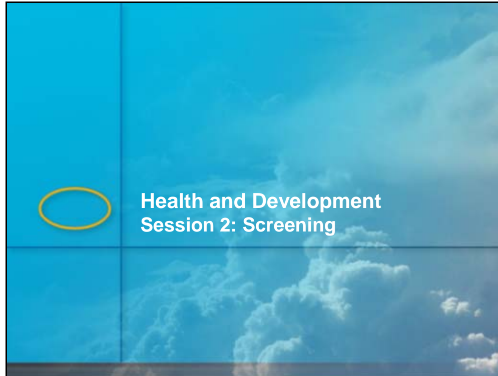
The Integration of Services Training Series

MODULE 1. HEALTH AND DEVELOPMENT

Session 2: Screening

SLIDE 2-1: TITLE SLIDE



Greet the participants as they come back from break and go over the Session Objectives.

TRANSITION

Tell the participants that we are going to spend a little more time reviewing brain development.

Say:

*As we discussed this morning, development results from a fascinating and complex interplay between biology and experience. The new question is not whether it is nature or nurture but instead, "How does nurture selectively influence the expression of nature?" Remember that Dr. Shonkoff stated in the video that we saw this morning that experience determines how genetics are expressed (Davies, 2004)***.**

Say:

Every child and family has protective and risk factors that impact their family dynamics and family members' development. Simply speaking, protective factors can be seen as buffers that help children and families address any adversity in their lives. Risk factors, on the other hand, increase the likelihood that a particular negative event will occur.

Slide 2-2: Protective and Risk Factors

Protective and Risk Factors

- Protective and risk factors are transactional in nature
- Identification of protective and risk factors is an essential component in screening and assessments.
- Factors are viewed as part of the individual's characteristics or part of environment features and transactions.

- Davies, 2004 and Horwath, 2009

Say:

- *Protective and risk factors have a transactional impact on family dynamics. A risk factor may effect one member of the family but not another, while the interaction of two family members may be a protective factor for a child, etc. Protective and risk factors should not be viewed in isolation of one another.*
- *Identifying protective and risk factors is a necessary function in any child welfare screening and assessment activity.*
- *These factors tend to be viewed as factors that are part of the characteristics of an individual or are characteristics of the environment.*
- *Protective factors help develop resiliency in children and adults.*

Slide 2-3: Protective Factors May Include Areas Such As:

Protective factors may include areas such as:

- Intelligence
- Athletic ability
- Good school performance and relationships with peers
- A close relationship with an adult
- Faith and community participation
- Shared care giving with adult family members and friends, etc.

- Davies, 2004 and Horwath, 2009

Say:

Protective factors may include areas such as:

- *Intelligence*
- *Athletic ability*
- *Good school performance and relationships with peers*
- *A close relationship with an adult*
- *Faith and community participation*
- *Shared care giving with adult family members and friends, etc.*

Slide 2-4: Risk Factors May Include Areas Such As:

Risk factors may include areas such as:

- Medical problems
- Sensory integration and emotional regulation problems.
- Unresponsive parenting
- Poverty
- Social Isolation
- Poor relationships with extended family etc.

- Davies, 2004 and Horwath, 2009

Say:

Risk factors may include areas such as:

- *Medical problems*
- *Sensory integration and emotional regulation problems.*
- *Unresponsive parenting*
- *Poverty*
- *Social isolation*
- *Poor relationships with extended family etc.*
- *Temperament which may be challenging to the parents.*

Summarize:

- Protective factors and risk factors must be indentified in the screening and assessment process. Protective factors are seen as sources of strengths and can be "built upon" to help establish resiliency with both children and adults.
- Risk factors must be addressed. In looking at risk factors we should think about both the risk for lack of safety and risk for poor developmental well-being and developmental outcomes.

TRANSITION

We are now going to complete a short review of child development. The purpose of this review is to be sure that the child welfare practitioners have basic knowledge of child development milestones to help them have a "trained eye" to complete a rough screen for developmental or medical issues.

Say:

Participant Guide
Module 1, p. 5

- *There is not enough time available in this model to discuss developmental milestones for each age group. However, it is very important for child welfare workers to be aware of these. The participant guide includes a chart of developmental milestones from the Centers for Disease Control. This information is included on pages 5 through 10 in the participant guide.*
- *Some children welfare workers carry a small developmental wheel or chart with them to help them identify questionable developmental status.*
- *To get a sense of the child's developmental level and skills, children and adolescents must be observed in different environments. A young child may act very differently in the childcare center than they do with her grandmother or father.*
- *Visitation is a time when parent and child interactions are often observed. This could be a very stressful time for both the child and the parent. Therefore, interactions should be observed with this in mind.*

Materials:
Trainer Handout: Crossword puzzle

Activity 2-1: Child Development

PURPOSE: To review child development milestones.

TIME: 20 minutes

DIRECTIONS:

1. Trainer hands out the crossword puzzle on milestones in child development.
2. Ask participants to complete the crossword puzzle. They should feel free to discuss the issues at their tables.

Review correct answers and discuss key milestones.

TRANSITION

When discussing screening for developmental and health issues, it is necessary to briefly review three areas that can drastically impact child welfare service delivery. These include Sudden Unexpected Death of an Infant (SUDI), Prenatal Exposure to Substances, and Traumatic Brain Injury (TBI). The topics are briefly discussed below.

SLIDE 2-5: SUDDEN UNEXPECTED DEATH OF AN INFANT

Sudden Unexpected Death of an Infant (SUDI)

- Sudden Unexpexted Death of an Infant (SUDI) is an initially unexplained death
- The cause of deaths such as suffocation are determined later
- Sudden Infant Death (SID) is the term used for a death when no cause is determined

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Say:

- *Sudden Unexpected Death of an Infant (SUDI) is a sudden, initially an Unexpected death of an infant under the age of one.*
- *Most deaths occur between the ages of 2 and four months.*
- *Often the cause of death is determined through investigations.*
- *Sudden Infant Death is a type of SUDI.*
- *This label is given when no cause can be found for the death.*

SLIDE 2-6: SUDI RISK FACTORS

Sudden Unexpected Death of an Infant –Risk Factors

- Young maternal age
- Smoking during pregnancy
  – five times the risk
- Exposure to second hand smoke
- Inadequate prenatal care
- Low Birth Weight

- Bright Futures

Say:

- *Research shows that there are several factors that raise the risk for SUDI. These are listed on the next two slides.*
- *For example, risk for suffocation can be reduced by not sleeping with the baby in the bed and not allowing the baby to sleep on soft surfaces.*
- *Several risks factors for SUDI can be eliminated through parental precautions.*

Slide 2-7: Risk Factors that Parents Can Control

Risk Factors that Parents Can Control

- Don't smoke are be around smokers during pregnancy and don't expose the baby to smoke.
- Where children sleep and on what surface– don't co-sleep and have the baby sleep on a firm surface.
- No loose bedding, or soft objects in the crib.
- How children sleep--- Back to Sleep

- Bright Futures

Summarize the content of the slides for the participants.

Say:

- *Child welfare workers can help families by being alert to risks for SUDI and counsel parents regarding safe sleeping practices.*
- *Sometimes it is very difficult to convince parents that co-sleeping is dangerous.*
- *It is especially dangerous if the parent uses drugs or alcohol, and/or takes medications that can cause drowsiness or fatigue.*
- *Parents should never sleep with an infant on a sofa, chair or water bed.*

Note: Information on SUDI was retrieved from the *Bright Futures: Guidelines for Health Supervision of Infant, Children and Adolescents* website at http://www.brightfutures.org/guidelines.html.

Slide 2-8: Substance Exposed Newborns

Substance Exposed Newborns

- This discussion includes the use of alcohol and illicit drugs and does not address cigarette smoking.
- About 10 to 11% of births show exposure.
- Harm can be lifelong
- Younger women are at a higher probability for using substance during pregnancy.

- SAMHSA, 2009

Say:

- *Now we will briefly discuss Substance Exposed Newborns.*
- *About 10 to 11% of births show exposure to alcohol or illicit drugs.*
- *The harm caused by this exposure can be long-term.*
- *Usually the younger the mother, the higher the likelihood that she has used illicit drugs during the pregnancy.*

Slide 2-9: Risk Has Not Been Reduced

Risk Has Not Been Reduced

- The rate of substance abuse in women has not improved significantly.
- If the mother does not disclose use it is often difficult to detect exposure at the time of birth.

- Office of Applied Studies

Say:

- *Unfortunately the number or women with substance abuse disorders has increased slightly between 2002 and 2005 (Office of Applied Studies).*
- *For many newborns, the use of substances is not detected at the birth. The parent may have used several months ago and not have disclosed the use.*

SLIDE 2-10: SUBSTANCE USE AND ABUSE REMAINS A PROBLEM

Substance Use and Abuse Remains a Problem

- Illicit drugs used during pregnancy can include:
  - Cocaine
  - opiates
  - Methamphetamines
  - Barbiturates

Say:

- *Illicit drug exposure may include exposure to cocaine, opiates, methamphetamines, barbiturates, etc.*
- *These children are at high risk for miscarriage, pre-mature birth, low birth rate, complications during delivery, eventual detection of neurological problems such as learning disabilities, and possibly other health issues.*

SLIDE 2-11: RISKS FOR THE INFANT

Risks for the Infant

- Risks include:
  - Miscarriage
  - Pre-mature birth
  - Complications at delivery
  - Later neurological problems
  - Medical problems

Review the risks on the slide.

SLIDE 2-12: USE OF ALCOHOL DURING PREGNANCY

Use of alcohol during pregnancy

- The use of alcohol during pregnancy can have a devastating impact on the child' development and future.
- Fetal Alcohol Spectrum Disorder includes physical, neurological, behavioral and cognitive disorders.
- Fetal Alcohol Syndrome (FAS) is recognizable through craniofacial abnormalities
- Fetal Alcohol Effect (FAE) is not physically obvious but can have very similar consequences for health and development.

Say:

- *Alcohol use during pregnancy can have a devastating impact on the child.*
- *Fetal Alcohol Spectrum Disorder (FASD) describes the range of physical, behavioral, and cognitive impairments that result in maternal consumption of alcohol during pregnancy.*
- *FASD may result in physical and facial anomalies as well as possible intellectual and behavioral disabilities.*

SLIDE 2-13: FETAL ALCOHOL EFFECT

Fetal Alcohol Effect

- Women may drink not knowing that they are pregnant.

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Say:

- *Many women reduce or stop drinking after they find out that they are pregnant.*
- *However damage may have been done to the developing fetus during the first weeks or months of pregnancy.*

SLIDE 2-14: FETAL ALCOHOL EFFECT, CONT.

Fetal Alcohol Effect, Cont.

- Symptoms may include cognitive delays, speech and language delays, behavioral problems, problems in regulating emotions and deficits in problem solving.
- Children with FAE may have problems forming relationships.

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Say:

- *The brain damage and central nervous abnormalities are known as Fetal Alcohol Effect (FAE) but there are no craniofacial abnormalities.*
- *FAE is considered when alcohol use during pregnancy is confirmed.*
- *Remember that the use of alcohol with illicit drugs is common. Therefore if the infant is exposed to cocaine, there is a good possibility that the mother drank alcohol as well.*
- *FAE symptoms include cognitive delays, speech and language delays, behavioral problems, deficits in problem solving, etc.*

TRAINER'S NOTE

Some of the participants may have shown the impact of alcohol when they created their collage. If so, go back and remark about how the brain structure is impacted by the use of illicit drugs and alcohol.

TRANSITION

Now we will briefly discuss Traumatic Brain Injury which is a condition that you may frequently encounter but not be aware of its presence.

SLIDE 2-15: INFLICTED TRAUMATIC BRAIN INJURY

Inflicted Traumatic Brain Injury

- Child maltreatment is the leading cause of serious head injuries in children under the age of two.
- Rates of survival of a serious head injury for infants and toddlers is from 60 to 85%

Keenan et al. 2003

Say:

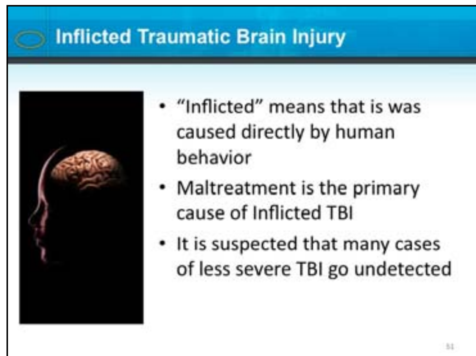
- *Child maltreatment is the leading cause of infant death and serious head injury in children.*
- *Inflicted TBI (maltreatment) usually occurs most frequently in infants and toddlers.*
- *Survival rates for children with serious inflicted TBI are about 60 to 85%.*
- *Therefore, some of the children in the child welfare system are likely survivors of serious head injuries.*

- *A population based study showed an incidence of inflicted TBI in children under age 2 to be about 17 per 100,000.*

TRANSITION

Traumatic Brain Injury (TBI) may be present in more children than previously thought. We are now going to briefly discuss TBI in children in the child welfare system.

SLIDE 2-16: TRAUMATIC BRAIN INJURY



Say:

- *Inflicted Traumatic Brain Injury is a TBI that is the direct result of physical action by another person.*
- *Maltreatment is the primary cause of inflicted TBI in young children.*
- *It is also a cause of TBI in older children.*
- *Researchers suspect that many causes of TBI in children are undetected.*
- *In a small sample of children with known maltreatment but no previous record of a head injury over 50% had physical evidence of skull fractures and intercranial damage (Rubin et al, 2003).*

Say:

- *Undetected TBI can be a result of an unreported head injury or a delayed response.*
- *Often, cognitive and behavioral impairments are not fully evident until several years after injury.*
- *This is especially true with mild TBI.*

SLIDE 2-17: MILD TO MODERATE TBI

Mild to Moderate TBI

- Mild to moderate TBI may be difficult to diagnose
- Symptoms are very similar to the symptoms for mental health disorders, and results of pre-natal exposure to substances.
- It is almost impossible sometimes to tell why a child or parent is having a particular problem.
- The most important thing is to try and find an intervention or coping mechanism that helps.

- Keenan et al JAMA 2003

Say:

- *While serious TBI is usually identified, mild TBI may not be.*
- *Mild to moderate TBI is sometimes difficult to determine, especially if it is not suspected for several years after the injury.*
- *Children with mild to moderate TBI may recover completely while others will have longer lasting symptoms.*
- *Children with a history of repeated head injuries or migraines are at a higher risk for long lasting effects (National Brain Injury Association).*

- *Symptoms may include academic problems, issues with anger and behavioral problems, inability to concentrate, reduced problem solving capacity, etc.*
- *These symptoms of course look like the behaviors that are seen with many children who come into contact with the child welfare system.*
- *The symptoms may also be a result of Chronic Complex Trauma.*
- *Physicians should screen for both FASD and TBI when they are completing the physical exams.*

TRANSITION

As we have discussed today, there are many reasons that children and families in the child welfare system may have some serious health issues that can impact their functioning. It is very important that family members receive appropriate medical assessments as recommended by their physician. All members of the family should have a primary care physician. When working with children and families, the child welfare practitioner has the responsibility to complete the most thorough screening and assessment as possible at the beginning of the case and continue these functions through the life of the case.

We are now going to complete an activity regarding screening and assessment.

Materials:
Participant Guide worksheets

ACTIVITY 2-2: Screening

PURPOSE: To show why it is so important to gather as much information about the family as possible at the beginning of the case and throughout the life of the case. It illustrates the impact of medical problems on the mother's ability to parent; and the possible developmental issues with the child that may be apparent and need to be addressed immediately.

TIME: 20 MINUTES

DIRECTIONS:

1. Ask groups of three to four to work together at their table. If you have time and the groups at the table are too homogeneous you may want to have them group together in another way.

Participant Guide
Module 1, p. 11

2. Have the participants turn to Module 1, page11 in their Participant Guide and read the scenario (see left column).
3. After reading the scenario, ask participants to answer the questions following the scenario. Observe the progress and move around the room to answer any questions.
4. After 20 minutes, have the groups report back to the large group.
5. When it is time for the groups to give their reports, go around the room and ask group one and two what health issues the mother could be facing. ***How would they address these?*** Ask group three and four to discuss their concerns regarding the child. ***What actions would they take to address these issues?***
6. When the participants are reporting their findings, ensure that the following points are addressed. This can be done by expanding on answers given, following up comments with additional questions, or posing a new question to the group.

Points to make:

- There are several reasons that the mother is lethargic and not providing proper supervision to the children. These could include depression, substance abuse, mobility problems due to her weight, being overwhelmed, or recently traumatized.
- Medical conditions should be ruled out. Has the mother had a physical exam in the last year? Is it possible that the mother has untreated diabetes because of lack of health insurance? What about a thyroid disorder?
- There are also several factors that could contribute to the boy's behavioral problems. Is his language at age level or does he experience frustration in communication? Is he able to process sensory input? What events precipitate his acting out? Does he act differently in other settings? Is he afraid or grieving for his mother, etc.?
- Do we know about his birth history? Was he low birth weight? When did his behavioral problems first surface? Is Fetal Alcohol Effect Disorder a possibility?

- What may be the reasons for the young girl's "shyness," and reluctance to respond? Is her hearing normal? What about her speech? Are you suspecting attachment disorders? Does the child need a full developmental assessment? Could she be a "slow to warm-up child" and is otherwise doing fairly well? How would you know?
- Has the child had a recent medical exam? What were the results?

TRAINER NOTE

Following the reports from the group, provide the additional information to the participants about the case. Acknowledge that they did not have much information to go on, but that is often the case when they are working with families.

Say:

- *In this case, the investigator interviewed the grandmother who provided good information. She stated that the little boy's behavior problems have been evident since he started crawling. He has always been very aggressive. She says that he is such a beautiful little boy that it is hard to imagine that he can be so mean. She said that the boy's mother is a serious alcoholic and could not handle the child's behavior at all. She stated that she is afraid of the child. Sometimes he is a sweet boy and then out of nowhere he becomes angry and defiant.*

- *She said that the little girl has always been a "shy little thing just like her mother" and won't talk to anyone unless her mother is there. She knows that her daughter is not able to handle both children but doesn't know what to do. She explained that her daughter has a problem with sugar but doesn't have any money and can't go to the doctor. She knows that she should help her daughter more but just can't do it. She did say that she had a son living in a town about 20 miles away that was doing good. He had a drug problem but had kicked it. He has a job now.*

Ask:

Knowing this what would you do immediately?

Suggested Responses:

- At minimum, get the mother to a doctor for a physical exam and treatment for her diabetes.

- Get both children a full physical exam and a developmental screen.
- Try to get birth history on the little boy because Fetal Alcohol Syndrome or Spectrum is now suspected.
- Work with the school to get a full behavioral assessment for the boy.
- Investigate natural supports to help the mother handle the little boy.
- Acknowledge the participants that made these recommendations when they made their reports.

Ask:

What types of barriers would you face when you attempted those actions?

Let the group discuss. Ask for recommended solutions from the group.

SLIDE 2-18: THE AAP SAYS

American Academy of Pediatrics

The American Academy of Pediatrics (AAP) has long recognized that the health of the individual child is the product of myriad social, environmental, and genetic factors and that adverse conditions in any of these areas undermine the wellness of the child.

Point to make:

- As you see with this quote the dynamics that we have been talking about today are clearly acknowledged by the AAP.

SLIDE 2-19: VULNERABILITY OF CHILDREN IN THE CHILD WELFARE SYSTEM

Health Care Vulnerabilities

Children and adolescents in foster care are known to be at high risk for persistent and chronic:

physical
emotional
developmental conditions

because of multiple and cumulative adverse events in their lives.

- AAP

Points to make:

- This morning we discussed the high rate of physical and developmental disorders that are likely for children coming into foster care.
- Remember the results from the National Survey of Child and Adolescent Well-Being. Findings were that the developmental and health status were similar for children for whom abuse or neglect was substantiated and those for whom it was not.

SLIDE 2-20: RESEARCH SHOWS…

Points to make:

- The slides provide a reminder that serious medical issues are common in children who have experienced maltreatment.
- Also we know that in many cases medical issues have not been addressed due to family circumstances, poverty, lack of transportation, etc.

SLIDE 2-21: PHYSICAL CONDITIONS

Points to make:

- This data demonstrates how critical it is to address the health care needs of children and parents.
- We know from our Family-Centered Practice material that engaging the parents and children in the identification of their strengths and needs is critical.
- The parents should be closely involved in the screening for medical needs and understand the outcomes of the screening.

SLIDE 2-22: SCREENING PROCESS

Points to make:

- As part of gathering information, the investigator and the case manager will collect information, talk to extended family members, the police, service providers, school personnel, etc. It is also important to try to talk to the physician about both the children's health care as well as the parents'.
- The American Academy of Pediatrics recommends that the investigator and case manager try to obtain a copy of the medical records for the children.
- The investigator and the case manager should also carefully observe the physical appearance, developmental level, and health signs for the parents and children beyond those of apparent physical abuse.
    - Does the child appear underweight?
    - Small for the age?
    - Does the child have a cough or sound congested?
    - Is the child walking, talking, and eating with a spoon or still on a bottle?
    - Do older children appear to be functioning at their age level?

- When discussing the person's "story" with parents, it may be necessary to include open ended questions about the parent's and children's health status.
- More specific screening also may be completed using a standardized screening tool or process.

Conduct a short discussion:

Participant Guide
Module 1, p. 12

Tell the participants to review the information in their Participants Guide, Module 1, and page 12 and discuss with one another their experiences in obtaining this kind of information.

Participant Guide
Module 1, p. 13

Ask the participants to review the suggested open-ended questions in their Participants Guide in Module 1, page 13.

Ask:

Do you think that asking these questions will help obtain the necessary information?

What other strategies could be employed to engage the parents in addressing the health care needs of their children?

After about five minutes of conversation at the tables, ask if anyone wants to share additional open ended questions or strategies to obtain the necessary information.

Comment and process the information with the participants.

Participant Guide
Module 1, p.19

Next, ask the participants to turn to Module 1, page 19 of their Participant Guide. Ask them to read the interview guide for healthcare issues.

Discussion Questions

1. ***Do you currently address the parent's health care needs? Why or Why not?***

   Ask questions about the practice and barriers.

2. ***Has any of the information presented today changed your mind about the need to address the parent's health care?***
3. ***Thinking about your experiences, is there a case that comes to mind that now you wonder if there may have been unidentified health care issues?***

If no response, give an example of a case that you are familiar with.

TRAINER NOTE	*Be prepared to lead the following discussion. Ask each question separately, allowing time for participants to respond before asking the next question. Engage the participants with examples, if possible.*

Tell the participants to think about their own ability to take care of their health.

Ask:

- ***Do you pay attention to your health?***
- ***Those of you who are parents, do you think that you became more concerned with your health when you had children to take care of?***
- ***What about the parents that you work with? Do you think that they realize how important their health is to their children?***
- ***Are there strategies that we could use to help the parents understand the importance of their own health care as well as their children's?***

TRANSITION

Let's review what we discussed in this session.

- *Personal development and health is impacted by one's biological make-up, interactions with close family members, and the external environment. All behavior should be viewed from a contextual approach.*
- *Protective and risk factors significantly impact development, and child safety.*
- *Screening and assessments must include a review of protective and risk factors.*
- *Medical professionals can provide a wide range of information to the child welfare worker regarding the child's health and developmental status.*
- *In screening and collecting information, child welfare practitioner's should not "jump to conclusions" and premature judgments. Collecting a wide range of information helps the worker and the team members make a better decision.*

- *These observations should be shared with the medical practitioners who are working with the child and family.*

SESSION CONCLUSION

Summarize the session and answer any questions to this point.