

INFANT MENTAL HEALTH INTERVENTIONS IN JUVENILE COURT

Ameliorating the Effects of Maltreatment and Deprivation

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The juvenile court has provided a fertile opportunity for the exercise of therapeutic jurisprudence since its inception a century ago. Unfortunately, until 1997 when the Adoption and Safe Families Act (ASFA) was passed, the parent (and not the child) was the center of the child welfare system. With the change in dependency law after ASFA, the juvenile court has a legal responsibility to focus on the well-being and safety of the child as its paramount concern. The juvenile court, acting in concert with the community in an interdisciplinary effort, can focus on healing the child while adjudicating the case and working with the family. Now that infants are the largest cohort of children in the child welfare system, an emphasis on the needs of infants and toddlers, a previously ignored population in juvenile court, can result in true prevention of intergenerational transmission of child maltreatment.

The parent–child relationship provides the most important context for promoting healthy child development (Sims, 2000). However, a healthy parent–child relationship is unlikely to be seen in the environment of the juvenile court. Created 100 years ago in Chicago, the juvenile court is charged with the responsibility of protecting children from the family members who have abused, abandoned, and neglected them. Juvenile court is a place of last resort where the state’s interest in protecting the lives of children is more compelling than the sanctity and privacy of the relationship between a parent and child. The juvenile court intervenes to protect and rehabilitate children when all else has failed. Once the mother has reached the juvenile court, tremendous harm has already been done, the negative effects of which can only be decreased by facilitating a healing process for the child and the family. The juvenile court is in a unique position to initiate the marshalling and creation of community resources to fulfill the statutory duty of the court to heal the child.

Emerging research indicates that young children in the child welfare system are at great risk for cognitive and developmental delays (Dicker, Gordon, & Knitzer, 2001). Entry in the child welfare system may provide an opportunity for the juvenile court to evaluate and treat the child for previously undiscovered problems. The children who are under the jurisdiction of the juvenile court see doctors usually only for emergencies and have poor health care. Their parents are not able to determine the nature and extent of developmental and cognitive

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problems. In fact, when confronted, the parents often deny that their child has any problems.

Several studies have found that at least half of young foster children exhibit developmental delays, which is approximately four to five times the rate of developmental delay found among children in the general population (Dicker & Gordon, 2001). Without intervention, by the time these children reach school age, they will also likely be at risk for social problems in addition to their learning deficits. Observations of these children further reveal that even in infancy, many of the children appear uninterested in adults, unable to play, and unable to explore the world around them. Many of the children exhibit signs of traumatic stress, including withdrawn behavior, fearfulness, aggression, and sadness. It is often the case that parents do not understand these children, whose needs are significant and complex. Often the parents are overwhelmed, traumatized, substance abusing, and victims themselves, all of which lead to problems in the parent–child relationship (Lederman, Osofsky, & Katz, 2001).

At times, in Miami–Dade Juvenile Court, the task seems almost impossible, and the responsibilities of the juvenile judge to rule on the fate of children can be overwhelming. For example, each dependency juvenile judge in Florida manages a caseload of over 1000 cases a year. Since there are on average 1.7 children per case, each judge is responsible for approximately 1700 children annually. Each week, more than 100 families appear before each dependency judge, creating an apparent sea of chaos, despair, and uncontrolled emotions, ranging from anger, confusion, and desperation, to hope. It is not unknown for tears to be shed from the bench, from the lawyers' lecterns, and from the courtroom gallery.

Despite the thousands of adults and children who pass through the courts, it is rare to witness an expression of caring, love, or contrition from a parent to a child. Unlike the positive and hoped for "good enough" parent–child relationship (Winnicott, 1987), the courtroom is rarely the scene of a parental caress, a gesture of concern, or an expression of maternal or paternal pride. The juvenile courts in this country are teeming with dysfunctional families, emotional impoverishment, and every conceivable form of deprivation a child can endure. It is a difficult, if not impossible, context from which to promote healthy child development that, by necessity, requires both sensitivity and the difficult task of modifying maladaptive behavior that may have become the norm in these families, passed on from generation to generation.

Moreover, in the experience of the first author, judges who have been presiding over juvenile court cases for several years fear that the mental and emotional health of the parents and children who appear before them is declining. Consistent with this experience, there is objective evidence that behavioral and emotional problems have increased among children in the United States over the last 18 years. A recent study reports that from 1976 to 1996, clinician-identified psychosocial problems increased from 6.8% to 18.7% in all pediatric visits among 4 to 15 year olds (Kelleher, McInerney, Gardner, Childs, & Wasserman, 2000).

In addition to the necessary functions of the juvenile court to address the legal issues of custody, visitation, dependency and termination of parental rights, the court attempts to modify the behavior of the offending parent so that the family can be reunified and achieve permanency. Historically, the emphasis of the court has not been on the needs of the child.

A recent and revolutionary change in dependency law, the Adoption and Safe Families Act of 1997 (ASFA), now mandates that the safety and well-being of the child is the paramount consideration of the court in dependency decision making. States must now ensure that:

- families have enhanced capacity to provide for their children's needs.
- children receive appropriate services to meet their educational needs, and
- children receive adequate services to meet their physical and mental health needs (42 U.S.C. § 670 *et seq.*; 45 C.F.R. § 1355).

The ASFA finally recognizes, in an important departure from the previous law, that reunification may not always be possible. For almost two decades, the Adoption Assistance Act of 1980 mandated reasonable efforts to reunify families. The emphasis on reunification was a legislative response to the concern about the increasing length of stay of children in foster care. While many of the tenets of the Adoption Assistance Act are unchanged, ASFA (1997) shifted the emphasis away from reunification to the safety and health of the child. ASFA imposes a one year deadline for judicial decisions about permanent homes for children and clearly favors the permanency option of adoption. For the first time, there is a legal understanding that reunification may not be in the best interest of all children and, in fact, could result in further harm to the child. Empirical studies of intensive family preservation services have shown that while these services represent an important part of the continuum of family support services, they may also result in child endangerment when children remain in family environments that threaten their health or physical safety (Chalk & King, 1998).

At present, children's health and safety are of "paramount concern" (AFSA, 1997, 42 USCS § 671(a)(15)) for the court in deciding what reasonable efforts should be made to reunify families. ASFA has specified services that should be provided to families, including counseling, substance abuse treatment, mental health services, domestic violence services, and crisis counseling (42 U.S.C. § 629(a)). With this new emphasis, the child is finally the focus of the dependency case and not the rights of the parent over the child. The fundamental liberty and interest each parent has in the care, custody and management of their children (*Santosky v. Kramer*, 1982) is not absolute.

Children in the child welfare system now have substantial new statutorily enforceable rights. In a recent decision from the U.S. District Court in the Eastern District of Wisconsin, *Jeanine B. v. McCallum*, (2001), the court held that ASFA creates a federal statutory right to have the state initiate a proceeding to terminate parental rights when a child has been in foster care for 15 of the most recent 22 months. Further, the court ruled that, after termination of parental rights, the child has the right to have the state identify and approve a qualified family for adoption (Marsh, 2001). The violation of the child's newly designated rights under ASFA were deemed to create a federal civil rights cause of action under 42 U.S.C. Section 1983. More than 40% of the children in foster care are born with low birth weight or premature, more than half suffer from serious physical health problems, and over half experience developmental delays (Dicker, Gordon, & Knitzer, 2001). Perhaps the state's failure to provide medical and mental health services to the child will be actionable in the future.

The juvenile court has exemplified the most fertile opportunity for the

exercise of therapeutic jurisprudence beginning with the creation of the first juvenile court a century ago in Chicago. The 1899 Illinois Juvenile Court Act defined a rehabilitative rather than punitive function of a court of special jurisdiction for neglected, dependent and delinquent children under the age of sixteen. Some would argue that despite the rich context for exploring the application of therapeutic jurisprudence, the juvenile court has failed to fulfill its therapeutic potential and in fact has contributed to the creation of an anti-therapeutic child welfare system (Brooks, 1999). While many lament the fact that the juvenile court, since its inception in 1899, has undergone a transformation from a therapeutic to a punitive institution, fortunately the child welfare laws, unlike laws governing juvenile delinquency, have become more child-focused. This significant change in the law provides a basis for the argument that one of the most important functions of the juvenile court, post-ASFA, can be to heal the child.

An opportunity exists to create an interdisciplinary, research-based, health-focused response to ensure the therapeutic needs of the child are met and expand the biannual statutory judicial review hearings from a legal checkup (Brooks, 1999, p. 953) to a therapeutic checkup as well. If all else fails, and the parent cannot be rehabilitated and the child returned home, at least the court can try to ensure that the child receives the therapeutic intervention he or she needs to cope with the trauma associated with maltreatment.

The child welfare system partners and the judges who preside in juvenile court must face this challenge in an environment that is devoid of science and has been created and is controlled by reactive laws. It is also an environment that often is ill-equipped to modify human behavior and promote healing. There is never enough time for every child (Amendment to Florida Rules of Juvenile Procedure, Florida Supreme Court, April 29, 1999). Complex decisions affecting the lives of children often must be made in a matter of moments.

The traditional regulations of the juvenile court can limit the ability of the court to exercise and oversee an essential therapeutic function and provide an opportunity, present and future, to change behavior. The courts' historical focus on adjudicating cases in an adversarial setting does not encourage a therapeutic inquiry or response. These limitations in concert with the level of dysfunction of the families who come before the court often create impossible challenges in enforcing the law and safeguarding the wellbeing of children. As maltreatment often is a family tradition, the result of an intergenerational transmission of neglect and abuse, the problem is extremely difficult to address effectively, especially in a court setting. The rate of intergenerational transmission of abuse is estimated to be 30% (Panel on Research on Child Abuse and Neglect, National Research Council, 1993). One third of the individuals who were abused and neglected as children can be expected to abuse their own children. The most frustrating moment for any juvenile court judge is to witness a dependent child become the mother of a dependent child. A child mother who has never felt safe, nurtured or loved as a young child must learn to create a healthy environment and develop a loving attachment with her baby who has been removed from her. At the same time, she must address her own problems resulting from her maltreatment as a child, within the 12-month period prescribed by ASFA. How can the juvenile court fulfill its legal mandate under these circumstances, especially in an adversarial system with the limitations of huge caseloads and inadequate services?

The difficulty in achieving these objectives is exacerbated by the probability that the social context within which the family lives is one of cumulative disadvantage. Success is often not feasible.

How can the juvenile court intervene to reduce the risk of transmission of child maltreatment from generation to generation in the families under its jurisdiction? Perhaps the most effective way to stop the intergenerational cycle of child maltreatment is to focus intensively on the youngest and largest cohort of children of the child welfare population immediately upon their entry into the jurisdiction of the court. At least one-third of the children in the child welfare system are babies and toddlers under the age of six (National Center for Child Abuse and Neglect, 1997), 25% are under age 2, and 20% are under one year of age (Dicker & Gordon, 2001). Yet the needs and problems of babies and toddlers are virtually ignored.

Directions for Making Changes in the System

The consequences of an anti-therapeutic child welfare system become more and more apparent as maltreated children become a part, albeit not a priority, of our national research agenda. Risk factors for a troubled start and uncertain future begin in the womb. Prenatal and perinatal factors present a host of latent and manifest risk factors that influence subsequent development. In fact, several studies have found an association between prenatal and perinatal complications and later delinquent or criminal behavior (McCord, Widom, & Crowell, 2001). How can a juvenile court begin to fulfill its therapeutic potential, remain within the confines of the law, and fill in the large gaps in the existence and provision of services provided by an under-funded, inadequate and often less than professional child welfare system?

To begin with, individuals who work in the child welfare system need to be educated about early intervention research and strategies that have proven effective in reducing child maltreatment and enhancing child well being. Workers in this area need to develop an understanding of the significant differences early intervention can make in child behavior, social and emotional development, mental health, cognitive development, and child health. Three examples of such interventions are important to note. First is the Infant Health and Development Program (IHDP), a clinical trial designed to test the efficacy of early childhood educational intervention including parental involvement and home visitation with low birth weight, premature babies in eight different sites. The results are most encouraging. After three years, the IQ levels of the children receiving intensive intervention were elevated from 6 to 13 points compared to the children in the control group who only received pediatric surveillance. Also, there were more reports of behavior problems in the children in the control group (Gross & Hayes, 1991). Second, from the Elmira Home Visitation Study, it was learned that an intensive home visitation program can result in a decrease in child maltreatment, substance abuse, and criminal behavior of the mother and the child (Olds, Henderson, Cole, Eckenrode, Kitzman, & Luckey, 1998). (It is important to note that the study concluded that effectiveness can be enhanced by careful selection and thorough training of the home visitors.) Finally, Ramey and Ramey (1998) demonstrated that early intervention greatly enhanced the development of chil-

dren whose mothers had little education and lived in poverty. The program children compared with the control group children had significantly higher IQs after three years and the effects held over time. They were less likely to repeat a grade in school and showed better achievement over the years.

The important new volume on the science of early childhood development from the National Research Council and Institute of Medicine, *Neurons to Neighborhoods* (Shonkoff & Phillips, 2000), developed by an expert committee of the Board on Children, Youth and Families, emphasizes that early environments matter and that nurturing relationships are crucial for healthy development. In this context, they emphasized that all children are wired for feelings and ready to learn. But the changing needs of young children are not being met by society, which requires rethinking and creative new strategies for policy and practices. One of the recommendations coming out of these policy and practice concerns is that substantial new investments are needed to address young children's socio-emotional and mental health needs. Essential first steps include more effective screening, early detection, treatment, and prevention strategies.

Home visitation and other types of intervention programs exist in every community funded by state and federal funds, and these programs can be accessed by the juvenile court. All pregnant mothers and children under the jurisdiction of the juvenile dependency court can be referred to home visitation programs and ordered to participate as part of the case plans. It is imperative that child welfare participants urgently shift their focus from the older child and begin to consider prevention by developing appropriate evaluation and treatment strategies for infants and toddlers. In addition to the fact that we know prevention and early intervention are important, research on early brain development shows clearly that stimulation, preferably in the context of a stable parenting relationship, is crucial for healthy development. The affection shown by parents to infants that includes touching, holding, comforting, rocking, and talking provides the best type of stimulation for the growing brain. Brain development is heavily dependent on early experience. Infants who are rarely spoken to, exposed to few toys, and who have little opportunity to explore and experiment with their environment may fail to develop fully the neural connections and pathways that facilitate later learning.

The Case of Linda and Katrina Brown: Part 1

In order to "bring to life" the discussion and illuminate some of the dilemmas faced in the juvenile court, we shall describe the situation of an actual family (except for the names and other identifying data) that is illustrative of the majority of cases that comprise the court docket day after day, especially in large urban jurisdictions. This case appeared under the jurisdiction of the first author, who is a juvenile court judge in Miami-Dade Florida.

Linda Brown, a mother of seven children, appeared in juvenile court after her children were removed from her care. The alarming reality of the emotional and psychological harm caused to these children presents a frightening picture seen over and over again. The extent of the deprivation of the children can be understood from the report by the psychologist who examined the family members.

The children of this family have been exposed to chronic emotional neglect and are experiencing symptoms of depression, emotional impoverishment, low self-esteem, low academic achievement and aggression. There are strong indications that they have been exposed to long term family and community violence (Miami-Dade Juvenile Court Evaluation Unit, 1997).

What can be done to prevent another generation of Brown children from facing this fate? Linda Brown came into dependency court for the first time in 1994 when a child protection worker visited her home. At that time, her children all lived with her. They included the two oldest children, Vanessa, 11, and Katrina, 10, together with twin daughters, aged 9; a mentally retarded son, aged 7; another son, aged 4; and another daughter, aged 3. The home was fly infested, unfit for human habitation, and emitted a foul odor. The children were dirty and there was no food for them as Linda used her food stamps to support her boyfriend. A 7-year-old boy who was mentally retarded was often left alone in the home. In 1994, when this family presented to the court, the Adoption Assistance and Child Welfare Act (PL 96-272, 1980) required reasonable efforts to reunify the family as a legal priority. The health and safety of the children were a secondary concern.

Services were offered and Linda was reunified with her seven children a year later in 1995. Linda had completed a parenting class that consisted of a series of lectures where success was measured by attendance in the class, not by the attainment of insight and learned skills.

After twelve calls to the abuse hotline (these are confidential, so their sources are not known), the children were removed again in August 1997. This time the allegations included physical abuse of the children by the mother's boyfriend. The children were living in the same filthy environment and they were found dirty and begging for food. The retarded child, now 10, was found unsupervised, in bed, wearing a dirty diaper. Linda was not home. The home was identified by local police as a frequent site of drug related activities.

In 1997, at her first appearance in court after her children were once again removed, Linda asked angrily how she could be expected to care for her seven children when she only received \$122 a month. Linda, whose I.Q. is 73, was not employed but earned money from time to time by babysitting. The children, now aged 6-14, were very closely bonded to their mother despite the fact that Linda's ability to parent was almost non-existent. Eventually, her parental rights were terminated.

The two oldest girls, Vanessa and Katrina, were removed from their mother again and placed with an aunt, and the other five children were placed in foster care. The girls were then sexually abused by the landlord when living in the home of their aunt. The girls reported that their mother's boyfriend had abused them as well. At age 14, Vanessa was pregnant and her younger sister, Katrina, was diagnosed with a venereal disease. All of the older children had dropped out of school and regularly run away from their foster homes to return to their mother, despite the fact that the mother's parental rights had been terminated and they were not permitted to reside with her.

This is not an unusual case. Children like Vanessa, Katrina and their siblings appear in every juvenile court in the United States everyday. The number of

children referred to child protection agencies nationwide is staggering; almost three million children a year (Panel on Research on Child Abuse and Neglect, National Research Council, 1993). The most serious cases result in an adjudication of dependency, in which children are removed from the home and the court assumes the legal role of parent. Approximately half a million children each year are under the jurisdiction of the courts, which represents nearly two percent of the children in every community (National Council of Juvenile and Family Court Judges, Permanency Planning for Children Department, 1998). In Miami-Dade County alone, this translates to 9,000 children annually (Florida Department of Children and Families, 2001), many of whom are infants. In Miami, 27% of the children in foster care are under the age of 5 (Florida Department of Children and Families, 2001).

In the case of the Brown family, the intervention was too little, too late. The court was unable to stop the cycle of deprivation, impoverishment, and violence from continuing from generation to generation. Vanessa and Katrina, caught in the cycle, are now child mothers. Both of their children have been removed from them by the juvenile court for virtually the same reasons they were initially taken from their mother. They are angry and they do not understand why their children cannot live with them. They have no idea what a baby needs in order to thrive and they are unable to care for their children. They are angry that something that belongs to them has been taken away.

Vanessa and Katrina have no support from the babies' fathers who have virtually abandoned the mothers and their children. The seventeen-year-old father of Vanessa's baby had dropped out of school and did not have a job. When the court asked how he spent his days, he responded, "I chill." He is now serving a prison sentence for aggravated battery. Katrina does not know the identity of the father of her child, Charles. After a paternity test was done, the man she identified as her baby's father was found not to be the biological father of the child.

Vanessa's child was removed within 2 months of birth. Vanessa was never willing to accept any services and could not overcome her own anger. She was defiant and disrespectful in court and refused to comply with any court order. Vanessa's parental rights have been terminated.

Katrina had been living in a foster home with her baby, Charles; however, at the age of 14 months, the child was removed from her care. Still under the jurisdiction of the court as a dependent child, the court would regularly see Katrina. She was the one child in the family who appeared to have the capacity and the desire to accept services and work with the court. When Katrina gave birth she was admonished that she would have to stay in school, cease her chronic running away, protect and care for her baby, accept mental health and parenting services or risk losing custody of her baby. At each hearing the court would implore Katrina to comply with her case plan, and she would be praised for doing well.

During one court appearance, Vanessa and Katrina, one a mother of an infant and the other a mother of a 1-year-old, were asked to watch a video entitled "It Feels Good to Help My Baby Learn" (Weissbourd, 2002). They were asked to write down three things that they learned from the video about being a good parent. Vanessa and the father of her baby refused to watch the video. Katrina watched and wrote:

Don't let your child cry for a real long time. Something is wrong and when the times get to hard and you can't handle it call an adult you can trust.

Babies cannot be spoiled. Don't shake the baby—the baby can get brain damage.

Unfortunately, Katrina began repeatedly to run away from her foster home with her baby. The last time the 15 year-old-mother and her one-year-old baby Charles were missing for two days. The baby was removed and Katrina decided to go back to her mother where she resided for several months. Katrina then disappeared for a while.

Six months after the removal of the baby, a petition for termination of parental rights was filed. Katrina was not in compliance with any services in her case plan although she was intermittently visiting her baby.

Katrina finally appeared in court and was served with the petition for termination of parental rights. Once again, in a desire to influence Katrina's behavior, the court begged Katrina to go back to school and agree to live in a foster home. She was told what the consequence would be of her refusal to accept the court's help. Many parents in dependency court are motivated only when they learn the next step in the process is termination of parental rights.

Katrina agreed to come back into foster care. The community's private foster care provider was asked to interview Katrina for placement. Katrina enrolled in school and in parenting classes and continued to have visitation rights with her baby. In addition, she was receiving individual counseling.

Since Katrina's entry into the Miami-Dade dependency court, first as a neglected child and then as a child mother, significant systemic, research-based reform has taken place. As described below, the dependency court itself has developed state-of-the-art assessment and evaluation protocols for infants and toddlers. It has also developed a dyadic child-parent psychotherapy program for babies and their parents, and it has created additional interventions described later in this article.

Initiatives in Miami-Dade Juvenile Court

Few jurisdictions provide court-based and court-created prevention and intervention opportunities for children and families. However, groundbreaking prevention and early intervention work is being done through a collaboration between the Miami-Dade County Juvenile Court and its early intervention partners. Several initiatives have been undertaken, with the first being a systematic examination of the developmental functioning and treatment needs in maltreated and violence-exposed young children.

“Prevention and Evaluation of Early Neglect and Trauma” (PREVENT)

The PREVENT initiative of the Dependency Court Intervention Program for Family Violence is a national demonstration project in the Miami-Dade Juvenile Court funded by the US Department of Justice, Violence Against Women Grants Office. PREVENT has developed a program to evaluate all infants, toddlers, and preschoolers who are adjudicated dependent by the court. During assessment sessions in a playroom setting, the parent and child are observed and videotaped engaging in a number of tasks during play interaction. Reciprocal bonding and

attachment is evaluated as well as the developmental and cognitive functioning of the child. By observing these children with their caregivers and allowing them to speak through their actions, behaviors, and emotions, it is possible to understand a great deal about their development, their needs for safety and security, and the quality of their relationship with their caretaker. In the initial PREVENT study, approximately 75 children and their parents were evaluated. While the assessments on this group were considered exploratory, the information obtained was quantitatively captured in established, standardized research measures, including the Bayley Scales of Infant Development (Bayley, 1993), the Peabody Picture Vocabulary Test, used for the older children (Dunn & Dunn, 1997); the MacArthur Communicative Development Inventories (Fenson et al., 1993); the Beck Depression Inventory II (Beck, Steer, & Brown, 1986); the Parenting Stress Index Short Form (Abidin, 1990); the Ages and Stages Questionnaire (Bricker & Squires, 1986); and a Parent–Child Observational Assessment and Manual modified from the Crowell Assessment (Crowell & Feldman, 1989; Crowell & Feldman, 1991).

The group results on these measures have been used to develop a formal program evaluation plan for the PREVENT initiative as it accumulates more cases. In addition to the quantitative, group data, in the formal evaluation the information obtained in the assessment sessions will be qualitatively captured and analyzed, informing judges with more individualized information about the particular children and families before them. More specifically, reports generated by the evaluations will be designed to combine the quantitative and qualitative data with a focus on the appropriateness in a particular case of court referrals for infants, toddlers, and/or caregivers to early intervention and therapy programs.

“Infant and Young Children’s Mental Health Pilot Project” (IMHPP)

A second major initiative was undertaken in 2000 to build on the previous pilot program and to expand services and capacity in infant mental health in the State of Florida the project, with the Miami Juvenile Court being one of three intervention sites chosen for. State funding was allocated to the juvenile court to establish an “Infant and Young Children’s Mental Health Pilot Project” (IMHPP) for maltreated infants and toddlers. Additional sites were established in both Pensacola and Sarasota, Florida, but the Miami project is the only one of its kind in a juvenile court setting.

The pilot program includes parents and toddlers in the dependency court system who participate in an evaluation and a dyadic therapy program for 25 weekly sessions with a trained clinician. Therapeutic interventions and parental guidance are provided through the court’s early intervention partner, the University of Miami’s Linda Ray Center, and are designed to help the parents learn new ways to respond sensitively and play reciprocally with their young children, to understand their non-verbal cues, and to follow their lead, supporting healthy development. For many caregivers, the parent–child interactive play is uncharted territory as most of them did not have similar positive experiences in their own childhood. Extensive assessments are completed on the parent and child to evaluate the quality of their interactions as they begin and end the program. This is an ongoing program. The following quantitative and qualitative measures are

being used to evaluate the program: the Beck Depression Inventory II (Beck et al., 1986); the Parenting Stress Index Short Form (Abidin, 1990); Ages and Stages Questionnaire (Bricker & Squires, 1986); and a Parent–Child Observational Assessment and Manual modified from the Crowell Assessment (Crowell & Feldman, 1989; Crowell & Feldman, 1991).

As of this time, only preliminary data are available on approximately 38 infants and their parents. These data strongly suggest that many of these very young children are having difficulties at the basic level of thought and speech development. More than half of the maltreated infants, toddlers, and preschoolers seen so far using the PREVENT evaluation suffer from significantly delayed cognitive and language development, placing them at serious risk for learning problems, difficulty expressing their thoughts and needs to others, and a lack of ability to understand their world. However, at the end of the second year of the program, the preliminary post-test results based on observational data suggest promising improvements in parental responsiveness to their infants and toddlers both behaviorally and emotionally. The children, consistent with the increased responsivity of the caregivers, appear to show more positive emotions, more persistence, and more emotional and behavioral responsiveness.

A third year of the IMHPP funding was awarded and will extend the opportunity for continued implementation of the model with more children and parents, allowing for formal statistical analysis of the results. Complete data analysis from the three years of the program will be available in June 2003.

“Miami Safe Start Initiative”

Concurrent with the clinical IMHPP pilot activities, the Miami Juvenile Court is implementing the Miami Safe Start Initiative for maltreated infants and toddlers. Funding for this program was awarded to the Eleventh Judicial Circuit in Miami from the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, to expand the community’s ability to provide intervention services to young children who are the victims of, or who are exposed to violence in their homes and/or communities. As a result of this initiative, the first Juvenile Court Early Head Start program for maltreated toddlers is being established in Miami. A pilot group of court-referred young children, who otherwise would go underserved in early intervention programs in the community, is enrolled in the comprehensive Early Head Start program during the day and concurrently receives dyadic therapy with their primary caregiver (Lederman, Osofsky, & Katz, 2001). The dyadic therapy for the infants and toddlers in the Miami Safe Start Initiative is again provided by the court’s early intervention partner, the University of Miami’s Linda Ray Intervention Center.

To date, 18 children have received services and been evaluated with their caregivers on the measures listed above. Overall, mothers report low levels of depression on the Beck Depression Index. This finding, while unexpected, is not uncommon among mothers who are evaluated in conjunction with a court hearing and do not want to “look bad” for the judge. On the Ages and Stages Questionnaire, just over 71% of the children showed delays in at least one of the domains, with the most prevalent problems being in language and communication. On the Bayley Scales of Infant Development, on average the children scored in the

borderline risk range, with a majority of them considered at serious risk for developmental delays. On the MacArthur Communication Developmental Index, used to assess vocabulary skills, the majority of the mothers reported children's expressive language to be below average. Evaluation of outcome data related to the effectiveness of the dyadic therapy and other interventions are currently ongoing. Again, as the number of children in the program increase, a more formal statistical analysis of the results is planned.

The Case of Linda and Katrina Brown: Part 2

Katrina and her son, Charles, who was now 2 years, 11 months old, recently appeared for a PREVENT evaluation. Charles was inhibited during the evaluation. He needed considerable encouragement from the examiner and his mother to participate. There was some concern about his receptive language skills. For example, when the examiner asked Charles to identify a particular picture in a book, Charles pointed to all of the pictures on the page. His articulation was poor and his speech was difficult to understand. He spoke in one-word sentences. From the Peabody Picture Vocabulary Test-III we learned that Charles falls within the Extremely Low range of functioning.

During the play period, the play was led by Katrina and consisted of labeling items and teaching, with minimal play interaction between Katrina and her son. Katrina appeared unable to allow Charles to explore and initiate himself. Charles was comfortable with Katrina, whose affect was neutral to positive, and they were not inhibited while playing together. Charles was content to follow his mother's lead. There were occasional smiles from Charles. When Katrina was instructed to leave the room, Charles continued playing with his toys and was not overtly distressed by his mother's absence.

Of concern were statements from Charles' day care teacher, who expressed frustration with Charles' aggressive behavior. She stated that he is very active and hits and bites other children. Charles will now be referred to an early intervention program operated by the school system for a full evaluation for adequate preschool placement and services. He will also be referred to the above-mentioned Miami Juvenile Court Early Head Start Program. In addition, Charles and his mother have begun the dyadic therapy initiated by the court through its IMHPP program, referred to above. Katrina continues to come to court and is lauded for her accomplishments. She is very actively involved in her school, maintains a B average, and wants to become a chef. She was recently nominated by her school for a special award for "turning her life around." Reunification with Charles appears imminent.

In sum, this new approach to prevention and early intervention can make a difference. For young mothers who have never been adequately parented and often are abused and neglected, it is not unexpected that they do not have the capacity to parent their own children. Indeed, they are continuing patterns of parenting that are familiar to them and the only ones they know. At the same time, these mothers often are attached to their babies and, although they are incapable of providing good care, do not want to lose them.

The IMHPP dyadic treatment approach focuses on the relationship between mother and baby in an effort to help the mother gain insight about how the "ghosts

in her past" (Fraiberg, Adelson, & Shapiro, 1975) interfere with her being able to care for her own baby. She is able to learn not only better parenting skills, but also more about her own conflicts with her baby that may interfere with her being able to nurture the child. For example, Katrina knew that it was not good for her baby to cry for a long time; however, she did not know what to do to help the child. And it is likely that she had no help from her mother or peers about what to do.

In dyadic therapy, the mother is also able learn more about how the baby's crying may make her feel helpless and even desperate. Katrina learned through the video that it is harmful to shake her baby. However, she also needed to learn what to do through modeling, learning how to play, how to follow her baby's lead, and how to experience the pleasure of responsive interactions. In this way, and with support and guidance, Katrina may be able to take advantage of her last chance to keep her baby.

An adjunct to the therapy and parental guidance is a sensitive and responsive child care environment in the Miami Safe Start Initiative that will offer stimulation to the baby and help support Katrina's responsible parenting role. All of these experiences are new to a mother who was a neglected and abused child. However, we know that a comprehensive approach for the baby, mother and environment is needed to effect change.

As of this date, Katrina has shown signs of success in response to programs sponsored by this court reform. Since this has led to the Court's hope that Katrina can learn to care for and be reunified with her baby, the termination of parental rights petition has been abated. Katrina, for the last time, is being afforded the opportunity and support developed through the court to learn how to care for her baby. This time the services she will be offered are the best that any community has to offer.

The Need to Educate Judges About Early Development

Forensic examinations in court settings rarely occur before age 5 because there is a general belief that there is nothing to learn from a child until he can verbalize. Courts appear to ignore the fact that there is a tremendous amount to be learned about a baby's health, well-being, and attachment relationship by observing him, and there are virtually no tools in a court setting to conduct the observations. The Individuals with Disabilities Education Act (IDEA) (2002) provides free entitlement for multidisciplinary screening for developmental functioning (commonly referred to as "Part C" for all children under the age of 3 if there is some indication of developmental delay). Children who are delayed have an "Early Intervention Plan" (EIP), developed by the professionals with the participation of family members or custodians, and are referred to appropriate services in the community. These children are re-examined and monitored.

State child welfare agencies are often unaware of this entitlement, and young maltreated children are not being routinely referred for this assessment. That is the case in Florida. The developmental and cognitive functioning of babies is virtually ignored in the child welfare system. When state agencies fail, courts must step in. Courts can make the referrals for Part C evaluations when the child welfare professionals fail. However, judges do not learn about these entitlements in law school or as part of judicial education programs. Multidisciplinary partnerships

and education are essential to increase judges' knowledge about such services and to give them more tools to help the many disadvantaged children that they see in the courtroom day after day.

Conclusions and Recommendations for Policy

Initiatives such as those taken in Miami–Dade Juvenile Court can be an impetus for practice and policy changes, so that maltreated babies and toddlers who are rarely seen and thought about in the courtroom will become a focus of the child welfare system and juvenile court. Such practice and policy changes can serve as the impetus for a change of culture through which the needs of the youngest children who are just beginning to exhibit delays are emphasized as strongly as the needs of the older children who more often capture attention because their untreated psychosocial problems have begun to manifest significant negative sequelae.

It has become clear through the work described in this paper that the maladaptive behavior of the older child should not be the first indication of a long undiagnosed disorder. The adolescent who appears in juvenile court who has dropped out of school, repeatedly runs away from out-of-home placements, refuses services, and engages in self-destructive behavior creates an often insurmountable challenge for the juvenile judge. Judges often feel frustrated and impotent because they are unable to protect the child under the court's jurisdiction. The change in focus and culture suggested in this paper would necessitate modifications to federal entitlements to include maltreated children as a priority for services. Part C entitlement criteria for services under IDEA, determined by each state, should include children who have been abused and neglected. Every young child in the child welfare system should receive a Part C evaluation and be eligible to receive the rich array of services that IDEA provides as a result of an adjudication of dependency. Maltreated children often exhibit emotional and social delays that should form a basis for intervention under Part C.

Maltreated children should receive priority placement in Early Head Start and Head Start programs. For the first time, the Department of Health and Human Services established a set aside for children in the child welfare system as part of the 2002 Early Head Start funding. This promising beginning must include an examination of modifications in the programs to meet the needs of maltreated babies and toddlers and their caregivers. Maltreated children do not have parents who will advocate for them and involve themselves in a proactive way in the school curriculum and programs.

Currently, comprehensive assessments required of children in the child welfare system in Florida are only available to children five years of age and older. Ignored are the children who can be helped immeasurably by early identification and immediate intervention with problems that are just beginning to emerge. The science of early childhood development must be a basis of practice and policy to maximize the child welfare system's potential to prevent and to heal while exercising its legal mandate to ensure child well-being, instead of overseeing crisis intervention when the harm has gone untreated and undetected. Volumes like *Neurons to Neighborhoods* (Shonkoff & Phillips, 2000) must take their place beside the statute book.

The juvenile court can be the leader in gathering, organizing, and even creating community resources to fulfill the statutory duty of the court to heal the child. An important first step is to make child development research and the possibilities for prevention and intervention strategies available and understandable to the lawyers, judges and social workers who comprise the child welfare system. Through a combination of judicial leadership, consultation with experts, and collaboration with the pediatric and early childhood professionals in the community, prevention can be made a priority in juvenile court. Many dependent children only see physicians in the event of medical emergencies and do not receive well-child care or other professional intervention. By putting interventions in place like those described in this paper, the court can play a crucial role in ensuring, often for the first time, that all children receive a chance for success through early evaluation, treatment and monitoring to take advantage of the best resources each community has to offer. For some children and families, this will make all the difference.

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