresses the physical and mental well-being of children. To be in substantial conformity, the state must receive positive ratings in at least 90% of the cases reviewed when it comes to providing both physical health and mental health services.

Physical health findings

Of the 52 initial CFSRs, only 20 states received a positive rating for addressing the physical health needs of the children they serve (39%). Among the most commonly cited issues in this area were:

1. The number of dentists and physicians in the state willing to accept Medicaid was not sufficient to meet the need (a problem identified in 27 states).

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2. The agency was not consistent in providing children with preventive health and/or dental services (a problem identified in 14 states).
3. The agency was not consistent in conducting adequate, timely health assessments (a problem identified in 13 states).

Mental health findings

Of the 52 initial CFSRs, only 4 states received a positive rating for addressing the mental health needs of the children they serve (8%). Among the most commonly cited issues in this area were:

1. The agency was not consistent in conducting mental health assessments (a problem identified in 24 states.
2. Mental health assessment and treatment services were not sufficient to meet children's needs (a problem identified in 31 states).

Obviously, we must do better. This commitment requires:

1. a multidisciplinary approach to jurisprudence;
2. a marriage of law and science; and
3. adequate financing to meet the special needs of these children.

The Florida Legislature in 2004 enacted the Medicaid Pre-Paid Dental Pilot, a 2-year experiment in capitation, in an attempt to reduce the Medicaid budget and assure accountability. Can the costs of Medicaid be accurately predicted?

This experiment in financing is rare in dentistry. The results were conclusive. The costs of providing the services before and during the pilot were about the same. The quality of the services in the pilot was quite inferior. Fewer children obtained dental care (a 42% decline), fewer dentists were available to the children (a 59% decline), fewer children had a preventive dental visit (a 59% decline), dentists saw fewer children (a ??% decline), and the expenditures per child increased (by ???%).[3] The overall results were no cost savings and a lower quality of care.

Financing will continue to be a major impediment to quality services. What reform is needed in the justice system? Juvenile courts have the legal responsibility to rehabilitate, protect, and heal. This requires changing human behavior, which is not a historic legal function. The legal system, alone, is not equipped to look beyond the adjudication of the case. There is a growing understanding that, in some areas of the law, the court must be involved in trying to solve the underlying problem that brought the families into the court. The court system cannot continue to be a revolving door through which the same families pass again and again. The use of therapeutic jurisprudence is thought to be the key.

Juvenile courts were the first judicial forum where therapeutic jurisprudence was been exercised. As articulated by its 2 leading proponents, David Wexler and Bruce Winick, therapeutic jurisprudence has been defined as "the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects."[4-5] One of the goals of therapeutic justice is to allow judges to make better use of social science.

While these courts decide what people deserve because of past actions, there is a much greater emphasis on what they need for future success. Therapeutic jurisprudence tries to use legal rules, legal procedures, and, most importantly, a more active role for judges and other legal forces to promote the psychological or physical well-being of the people it affects.[6]

Unfortunately, decision-makers in family law and mental health fields remain largely ignorant of decades of research on child development. Child development researchers and child custody decision-makers, especially judges, rarely intersect, and the opportunity to learn from each other is nonexistent.[7] Judges, by necessity and not by choice, are forced to make monumental decisions in the lives of children in a few minutes—often with limited, inadequate, and sometimes incorrect information. The judicial decision can have a significant impact on the future course of a child's life and well-being. Often, these decisions are made without any form of representative, guardian ad litem, or attorney appointed or speaking for the child. The judge must discern from the information provided and the court's training in the law, not the science of child development, what is in the best interest of the child. The judge's task is analogous to riding a bicycle down a steep hill blindfolded.[8]

Through working together on national initiatives like Healthy Foster Care America—which was initiated by the American Academy of Pediatrics—a collaboration of national organizations can become a well-informed, effective national imperative. These national organizations include the National Council of Juvenile and Family Court Judges, the Child Welfare League of America, the American Academy of Child Psychiatry, the American Academy of Pediatric Dentistry and many other national organizations that work with children in foster care and aim to heal children in the child welfare system. Working together, all the blindfolds might actually come off.

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Abstract of Science of Literature

3D Comparison of Residual Adhesive and Enamel Loss after Debonding

This purpose of this study was to assess quantitatively 3D changes on enamel surfaces after bracket removal and after removal of residual adhesive and finishing. Brackets were bonded to enamel surfaces using resin-modified glass ionomer cement (Group 1) or composite resin (Group 2). The samples were debonded after 24 hours on a testing machine. Impressions and models were made of each tooth before debonding, after debonding, and after removal of residual adhesive. Models were scanned with a 3D laser-scanning machine, and images were analyzed using modified analytical software. Significant differences (P <.001) were observed with respect to adhesive thickness and enamel loss between the two groups. The authors found evidence of the following: 1) 3D laser scanning technology successfully measured adhesive thickness and enamel loss due to orthodontic procedures, and 2) bonding in moist conditions resulted in little or no adhesive left on the enamel surfaces after bracket debonding, thus greatly reducing risk of iatrogenic damage to the enamel surface.

Comments: *Debonding-induced enamel surface alterations may damage the outermost layer of enamel. This layer is important because of its hardness, higher mineral content, and fluoride concentration. The loss of surface enamel and associated exposure of the enamel prism endings may decrease enamel resistance to organic acids produced in plaque and increase the risk of decalcification. Resin-modified glass ionomer cements can be used for bonding in the presence of moisture. Their fluoride-releasing ability is significantly greater than that of fluoride releasing composites, sufficient to inhibit demineralization and promote remineralization of adjacent tooth structures, as well as reduce any irreversible effects on enamel texture following debonding.* ***RKY***

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