CHAPTER 9

HEALING THE CHILD IN JUVENILE COURT

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Juvenile court, perhaps unexpectedly nationwide, has become an important place to "heal the child." There were 903,000 substantiated cases of child maltreatment in 2001, most of which involved neglect (U.S. Department of Health and Human Services, 2003). Every day, the courts are making decisions, often irrevocable ones, about children's lives. This situation places a heavy burden on juvenile court judges; at the same time, the decisions have to be made and will be made. Building partnerships between these judges and mental health professionals can be helpful because they provide an important opportunity to help the judges make better—or at least better-informed—decisions about young children's lives. In addition, juvenile court judges can be supported in their difficult work by gaining more knowledge and information about developmental issues for young children as well as referrals and services.

The objectives of this chapter are the following: (1) to describe the plight of young children in the child welfare system as it relates to the work of juvenile court; (2) to review the literature on exposure to domestic violence and child maltreatment that is relevant to young children in dependency court; (3) to elaborate on how collaborations between mental health professionals and judges on behalf of young children can be helpful in juvenile court; and (4) to illustrate the conceptualization and principles of "healing the child" by describing the course of a young child and mother who appeared in juvenile court.

THE JUVENILE COURT AND CHILDREN

Initially, the juvenile court was created in Chicago at the end of the 19th century (Illinois Juvenile Court Act, 1899) and was charged with the responsibility of protecting children from family members who had abused, abandoned, and neglected them as they were unable to fulfill their roles as loving, nurturing parents. Under these circumstances, the juvenile court must intervene to protect and rehabilitate children when all else has failed. The judges have the weighty responsibility of making crucial decisions about the health, safety, and well-being of vast numbers of children every day. The juvenile court is a place of last resort where the state must act to protect the lives of children when there is a compelling reason to intervene in the sanctity and privacy of the relationship between a parent and a child. By the time children appear in juvenile court, tremendous harm has already been done. That is why the juvenile court can become a place to heal in trying to address the negative effects that can only be decreased by giving the child and family opportunity to change their harmful behaviors.

An additional burden for juvenile court today is that the children within the child welfare system increasingly are becoming younger. Of the almost 600,000 children currently in foster care in 2002 in the United States, one in five of them have entered care for the first time during their first year of life (Wulczyn & Hislop, 2002). Furthermore, there has been an unprecedented increase in younger babies entering care, with 1 in 20 in urban areas being birth to 3 months of age. Because babies who enter foster care younger stay in placement longer, it is crucial that those coming in contact with the babies, including judges, lawyers, CASA (court-appointed special advocates), court personnel, and others in the child welfare system, be informed about ways to better protect and promote the healthy development of these innocent children, who can be seen as "silent victims" with no voice. These children are rarely seen in the courtroom; often their parents are unable to recognize their needs. The judges, attorneys, and guardians in court are often overburdened, frequently have little knowledge about child development and the needs of these children, and have limited opportunity to interact with the child.

CO-OCCURRENCE OF YOUNG CHILDREN'S EXPOSURE TO DOMESTIC VIOLENCE AND CHILD MALTREATMENT

Because so many children who appear in dependency court are exposed to both domestic violence and other forms of child maltreatment, a reality that is frequently ignored, a review of relevant literature will be presented to frame our understanding of the potential environment of a dependent

child. Since the mid-1970s, researchers have explored the co-occurrence of child maltreatment and domestic violence. In 1975, a national survey was conducted of 1,146 families indicating that 77% of children living in high-violence families were abused during their lifetime (Straus, Gelles, & Steinmetz, 1980). Senate Report No. 101-939 (1990) revealed that in homes where domestic violence occurs children are physically abused and neglected at a rate 15 times higher than the national average. Several studies have found that in 60–75% of families where a woman is battered, children are also battered (Straus et al., 1980; Bowker, 1988; McKibben, DeVos, & Newberger, 1989). According to a recent report, "In Harm's Way: Domestic Violence and Child Maltreatment," researchers have typically used one of two methods to study the overlap (National Clearinghouse on Child Abuse and Neglect Information, 2002). They either identify evidence of woman battering in families where known cases of child abuse exist, using child protection services records, or they search for evidence of child abuse in families where abuse of the mothers has been documented using shelter samples.

Several federally funded studies done in the late 1970s included questions for families about major presenting problems in additional to child maltreatment. Those families reporting domestic violence as a significant co-occurring problem ranged from 11% in a 1977 study to 42% in a 1982 study (Daro & Cohn, 1988). A 1990 review of 200 substantiated cases of child abuse in the Massachusetts Department of Social Services indicated that adult domestic violence was cited in 30% of the cases, with more recent studies indicating the rate may be as high as 48% (Dykstra & Alsop, 1996). A similar review done by English (1998) in Washington State indicated that 55 percent of the physical and emotional abuse referrals involved domestic violence.

In a study of Minnesota child welfare cases, 71% of the families in crisis reported issues related to domestic violence (Shepard & Raschick, 1999). Edleson's 1999 review of 35 published studies of co-occurrence concluded that the majority of the research supports the notion of a high level of overlap ranging from 30 to 60% in most studies. In Margolin's (1998) review of the effects of domestic violence, she noted that 45–70% of children exposed to domestic violence are also victims of physical abuse and that as many as 40% of child victims of physical abuse are also exposed to domestic violence. McCloskey, Figueredo, and Koss (1995) reported that children living with a battered mother are also at serious risk for sexual abuse either by the mother's partner or outside of the home. Beeman, Hegemeister, and Edleson (2001), in their review of police records cross-referenced with child protection referrals, identified that more than 64% of the cases were identified as dual-violence families (see also Edleson, 1999).

As might be expected, negative outcomes are more likely for children who experience both domestic violence and child maltreatment when com-

pared to outcomes for those who experience one form of violence. Further, not infrequently in families where there is domestic violence and child maltreatment, there are also other risk factors including parental mental health problems, substance abuse, divorce, criminality, poverty, and general family dysfunction. Thus, there are many factors that may be contributing to the negative outcomes for children. With the literature indicating that the risk for exposure to domestic violence is higher for younger children who are also more vulnerable to child abuse and neglect, the field could benefit enormously from longitudinal follow-up studies.

Across all of these studies, irrespective of the methodology used, the following conclusions can be drawn

1. Child abuse impacts negatively on children affecting them cognitively, socially, and emotionally.
2. Witnessing violence impacts negatively on children of all ages, regardless of severity or frequency.
3. Being victimized by both child abuse and exposure to domestic violence impacts more negatively on children.

With this information in mind, it is crucial to take into account additional family factors that may mediate to influence outcomes more positively or aggravate the situation leading to more negative child outcomes. These factors include stress, poverty, parental mental illness, substance use, age of the parents, and age of the child. All of these risk factors impact heavily on dependent children and their parents or caregivers.

BUILDING COLLABORATIVE RELATIONSHIPS TO HELP CHILDREN IN JUVENILE COURT

Mental health professionals, particularly those with expertise about child development, can provide assistance to judges and attorneys in several different ways (see Appendix 9.1 for a helpful checklist for judges). First, they can help by providing information and training for people who work in conjunction with the juvenile court about the science of child development and early intervention. Often education can result from expert testimony. Second, they can provide more knowledge about the needs of young children, especially those at considerable risk within the child welfare system. Third, they can provide resources in the form of information, screenings, assessments, evaluations, and therapeutic or other services. Finally, they can also offer assistance in the form of consultation, education, and/or ongoing collaborations.

Many years ago, Lenore Terr (1986) wrote about the baby in court. She emphasized that infant mental health specialists must assist the legal

system in understanding the infant's perspective. Direct "evidence" is needed from the baby, which for a young child who cannot talk must come either through careful observations of behaviors and emotions or adult reports. In this way, the baby will be protected and the court will be better informed. Although Terr's article was written in the late 1980s, we have not come a long way since then toward recognizing and intervening for young children who, through no fault of their own, are represented in juvenile court. Very often the representation relates to their well-being, that is, whether they will remain with their parent who often is not providing adequate care or whether parental rights will be terminated and they will be placed with a foster and/or adoptive family. Often the adults in these cases will be very poor reporters, as they may be the perpetrators of abuse and neglect. Developmental and clinical expertise may be needed to protect the baby and better inform the court. It behooves the court to be as well informed as possible about the needs of young children through the science of early childhood development so as to be able to use the law to support "the best interests of the child" (Goldstein, Solnit, Goldstein, & Freud, 1998).

Addressing the needs of the young child in court not only is vitally important so that the infant has a "voice," it is also crucial to prevent more damage from happening by placing the child in a living situation that will fail to nurture his or her development (Lederman & Osofsky, 2004). Brain growth and development are very active during the first few years of life. During the first 3–4 years of life, brain structures that influence cognitive development, social and emotional development, learning, ability to deal with stress, and personality are established and strengthened. The abuse and neglect that causes children to enter foster care, coupled with frequent substance abuse, poor nutrition, lack of stimulation, and exposure to violence, all contribute to impairments in the healthy development of the brain (Shonkoff & Phillips, 2002). The children in the child welfare system are victims of cumulative disadvantages and often live in families where emotional impoverishment is common. Further, early relationship experiences and attachments that optimize emotional development also build self-esteem and form the basis for all later relationships.

Partnering with a developmental mental health specialist can serve several roles for the judge. The specialist can provide information to help the judge make a more informed decision. She can also help the judge learn more about resources for dependent children and their families that may contribute to breaking an intergenerational cycle of abuse, neglect, and violence exposure. Infant mental health specialists can also develop specially tailored evaluations and intervention strategies for court-referred children that will be workable within this system in an effort to heal the child and support the emerging healthier relationships between young children and their caregivers. These collaborations generally work most successfully by first building trust between the judge and the mental health professional.

Then, with mutual respect for the expertise of people from multiple disciplines, a flexible program can be developed that will work in diverse settings. The case presented below illustrates some of these points.

CASE EXAMPLE

Brianna's baby was born in 1999 when she was 12 years old. She had only finished the eighth grade in school. As a child mother, she did not even know she was pregnant until half way through her pregnancy. She did not receive prenatal care. Because Brianna was a minor, the baby was released from the hospital into the custody of her mother. The baby's father was 19 years old and, not unexpectedly, abandoned Brianna and her baby. He had wanted Brianna to have an abortion. After the baby was born, he was arrested for statutory rape.

We know little about Brianna's life before she had the baby; however after the baby was born, her life was extremely chaotic. She lived with her mother, who would not allow her to go to school. They moved from motel room to motel room as her mother tried to find work. Because Brianna's mother was an alcoholic who also used cocaine, contributing to instability, inconsistency, and likely violence, it was difficult for her to find work. One of the ways that Brianna's mother supported her drug habit was by shoplifting—and with little concern for the baby, she took her grandson along and used him as a decoy. Following in her mother's footsteps, Brianna was arrested for petty theft in 2000 and 2001 after first stealing clothing for herself and then jewelry.

In 2001, Brianna's mother was arrested for child neglect and possession of cocaine when Brianna's 2-year-old son was found wandering around a motel parking lot unclothed at 4:00 in the morning. When searched during the arrest, cocaine was found in Brianna's mother's pocket and worms were found in the baby's bottle. Brianna's mother was placed on probation. Apparently, however, the situation worsened and finally the local child protection service (the Department of Children and Families) intervened. At that time, the family had moved to a trailer located in an open field. There was no electricity or water, and the trailer was filthy and overall in deplorable condition. It was insect infested, lacked windows, and had one bed.

At the time Brianna appeared in juvenile court in the spring of 2002, she had not seen or heard from her father in 3 years. She was a 15-year-old mother of a 3-year-old son. When she first appeared in court for the proceedings, she was distraught and confused. At that time, Brianna and her son were adjudicated dependent. Brianna told the court what she truly believed—that she was a good mother who loved her son and that she had not done anything to harm him. She asked over and over again at every

hearing, "When can I have my son back?" Because Brianna had never had adequate mothering herself, she did not know what it meant to be a good mother. She had never had a positive parenting role model. What was blatantly evident in court when Brianna appeared was that she did not understand what she had done to result in the removal of her child; however, she was highly motivated to work to get him back.

The judge recognized the strong motivation in this mother and had learned from her collaboration with child development/clinical specialists that change was possible, even when circumstances might seem almost impossible. Therefore, Brianna and her son were asked by the court to participate in an Early Childhood Relationship Assessment to learn more about their current relationship and evaluate the potential for change. The court was particularly concerned about Brianna's son after it was reported to the judge that he had violently killed a cat. The judge believed that the evaluation would help her decide what the prospects might be for success in changing the negative parenting behaviors of this young mother that likely resulted in the consequent very aggressive behaviors of this young child.

During the evaluation, it became obvious very quickly that Brianna had no idea about how to parent her son. How would she have learned to parent a child since her alcohol- and drug-abusing mother rarely if ever showed any positive parenting toward her when she was growing up? Throughout the play period of the evaluation, Brianna tried to engage her son; however, she repeatedly neglected his leads, was very directive, and didn't know how to play with him. This behavior is common in mothers who have received little attention and had negative parenting themselves. Further, Brianna was passive in response to his negative behavior, could not set limits or provide boundaries or guide him, and did not attempt to intervene or comment to him. When he did not want to clean up the toys and refused to surrender the toys he was playing with, Brianna took no action. She had no idea how to set limits, encourage him to comply, or distract or discipline him; she had no idea how to parent her son.

As always, during the evaluation, we look for strengths in the parent and the dyad in addition to the obvious weaknesses. At the end of the evaluation, the psychologist concluded that Brianna was able to keep her composure when dealing with her angry and difficult child, but she failed to set limits for him. There was no spontaneous affection between mother and son.

Brianna had some unusually positive characteristics not often observed in juvenile court. Despite the fact that she could only read at a fourth-grade level, she was engaging and bright. She also was psychologically minded enough to realize that she needed to make changes in her life in order to grow as an individual and as a parent. What was also evident was that she was motivated to change and genuinely wanted to improve her situation for her son. At that time, Brianna was exceptionally fortunate to be in a

nurturing foster home where she had a loving relationship with her foster mother.

The Part C screening for her son indicated that he was not only delayed in language development but also in social and emotional development and cognitive skills. At 3 years of age, he could not draw a circle, he did not know his colors, and he did not know his gender. His medical needs had been neglected as well in that he had not received the necessary immunizations.

After the evaluation, Brianna and her son were referred for dyadic child–parent psychotherapy. Both the judge and the therapist observed that there was much strength in the relationship. Brianna clearly loved her son but had little understanding of his developmental needs. Brianna failed to understand how important structure, boundaries, limit setting, and discipline were in the life of a child; yet she was motivated to be a good parent. In dyadic therapy, Brianna was forthcoming with the therapist about her son's behavioral challenges and her weaknesses as a parent. After 15 weeks of dyadic therapy the improvements were significant. Brianna was initiating developmentally appropriate play with her son. Her increasing knowledge of developmental milestones helped her to respond to her child's needs. She was learning to respond to his nonverbal cues. She was able to connect and communicate with her child, showed an ability to follow his lead in play, set limits for the first time, and praised him for appropriate behaviors.

As she made progress in dyadic therapy, the court began to allow an increasing amount of unsupervised visitations between Brianna and her child. The progress was incremental. First Brianna, quite proficient in the use of public transportation, was allowed to transport her child to therapy unsupervised. Later, she was given more and more unsupervised visitation.

Despite her progress, there were some instances of erratic adolescent behavior on Brianna's part that caused concern when she failed to adequately maintain her son's hygiene and when she violated her curfew and stayed out too late. The level of concern heightened significantly when the court was informed that Brianna was dating a 31-year-old man. During more than one of her dates with him, there was police involvement. During therapy, Brianna was praised for her success in therapy but strongly admonished about the dangers in her choice of men. This theme was repeated over and over at every court appearance, in her dyadic therapy, and in her conversations with her foster mother.

Brianna, who did not wish to be reunified with her mother, was at the same time repeating what she had learned from her by exhibiting these erratic behaviors. Brianna's mother still would not accept responsibility for her neglect, substance abuse, and abuse of her daughter and grandchild. She denied any wrongdoing and failed to gain any insight. She wanted her daughter and grandson back.

Brianna had learned enough to know that she did not want to live with her mother or live the life of her mother; however, it was difficult for her to learn that there is another way. Brianna is no longer seeing the 31-year-old man. She seemed to be reached by explaining the effect of an inappropriate partner on her child. Brianna knew from her past how dangerous an imprudent choice of relationship could be on a child. Now, Brianna can be reasoned with by being asked to reflect upon the ramifications of her behavior on her son. The fortunate conjunction of the court intervention, the dyadic therapy, and the nurturing foster mother, together with Brianna's strong interpersonal skills and motivation to provide a better life for her son, all bode well for his future. She has acknowledged after 6 months of dyadic therapy and increasing time with her son that parenting can be difficult! All of this progress and growth has occurred despite the fact that Brianna is still an adolescent.

CONCLUSION

The intergenerational transmission of child maltreatment is a heartbreaking cycle. The abused child who becomes the abusive mother to her baby as a consequence of maltreatment is particularly worrisome to all involved in the child welfare system. Yet, how can we expect a child mother who has never felt safe and never been nurtured to know instinctively how to parent? Our challenge and our hope must be to intervene with young mothers and their infants early in their development. In the late 1980s, Selma Fraiberg and her colleagues (Fraiberg, Adelson, Shapiro, 1987) wrote the groundbreaking paper, "Ghosts in the Nursery," which vividly explicated how unresolved conflicts from the past so often reappear in the present in maladaptive and harmful parenting behaviors. The only way to change these negative patterns is to acknowledge them, come to understand how they have developed, and work them through so that they will not continue to haunt present relationships.

Brianna thought being a parent was simple. From her mother who was neglectful and selfish, Brianna learned that parenting did not take a lot of time and effort. Protecting one's child from inevitable danger was not a parenting skill she had observed. Brianna was trying to be a better parent than her mother but did not know how to accomplish this goal. The court was always aware of Brianna's love for her son and desire to be a good parent, an important foundation not always observed in the dependency court parent population. Only through intensive self-understanding and dyadic child–parent psychotherapy was she able to learn healthy ways to interact with her son and try to meet his needs. One day, Brianna, having progressed to the halfway point in her therapy sessions, came to court for a review hearing. When asked by the judge what she was learning in her dyadic

therapy she said, "I am learning that being a good parent is really hard." That is the day it became clear to the court that Brianna could overcome her past and, with continued assistance and services, become a good mother to her child. There is hope that Brianna and her son will overcome their expected destiny and thrive together.

Collaboration between judges and child development/clinical specialists have provided a unique opportunity to "heal the child" in juvenile court. Dependency court can be understood and worked with in several different ways. Some people treat the court as the place of last resort for abused and neglected children who will suffer whether their parents are able to work with the court to achieve permanency or if the children languish for years in the child welfare system while a determination is made about whether there is any way their parents can be deemed adequate. As was mentioned above, very young children remain within the child welfare system longer than older children, often for 2–3 years before achieving some type of stability in their lives. And yet babies "cannot wait" because damage can result very quickly from instability in their lives and relationships in the first few years of their lives. The collaboration described in this chapter, illustrated by the case of Brianna, has led to the development of a successful intervention program in the 11th Circuit Juvenile Court in Miami. By referring young children early for evaluations and introducing dyadic therapy for them and their mothers who are motivated to become better parents, we have seen remarkable changes. We fully understand that it is an "uphill battle" in that these child mothers so often can still be "haunted" by the ghosts from their past and the difficult pressures and circumstances of their current lives. At the same time, we have seen mothers who based on their past life experiences knew nothing about parenting, playing with their children, holding their children, or talking to their children. Although these skills might seem obvious and basic to some, if a woman has never learned them from her own early experiences, it is difficult for her to parent. Further, what such women have most often learned is abuse and neglect and very negative early relationship experiences. Juvenile court is a place for the relearning to start with the support of other systems in the community, including mental health, education, early intervention, and family support services. We have found that this model can be implemented successfully if both the judges and the mental health professionals can join together and make the commitment to change the way the court has treated these cases that come before them every day. Brianna and her child are an excellent example of what can result from these efforts.

As Judge William E. Gladstone has said so wisely, "if we truly value our children and want to prevent the development of violent behaviors and consequent delinquency, it is vital that we put in place supports and prevention programs that address children's needs" (personal communication, July 16, 2001). Judges are generally not exposed to social science

literature or child psychology in law school or through judicial training where the law is emphasized almost exclusively. Education in other disciplines is not readily available to judges, many of whom fear that knowing "too much" about a subject may compromise their objectivity. Hence, every chance to help judges learn through testimony, education, and even casual conversation in multidisciplinary professional or social settings is important.

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REFERENCES

Beeman, S. K., Hagemeister, A. K., & Edleson, J. L. (2001). Case assessment and service receipt in families experiencing both child maltreatment and woman battering. *Journal of Interpersonal Violence, 16*(5), 437–458.

Bowker, L. H. (1988). On the relationship between wife beating and child abuse. In K. M. Bograd (Ed.), *Feminist perspectives on wife abuse*. Newbury Park, CA: Sage.

Daro, D., & Cohn, A. H. (1988). Child maltreatment evaluation efforts: What have we learned? In G. T. Hotaling, D. Finkelhor, J. T. Kirkpatrick, & M. A. Straus (Eds.), *Coping with family violence: Research on policy perspectives* (pp. 275–287). Newbury Park, CA: Sage.

Dykstra, C. H., & Alsop, R. J. (1996). *Domestic violence and child abuse* [Monograph]. Englewood, CO: American Humane Association.

Edleson, J. L. (1999). The overlap between child maltreatment and woman battering. *Violence against Women, 5*(2), 134–154.

English, D. (1998). The extent and consequences of child maltreatment. *The Future of Children, 8*(1), 39–53.

Fraiberg, S., Adelson, E., & Shapiro, V. (1987). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant–mother relationships. In S. Fraiberg & L. Fraiberg (Eds.), *Selected writings of Selma Fraiberg* (pp. 164–196). Columbus: Ohio State University Press.

Goldstein, J., Solnit, A., Goldstein, S., & [the late] Freud, A. (1998). *The best interests of the child: The least detrimental alternative*. New York: Free Press.

Illinois Juvenile Court Act. (1899). Ill. Laws (Vol. 132).

Lederman, C., & Osofsky, J. D. (2004). Infant mental health interventions in juvenile court: Ameliorating the effects of maltreatment and deprivation. *Psychology, Public Policy, and the Law, 10*(1), 162–177.

Margolin, G. (1998). Effects of witnessing violence on children. In P. K. Trickett & C.

J. Schellenbach (Eds.), *Violence against children in the family and the community.* Washington, DC: American Psychological Association.

McCloskey, L. A., Figueredo, A. J., & Koss, M. P. (1995). The effects of systemic family violence on children's mental health. *Child Development, 66*, 1239–1261.

McKibben, L., DeVos, E., & Newberger, E. (1989). Victimization of mothers of abused children: A controlled study. *Pediatrics, 84*, 531–535.

National Clearinghouse on Child Abuse and Neglect Information. (2002, February 24). *In harm's way: Domestic violence and child maltreatment*. Rockville, MD: U.S. Department of Health and Human Services, Administration for Children and Families. Available from *http://www.calib.com/nccanch/pubs/otherpubs/harmsway.cfm*

Senate Report No. 101–939. (1990). Hearing, Senate Committee on the Judiciary, 101st Cong.

Shepard, M., & Raschick, M. (1999). How child welfare workers assess and intervene around issues of domestic violence. *Child Maltreatment: Journal of the American Professional Society on the Abuse of Children, 4*(2), 148–156.

Shonkoff, J., & Phillips, D. (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.

Straus, M., Gelles, R., & Steinmetz, S. (1980). *Behind closed doors: Violence in the American family.* Garden City, NY: Anchor Books.

Terr, L. (1986). The child psychiatrist and the child witness: Traveling companions by necessity, if not by design. *Journal of the American Academy of Child and Adolescent Psychiatry, 25*(4), 462–472.

U.S. Department of Health and Human Services. (2001). *National statistics on child abuse and neglect.* Rockville, MD: Author.

Wulczyn, F., & Hislop, K. B. (2002). Babies in foster care: The numbers call for attention. *Zero to Three, 22*(5), 14–15.

APPENDIX 9.1

QUESTIONS EVERY JUDGE AND LAWYER SHOULD ASK ABOUT INFANTS AND TODDLERS IN THE CHILD WELFARE SYSTEM

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We need to change the culture in our courts. Instead of ignoring babies and toddlers and assuming they are fine despite abuse and neglect, we need to recognize that these children are at risk for developing some sequelae of their maltreatment. Such sequelae can range from short-term emotional problems to lifelong serious behavioral and cognitive impairments impacting learning and adult functioning.

The science of early development is unequivocal: Early intervention can be effective. Substantial evidence indicates that early intervention is most effective during the first 3 years of life when the brain is establishing the foundations for all developmental, social, and cognitive domains. We need to learn about the science of early childhood development and use that knowledge to promote the healthy development of the babies and toddlers who come to court. The juvenile court is the last resort for these children. Let's turn that tragedy into an opportunity and be the place where the healing begins.

We developed the following questions to be a guide for lawyers, judges, and child advocates in the child welfare system and to be a first step at advocacy and intervention for young children. Armed with the questions that need to be asked, and the scientific reasons and research on which they are based, we must use this guide and ask these questions over and over until the needs of maltreated infants and ba-

bies are addressed. It is our legal obligation under the Adoption and Safe Families Act of 1997, and it is our moral responsibility to these young children.

INTRODUCTION[1]

Increasing numbers of infants and young children with complicated and serious physical, mental health, and developmental problems are being placed in foster care.[2] The following checklists have been developed for use by judges, attorneys, child advocates, and other child welfare professionals in meeting the wide range of health care needs of this growing population.

PHYSICAL HEALTH

- **Has the child received a comprehensive health assessment since entering foster care?**

Because children are likely to enter foster care as a result of abuse, neglect, homelessness, poverty, parental substance abuse, or mental illness, all foster children should receive a comprehensive physical examination shortly after placement that addresses all aspects of the child's health. Under the early and periodic screening, diagnosis, and treatment provisions of federal Medicaid law,[3] foster children should receive a comprehensive assessment that can establish a baseline for a child's health status, evaluate whether the child has received necessary immunizations, and identify the need for further screening, treatment, and referral to specialists.[4] A pediatrician or family practice physician knowledgeable about the health care problems of foster children should perform the examination.[5]

Ensuring the healthy development of foster children requires that they receive quality medical care. Such care should be comprehensive, coordinated, continuous, and family supported. One person should be identified who will oversee the child's care across the various agencies and systems, including early childhood services, early intervention services, education, and medical and mental health. Family-supportive care requires sharing the child's health information with the child's caregivers and providing caregivers with education and training programs in order to meet the needs of their foster child.

- **Are the child's immunizations complete and up-to-date for his or her age?**

Complete, up-to-date immunizations provide the best defense against many childhood diseases that can cause devastating effects. Immunization status is an important measure of vulnerability to childhood illness and can reveal whether the child has had access to basic health care. Incomplete or delayed immunization suggests that the child is not receiving adequate medical care and is not regularly fol-

lowed by a provider familiar with the child's health needs. A child should have a "well-baby" examination by 2–4 weeks of age. Immunizations are recommended at 2, 4, 6, and 12 months of age. A child should have at least three visits to a pediatrician or family practice physician during the second year of life, with basic immunizations completed by 2 years of age.[6]

- **Has the child received a hearing and vision screen?**

Undetected hearing loss during infancy and early childhood interferes with the development of speech and language skills and can have deleterious effects on overall development, especially learning. Hearing loss during early childhood can result from childhood diseases, significant head trauma, environmental factors such as excessive noise exposure, and insufficient attention paid to health problems that may affect hearing. Studies reveal that 70% of children with hearing impairments are initially referred for assessment by their parents.[7] Because foster care children often lack a consistent caregiver who can observe their development and note areas of concern, they should receive ongoing evaluations of hearing, speech, and language development.

Vision screening is an essential part of preventative health care for children. Problems with vision are the fourth most common disability among children in the United States and the leading cause of impaired conditions in childhood.[8] Early detection and treatment increase the likelihood that a child's vision will develop normally and, if necessary, that the child will receive corrective devices.

- **Has the child been screened for lead exposure?**

Children who are young, low-income, and have poor access to health care are vulnerable to the harmful effects of lead.[9] Ingested or inhaled lead can damage a child's brain, kidneys, and blood-forming organs. Children who are lead poisoned may have behavioral and developmental problems. According to the Centers for Disease Control and Prevention (CDC), however, lead poisoning is one of the most preventable pediatric health problems today. Screening is important to ensure that poisoned children are identified and treated and their environments remediated.

The CDC recommends screening for lead poisoning beginning at 9 months of age for children living in communities with high-risk lead levels. The CDC also recommends targeted screening based on risk assessment during pediatric visits for all other children.

- **Has the child received regular dental services?**

Preventative dentistry means more than a beautiful smile for a child. Children with healthy mouths derive more nutrition from the food they eat, learn to speak more easily, and have a better chance of achieving good health. Every year, thousands of children between 1 to 4 years old suffer from extensive tooth decay caused

by sugary liquids—especially in bottles given during the night. Children living below the poverty level have twice the rate of tooth decay as children from higher income levels.[10] Furthermore, poorer children's disease is less likely to be treated.

Early dental care also prevents decay in primary ("baby") teeth, which is currently at epidemic proportions in some U.S. populations and is prevalent among foster children.[11] The American Academy of Pediatric Dentistry recommends that before the age of 1 year a child's basic dental care be addressed during routine well-baby visits with a primary care provider, with referral to a dentist if necessary. For children older than 1 year, the academy recommends a check up at least twice a year with a dental professional.

- **Has the child been screened for communicable diseases?**

The circumstances associated with the necessity for placement in foster care, such as prenatal drug exposure, poverty, parental substance abuse, poor housing conditions, and inadequate access to health care, can increase a child's risk of exposure to communicable diseases such as HIV/AIDS, congenital syphilis, hepatitis, and tuberculosis.

A General Accounting Office study found that 78% of foster children were at high risk for HIV but only 9% had been tested for the virus.[12] Early identification of HIV is critical to support the lives of infected children and to ensure that they receive modified immunizations. Modified immunizations are necessary to prevent adverse reactions to the vaccines while still providing protection against infectious diseases such as measles and chicken pox. The American Academy of Pediatrics recommends that all prenatally HIV-exposed infants be tested for HIV at birth, at 1–2 months of age, and again at 4 months. If the tests are negative, the child should be retested at 12 months of age or older to document the disappearance of the HIV antibody.

- **Does the child have a "medical home" where he or she can receive coordinated, comprehensive, and continuous health care?**

All children in foster care should have a "medical home," a single-point-of-contact practitioner knowledgeable about children in foster care who oversees their primary care and periodic reassessments of physical, developmental, and emotional health, and who can make this information available as needed.

DEVELOPMENTAL HEALTH

- **Has the child received a developmental evaluation by a provider with experience in child development?**

Young foster children often exhibit substantial delays in cognition, language, and behavior. In fact, one half of the children in foster care show developmental de-

lay that is approximately four to five times the rate of delay found in children in the general population.[13] Early evaluation can identify developmental problems and can help caregivers better understand and address the child's needs.

Developmental evaluations provide young children who have identified delays with access to two federal entitlement programs:

1. The Early Intervention Program for children under the age of 3 years, also known as Part C of the Individuals with Disabilities Education Act (IDEA; 20 U.S.C. Section 1431 2000])
2. The Preschool Special Education Grants Program for children with disabilities between the ages of 3–5 years (20 U.S.C. Section 1419[a] [2000])[14]

- **Are the child and his or her family receiving the necessary early intervention services (e.g., speech therapy, occupational therapy, educational interventions, or family support)?**

Finding help for young children may prevent further developmental delays and may also improve the quality of family life. Substantial evidence indicates that early intervention is most effective during the first 3 years of life when the brain is establishing the foundations for all developmental, social, and cognitive domains: "The course of development can be altered in early childhood by effective interventions that change the balance between risk and protection, thereby shifting the odds in favor of more adaptive outcomes."[15] Children with developmental delays frequently perform more poorly in school, have difficulty understanding and expressing language, misunderstand social cues, and show poor judgment.

Early intervention provides an array of services including hearing and vision screening, occupational, speech and physical therapy, and special instruction for the child, as well as family support services to enable parents to enhance their child's development. Such services can help children benefit from a more successful and satisfying educational experience, including improved peer relationships.[16] Foster children can be referred for early intervention and special education services by parents, health care workers, or social service workers. Early intervention services are an entitlement for all children from birth to 3 years and their families as part of Part C, IDEA. Both biological and foster families can receive early intervention family support services to enhance a child's development.

MENTAL HEALTH

- **Has the child received a mental health screening, assessment, or evaluation?**

Children enter foster care with adverse life experiences: family violence, neglect, exposure to parental substance abuse or serious mental illness, homelessness, or chronic poverty. Once children are placed in foster care, they must cope with the separation and loss of their family members and the uncertainty of out-of-home

care. The cumulative effects of these experiences can create emotional issues that warrant an initial screening and sometimes an assessment or evaluation by a mental health professional. Compared with children from the same socioeconomic background, children in the child welfare system have much higher rates of serious emotional and behavioral problems.[17] It is important to both evaluate them and offer counseling and treatment services when needed so that early difficulties are addressed and later problems are prevented.

Children exhibiting certain behaviors may also signal a need for a mental health assessment and neurological and educational evaluations. Many of the symptoms associated with juvenile emotional and behavioral health problems can be alleviated if addressed early. The American Academy of Child and Adolescent Psychiatry[18] recommends assessments for infants who exhibit fussiness, feeding and sleeping problems, and failure to thrive. For toddlers, the academy recommends assessments for children exhibiting aggressive, defiant, impulsive, and hyperactive behaviors, withdrawal, extreme sadness, and sleep and eating disorders.[19]

- **Is the child receiving necessary infant mental health services?**

The incidence of emotional, behavioral, and developmental problems among children in foster care is three to six times greater than that among children in the general population.[20] Children with emotional and behavioral problems have a reduced likelihood of reunification or adoption.[21] Children with externalizing disorders (e.g., aggression and acting out) have the lowest probability of exiting foster care.[22] During infancy and early childhood, the foundations are laid for the development of trusting relationships, self-esteem, conscience, empathy, problem solving, focused learning, and impulse control.[23]

To promote and facilitate permanency, children identified with mental health problems should receive care from a mental health professional who can develop a treatment plan to strengthen the child's emotional and behavioral well-being with caregivers. Services may include clinical intervention, home visiting, early care and education, early intervention services, and caregiver support for young children.

EDUCATIONAL/CHILD-CARE SETTING

- **Is the child enrolled in a high quality early childhood program?**

Children cannot learn unless they are healthy and safe. Children learn best in high-quality settings when they have stable relationships with highly skilled teachers.[24] Such programs nurture children, protect their health and safety, and help ensure that they are ready for school. Early childhood programs also provide much needed support for caregivers. Considerable research has indicated that early education has a positive impact on school and life achievement. Children who participate in early childhood programs have higher rates of high school competition, lower

rates of juvenile arrest, fewer violent arrests, and lower rates of dropping out of school.[25] Many foster children are eligible for early childhood programs such as Head Start, Early Head Start, and publicly funded prekindergarten programs for 4-year-olds.

- **Is the early childhood program knowledgeable about the needs of children in the child welfare system?**

Most children are placed in foster care because of abuse or neglect occurring within the context of parental substance abuse, extreme poverty, mental illness, homelessness, or physical disease (e.g., AIDS). As a result, a disproportionate number of children placed in foster care come from the segment of the population with the fewest psychosocial and financial resources and from families that have few personal and extended sources of support.[26] For all of these reasons, it is very important that these children's child care staff and teachers be well trained and qualified.

PLACEMENT

- **Is the child placed with caregivers knowledgeable about the social and emotional needs of infants and toddlers in out-of-home placements, especially young children who have been abused, exposed to violence, or neglected?**
- **Do the caregivers have access to information and support related to the child's unique needs?**
- **Are the foster parents able to identify problem behaviors in the child and seek appropriate services?**

Childhood abuse increases the odds of future delinquency and adult criminality by 40%.[27] Maltreated infants and toddlers are at risk for insecure attachment, poor self-development, and psychopathology.[28] Children in out-of-home placements often exhibit a variety of problems that may be beyond the skills of persons without special knowledge or training. Therefore, foster parents require and should receive information about the child's history and needs as well as appropriate training.[29] Early interventions are key to minimizing the long-term and permanent effects of traumatic events on the developing brain and on behavioral and emotional development. It is imperative that caregivers seek treatment for their foster children and themselves as soon as possible.[30]

- **Are all efforts being made to keep the child in one consistent placement?**

An adverse prenatal environment, parental depression or stress, drug exposure, malnutrition, neglect, abuse, or physical or emotional trauma can negatively impact a child's subsequent development. Therefore, it is essential that all children, especially young children, are able to live in a nurturing, supportive, and stimulat-

ing environment.[31] It is crucial to try to keep children in one consistent and supportive placement so that they can develop positive, secure attachment relationships.

> To develop into a psychologically healthy human being, a child must have a relationship with an adult who is nurturing, protective, and fosters trust and security. . . . Attachment to a primary caregiver is essential to the development of emotional security and social conscience.[32]
>
> What happens during the first months and years of life matters a lot, not because this period of development provides an indelible blueprint for adult well-being, but because it sets either a sturdy or fragile stage for what follows.[33]

The material in this appendix was first developed by the National Council of Juvenile and Family Court Judges' Permanency Planning for Children Department as a Technical Assistance Brief and has been available to the field since January 2003. Since that time, it has been incorporated in over 25 trainings, and more than 4,600 copies have been disseminated nationally to members of the juvenile and family court systems, as well as numerous child welfare professionals. The feedback about this publication has been overwhelmingly positive.

NOTES

1. Several of the questions follow the formats and contain excerpts from the "Checklists for Healthy Development of Foster Children," *Ensuring the healthy development of foster children: A guide for judges, advocates, and child welfare professionals*. New York State Permanent Judicial Commission on Justice for Children, 1999. Excerpted with permission.
2. American Academy of Pediatrics. (2000). Developmental issues for young children in foster care. *Pediatrics, 106*(5), 1145–1150. American Academy of Pediatrics. (2002). Health care of young children in foster care. *Pediatrics, 109*(3), 536–541.
3. 42 U.S.C. Section 1396(a)(10) and (43)(2000); 42 U.S.C. Section 1396d(a) (4) (B) (2000) and 1396 (r).
4. 42 U.S.C. Section 1396(a) (10) (2000); 42 U.S.C. Section 1396d(a) (4) (B) (2000).
5. *Supra* note 1.
6. American Academy of Pediatrics. (2002, June 27). Immunizations and your child. American Academy of Pediatrics website.
7. NIH Consensus Statement, Early identification of hearing impairment in infants and young children. Online Mar 1–3, 1993 [cited October 8, 2002]; *11*(1), 1–24.
8. American Academy of Pediatrics. (2001). Developmental surveillance and screening of infants and young children. *Pediatrics*, *108*(1), 192–196.
9. American Academy of Pediatrics. (1998). Screening for elevated blood lead levels (RE9815). *Pediatrics*, *101*(6), 1072–1078.
10. Testimony of Ed Martinez, Chief Executive Officer, San Ysidro Health Center, San Diego, CA, to the Senate Subcommittee on Public Health in support of Senate Bill 1626, June 25, 2002.
11. American Academy of Pediatrics, Early childhood caries reaches epidemic proportions (press release, February 1997).

12. General Accounting Office (1995, May). *Foster care: Health needs of young children are unknown and unmet* (pp. 95–114). Washington, DC: GAO/Health, Education and Human Services Division.
13. Dicker, S., & Gordon, E. (2000). Connecting healthy development and permanency: A pivotal role for child welfare professionals. *Permanency Planning Today, 1*(1), 12–15.
14. Website: *http://www.nectac.org/default.asp*
15. Shonkoff, J. P., & Phillips, D. A. (2000). *From neurons to neighborhoods: Committee on integrating the science of early childhood development*. Washington, DC: National Academy Press.
16. American Speech–Language–Hearing Association. (2002, July). Frequently asked questions: Helping children with communication disorders in the schools—speaking, listening, reading, and writing. American Speech–Language–Hearing Association website.
17. Halfon, N., Berkowitz, G., & Klee, L. (1993). Development of an integrated case management program for vulnerable children. *Child Welfare*, *72*(4), 379–396.
18. American Academy of Child and Adolescent Psychiatry. (1997). Practice parameters for the psychiatric assessment of infants and toddlers. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(10, Suppl.).
19. Ibid.
20. Marsenich, L. (2002, March). *Evidence-based practices in mental health services for foster youth*. Sacramento: California Institute for Mental Health.
21. Ibid.
22. Ibid.
23. Greenough, W., Gunnar, M., Emde, N., Massinga, R., & Shonkoff, J. (2001). The impact of the caregiving environment on young children's development: Different ways of knowing. *Zero to Three*, *21*, 16–23.
24. National Association for the Education of Young Children. (1999). Week of the young child: April 18–24. *Early Years Are Learning Years*, *99*(6).
25. Reynolds, A., Temple, J., Robertson, D., & Mann, E. (2002). Long-term effects of an early childhood intervention on educational achievement and juvenile arrest: A 15-year follow-up of low-income children in public schools. *Journal of the American Medical Association*, *285*(18), 2339–2346.
26. National Commission on Family Foster Care. (1991). *A blueprint for fostering infants, children, and youths in the 1990s*. Washington, DC: Child Welfare League of America.
27. Widom, C. S. (1991). The role of placement experiences in mediating the criminal consequences of early childhood victimization. *American Journal of Orthopsychiatry, 61*(2), 195–209.
28. Widom, C. S. (2000). Motivations and mechanisms in the "cycle of violence." In D. Hansen (Ed.), *Nebraska Symposium on Motivation: Vol. 46. Motivation and child maltreatment* (pp. 1–37). Lincoln: University of Nebraska Press.
29. National Foster Parent Association. (1999). *Board manual: Goals, objectives, position statements, and by-laws*. Gig Harbor, WA: Author.
30. Carnegie Task Force on Meeting the Needs of Young Children. (1994). *Starting points: Meeting the needs of our youngest children*. New York: Carnegie Corporation.
31. *Supra* note 2.
32. Ibid.
33. *Supra* note 15.

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