

Addressing Infant and Toddler Issues in the Juvenile Court: Challenges for the 21st Century

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A B S T R A C T

I N T R O D U C T I O N

The juvenile court system in this country was created more than 100 years ago on the premise that children have legal rights and should be treated in a humane fashion. The first century of juvenile court functioning has evolved into a court venue in which children and families receive justice tailored to the diagnosis and treatment of children and their issues. In order to serve the "best interests of the child," the court must not only exercise its legal expertise by adjudicating cases, but also be knowledgeable in nonlegal areas such as children's cognitive, social, and emotional development, the impact of the early environment on brain development,

To achieve the goal of permanency for children in the child welfare system, it is critical that different disciplines work together, improve communication, and understand each other's role and expertise in the process. Through a case study, this article attempts to show the problems, conflicts, and solutions in working to ensure a child's best interests from three points of view: a children's attorney from New York City, a judge from Miami, Florida, and an infant mental health specialist and interdisciplinary trainer from Los Angeles. First, we propose that emotional caregiving is a fundamental right of all children and includes a stable, nurturing, and permanent long-term relationship. Conflicts between the timing of children's needs, parents' needs, and the judge's legal duties are discussed as a tension with which we all must struggle to resolve if we are to successfully address children's "irreducible needs" (Brazelton & Greenspan, 2000). If the provision of custodial care shifts toward including emotional care as a goal for the growing number of infants entering the foster care system, the ensuing conflicts will provide opportunities for all parts of the foster care system—including the courts—to rethink how infants' needs are evaluated and factored into decision making.

principles build on implications from neuroscience, which have been integrated into a larger body of knowledge called "infant mental health." The knowledge of the

alcohol and substance abuse, mental health/mental illness, and the impact of family violence on children and families.

This article establishes case material as a framework from which three different points of view, representing different disciplines and different regions of the country, explore the collaborations and conflicts that emerge. Implications from socio-emotional development, integrated with other developmental domains, are presented in the format of guiding principles. These

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science linked with infant development both benefits and creates additional issues for courts, judges, and practitioners. Two foremost national child specialists, an infant pediatrician and a child psychiatrist, frame the challenge in this way: "In terms of providing physical protection and care for our children and providing protective environments that can guarantee healthy development beginning with the inception of life throughout childhood and adolescence, we must face the fact that we are not making adequate progress...every baby needs a solid continuing relationship" (Brazelton & Greenspan, 2000, p. 54).

The discussion proceeds on several layers: Part I discusses different disciplines, roles, and biases; Part II focuses on points of convergence and divergence; and Part III concludes with suggestions for policies and practice. Key points of this discussion include the need to integrate infant mental health specialists into courtroom teams, the need to shift the focus in the foster care system from merely providing custodial care to providing emotional care, and the need to provide training across all disciplines that interface with the child welfare system. All three authors will discuss the "case" from their unique perspective and how their view is impacted by the facts.

Case Presentation

"Tammy" is a three-year-old Caucasian girl who, in her short lifetime, has been abandoned twice by her biological mother, a heroin addict. After the second abandonment, Tammy was placed in a foster-adoption agency and has now been separated from her biological mother for 10 months. When she was placed with a new foster parent at 22 months of age, she did not show any expressive speech or language. She was very withdrawn and shut down and her only display of emotion was to laugh when someone was hurt. She did not engage in any form of two-way communication as her gestural system for communication and problem solving was nonexistent. Her walking was clumsy, and no symbolic play was present. Tammy was delayed in development across these functional domains, reflecting a historical difficulty between her and her caregiving environment. With the guidance of an infant mental health therapist, the foster mother—a divorced Caucasian woman—pursued a variety of services, including occupational and

physical therapy, speech and language therapy, and developmental play therapy. In the process of playing and interacting with her, the foster mother "fell in love" with Tammy. Tammy began to recover and to thrive across all domains.

The foster mother was in the process of following through with the adoption when, at the 10-month juncture, the biological mother resurfaced. A heroin addict for the previous 10 years, she was in a drug rehabilitation center. The biological mother requested activation of the reunification process, and the court approved reunification visits to be scheduled at the foster-adoption agency, with a social worker present to monitor the visits.

The foster mother, now emotionally invested in Tammy, began to feel concerned about losing her chance to adopt Tammy. She and Tammy were attached to each other, and there was a strong rapport between them. The foster mother became even more concerned about Tammy when the visits with the biological mother began. During the first visit with the biological mother, Tammy appeared very disoriented, clinging to the foster mother, intermittently walking toward her biological mother who was crying and reaching out to hug Tammy with outstretched arms. Tammy never accepted her biological mother's embrace, and the biological mother became further distressed. By the end of the visit, Tammy was walking in a daze. With glazed eyes, she collapsed in the car, exhausted, and immediately fell asleep. The foster mother began working again with an infant mental health specialist for support following the first disturbing visit.

During the first week following the initial visit with the biological mother, Tammy's appetite sharply decreased, she became aggressive with the family cat, and bit her foster mother. She began to have rages, which included turning over the furniture, spitting and hitting the foster mother, and screaming at the top of her lungs when limits were set. When the foster mother reported these symptoms to the social worker, the social worker replied, "Let me know if these symptoms continue over the next few months."

During the next few weeks of visits with the biological mother, Tammy evidenced the following symptoms either during the visit or later that day at the therapist's office: calling her biological mother "the booboo

woman” and making hissing sounds that were identified as sounds of fear; vomiting in the therapist’s office when asked about “the booboo woman”; biting the foster mother so hard that she broke the skin; and walking around in an aimless, disoriented manner. Following a visit with the biological mother, Tammy required hospitalization overnight for a severe asthmatic attack. In addition to her decreased appetite, as time progressed, Tammy began waking up in the middle of the night screaming and crying with inconsolable terror from nightmares, which she could not articulate. Along with this, Tammy’s rages increased in intensity and severity toward bedtime; she refused to go to sleep and became dangerous to herself and her foster mother by hiding in places where she could not be found and attempting to run out of the apartment. The foster mother was overwhelmed and increasingly considered having Tammy removed from her home.

PART I: Different Disciplines, Different Roles, Different Biases

The authors will each discuss first, their discipline’s general role in the child welfare system and second, what they see as most salient about this case as it applies to their discipline and inherent bias.

The Role of the Child’s Attorney

Lawyers for very young children in child protective proceedings must re-conceive their role and responsibilities to determine how to advocate for what is in the child’s best interests. To derive a principled, integrated approach in regard to fulfilling the best interests mandate, the lawyer must familiarize him or herself with the child’s point of view. Although the age of the child affects the lawyer’s representation, lawyers need to recognize that every child client can contribute to his or her legal representation. Every child brings a personality, a level of health, physical characteristics, a birth history, and a family context as distinguishing characteristics to the lawyer’s advocacy. Legal representation must reflect what is uniquely characteristic of this child in *this* case.

Due to the Adoption and Safe Families Act of 1997, courts are required to hold permanency hearings in cases such as Tammy’s within a strict timeframe. ASFA highlights the need for timely permanency for children.

Finding permanency for a child like Tammy is a critical issue to the well-being of this child. The challenge for Tammy’s lawyer is two-fold: to make an assessment as to the viability of the mother’s legal claim to the child, and to make an assessment of Tammy’s needs, translated into the language of “best interests.” Often the fact-finding about whether or not the parent has been neglectful proceeds simultaneously with the court assessment as to what reasonable efforts the agency working with the parent needs to be making to reunite the child with the parent or change the goal to adoption. In this case, Tammy’s attorney would advocate that the court not make a final determination on the termination issues until it received an in-depth assessment of this young child’s needs. It is unlikely that any of the court mental health experts, without additional and specific training in infant mental health, would be able to conduct or interpret such an assessment. (This situation is beginning to change in some locations, however. New York’s “Babies Can’t Wait” project, discussed in detail elsewhere in this publication, is focusing on training Family Court personnel on the specific needs of young infants.) In this case, the child’s attorney would request an outside evaluation by an infant mental health expert. The lawyer would want an assessment and independent screening for Tammy with a specialist who understands post-traumatic stress disorders in very young children.

A child’s attorney faced with as troubling a case as Tammy’s must work with the child’s therapist as well as the attorney’s own social worker. The primary concern of all of these professionals must be the best interests of the child. Although the child’s attorney must evaluate the legal issues in the case, he or she can benefit from the insights of these other disciplines. An interdisciplinary meeting to identify responsibilities helps establish pathways for clear communication about the issues in the case. Sometimes nonlegal professionals can help to forge an out-of-court settlement on issues central to the case, (e.g., through family group decision making or mediation), that more effectively addresses the needs and rights of all parties.

Although written material on child development can be useful to an attorney, an actual consultation with a professional who has specific expertise with young children is more helpful. This information guides the child’s lawyer in determining what he or she

should advocate for in the particular context of a young client. The lawyer must be aware that the court may be looking for a single focus of attachment for a child and could well find the biological mother deficient in that area. The child's attorney must raise the question of what is the best placement option for the child. The attorney may want to explore with the experts a nontraditional alternative. A shared parenting model is one such alternative that is common in many cultures. Children raised in an environment populated by caring adults, in addition to the biological parent, can experience a healthy emotional network. The termination of the biological parents' rights here might not be the only solution if we want to allow this very young child to deal adequately with her traumatic relationship with her birth mother. The trauma of the relationship with the biological parent must be addressed with this child either in actual interactions with the biological parent or through therapy that helps the child to cope with the harm that has been inflicted. The child's attorney would also want to preserve the stability of the child's current placement. To ensure a loving, compassionate, and stable situation for this fragile child, the child's attorney would argue for the provision of a wide array of supportive services to both the biological and foster parent.

With the movement to have courts move to a "problem-solving mode," the best practices parts in New York City Family Court are much more involved in working with the parties in developing creative solutions, especially in difficult cases. The court no longer sits as just a passive recipient of information. As a result of more participatory case conferencing, the Family Court is more informed about alternative dispositions and more involved in shaping outcomes. The question of termination or another alternative would be considered carefully. Convincing a court to consider a dispositional alternative based on a new model would be one of the real challenges of such a case. This child's lawyer may need to bring in experts to educate and convince the court to look at a situation in a new and creative way.

To effect these goals in Tammy's case, the child's lawyer would ask the court to order additional support services for the foster mother so that Tammy does not have to be moved. Having a trained family support

specialist involved would assist the foster mother in coping with Tammy's behavior as well as the foster mother's own stress. In collaboration with the interdisciplinary team, the lawyer would explore the best venue for visitation with the biological mother and what types of support are needed, such as therapeutic sessions with both the biological mother and Tammy, in place of monitored visits.

New York has recently begun to explore the use of "host" visiting families to enhance the experience of visitation. A host visiting family is a resource that is identified by the biological mother, often an extended family member or a church or community member who is connected to and familiar with both mother and child. Ideally, the host assists the foster parent with pick-up and drop-off of the child so that the child does not experience an abrupt transfer between caretakers. Additionally, a referral to mediation would allow both the biological mother and the foster mother to identify their roles in this child's life and explore whether a nontraditional arrangement would work for this child. Presenting an agreement to the court that the parties themselves have devised often results in the court accepting a resolution that is nontraditional, yet creative and in the child's best interests.

The child's lawyer would also have to engage in a great deal of outreach to the biological mother's attorney to inform his or her discussions with the biological mother. The biological mother's perspective, as well as her familiarity with the background of her child, could be very useful to the ultimate resolution of this case. Emphasizing the biological mother's role as a resource for information regarding the child could lessen the adversarial nature of the proceedings and potentially engage the biological mother and foster mother in helping to craft the best resolution for this young child.

The Role of the Infant Mental Health Specialist

The 1990s were heralded as the "decade of the brain," broadening our understanding of neurodevelopment and greatly influencing our comprehension of child development as an integrated science across all *functional domains* such as a child's capacity to talk, walk, process sensations, have emotions, and learn. Services for these functional domains are provided by

speech and language therapists, physical therapists, occupational therapists, infant mental health therapists, and early childhood educators/school psychologists. The field is now moving toward collaborative models that work to bridge the gap between the “mental health” needs of the child and “early intervention” services, shifting the field toward interdisciplinary teamwork.

Infant and toddler well-being is based on a network of complex circuits that determine how children learn to regulate their physiological and affective states. This self-regulation influences how children develop relationships with others and process their emotions—which in turn influences how they learn to speak, learn to walk, tolerate and make use of sensory information, and learn. These processes influence each other in an ongoing feedback loop. Infant mental health specialists are relatively new to the broader field of mental health, often bringing a specialized emphasis in assessing and working with the caregiver-infant/toddler relationship, rather than seeing only the mother or infant/toddler on an individual basis.

Many court systems and child welfare agencies may be completely unaware of the infant mental health specialty. Practitioners of this specialty need to be distinguished from psychologists, psychiatrists, and other licensed mental health professionals designated as mental health experts or forensic specialists. (Information about infant mental health training programs is listed at the end of the article.)

The field of infant mental health usually spans the first five years of life, with a particular emphasis on the first three years during which brain growth and pruning are most prolific. The phrase, “neurons that fire together, wire together” (Hebb, 1949; Kolb & Whishaw, 2001; Siegel, 1999) captures the foundational aspect of this time period. The study of infant mental health is usually geared toward understanding infants’ and toddlers’ nonverbal language, what their nonverbal cues mean, and the nature of their socio-emotional development (which includes assessing the relationship forming between the infant and caregiver and determining how to intervene to improve that relationship). A child’s “wiring” for emotional capacities is established, during these first few years, through his or her experiences within relationships. These emotional capacities have strong links with later behavior. The origins of troublesome conditions

such as conduct disorder, oppositional defiant disorder, antisocial personality disorder, and substance abuse are often found in histories that long predate the arrival of adolescents and adults in the courtroom.

Infant Mental Health Principles Regarding Safety, Permanency, and Well-Being

The following is the infant mental health specialist’s perspective in response to Tammy’s case. The guiding principles incorporate information that respect common infant mental health principles along with newer concepts reflecting applied neuroscience. The comments that follow each principle incorporate general information along with specific links to Tammy’s dilemma. While the behaviors described focus upon Tammy’s behaviors related to the case, these principles apply across the lifecycle, and these behaviors can be seen across all ages.

***Principle #1:** The infant’s first and only “language” for communication begins with nonverbal signs and symptoms; therefore, infant stress responses as well as conditions of well-being and safety are communicated and observable through bodily signals.*

Over the last 10 months, Tammy communicated her well-being in her relationship to her foster mother by establishing regularity in her eating, elimination, and sleeping patterns. She began to make good eye contact with bright shiny eyes, to smile with lots of reciprocal interactions, to babble and talk with an emergence of problem-solving capacities, and to develop coordinated motor skills. These are indicators that Tammy was functioning appropriately and thriving under conditions of safety. The ability to self-regulate emphasizes the capacity to achieve calm, alert states and to cycle into adequate sleep patterns; it applies to all ages. These states can only occur under conditions of safety.

***Principle #2:** Signs of distress and threat may be expressed via subtle, moderate, or severe forms of communication.*

The nervous system organizes stress signals in one of, or a combination of the following three affective avenues, along a hyperaroused to hypoaroused continu-

um expressed as anger, anxiety, and withdrawal (Als, 1982; Barnard, 1999; Lawhon, 1986; Lillas, 2000). These three stress responses are first described globally, as they apply to infants, children, and caregivers alike:

1. *Distress signaled through expressions of anger, with crying, screaming, arching, and tantruming behavior.* In older children, these signals are angry, violent responses, which include rage reactions toward self or others, often accompanied by dangerous acts. These children are most often moved from one foster home to another, where their level of anger and its degree of severity quickly escalates in the face of caregivers' exasperation. Labels such as "oppositional defiant," "conduct disorders," etc., are quickly ascribed to these children. Caregivers with a history of domestic violence are also likely to quickly escalate into rage responses.
2. *Distress signaled through expressions of anxious, hypervigilant, frightened, or clingy behavior.* In older children, these signals are often observed as "separation anxiety" with difficulty making transitions between events. This can be overwhelming to the caregiver or not noticed at all, if the hypervigilance leads the child to being quiet and withdrawn. These responses can lead to overly compliant behavior with a young child taking on parental roles. In adult caregivers, this type of coping style is most often referred to as "co-dependency." A coupling pattern can occur when an anxious caregiver is partnered with one whose coping style is explosive anger. In this family situation, the anxious partner's energy is focused upon keeping the volatile partner appeased rather than on the safety of the children.
3. *Distress signaled through expressions of emotional shut down, withdrawn, dampened behavior and glazed eyes that look "through you"* (Als, 1982). In young and older children, these signals often fly below the radar screen of being high-risk; they are described as "easy" children because they are emotionally shut down and do not cause any "trouble." On the other hand, these depressed children can also be reprimanded for appearing to not pay attention, being described as inattentive. Adult caregivers with post-partum depression, dissocia-

tion from post-traumatic stress disorder, and other mood conditions can be seen in this continuum.

Sleeping and eating disruptions may accompany any of these stress signals. In addition, while not commonly related to threat, more severe bodily signs of distress such as throwing up, defecating, or urinating can occur. The disruptions of these bodily processes usually indicate an intense source of real or perceived threat to the infant, child, or adult.

Relating these distress signals to Tammy's case, in addition to Tammy having been abandoned twice, she entered her foster care home with specific delays across all domains, necessitating treatment from services across disciplines. Fortunately, her foster mother sought an infant mental health specialist who guided her in obtaining immediate services for the delays she had noticed. Tammy had recovered from these delays and was thriving. Following the initiation of weekly visitation with the biological mother, the subsequent signals of stress responses re-emerged.

Tammy displayed subtle to severe signs of distress that began to increase in intensity as the weekly visits continued. She showed aspects of an *angry* response by hitting the cat and biting the foster mother. These escalated into violent rages as the visits continued with the biological parent. Her *anxious* response was demonstrated by her fearful reaction to her biological mother, clinging to her foster mother, sleep and eating disruptions, and waking up with nightmares. Tammy exhibited aspects of the *shut-down* response when she walked around in a daze during the visit with the biological mother, and showed up at the therapist's office in a stupor on the days of visitation. Tammy's vomiting at the mention of the "booboo woman" and the asthmatic attack are indicators of severe stress responses. With the resumption of visits with the biological mother, all three stress signals had been activated in Tammy. They were accompanied by other signals of traumatic stress responses—such as her nightmares and sleeping and eating disturbances. Her escalations surrounding bedtime appeared to be related to her intense desire to avoid sleep, when her nightmares occurred.

Principle #3: *A common myth is that infants and young children have "no memory" because they cannot*

speak. It is now commonly accepted that infants and young children may have the capacity to retain implicit and preverbal memories (Schore, 1994; Siegel, 1999).

Just as a memory of a certain odor (breast milk) can stimulate an infant's anticipation for a pleasurable feeding, disturbing environmental stimuli (from people or inanimate objects) can stimulate a memory of an adverse event. Our brains read the sensory signals as either safe or dangerous and if dangerous, relay the threat to our bodies to trigger a stress response. The activation of these stress responses occurs very quickly and automatically, often creating "trigger happy" nervous systems that are set off by even subtle sensory input.

A working hypothesis regarding the severity of Tammy's stress responses would be that some memory of the traumatic relationship with her biological mother was being triggered by the biological mother's proximity during visits. The stress responses Tammy exhibited while with her biological mother became a part of her daily life, whether with her biological mother or not. Placing Tammy in a room with the foster mother she loved and the biological mother who distressed her resulted in continued activation and escalation of stress responses.

Principle #4: Stable self-regulation is the foundation for all socio-emotional relationships as well as for the capacity to learn.

When infants and very young children are left in chronic states of distress, threat, or neglect, their ability to grow and develop is compromised across all domains—social, sensory, motor, affective, speech and language, and cognitive. Tammy arrived at her second placement with significant delays in most areas; however, she began to thrive with early intervention and an engaging caregiver. Given the severity of Tammy's stress signals with the biological mother, taking rapid action to reunite the pair because of the biological mother's legal rights would likely keep Tammy in chronic states of distress, undermining her development across these multiple domains and replicating the delays Tammy displayed when placed in the latest foster home. With the degree of severity and continued escalation of traumatic responses, the continuation of visits with the biological mother needs to be questioned immediately. Until further evaluation can be done under different conditions,

a recommendation for a temporary termination of visits with the biological mother would be in Tammy's "best interests" from the information just discussed.

Principle #5: Emotional care within a stable, long-term, and continuous relationship is a fundamental need of children.

Multiple milestones are built upon the foundation of self-regulation (Shonkoff & Phillips, 2000; Fenichel, 2001). The capacity for relational and cognitive growth is dependent upon the capacity to stay organized and regain self-regulation following distress. Building upon the capacity to sustain a calm, alert state is the capacity to form a loving attachment. Thus, the capacity to fall in love with a caregiver, and vice versa, under conditions of safety, is the next most salient point of this discussion. If this is an essential piece for emotional development, then we face the need to shift our focus from *custodial* care in our foster care system to *emotional* care. Emotional care involves *mothering as a practice*; this practice means seeing children as "demanding protection, nurturance, and training" (Ruddick, 1994, p. 33) and then committing oneself to the work of trying to meet these demands. Mothering as a practice is gender free and not a biologically determined role (Lawlor, 2003).

Falling in love with her foster mother has given Tammy a capacity for self-nurturance, a template for empathy and caring for others, and a motivation for learning and exploring the world with security. Reciprocally, this experience also is powerful for the foster parent(s). Herein lies a challenging conflict: It is common for foster parents to be advised to remain neutral in their approach to their foster child. First, this is not in the "best interests" of the infant, whose future emotional capacities are dependent upon having a thriving, loving experience. Even ASFA's shortened 12-month timeframe for permanency decisions is too long for an infant to wait to secure a loving, stable tie. Second, if the infant deserves to be loved in a profound way, the foster parents must participate in this "falling in love" process. This inherently is a bi-directional process. Third, even when "advised" by practitioners to stay neutral, foster parents are not always going to remain neutral. We are biologically drawn to infants and are given an evolutionary push toward connecting and emotionally caretaking our most vulnerable young. The threat to a foster family who

has emotionally committed itself to a child can be enormous when the biological parent desires reunification with his or her child. The stage is set for rivalries, envy, and destructive urges to emerge between foster and biological parents, with the child often caught in the middle. If an infant mental health perspective includes a child's formation of a deeply loving, lifelong connection to a caregiver without waiting, how does the child welfare system manage the implications of this? Tammy deserves to have her loving connection with her foster mother secured, rather than threatened.

Principle #6: *Stress signals may have multiple meanings and multiple causes.*

When infants are under conditions of stress and threat, the first cause that must be ruled out is trauma. The *Diagnostic Classification System: 0-3* (1994) offers a most useful way to triage the possible meaning of stress signals. Tammy's signals evidenced a great deal of distress and threat to her and seemed to be directly attributable to "monitored" but non-therapeutic reunification visits with her biological mother. Tammy's signs and symptoms showed a post-traumatic stress response initiated by contact with her biological mother, and the traumatic responses were reinforced with each weekly visit. Under these conditions, recommendations by the infant mental health specialist to the social worker, attorney, and court for reunification visits to be stopped would be strongly advised.

However, it is not uncommon for there to be more than one meaning to exhibited distress signals. The infant mental health therapist, with the help of the *Diagnostic Classification System: 0-3*, will be able to traverse the range of causal and underlying factors that can contribute to similar behavioral patterns.

The Role of the Judge

Traditionally, the juvenile court's responsibilities in cases involving child abuse and neglect have been the same as any other court: to determine the facts of each case, to ensure the child's protection, and to ensure that the parent's rights are respected. This role has expanded since the early 1970s to include consideration of whether the child needs to be placed in foster care or remain at home under agency supervision, and taking an active role after the child is released to ensure that the

child is placed in a legally permanent and stable home. Historically, children have drifted through foster care with little attention paid to their ultimate placement. With the passage of the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272), measures supporting the concept of permanency planning—exerting concerted efforts to achieve permanent homes for foster children—began to be passed by the states. The emphasis was on family reunification. These family-focused plans were not as successful as had been hoped. Consequently, the Adoption and Safe Families Act of 1997 (ASFA, Public Law 105-89) mandated that child safety and health were paramount and no longer tied to reunification of the family at all costs. The judge's role has expanded to encompass the need to achieve a timely, safe permanency for these children, to address children's special needs while in foster care, and to provide procedural protections for all of the parties.

In Florida, as in most other states, once there has been an adjudication of dependency and the child has been removed from the caretakers, the court must determine the child's placement. The judge must review the case plan and determine if the department has deployed reasonable efforts to reunite the family. If, despite those reasonable efforts, the child cannot safely be returned home, the court must first look to the non-custodial parent, if any, then to suitable relatives, and then to the child welfare department as temporary legal custodian. The court must determine a visitation schedule and any additional services needed, order child support (if appropriate), approve the case plan, advise the parents of their right to appeal and counsel, and set the next hearing.

Under ASFA, the parents have just 12 months to accomplish the case plan and have the child returned to them; if they fail to produce a suitable case plan or fail to accomplish the goals of an approved case plan, the state must move toward termination of parental rights. The judge is required to consider all of these matters within a framework mandated by federal law, the purpose of which is to provide a child permanency as soon as possible within 12 months of the date the child is placed in the custody of the state. The judge also must oversee the progress of the case to make sure that all parties are participating faithfully and conforming to whatever case plan has been approved by the court.

The judge is faced with many conflicting issues. First and foremost, what is in the best interests of the child? That answer clearly varies depending on the child, the number of children in the household, and the particular issues in a given case. There may be issues of paternity, support, neglect, abandonment, abuse, drug dependency and addiction, domestic violence, criminal behavior, and the potential for criminal prosecution of the parents. There are relatives, and perhaps non-relatives, to be considered, as well as placement in foster care. The age of the child, whether the child has disabilities, and whether other siblings are involved are important considerations. In addition, the judge must be concerned about the role of the Department of Children and Families (the state's social service department responsible for abused, abandoned, and neglected children), the resources it offers, and whether or not appropriate placements, other than placement with the state, are available. There are the concerns of the various attorneys (e.g., the child's attorney, the parents' attorneys, the department's attorney, and other interested parties), which may impact the issues before the court.

The introduction of the science of infant mental health demands that judges become familiar with early childhood development so that the court can translate and interpret the information it receives not only from the infant mental health specialist but also from the case-workers, case managers, parents, and others. The court also must be attuned and sensitive to what happens while the child and the parent appear before the judge at a particular hearing or conference. The non-verbal language of the interactions between child and parent or guardian or caretaker may provide invaluable data to the judge in ultimately formulating an appropriate decision and monitoring the family's case plan. The court must be in a position to ask appropriate questions of the parents, social workers, and case managers to avoid misinterpreting signals and accepting reports at face value.

PART II: Points of Convergence and Divergence

In the following discussion, we see various points of overlap and disconnect between the various disciplines and their perspectives.

From the Child Attorney's Perspective

Tammy was abandoned twice by her biological parent, and her advocate must assure that the child's needs for permanency and a stable, nurturing living situation are met while she is in foster care. A lack of meaningful, individualized services creates a situation that is painfully unfair to the child, the biological parent, and the foster parent. During this difficult juncture, both caregivers need to meet with a trained infant mental health specialist to discuss how each person's role affects this child. Rather than general parenting classes, Tammy's biological mother should have the opportunity to work with a family support specialist who can observe her interactions with Tammy and assist the mother in responding to her child in a non-threatening way. Equally, the foster mother would benefit from working with a family support specialist to identify how to respond to Tammy's aggression, anxiety, and withdrawal in a way that alleviates the child's stress level. Recent changes in federal law mandating permanency decisions within 12 months of a child's entering care heighten the significance of implementing timely and meaningful interventions.

Parents and their attorneys are often hesitant or afraid to discuss openly the child's needs, since the court could perceive such information as prejudicial. Without input and participation from a well-informed lawyer for the child, the court may miss critical information. The child's advocate must be able to provide important information about the child's life experiences and the circumstances that brought the case to the court's attention. The child's advocacy team can identify other supportive family members as well as the child's medical and educational needs.

The child welfare agency involved in this case may also be in conflict with the child's lawyer regarding the service plan for this child. Budgetary constraints often force agencies to take positions based on institutional constraints and not the needs of an individual child. Thus, it is essential to have a well-trained advocate familiar with the particular needs of infants and toddlers appointed for the child whose sole responsibility is to learn the child's unique needs and goals and to ensure that those goals are advocated as part of the proceedings.

From the Infant Mental Health Specialist's Perspective

Although in theory everyone is working toward the “best interests of the child,” inherent competing forces cycle around the meaning of that phrase. Divergence occurs between the fundamental needs of young children and the way the legal system is structured. Legal compliance with court mandates, such as sobriety for the parent and completion of parenting classes, cannot be equated with the emotional capacity to “mother” a child who is already laden with stress responses. Furthermore, the child’s stress responses may stem from implicit memories associated with the biological parent. An inevitable collision then occurs. Biological parents may need 18 to 24 months, rather than six to 12 months, to secure their sobriety. They may have the potential capacity to become good emotional caregivers, but the capacity is unlikely to be realized if they do not participate in dyadic treatment with their child, where the traumatic attachment and a pattern of intergenerational abuse can be healed slowly over time (Larrieu, 2002). If reunification is not provided in the context of therapeutic services for the parent-child dyad, the chances for relapse are high. When needy and vulnerable biological parents are forced prematurely to take care of an emotionally demanding child, re-abuse and another abandonment of the child is all too often the outcome. In the meantime, the child has an immediate need for a sense of safety, permanency, and well-being that can only be experienced in the presence of a stable caregiver on whom the child can depend.

The fundamental needs of children are often in direct conflict with: (1) the legal rights of biological parents; (2) court timeframes; (3) service availability; and (4) foster care capacities for open adoptions. Child specialists Brazelton and Greenspan (2000) state that the longer the infant or child has been cared for in a safe, nurturing relationship, the more compelling the reasons would have to be to remove him or her from the positive environment (whoever is the caregiver) to return to another caregiver; to do so would undermine the infant’s rights to security, self-esteem, and the capacity for intimacy. While this position can be supported under ASFA, it radically departs from how the legal system currently prioritizes care and functions.

A decision-making process now can be suggested. The

child’s need for a solid caregiving relationship is a priority. The younger the child, the more difficult it is for the child to negotiate safety, threat, and instability with multiple caretakers (Haight, Kagle, & Black, 2003). From this vantage point, the most nurturing relationship should take priority legally. Biological parents need to be informed early on in the process that their young children need them emotionally and that if they are not able to provide emotional security, others will need to do so because their infants cannot wait. Next, the degree of emotional stability in the primary relationship, in conjunction with professional assessments of the biological parent(s) and the child’s degree of distress, would determine the appropriateness for an open adoption, with therapeutic and educational services provided for the traumatic attachment between the child and his or her biological parent(s). If the court has determined that reunification with the birth mother is the case plan, then both sides of the equation must be strengthened: The foster family must be supported so that they can maintain their emotional care to the child in the context of a long-term, open-ended relationship as well as receive guidance on how to best help the child recover from often provocative stress responses (Dozier, Dozier, & Manni, 2002; Groppenbacher, Hoard, & Miller, 2002). Furthermore, therapeutic services should be provided to help the biological parent and child overcome their traumatic attachment and engage in a reunification process that proceeds at a pace that matches their dyadic connection. However, depending on the degree of rupture between the biological parent and child, this type of repair is not always available, nor possible with a child who has securely attached to another caregiver. All parties involved need help to grieve their losses. These nontraditional options parallel conditions for divorced parents, where both sides of the equation—parental rights of the mother and the father—are honored as significant attachments.

This shift in perspective would have long-range effects that would beneficially address the long-term sequelae of child maltreatment experiences. Typically, such children exhibit a variety of severe emotional and behavioral problems throughout their lives. For example, Tammy’s escalated behaviors were building toward a clinical picture of poor impulse control, low frustration tolerance, and decreased empathy—all hallmarks of significant emotional disturbance that maltreated and disturbed children often exhibit (Malik, Lederman, Crowson, &

Osofsky, 2002; Lederman, Osofsky, & Katz, 2001). Without stopping the visitations and re-establishing safety within the foster care home, Tammy was on her way to either a forced reunification with a traumatic attachment or to become a lost child in the foster care circuit.

From the Judge's Perspective

In Tammy's case, the court reviews the case plan to determine what Tammy's biological parent, the child welfare agency, and the foster parent are required to do. Then, the judge listens to the caseworker's perspective of the situation, whether the biological parent has been following the plan, how Tammy is doing, and any other information the caseworker deems important. Next, the judge listens to the biological parent's attorney, who will likely say that his client is doing well...she is attending the visits, as required, participating in drug rehab, attending parenting classes, paying her fees, missing her baby, and seeking reunification as soon as possible. The foster mother, either on her own or through Tammy's attorney, will likely tell the court how terribly the child is doing now that the biological mother has returned. The tantrums, loss of regularity in bodily functions, display of fears, aggressive acts, nightmares, and emotional distress will be presented as detrimental to the child and the foster mother. She will also tell the judge that she has taken Tammy to an infant mental health specialist for an evaluation and counseling. The foster mother will complain that the caseworker is not paying attention, that there is no consistency during the visitations, that she is upset and on the verge of giving the child back to the department. Next, the judge will listen to the child's advocate and the attorney for the Department of Children and Families. If necessary, and after due notice to all parties, the judge may hear testimony from experts. In Tammy's case, the judge would have a difficult placement decision to make because the biological parent seems to be complying and the foster mother seems to be close to giving up on her caretaking of this child. The biological mother's caseworker will likely hail the advisability of an ongoing relationship with the biological mother and recommend that visitation be expanded for a few more months. The foster mother and the mental health specialist will say that the child is being harmed by the visits with the biological mother and that the visits should be terminated.

Typically, the judge will probably seek an independent evaluation of the situation by a court-appointed expert. The court should order the expert to observe the biological mother's visits with the child for a period of time and conduct an independent evaluation of the child. The court should encourage the foster mother to follow treatment recommendations; it should also admonish the department to schedule the same worker to monitor the visitations and the child's reactions. The court will probably set the next hearing in 60 to 90 days, when it would hear any additional information and determine how to proceed or enter an order. This approach is conservative and highlights the efforts of the mother to be reunited with her child. The hope is that a reunification can be effected by the next hearing, or it will prove out that the mother cannot be reunited with her child.

In my opinion, Tammy's case presents a very serious and potentially dangerous situation. Tammy has been abandoned by her mother twice before. Tammy is acting out and has regressed to the point that her physical and emotional well-being is being impacted by the visits. The likelihood of the biological mother becoming an adequate parent, notwithstanding her present effort, is remote. Tammy can no longer afford to "wait" for "mom" to get her act together. The law requires (demands) that judges hold Tammy's best interests as paramount. In this case, I would terminate the mother's visitations immediately. I would order that all services necessary to stabilize Tammy with her foster parents be instituted forthwith. Based upon the mother's long history of abuse and abandonment, I would order the department to begin the process of terminating the parental rights of the mother because this would be in Tammy's manifest best interests and would reduce any further trauma for her.

Using the information that I have learned about early childhood development, infant mental health, and the effects of neglect and abuse on children, and applying those principles to the facts of Tammy's case, would bring me to the conclusion that prolonging the status quo would be detrimental to Tammy. Granted, this may be a more aggressive approach when compared to the traditional way of handling this type of case. However, the judge must put Tammy's best interests first—based on the facts of the case and the mother's long history of failure and abuse.

PART III: Conclusions and Implications for Practice and Policy

Following are recommendations for best practice and policy changes. Best practices are often long-term goals, which require systems changes and long-term planning. Policy changes can at times be implemented in a more timely fashion than other types of reform.

1. All children entering the foster care system must receive an individualized and thorough developmental assessment across physical, emotional, speech and language, sensory, motor, and cognitive systems, optimally conducted with an interdisciplinary team approach.

More than half of children in foster care in the United States “have developmental delays including motor development problems, hearing and vision problems, growth retardation and speech-language delays—four to five times the rate found among all other children” (Dicker & Gordon, 2002, p. 28). In addition, 40% of foster care children are born prematurely or at low birthweight (Halfon, Mendonca, & Berkowitz, 1995), which increases their vulnerability for regulation, emotional, developmental, and health difficulties. Collaborative models of assessment, diagnosis, and intervention across these multiple domains (Greenspan & Wieder, 1998), while available in theory, are needed in practice within courtroom settings. In 1999, the New York State Permanent Judicial Commission on Justice for Children introduced the “Checklist for Healthy Development of Foster Children” which serves as a guide for judges and attorneys to assess the health status of children across developmental domains.

2. A match should be made between the level of care a foster child will need and the emotional capacity of the foster parent to accompany the child to services, as well as actively participate in the service delivery by providing high quality emotional care.

Taking seriously the physiological and emotional needs of traumatized children shifts the goal of providing safety from a generic attitude to an individualized, thoughtful approach of matching the appropriate level of care with the depth and intensity of a child’s delays that will need attention right from the start.

3. Selection of foster parents should include evaluating applicants’ capacity for providing emotional nurturance to a child who will probably experience one or more stress responses, making it difficult to fall in love with the child without special professional help.

Anticipating that abused and neglected children will have difficulty relating and showing their emotional needs through distress signals allows us to plan ahead for emotional resources that foster parents will need in order to cope with the stress induced upon them (Dozier et al., 2002). Foster parenting is emotionally taxing. Screening, selecting, preparing, and guiding parents for this challenge is the best way to deal with subsequent problems that arise, which keep the cycle of multiple placements so prolific with this population.

4. Emotional milestones can be used to assess the well-being of infants, toddlers, and adults.

Foster caregivers and biological parents can be assessed for: (1) their capacities to nurture and love; (2) their openness and capacity to receive help in dealing with difficult infant/child stress response behaviors; (3) their own stress responses and capacity for stress recovery; (4) their interest in, and ability to meet the developmental needs of the young children in their home; and (5) their capacity for cause-and-effect thinking regarding their own behavior on the children for whom they are caretakers (e.g., “If I treat the child in an angry way, he or she will likely have an angry response”). This assessment can take place via observation of the dyadic interactions between caregiver and child over time, and/or through an interview process with the caregiver that focuses on eliciting the caregiver’s capacity for self-awareness, self-reflection, and empathy (Greenspan, DeGangi, & Wieder, 2001; Malik et al., 2002; Orfirer & Kronstadt, 2002).

5. Safety, threat, permanency, and well-being are inter-related conditions that cannot be isolated into different domains.

In order to feel safe, infants must attach to someone who is permanently in their lives; this basic attachment promotes infant well-being across all developmental domains. Providing emotional care carries responsibility and involvement that is not learned through a parenting class; both foster and biological caregivers must be suf-

ficiently prepared and equipped for the real task of emotional parenting. Professionals who understand emotional development and infant and toddler cues are often necessary to serve as guides in helping the dyad connect and teaching the caregivers how to recognize signs of threat and work toward repair of damaged ties and intergenerational patterns of abuse or neglect. For example, in Florida, specific protocols are enforced in one courtroom to screen for biological parents who show the capacity for making use of intervention and therapeutic dyadic reunification services (Information available online at www.Miamisafestart.org and www.Miamidcip.org). If identified as good candidates, they are provided with dyadic therapy to stop the intergenerational transmission of abuse and neglect. The results are promising.

6. A shift in priority from custodial care to emotional care requires that children's rights be extended to include their right to, and fundamental need for, a primary, stable, nurturing caregiver in their life for the long term.

Once a child has been removed from the biological home, the course of that child's life is changed (Eldridge, 1999). The momentous decision to remove a child requires training at the front end so that emergency social workers can accomplish much more thoughtful assessments regarding the capacity of the biological home. Delivering appropriate services to at-risk families when the child is not removed is essential. This cannot be emphasized enough.

Assuming that removal of the child from the home is a result of severe high-risk parenting behaviors, the legal system needs to consider expanding the concept of "familial" rights to encompass the child's emotional caregivers. Nuclear families are no longer our typical family scenario. We have single-parent biological homes, gay and lesbian foster care parents, single-parent foster homes, etc. According to a 2002 U.S. Census Bureau report, 23% of children lived only with their mother, 5% lived only with their father, and 4% lived in households with neither parent present (Fields, 2003).

An open adoption system means the legal system should recognize two realities: (1) Foster parents who have developed a secure, emotional tie to the foster child need to have permanent rights to be involved in that

child's life; and (2) biological parents who may need years, instead of months, to develop the capacity to nurture their children need to have creative ways to remain involved with their children. A co-parenting or extended family constellation that preserves the most stable, nurturing relationship in the child's life as the primary and legal guardian, and provides for secondary caretakers (such as extended family members) is in the best interests of the child. Cultures that are more communal in their organization (e.g., island cultures, Israeli kibbutzes, etc.) have models for this constellation as well as models for divorced parents who co-parent (e.g., one primary caretaker for the infant with visiting rights to the secondary caretaker). Biological parents need to realize that once they have significantly harmed their child, that child's needs take priority over the parents' rights, which they have abrogated by their mistreatment. If they are able to mature into emotional caregivers, however, they can become the "extended family." In determining the ultimate legal guardian of the child, the focus should be on identifying the most reliable means of providing the secure, psychological relationship for the child. From this perspective, "the psychological parent is the real parent" (Brazelton & Greenspan, 2000, p. 32).

7. Coordination, cooperation, and collaboration among all systems of care that interface with infants and toddlers from birth to five years old are needed so that common understanding and principles are developed over time.

Sharing languages and common principles that reflect current neurodevelopmental understanding are desperately needed in all aspects of child welfare systems. This effort requires training across all systems of care.

8. Mandatory training needs to be provided to all levels of judicial, legal, social work, and service providers within the dependency system.

This training includes the legal, mental health, regional center, early intervention, school district, and medical center continuum of care. It is inadvisable for judges to make lasting decisions regarding the needs and best interests of children without proper training in asking the right assessment and intervention questions. The provision of specialized information needs to become a part of the expansion of children's rights to be seen and heard.

We all agree that the best interests of the child are the priority. Recognizing this common ground, we need to move forward in providing interdisciplinary training across all systems of care. The training must include the legal system and the infant mental health system. Infant mental health practitioners require guidance on what information the legal system needs, how to write efficient and understandable court reports, and what conflicts can arise with the sharing of that information. The legal system requires comprehensive training regarding the fundamental needs of infants and young children. Training increases awareness—which may lead to another realization: Are services available for these children, once we recognize their needs?

Systems-wide change within counties is necessary so that collaborations among the Department of Mental Health, the Department of Child and Family Services, regional centers, medical centers, Early Intervention, Early Head Start, Head Start, school districts, the private sector, and all aspects of the legal system can build alliances that provide integrated service delivery through interdisciplinary training. As a result of a collaboration between the Department of Mental Health, the Department of Child and Family Services, and South Central Los Angeles Regional Center, Los Angeles County, California, has graduated 46 candidates in its first one-year course in infant mental health training, a program that was housed at the Department of Psychiatry and Mental Health, Cedars-Sinai Medical Center (e-mail contact is infantmentalhealth@earthlink.net).

The next level of integration would allow an infant mental health specialist to work with a particular judge and his or her court officers to access integrated services for high-risk children and their families. Several major cities across the country have begun training for judges and attorneys, where infant mental health specialists are providing assistance to judges in evaluations and triage, either outside or within the

courtroom. For example, the mission of the Judicial Consultation Project of the Institute for Infants, Children, and Families, Jewish Board of Family and Children's Services in New York City, is to provide training for raising awareness in the judiciary and child welfare systems about the importance of early relationship development and how separations, loss, and multiple placements negatively impact the lives of young children (contact person is Dorothy Henderson at dhenderson@jbfcs.org).

As we begin to recognize the importance of relationships during these early years, in addition to the innovative programs mentioned, other creative services are being provided in different parts of the country. A Home Within is a national organization of licensed, very experienced private practice clinicians who offer long-term, weekly, *pro bono* psychotherapy to children and youth in foster care. These therapists make a commitment to see the child "for as long as it takes." The goal is to have such dedicated services organized within 50 major cities across the country. This is an example of crossing traditional boundaries between private and public sectors to provide quality care. (Information is available online at www.ahomewithin.org).

We need to think "outside of the box" and question whether the laws, as they are presently written, are sufficient to deal with what we are learning about vulnerable young children and their families. Our ability to understand "Tammy's" needs depends on our ability to open up the legal process to listen and incorporate new knowledge. How exactly these principles and approaches can be integrated into our legal system is worth further exploration. Unless we take the time to develop this deeper understanding, our assessments of what is best for our youngest clients will tend to remain vulnerable to our biases toward foster versus biological parenting rights rather than a contextual understanding of their young lives.

APPENDIX OF ONLINE RESOURCES

www.futureunlimited.org.

Go to the Reference Library section for downloadable information regarding infant mental health and dependency court.

www.Miamidcip.org.

Go to the Resource Library section for downloadable information regarding maltreated children and dependency court.

www.Miamisafestart.org.

Go to the Reference Library section for information on issues regarding abused and neglected young children and the court and foster care systems.

www.zerotothree.org/imh.

Click on "resources" and then "training" for a listing of mental health training sites across the country.

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- The Adoption Assistance and Welfare Act of 1980, 42 USC 670, et seq.
- The Adoption and Safe Families Act of 1997, 42 USC 620, et seq.