CHILDREN'S COURT OF VICTORIA

SUPPLEMENTARY SUBMISSION

to the

PROTECTING VICTORIA'S

VULNERABLE CHILDREN INQUIRY

6 SEPTEMBER 2011

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ABBREVIATIONS

ADR	Alternative Dispute Resolution (aka Appropriate Dispute Resolution)
BCG	Boston Consulting Group
BERC	Business Expenditure Review Committee
CPLO	Child Protection Litigation Office - formerly Court Advocacy Unit (CAU)
CYFA	Children Youth and Families Act 2005 (Vic)
DHS	Department of Human Services
DOJ	Department of Justice
DRC	Dispute Resolution Conference
GIC	Governor in Council
IAO	Interim Accommodation Order
IPO	Interim Protection Order
NMC	New Model Conference
VCAT	Victorian Civil and Administrative Tribunal
VLA	Victorian Legal Aid
VLRC	Victorian Law Reform Commission
WCJC	William Cooper Justice Centre

EXECUTIVE SUMMARY

The Panel of Inquiry has invited the Children's Court to make supplementary submissions on some of the themes that have emerged during the course of its investigation.

The inquiry considered material relevant to the Children's Court that included:

- the Victorian Law Reform Commission's (VLRC) 2010 Report, the Ombudsman 2009 Report and the Premier's Taskforce 2010 Report;
- written and verbal submissions from a number of community service organisations, professional groups and individuals; and
- matters raised in consultation with the Inquiry's Reference Group and consultation with Department of Human Services (DHS) Child Protection staff.

The court provides the following summary of its supplementary submission:

A court of law

The Children's Court is a court of law and conducts its hearings in an open and public manner. The court provides reasons for its decisions and is accountable for its decision-making through the appeal process. The court does not support replacing the current court structure with a panel/tribunal system. Recent reviews of child protection systems in other jurisdictions have also rejected such change.

An effective and efficient state-wide court

The Children's Court delivers an effective and efficient service to the Victorian community and engages with a wide range of agencies, organisations and groups regarding its work. The court is implementing the recommendations of the Child Protection Proceedings Taskforce and is actively involved in developing Alternative Dispute Resolution (ADR) processes and specialist lists. Developing some of these initiatives will require the provision of appropriate resources. In particular, the court requires the appointment of additional judicial officers, registry staff and administrative staff. The court is currently under-resourced.

Children's Court proceedings

The current use by the Department of Human Services (DHS) of the apprehension process contributes to family members adopting an 'adversarial stance' at the commencement of proceedings. A focus on intervening in a crisis undermines an approach based on the concept of 'cumulative harm'. Cumulative harm is a concept that the court fully understands and applies in appropriate cases.

Contested hearings and court culture

The court exists in an adversarial system that requires the parties to present relevant admissible evidence. Within the constraints of the current legislation, the court has led measures to improve ADR and develop problem-solving approaches. The court acknowledges that the experience for workers appearing in court can be difficult. However, the court is committed to implementing measures to assist in addressing these issues including implementing best practice ADR, developing specialist lists, moving some matters out of the Melbourne court, participating in collaborative training and encouraging measures designed to improve collaborative practice.

Responses to other themes and issues such as reducing the range of orders, children as a party, a court of record, specialist lists, sex abuse cases and high frequency child contact

The court submits that the current system of child protection adjudication should not be fragmented and that its New Model Conference (NMC) process is a good model for enhancing child centred agreements. The court submits that the current range of orders is appropriate and reducing the range will limit the options available to the court and result in more contested hearings. The court agrees with the principle that a child should not be required to attend court unless the child has capacity to understand the proceedings and wishes to attend. The court is developing two specialist lists – a Koori Family Division list and a Family Division sex abuse list. Resources would be needed to implement these proposals.

Children's Court Clinic

The clinic provides expert evidence to the Children's Court that assists in its deliberations. In many cases, the report provided by the clinic is the only independent expert evidence provided to the court. It appears that some people have been critical of the court for simply 'rubber-stamping' clinic recommendations. Recent research shows that such anecdotal assertions are unfounded. It has also been suggested that the evidence of a clinician cannot be tested in court. Such a suggestion is incorrect.

SECTION ONE

A Court of Law

Courts are valued in a democratic community as the third arm of government. Courts are independent of the executive and the legislature and offer open and accountable decision-making in a society governed by the rule of law. A court guarantees all parties the right to be heard and is not subject to the influence of any party no matter how powerful. As one former Chief Justice has noted, "the law restrains and civilizes power".[1] He continued -

> *"When the jurisdiction of a court is invoked, and the court becomes the instrument of a constraint upon power, the role of the court will often be resented by those whose power is curbed. This is why judges must be, and must be seen to be, independent of people and institutions whose power may be challenged before them. The principle that we are ruled by laws and not by people means that all personal and institutional power is limited".*[2]

In its child protection jurisdiction, the Family Division of the Children's Court of Victoria has the statutory power to hear a range of applications and to make a variety of orders upon finding that a child is in need of protection. The legislative provisions of the *Children, Youth and Families Act* 2005 (CYFA) govern the operation of the court.

The court exists in an adversarial system that requires the parties to present relevant and admissible evidence. This includes the ability to call expert evidence. The court does not have an investigative arm like the Coroners Court, nor does it have the power to collect evidence or conduct an investigation independent of the parties involved in the case.

The court has argued for many years for amendments to the legislation to allow for a more inquisitorial or less adversarial approach in child protection cases[3]. In its recent submission to the VLRC, the court proposed legislative amendments modelled on the Family Court's 'less adversarial trial' model.[4] The court also supports facilitated conferencing as a process to assist parties to reach agreement. The court has a long-standing commitment to ADR and, in more recent times, has developed a new model for conferencing that was endorsed by the Child Protection Proceedings Taskforce.[5] The court is now implementing the new model process in Melbourne and would like to expand this model throughout Victoria. Additional resources would be required to support this expansion. The court also supports the development of specialist lists. It is already working on the development of a Koori Family Division list and a specialist list for sex abuse cases in the Family Division. The matters raised in this paragraph are discussed later in this submission.

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[1] "The Rule of Law and the Constitution" , The Hon. Murray Gleeson AC, ABC Books, 2000 at p. 1.
[2] Ibid p. 2.
[3] See the discussion at p. 29 of the court's submission to the VLRC.
[4] See submission to VLRC at pp. 75-83 and Appendix 7 and Appendix 8 at pp. 119-124.
[5] Membership of which included the Secretary of the Department of Justice, Secretary of the Department of Human Services, the President of the Children's Court, the Child Safety Commissioner and the Managing Director of VLA.

Court decision-making

The judicial members of the court engage in judicial decision-making with respect to those applications that come before them. The court hearing is conducted in an open and public manner although there are limitations on the way proceedings can be reported. Proceedings are recorded and parties are able to apply to the court for a copy of the recording upon payment of a fee.

The court provides reasons for its decisions and in the overwhelming majority of final contests provides detailed written reasons. The court is accountable for every decision it makes through the appeal process. As with all courts, "*the reasons for decision are tested and, if wrong, corrected in the appellate courts, not the court of public opinion*".[6]

The relevant legislation that governs the operation of the court provides for a comprehensive system of appeals and reviews of Children's Court decisions. This comprehensive appeal process is available to any party aggrieved by a decision of the court and includes a right of appeal to the Supreme Court from the court's decision to make, or refusal to make, an interim accommodation order (IAO).

In the financial year 2007-2008, the Family Division of the Children's Court made 13,499 orders.[7] Only 12 cases were subject to appeal or review.[8] Two cases involved the complete over-turning of the court's orders and a third case involved a partial over-turning. There were only three cases out of 13,499, where the court's decision was altered by a superior court. Notwithstanding the low number of appeals, there have always been (and most likely still are) some people within the child protection sector who oppose judicial oversight of child protection decision-making.

In his 1993 review of child protection, Justice Fogarty said this:

> *"A significant reason for the existence of the Children's Court is that it stands independent of the Department, the children and the parents and represents the community in the determination of these extremely difficult and delicate issues which are likely to have a profound, perhaps permanent, effect on the lives of the young children involved. Consequently, it is necessary for the court to be independent and to be seen to be independent, especially from the Department, which is a party in every proceeding before it. It must have the confidence of the parents who come before it and the confidence of the community that it will act in an independent way in accordance with the legislation.*
>
> *At times, I was left with the impression in discussion with some officers of the Department, that they would really like to regard the court as a natural extension of the Department and that they are uncomfortable with its independence. Whilst that view was not articulated in a direct way, it is important that even at a subconscious level that attitude be recognised and rejected. I felt at times, both at a high level within the Department and from speaking with some workers, that there was a view that because*

[6] See Chief Justice Warren in *The Age* newspaper at page 15 on 23/9/2010.
[7] This figure excludes orders extending interim accommodation orders and orders under family violence or stalking legislation.
[8] The court has endeavoured to obtain updated information on appeals. However, the registries of the Supreme Court and the County Court advise that they are unable to provide such statistics.

> *a notification of abuse had been investigated by the Department and because it had reached a conclusion as to what order should be made, there was something obstructive about a process by which those opinions and views were independently assessed and at times rejected."* [9]

There are some critics of the court who have come very close to suggesting that the whole system be re-designed because it is too hard for DHS, the party initiating applications in the court. One writer has said of that argument -

> *"We urge caution about a review of the Children's Court in a context where the issue of concern is the stress and trauma this process causes for Child Protection staff. There are many fundamental reasons why a court process is necessary to ensure the protection of vulnerable children and their families – fairness and the rule of law should not be sacrificed lightly for a risk management approach that puts expediency ahead of thoroughness."*[10]

The court accepts that many child protection workers find contested court cases extremely difficult. In the court's experience, the difficulty for child protection workers is due to a number of factors including inexperience, a lack of rigorous training and a lack of support for the task of collecting and presenting evidence, huge workloads and a lack of time to prepare for court. The unhappiness of their court experience is explained by problems within Child Protection's work environment.[11]

In the court's view, proper supervision and support, reduced workloads, allowable preparation time and training in general forensic legal matters would assist in resolving the stress of legal proceedings on child protection workers. The court would be willing to be involved in such training.

The Scottish model

Some submissions to the panel suggested changing the system of adjudication in child protection but provided little detail about how this could work in the Victorian context. Certainly, there was no attempt to grapple with the relevant term of reference of this inquiry and no attempt to deal with the options presented by the VLRC. Indeed, the VLRC report is dismissed in one submission as suffering "from the vice of being a review of the law by lawyers".[12]

The VLRC provided cogent reasons for rejecting a panel model or tribunal system in Victoria[13]. The reasons included acknowledging the constitutional complexities of change identified by the court in its submission. It is reasonable to suggest that those proposing to change a court based system that has served the Victorian community well for many years, would have developed their position in a sophisticated way, would have tried to present evidence to support it and would have tried to engage with the reasoning of the VLRC.

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[9] "Protective Services for Children in Victoria" (1993), pp. 142-143.
[10] Rebecca Boreham, "The chance to be heard", *The Age*, 21/12/09 at p. 17.
[11] For a fuller discussion see the court's submission to the VLRC at pp. 28-29.
[12] See submission to Protecting Victoria's Vulnerable Children Inquiry – Anglicare Victoria, Berry Street, MacKillop Family Services, The Salvation Army, Victorian Aboriginal Child Care Agency and the Centre for Excellence in Child and Family Welfare at p. 52.
[13] See pp. 206-212 of the VLRC report.

The court provided a detailed response to the VLRC on the issue of courts, panels or tribunals. A copy of that part of the court's submission is attached to this document as Appendix 1.

In addition to the matters that were presented to the VLRC the court makes a number of additional points. First, a number of recent reviews of child protection systems in other jurisdictions have looked at panels or tribunals (instead of courts) and rejected them. The Layton review in South Australia, the Wood review in New South Wales and the very recent Family Justice Review in England all investigated other decision making models and determined that they were not appropriate.

For example, the Wood report quoted from a Department of Community Services (DoCS) submission highlighting some of the problems with the Scottish model and continued –

> "*The Inquiry does not however favour a model that includes lay, volunteer panels who often lack the rigour and experience in decision making that is necessary in such a sensitive and complex area*."[14]

The English review noted that the Scottish model "*offers children less sense of permanence*"; has "*issues around consistency of decision making;*" and that introducing such a model would be "*disruptive and would not offer sufficient advantage over our current court led process*".[15]

Second, panels "do not appear to significantly reduce the number of cases subject to adversarial processes, as some 80% of cases end up moving to the Sheriff Court for establishment". [16]

Third, it has been said of the Scottish system that the existence of a number of different decision-making arenas for child protection was "cumbersome" with the Children's Hearing System effectively adding "an additional layer to the child protection system when compared with the system in England and Wales".[17]

Finally, the court submits that it is instructive to look at the outcomes produced by the Scottish system. The court has reproduced a table from the Australian Institute of Family Studies (AIFS) submission to the VLRC. The table presents comparative child protection data from 2007/08 for Victoria, Australia and various other western countries.[18] It shows that, compared to Victoria (and Australia and most other

[14]See Wood report at p.489.
[15] See Family Justice Review Interim Report at pp. 115 and 116.
[16] See p.5 of the "Discussion Paper on Alternatives for Hearings and Making Decisions in Child Protection Matters, DoCS, February 2008 (also p. 28).
[17] Safeguarding and Protecting Children and Young People by Anne Stafford and Sharon Vincent, Dunedin Academic Press Limited, 2008 at p.56.
[18] Briory Horsfall et al, 'The AIFS Submission to the VLRC Review of Victoria's Child Protection Legislative Arrangements (April 2010).

jurisdictions), Scotland has a very high number of children on care orders and a very high number of children in out of home care.[19] The court accepts that this does not necessarily mean the Scottish system is "worse" than the Victorian system. It all depends on "how harmful or helpful it may be to be in care in that system".[20] Nonetheless, in comparing one approach to another the outcomes produced are worth considering.

Table 1: Child protection statistics, rate per 1,000 children (0-17 years), comparing Victoria, Australian average and international populations

Nation	Annual notifications/ reported/ referred cases	Annual total substantiated/ registered cases	Children in notifications /referrals	Children in substantiations/ on child protection register/ plan	Children on care orders/ looked after/ in care of authorities	Children in OOHC/ looked after (not with parents)
Victoria	35.1	5.2	27.6	5.0	5.0	4.3
Australia	67.2	10.8	41.0	6.5	7.0	4.5
United States	43.0	6.3	77.8	n.a	n.a	6.7
England	49.0	3.1	n.a	2.7	5.4	5.0
Scotland[21]	11.8	2.7	n.a	2.3	14.0	8.0
Wales	68.1	4.6	n.a	3.6	7.3	6.4
Northern Ireland	7.1	3.5	n.a	4.8	5.6	4.2
Canada[22]	n.a	21.7	n.a	n.a	9.2	9.0
New Zealand	82.5	19.0	n.a	n.a	n.a	4.2

[19] The calculations for "Children on care orders" and "Children in OOHC" for Scotland are based on the "Statistics Publication Notice: Children Looked After Statistics 2007-2008", a copy of which is attached to this submission as Appendix 2A. A copy of working sheets for the calculations made on this issue for the AIFS paper are attached as Appendix 2B. The court has also attached a graph prepared by the Scottish Government on "Children looked after per 1,000 of 0-18 population by type of placement, March 1987-2008" as Appendix 2C. For completeness, the legal definitions are attached as Appendix 2D.

[20] Quoted to the President of the Children's Court by Professor Dorothy Scott.

[21] See Appendices 2A, 2B, 2C and 2D.

[22] Trocmé et al., 2005. (includes Quebec). Children in care and out-of-home care from Federal/Provincial Working Group on Child and Family Services Information (2005). Child and Family Services Statistical Report 1998-1999 to 2000-2001. Excludes Quebec and Nunavut. The total numbers in care and out-of-home care calculated using provincial/territory estimates and exclude Quebec and Nunavut. There are no national level comparable data for child protection or out-of-home care in Canada. Therefore, this figure is an estimate only for purposes of discussion.

In Summary

- ❖ The Children's Court is a court of law and exists in an adversarial system that requires all parties to present relevant admissible evidence.
- ❖ Criticisms of court decision-making are not supported by appeals by DHS.
- ❖ The court opposes adopting a panel or tribunal system in Victoria. Various recent reviews conducted in other jurisdictions have rejected the suggestion that a court based model should be replaced by a panel or tribunal system.

SECTION TWO

An Effective and Efficient State-wide Court that Engages with the Community

The court submits that it provides an effective and efficient service for the children of Victoria including those in need of protection and child offenders, categories that often overlap. The Children's Court provides a responsive service in both the Melbourne metropolitan area and throughout rural and regional Victoria. The court is able to offer a preliminary hearing to any child apprehended by Child Protection (as allegedly being in need of protection) and to all other parties within 24 hours of the child's apprehension.[23] In conjunction with the Magistrates' Court After-hours Service, it also provides DHS with the ability to seek safe custody warrants for children believed to be in need of protection throughout the whole state 24 hours a day, 365 days a year.

In 2009/10, the court resolved 46.8% of primary applications (or 1,301 cases) within three months of the first hearing and 77.8% of cases within six months of the first hearing. In analysing these figures, it is important to note that the court made 795 Interim Protection Orders (IPOs). These orders require the court to adjourn the proceedings for three months before they can be finalised. The court will also present material later in this submission indicating that the major part of the court's workload involves the determination of secondary applications (close to 7,000 applications). Between 75%-80% of these applications are resolved within three mentions.

The court acknowledges that in the small percentage of cases that proceed to contest, there is an unacceptable delay between the date of a dispute resolution conference and a final contest date. In 2002-03, it was nine weeks. By the end of July 2011, it was 18 weeks. The court has introduced strategies to reduce this delay, including new ADR processes that are discussed later in this submission. One obvious way to address this issue would be to appoint more judicial officers. The court has initiated a budget bid for 2012-13 in which it seeks funding for that purpose.

Children's Court engagement

One submission to the panel has suggested that the court has been slow to engage with DHS (and more broadly), to bring about a 'better' system. The court welcomes the opportunity to refute that assertion. Later in this submission, the court will highlight how it established the working group to develop a model of 'best practice' ADR and how the Child Protection Proceedings Taskforce (the taskforce) adopted the recommendations of that working group. The working group is continuing to meet and oversee the NMC process. The court will also highlight the multi-disciplinary work on the development in the Family Division of specialist koori and sex abuse lists.

[23] The CYFA provides that unless an apprehended child is brought before the court within 24 hours after the child was taken into safe custody, he or she must be brought before a bail justice as soon as possible within that period of 24 hours for the hearing of an application for an interim accommodation order. See sections 242(2) & 242(3).

This section of the court's submission, will focus on the work of the court in implementing the taskforce recommendations, the work of the court in the community, including interagency cooperation and the research projects undertaken in the court during the past five years. Finally, the court will make some general comments on its resource needs.

Implementing taskforce recommendations

The court is progressing the Child Protection Proceedings Taskforce recommendations in accordance with the implementation plan and phased funding. The following sections provide a brief overview regarding the status of those recommendations:

a) *New Model Conferences* - The Implementation and Evaluation Plan provided in August 2010 set out implementation milestones for New Model Conferences in the Children's Court. The phase one rollout was implemented within the set timeframe. Phase two rollout involved the relocation of the Conference Unit by January 2011. This has not occurred because the William Cooper Justice Centre (WCJC) has been unavailable for occupation. Conferences are currently conducted at the Victoria Legal Aid (VLA) Roundtable Dispute Management office or at the Children's Court, pending the completion of building works at WCJC. There is currently no capacity to list more conferences while accommodation is restricted. The court anticipates that the Conference Unit will be relocated by early 2012. There is a full discussion of NMCs later in this submission.

b) *Dispute resolution conferences in the regions* - Regional courts continue to operate under the 'old' model of dispute resolution conferencing – conducted by registrars in addition to their normal duties. There is no funding for the introduction of NMCs outside the metropolitan area. In 2009-10, regional courts conducted 38% of all dispute resolution conferences. Persons appointed as convenors after January 2011 must meet performance indicators developed by the court and included in the schedule to the Order in Council. This year, the Children's Court will fund accredited LEADR training for 21 country registrars to assist them in the conduct of conferencing in their regions.

c) *Legislative amendments* - 'Convenors' are responsible for undertaking all dispute resolution conferences (DRCs) within Part 4.7 of the Act. Under section 227 of the CYFA, all DRC convenors (including any court registrar undertaking convenor duties) are required to be appointed by the Governor in Council (GIC) on the advice of the Attorney-General. The GIC appointment process presents a significant challenge to efficient court administration. Considerable delay and inconvenience is occasioned in the drafting of the relevant orders, briefs and documents necessary for GIC appointments when appointing new convenors, or extending the GIC appointment terms. The court has recommended to government an amendment to the legislation that removes this requirement and allows convenors to be appointed by the President of the court. It is anticipated that this amendment will be included in a Justice Miscellaneous Bill.

d) *Decentralisation of the Family Division* - The court has tentatively secured a two-year booking of two courtrooms at the WCJC. The court hopes to relocate

Family Division cases from the DHS Eastern Region to that venue in 2012. The court is working with the Magistrates' Court in planning for future court facilities to meet the growing demand in the Casey and Wyndham areas. The Children's Court is determined to build capacity to conduct Family Division sittings in venues outside the Central Business District (CBD).

e) *Improving preparation for court* - Various forms and processes have been introduced at Melbourne Children's Court and at the Moorabbin Justice Centre, which have improved preparation by the parties and supported early information exchange.

f) *Facilitating children's participation without the need for them to attend court* - A Child Participation and Representation Working Group has been formed by the ADR Working Group. The Working Group has strong representation from DHS. The Principle Practitioner within DHS (Robyn Miller) is a member of the group.

g) *A more collaborative approach between court users* - The court has been consulted by DHS and VLA during the development of a Code of Conduct.

h) *Improving the physical environment of the court* - The court cannot reduce the physical burden on the Melbourne Children's Court until the WCJC is operational. Once the relocation of part of the court's caseload is finalised, the court can use allocated funds to make minor improvements to the Melbourne building. The court is involved in the Legal Services Master Plan that is concerned with the infrastructure and capacity of suburban court venues.

i) *Improving legal and administrative processes to reduce time in court* - Legislative reform that saw the repeal of the 21-day limit for certain types of IAOs and the abolition of suitable person undertakings has improved process within the court and, one assumes, has reduced file handling within the Child Protection Litigation Office (CPLO). In addition, an electronic diary for court listings has been implemented at Melbourne to assist in reducing delays.

Engaging with the community

Judicial officers of the Children's Court regularly engage with groups of tertiary students studying Social Work, Community Services Work, Children's Services and Maternal and Child Health. Some of these students may gain employment working in child protection and associated areas of the welfare sector. Magistrates also regularly talk to groups from community organisations including foster carers.

The court maintains a website that is available to anyone who is interested in its work. The website includes comprehensive Research Materials, published papers, de-identified decisions on cases that involve points of principle and general information about the court. The website also has a virtual court site that includes videos, virtual tours, information on court processes and tips for going to court. The court is also part of a Courts Portfolio Community Engagement Working Group, whose efforts this year include developing a strategy for community engagement.

A collaborative approach to professional development

On a monthly basis, a magistrate facilitates an information session with a group of new child protection workers at Melbourne Children's Court. This session forms part of the DHS 'Beginning Practice' training program for new workers. Victorian Aboriginal Child Care Agency (VACCA) workers often attend these sessions. The court also has a strong relationship with DHS Child Protection and Youth Justice Professional Development Unit.

In addition, the court regularly invites guests to speak on various aspects of child protection. Over the past 12 months, guests have included Muriel Bamblett and Suzanne Cleary (VACCA), Ric Pawsey (Take Two), Dr Bruce Perry (American psychiatrist and expert on child trauma), Dr Marion Brandon (University of East Anglia) on child deaths and serious injury through child abuse and neglect, Karen Mapleston (DHS) on family coaching, and representatives from the Northern Territory on indigenous family group conferencing. The court also recently spent a day at the Queen Elizabeth Centre talking with staff about the work of QEC and the work of the court.

The Training Board

In 2010, a board of senior management staff from the court, DHS, Department of Justice (DOJ) and VLA was established to examine ways of delivering training and professional development to agencies and lawyers working in the Family Division of the Children's Court. On 16 and 17 June 2011, the Training Board was responsible for the inaugural Child Protection Legal Conference. The conference was a significant achievement in delivering cross-disciplinary professional development.

The Secretary of the Department of Justice and the Secretary of the Department of Human Services opened the conference. The program opened with a panel discussion and workshop on 'A day in the life of...' in an effort to aid all system participants to gain a better understanding of each other's roles. The experience of children, the role of legal representatives and the concept of working collaboratively were also examined.

The board has considered the views of child protection workers, set out in the *Child Protection Workforce: a Case for Change* report, and feedback gathered from participants at the Child Protection Legal Conference. The main themes identified for prioritisation include:

- facilitating future Child Protection Legal Conferences (for all court participants);
- arranging quarterly workshops/practice forums for court staff, VLA, CPLO lawyers and child protection workers on particular topics (e.g. interviewing children, ADR negotiation, child development and trauma); and
- improving training for child protection workers in evidence gathering, report preparation and court appearances.

It is anticipated that the board will continue to make recommendations to DOJ to inform its annual expenditure on multi-disciplinary training. In addition to facilitating these events, each agency represented on the board is committed to exchanging information, to ensure that those working in other parts of the system have access to training and expertise.

Multi-disciplinary training

With the introduction of NMCs in August 2010, the court participated in extensive joint training sessions for groups of practitioners including:

- DHS child protection practitioners;
- VLA lawyers;
- private legal practitioners;
- DHS CPLO lawyers; and
- barristers.

The training was conducted at the conference centre at VLA and covered topics such as the background to the changes, the guidelines for NMCs and the expectations regarding the roles and behaviour of participants. The training sessions provided an opportunity for practitioners to improve their understanding of other people's roles within the process and to observe a mock NMC.

In addition, the court was involved in four training sessions held for child protection practitioners from the Preston office prior to the rollout of NMCs in the North and West Metropolitan Region. Additional training sessions will be scheduled prior to the rollout of the NMC process in the Eastern and Southern Metropolitan Regions.

Court delivered training/professional development

The President and magistrates regularly address conferences, seminars and public forums in relation to the work of the Children's Court. Some of these include:

- facilitating court skills workshops in all metropolitan and regional offices of DHS to improve understanding of the court process;
- conducting regular lectures at Monash University and Leo Cussen Institute;
- presenting on NMCs to the Australasian Statutory Child Protection Learning and Development Group;
- attending agencies such as the Queen Elizabeth Centre to present information about the work of the Children's Court; and
- involvement in bail justice training.

Inter-agency collaboration

The ADR Working Group was established in December 2008. This working group has ongoing meetings every six to eight weeks involving the court, VLA, Child Protection, CPLO, private solicitors and the Victorian Bar. The Koori Family Division Working Group has representation from Aboriginal agencies, DOJ, DHS and the court. The Sex Abuse Working Group also has broad representation and will be discussed more fully later in this submission.

The State Manager

The creation in 2010 of the State Manager role in the Children's Court has enabled the court to engage with stakeholders at the highest management level. The State Manager liaises regularly with DHS, the CPLO and VLA to identify trends, issues and opportunities that may affect the Children's Court state-wide operations. The State Manager also assists in establishing consistency in the regions, supportive relationships in those areas, and organising court user forums at venues outside of Melbourne.

Research projects

The Children's Court regularly hosts researchers with an interest in the work of the court. Researchers, often completing PhD studies, are required to seek the approval of the President for the research project. They are also required to seek approval from the DOJ Human Research Ethics Committee and to sign a deed of confidentiality with the court. Many researchers will spend a day or days per week at the court over a period of months extracting data from court files and from the court's computerised case management system. The following research projects have been conducted at the court during the last five years:

Year	Research Project
2011	Dr Jess Dart, Clear Horizon Consulting Pty Ltd. Project entitled "Monitoring and Evaluation of New Model Conferences in the Children's Court".
2011	Dr Stuart Thomas, School of Psychology & Psychiatry, Monash University. Project entitled "The Changing Face of Youth Violence" (Children's Court Clinic data).
2011	Ms Briony Horsfall, Swinburne University of Technology. Project entitled "Children's Voices in Decisions About Their Best Interests: The Children's Court Context"
2011	Ms Aino Suomi, University of Melbourne. Project entitled "A Comparison of Clinicians' Recommendations and Magistrates' Court Orders for Protection Matters Referred to the court Clinic by Magistrates of the Children's Court of Victoria".
2011	Associate Professor Jeanette Lawrence, University of Melbourne. Project entitled "Analysis of the court's Processing of Secondary Protection Applications for Young Children Returned to the Melbourne Children's Court After Final Orders".
2010	Ms Greta Clarke, Victorian Aboriginal Legal Service Co-operative Ltd. Project entitled "Female Koori Youth and Diversionary Mechanisms: A Way Forward".
2010	Sentencing Advisory Council Project entitled "Ten Years of Sentencing in the Children's Court of Victoria".
2010	Ms Lillian De Bortoli, Monash University. Project entitled "Establishing and Comparing the Validity of the Structured Decision Making (SDM) and the Child Protection Risk Assessment (ChiPRA) Instruments Used to Assess Risk in Child Protection Practice."
2008 – 2010	Mr Max Travers Project entitled "The Sentencing of Children: Professional Work and Perspectives".
2008 – 2010	Associate Professor Rosemary Sheehan, Monash University and Professor Allan Borowski, La Trobe University Project entitled "Challenges, Possibilities and Future Directions: A National Assessment of Australia's Children's Courts".
2008 – 2009	Professor Allan Borowski, La Trobe University. Project entitled "Evaluation of the Children's Koori Court".
2007	Dr Teresa Flower & Dr Rosemary Purcell, Monash University Project entitled: A Study of Adolescent Stalkers: Clinical and Offence Characteristics".
2006	Dr Liam Tjia, Monash University. Project entitled "The Evidence Given by Expert Medical Witnesses in the Children's Court of Victoria Regarding Inflicted Injury and Future Research".
2006	Dr Rosemary Sheehan, Monash University and Magistrate Greg Levine. Project entitled "Parents as Prisoners: Maintaining the Parent/Child Relationship"

The resource needs of the court

In 2007, Boston Consulting Group (BCG) recommended to the former government that the Children's Court be funded (over three years) for four additional magistrates, a judicial registrar, 10 registry staff, one staff member to support the judicial registrar, a research officer, a pre-hearing conference coordinator and an assistant registry manager.

Over time, four additional magistrates were appointed, based at Melbourne. Two of them were appointed as acting magistrates. Generally, when a magistrate is appointed, there is related funding for 2.5 registrars. However, this did not occur for the Children's Court because two of the appointments were acting magistrates - even though they were (and are) working full-time. Apart from funding five registry staff no other positions were funded. This has placed considerable pressure on the court's Melbourne registry.

The staffing structure of the Children's Court does not contain any positions for research, project development, business analysis, or support for the judiciary and senior management. The court needs funding support to build capacity in these areas, to progress initiatives and business improvement.

The court has estimated that it immediately needs funding for a Chief Executive Officer and an Executive Assistant (Grade 3) to the President, a Research Officer (Grade 4) and a Project Manager (Grade 5). The court has provided this information to DOJ. The court is developing a Budget and Expenditure Review Committee (BERC) bid that seeks funding for three magistrates, nine registry staff, and the administrative positions mentioned above. A Research and Policy Officer position was recently advertised, but the court will fund this position internally.

The Children's Court budget allocation only funds operations at the Melbourne Children's Court and there is no designated position or definitive resource allocation for the jurisdiction's operations outside the CBD. The 2010-11 budget outcomes for the court were less than 1% in deficit. The Children's Court Clinic (funded from the Children's Court budget) continues to be under-funded (39% deficit in 2010-11).

In Summary

- The Children's Court provides an effective and efficient service for the children of Victoria. It is able to conduct preliminary hearings for any child apprehended by DHS within 24 hours of the child's apprehension or on the next court sitting day.
- The Children's Court engages with DHS, community groups and other organisations on the work of the court. The court also participates in a training board delivering joint training and professional development.
- The court is currently progressing the recommendations of the Child Protection Proceedings Taskforce.
- The court participates in working groups on ADR, Koori Family Division cases and sex abuse cases.
- The court is under-resourced and will need funding assistance if it is to reduce delay, better support country courts, expand the NMC model throughout the state and conduct specialist lists.

SECTION THREE

Children's Court Proceedings

How matters come before the court

It is important to know how the court becomes involved in child protection matters. The Family Division of the Children's Court becomes involved in the life of a child when DHS decides to invoke the court's jurisdiction. It may do this by issuing a notice for a future hearing or alternatively, by apprehending a child and seeking immediate orders from the court in relation to the child's placement.[24]

On a proceeding initiated by notice, the placement of the child remains unaffected, at least until the first mention date of the case and generally throughout the life of the case. On an apprehension, the court will either approve interim orders where all parties have negotiated an appropriate resolution, or alternatively determine where the child is placed (for example, with the parents, a suitable person or in out of home care) pending the determination of the application. The court determines these matters by way of 'submissions' rather than by the calling of witnesses and the cross-examination of witnesses. This process (which has been endorsed by the Supreme Court) acknowledges the difficulties inherent in the daily management of urgent applications. Any party aggrieved by a decision of the court, can appeal to the Supreme Court for an immediate and urgent hearing on the placement issue. Alternatively, a party can book the matter in with the court for an 'evidence based contest'.

Interim placement of children is by way of an IAO. These orders provide for temporary placement of a child with a parent, a suitable person, in out of home care, in secure welfare, with a declared parent and baby unit or in a hospital. The court may impose any conditions it considers to be in the best interests of the child. Determining interim placement is a significant part of the court's workload. In 2009-10, for example, the court made 5,494 IAOs although it is fair to say that a significant number of these were uncontested.

In making decisions about placement of children, 'the best interests of the child must always be paramount'[25]. When determining best interests the need to protect the child from harm, to protect his or her rights and to promote his or her development (taking into account his or her age and stage of development) must always be considered. Section 10(3) of the Act lists 18 further matters for the court to consider in determining what decision or action is in the best interests of the child.[26] The paramountcy principle has recently been the subject of extensive judicial analysis in *DOHS v Sanding.*[27]

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[24] The court also hears secondary applications. These are applications to extend, vary, revoke or breach existing orders.

[25] s.10 of the CYFA.

[26] The CYFA also details additional decision-making principles for Aboriginal children. In making a decision or taking an action in relation to an Aboriginal child, DHS must consider the principles in s.12. If it is determined that it is in the best interests of the child to be placed in out of home care, DHS must, in making the placement have regard to the advice of an Aboriginal agency, the criteria in s.13(2) of the Act and the principles in s.14 of the Act. The principles in s.13-14 are also relevant to the court's decision-making.

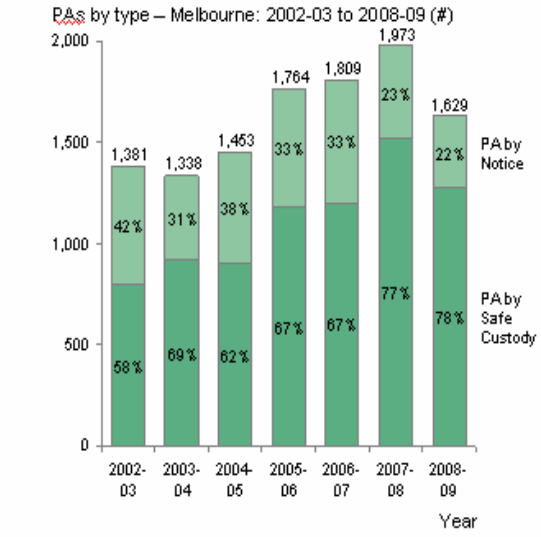
[27] [2011] VSC42 per Bell J.

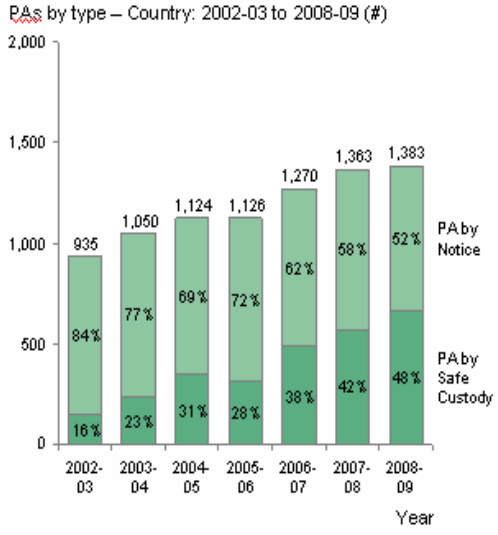
Applications by safe custody (apprehensions)

Applications by safe custody (apprehensions) have become the principal way for DHS to bring a case before the court. The court agrees with the VLRC that this should not be the preferred method of bringing a case to court.

In 2010, BCG conducted some research on this issue.

Graph 1: Primary applications (protection applications) by safe custody in Melbourne and the country





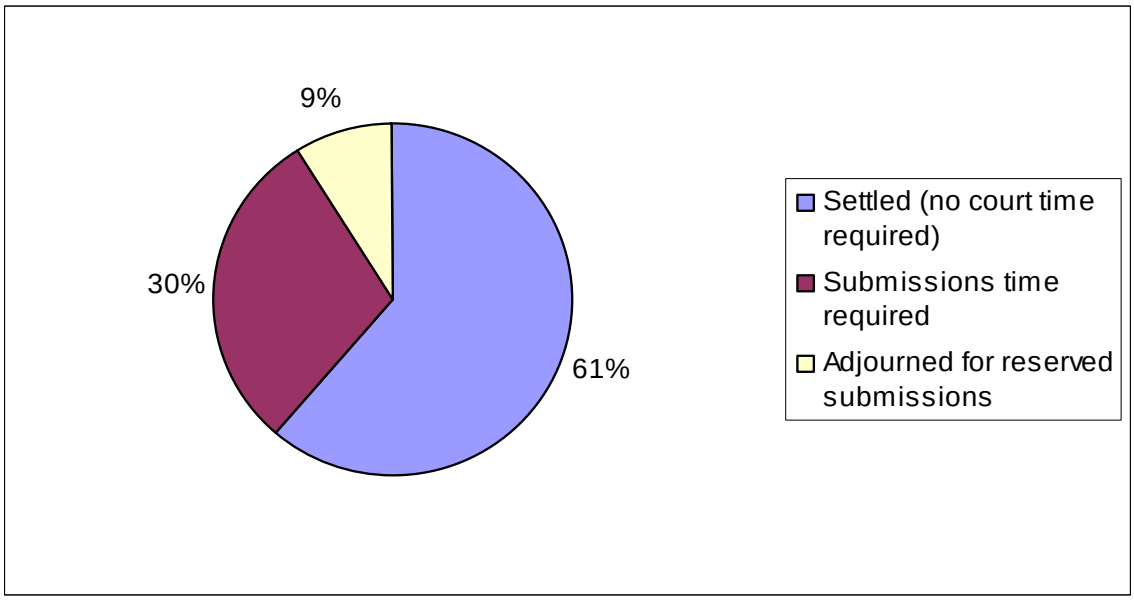
These graphs show Child Protection's increasing use, over time, of the apprehension process. By 2008-09, close to 80% of matters listed at Melbourne commenced by 'apprehension'. This is significant because the removal of a child from the family and coming to court within 24 hours to seek orders on the child's placement is generally an extremely confronting and distressing process for families, children and child protection workers.

When the matter comes before the court, emotions are raw and, unsurprisingly, there is often a sense of grievance and opposition from family members. This process contributes to family members adopting an 'adversarial' stance at the very beginning of the court process.

In the court's experience, the majority of lawyers allocated to parents/guardians and children after the case arrives at court assist the process by commencing negotiations with DHS on an appropriate resolution of the case. This explains why many apprehensions are resolved on an interim basis without recourse to a submissions hearing.

67 applications by safe custody were listed at the Melbourne Children's Court between 10 and 24 August 2011. 41 of those applications settled, 20 required submissions time and a further six applications were adjourned for reserved submissions.

Graph 2: Applications by safe custody that were resolved at Melbourne Children's Court between 10 and 24 August 2011



In its submission to the VLRC, the court estimated that in about 50% of apprehensions, children are returned to parent/s or placed with a suitable person (family member or friend). It should not take a court event to bring people with information about the family together or to start a conversation about how best to protect the child. This is part of the VLRC point about having properly structured interventions through Family Group Conferences early in the process.

There is a further point to be made about the current DHS practice of proceeding by way of apprehension. Work undertaken by BCG reveals that the time taken between intake and filing of an application by safe custody has grown over the past few years. In 2006-07, the average time from intake to filing was 20 days. Three years later, this had increased to 42 days.[28]

During the same period, the number of cases substantiated by DHS fell from 6,939 to 6,815. This period between intake and filing of an application is an important time and it needs to be subject to detailed research. If substantiations are falling and applications to the court are growing, DHS must be focusing on the hard cases. It is clear that DHS already know a significant percentage of these families. It is reasonable to ask why DHS is not bringing the families to court before the crisis event that precipitates the apprehension. That would be more consistent with good practice and more consistent with a sound understanding of cumulative harm.

[28] See BCG materials provided to the Child Protection Proceedings Taskforce.

It appears to the court that the time between intake and filing of an apprehension is a period where many cases seem to enter a 'waiting time'. In the BCG work for the Child Protection Proceedings Taskforce it is noted that the number and proportion of applications made after more than 70 days from the date of intake report is increasing, "*indicating some child protection workers may be waiting for a development in the case to warrant*"[29] apprehending the child.

This observation resonates with the experience of the judicial officers in the court. Regularly the court is presented with apprehensions that centre on a crisis event.[30] In this approach, DHS continues to focus on 'event' based interventions rather than intervening earlier to support the family. Clearly, DHS regards the authority of an order as a powerful tool in encouraging family compliance.

Cumulative harm

Cumulative harm is a concept well understood and applied by the court. Some submissions[31] maintain that the court does not understand the concept. This assessment does not reference any research, and the court can only assume that it is based on anecdote.

'Cumulative harm' was introduced into the legislation by section 162(2) of the CYFA which provides that for the purposes of proving harm pursuant to subsections (1)(c) to (1)(f), the harm may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances. From the court's perspective, this legislation was hardly necessary as it had long been part of the common law and therefore applied by this court. In an English case involving the interpretation of very similar English child protection legislation, Lord Nicholls of Birkenhead [32] said:

> "*Facts which are minor or even trivial if considered in isolation, when taken together, may suffice to satisfy the court of the likelihood of future harm.*"

Ms Robyn Miller[33] when explaining the rationale for the inclusion of section 162(2) in the CYFA said as follows:

> "*One of the unintended consequences of the practice, which developed from the Children and Young Persons Act 1989, is that intake and initial investigations were increasingly based on episodic assessments, which were focused on immediate risk and safety, and less focused on the developmental wellbeing of children, and patterns of abuse and neglect over time.*"[34]

The court agrees with this analysis. The legislative provisions were not introduced because of some problem with the court's application of the principle but because

[29] Child Protection Proceedings Taskforce (Background Materials) 19 February 2010. BCG.
[30] This would be consistent with the very high rates of proof in Victoria under the headings physical harm and emotional harm.
[31] See, for example, the submission of Professor Humphreys.
[32] *In re H. & Others (Minors)* [1996] AC 563, 591.
[33] The Principal Child Protection Practitioner, DHS.
[34] "*Cumulative Harm: A Conceptual Overview*" (December 2006) at p. 11.

child protection workers were not applying the principle in their daily work. Unfortunately, the problem with workers intervening in a crisis and using the crisis as the basis for the apprehension is, as discussed above, continuing. One does not have to look far to find evidence of the failure within Child Protection to give cumulative harm the priority it should have.

The recent finding of the State Coroner in the case of Aaron[35] shows how, in 2008, Child Protection were still locked into 'episodic responses' and failed to comprehend the concept of cumulative harm and respond appropriately. The State Coroner said this at pages 45 and 46 in relation to 'episodic responses/lacking analysis' –

> 83. *The DHS material reveals years of serious reports of child protection concerns for Aaron. The DHS interventions are characterised, at best, by a few months of involvement, some apparent level of "settling" of the issues and then a withdrawal with no apparent ongoing monitoring of Aaron's safety and well-being. The 'episodic' nature of DHS intervention into and withdrawal from Aaron's life over the years without a more strategic and planned involvement was not desirable and failed to take into account the need to look at Aaron's history and assess his behaviour and risks to his emotional and psychological safety in the context of his own history, rather than against some bench mark of 'high risk adolescents' generally.*

In relation to 'Lack of evidence of comprehension of cumulative harm', the State Coroner stated:

> *84. Whilst it is not difficult to understand how and why this may happen a few times, by the time DHS are receiving notification 6,7,8,9 and beyond, it is simply unacceptable that, with all of the expertise available to a child protection authority, it does not, at the very least comprehend the likely risk of cumulative harm for Aaron from years of exposure to the disruptions and issues detailed above.*

In relation to 'Failed to seek Statutory Intervention' the State Coroner reported -

> *85. When Aaron was 5 to 6 years old, he was subject to his seventh child protection notification. This notification was not from a concerned member of the public, this notification came from the Family Court of Australia, pursuant to its statutory powers. The end result of that report was that the concerns were 'not substantiated'. Aaron acquired seven more notifications after this. One cannot help but wonder at what point a reasonable child protection worker, looking at Aaron's history might have considered that, given the extraordinary number of notifications about this boy's risk of harm inside his family and the increasingly concerning nature of those reports as he reaches adolescence, that the patterns inside his family were not amenable to on-going voluntary involvement."*

[35] The findings are attached to this submission as Appendix 2. It is cited as Coroners Court reference 1430/08.

In November 2009, the Ombudsman delivered his report on the DHS Child Protection Program[36]. There is a discussion of cumulative harm at paragraphs 208-213. It commences –

> *"Throughout my investigation, it has been apparent that the department's capacity to respond is so stretched that cumulative harm to children has not been given the priority and attention that it should" A case review conducted by the Principal Practitioner identified several barriers for the department when recognising and responding to cumulative harm:*
>
> - *an event-orientated approach to child protection can result in practitioners (child protection workers) failing to observe or be able to act in response to a pattern of maltreatment*
> - *information is not carried over from one notification (report) to the next and therefore information is lost over time*
> - *assumptions are made that the problems presented in previous notifications (reports) are resolved at closure*
> - *risk frameworks consider pattern and history with the aim of predicting future behaviour of carers and likelihood of harm rather than establishing the cumulative harm suffered*
> - *IT systems summarise and categorise previous contact, and since workloads in Child Protection are demanding the assumption is made that reading case files is neither necessary nor a priority*
>
> *As I understand it, because the department and Child First separately received reports in relation to children, there may be times when the pattern of reports is not captured and therefore cumulative harm is not properly assessed. My investigators identified several cases where insufficient consideration had been given to the issue of cumulative harm.*

The court refers to case study 11 in the Ombudsman's report where Child Protection referred a matter to Child First with little evidence that the history of concern about the family was properly considered. In relation to that case, the Ombudsman's report stated –

> *"The department has a performance measure requiring a unit manager to review a case if there have been more than two reports within a 12-month period. The review is intended to determine whether further investigation is required on the basis of cumulative harm. In 2008, the department conducted a survey for the purpose of evaluating compliance with this performance measure and found only 52% compliance state-wide with this requirement. It was noted that there were 'significant variations between the regions' and the process had 'not yet become consistently embedded in practice across the state.'*

The court also refers to the most recent report of the Victorian Child Death Review Committee[37] which identified "the disjunction between the policy intention to respond more effectively to cumulative harm and practice that was actually occurring in relation to vulnerable adolescents which overall remains episodic and minimal.

[36] Ombudsman Victoria – Own Motion Investigation into the Department of Human Services Child Protection Program, November 2009 pp. 40-41.
[37] Annual Report of Inquiries into the Deaths of Children Known to Child Protection 2011 (Victorian Child Death Review Committee) page 47.

Assessments focus primarily on current events and do not give sufficient attention to family histories and longstanding patterns of functioning".

In the court's experience, Child Protection practice is still geared, for whatever reason, to a crisis event not the family history. The court also believes there is some confusion within Child Protection about the use of the words 'cumulative harm' in the court. There are six grounds for proving that a child is in need of protection. Cumulative harm is not one of the grounds. It is clear from s.162(2) of the CYFA that cumulative harm is an evidentiary concept for the purposes of proof under one of the six grounds in s.162(1). Just because in a particular case the court does not explicitly refer to 'cumulative harm' in finding a particular ground proved, does not mean that the court does not understand or apply the concept.

In Summary

- The court submits that there is a need to move away from apprehensions as the principal way of bringing families before the court.
- Changes to the apprehension process, together with a focus on the importance of conferencing and the development of specialist lists, will result in a less adversarial environment and be of benefit to children, families and child protection workers.
- The current apprehension process is affecting DHS ability to focus on 'cumulative harm'.

SECTION FOUR

Contested Hearings and Court Culture

One of the themes that has emerged from the inquiry is the claim that the Family Division of the court is too 'adversarial'. The court notes that this was something that the taskforce[38] considered and commented on -

> "*The Ombudsman's report stated that the Children's Court was overly adversarial. In his report on the NSW child protection system, Commissioner James Wood expressed the view that the term "overly adversarial" was unhelpful when considering how any jurisdiction might improve its processes. The reason for this, he stated, was that "it was not always clear what was meant by 'adversarial' and it seems likely that the term means different things to different people who use it."*
>
> *Commissioner Wood preferred an approach that considered which areas of practice and procedure might require change and improvement and he used that as the starting point for his recommendations, rather than whether the court was 'overly adversarial'.*
>
> *The taskforce found Commissioner Wood's approach helpful.*
>
> *"If there is an issue about the adversarial process, the Children's Court would welcome legislative recognition of a less adversarial approach. The recent amendments to Division 12A of the Family Law Act 1975 prescribing less adversarial trials offer one possible model for the Children's Court.*
>
> *Short of conducting less adversarial trials, the taskforce recommends implementation of a new dispute resolution process in the Children's Court."*

The court notes that some submissions made to the inquiry seem to suggest that Victoria is somehow more adversarial than other Children's Courts in Australia, the United States, England and Wales. The court urges caution in the acceptance of such a claim. Each child protection authority maintains that their system is too adversarial. Complaints of this type were made to the Wood review in NSW, the Layton review in South Australia and, most recently, to the Family Justice Review, in England and Wales. [39]

This does not mean that the Children's Court does not support an inquisitorial approach or less adversarial system. Clearly the court does. The court has proposed detailed legislative amendments to achieve that goal.[40] The court simply notes that wherever courts determine child protection cases, there have been vocal critics of that

[38] Membership of which included the Secretary DOJ, Secretary DHS, the Child Safety Commissioner, the Managing Director of VLA and the President of the Children's Court. The quote comes from p. 19 of the Taskforce report.
[39] Each of these inquiries rejected the notion of moving to a panel or tribunal system.
[40] See footnote 4 of this submission.

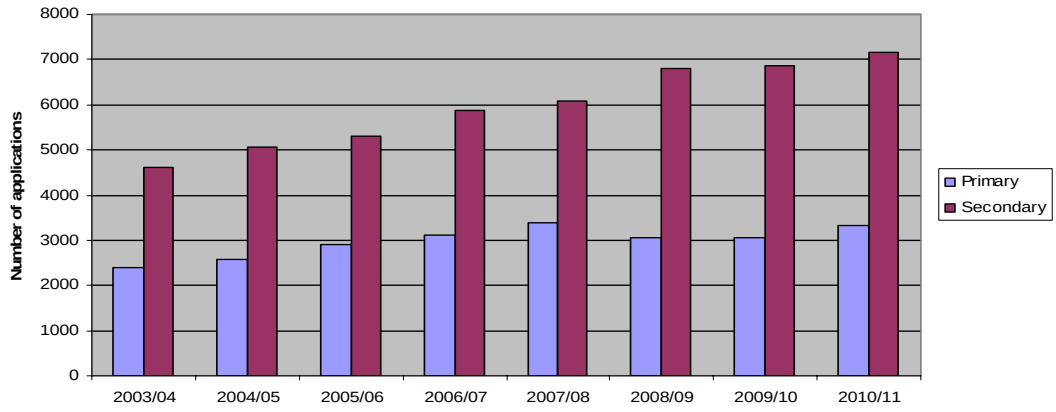
model from within child protection services and community agencies. The court made submissions to the VLRC on the adversarial nature of the court process and refers the panel specifically to the discussion at pp. 28 – 31 of that submission.

The court proposes in this submission to comment further on contested cases, court culture, and the implementation of alternative dispute resolution processes.

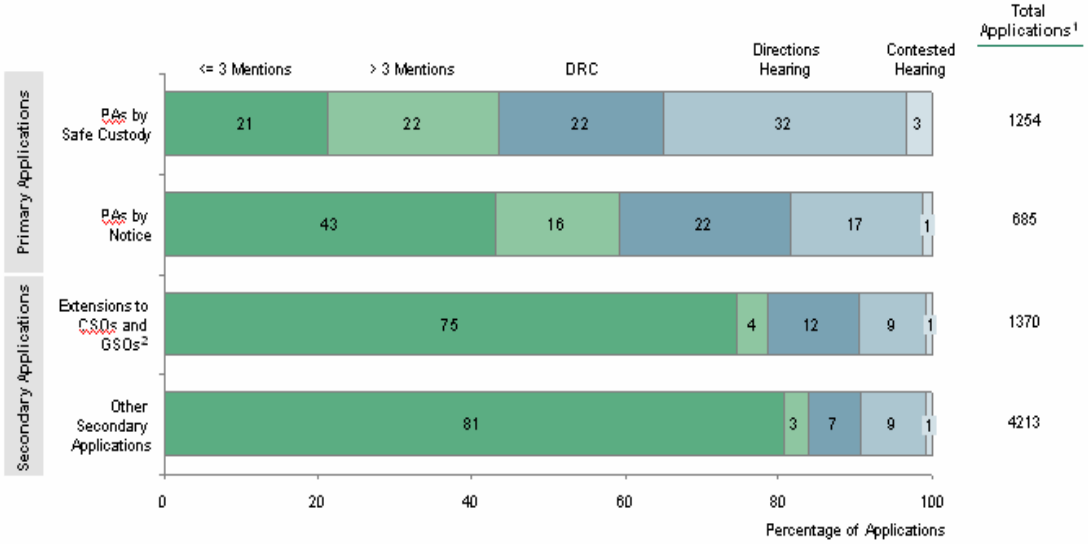
Contested cases

Every year, the Children's Court resolves more secondary applications than primary applications.[41] These applications include breaches, extensions, variations and revocations and constitute a significant part of the court's work.

Graph 3: Numbers of primary and secondary applications from 2003-04 to 2010-11



Graph 4: Primary applications by safe custody most likely to proceed past mention, grouped by furthest point reached in court process – 2008-09 (%)



1. All Applications for which final orders were made in 2008-09. This figure excludes Applications relating to siblings with identical hearings 2. Custody to Secretary Orders and Guardianship to Secretary Orders

Note: Percentage of Applications that proceeded to Final Contests based on the percentage of Applications listed for Final Contest that actually run as Final Contest hearings: Children's Court Monthly Listing reports

Source: Children's Court Registry data; BCG analysis

[41] The numbers in graph 4 are lower than those in graph 3 because BCG counted families rather than individual applications made for each child within the family.

Graph 4 confirms that only a very small percentage of all applications before the court proceed to a final contest. 99% of secondary applications resolved without the need for a final contest. Depending on whether the matter was an extension or some other type of application, between 75% and 81% of these applications resolved within three mentions. The progress of these matters is best described as swift and uncontentious.

Of the primary applications, only 1% of protection applications by notice proceeded to final contest. Significantly, in these cases the child is usually still within the family and this seems to enable the cases to proceed more smoothly than the apprehensions. On the other hand, of the applications by safe custody, only 43% resolved at a mention stage (22% had more than three mentions before resolution) and 3% proceeded to final contest. The Melbourne court is trying to do two things to manage these cases in a way that will address delay and reduce the number of contests. First, cases that have not resolved by the second mention are referred into the NMC process. Second, the NMC process provides the parties with an opportunity to work out solutions in a forum that is non-adversarial.

The court provides this information to support its submission that one of the problems with our current system, setting a case on the path to fractious disputation, is the current use of apprehensions. The apprehension process sets family against worker in a way that has potential to carry through the process. If there is a distorting influence in the court system, it comes from the over reliance on apprehending children and bringing them to court for immediate orders with conditions.

At the public sittings of the inquiry in Melbourne on 5 July 2011, Professor Scott made the point that –

> "*the model you're suggesting from Scotland is fundamentally not designed for the typical situation coming before the Children's Court…*"

As part of her response, Ms Cronin stated –

> "*A large part of what we're talking about is actually the need to move the entire system more to an early intervention, moving the whole system further up because you're right, they are different cases, but what we want to look at is shifting the system so that there is a much narrower gateway into removing children and putting them in out of home care".* [42]

If there is going to be a strong investment in early intervention that results in less removal of children and placement in out of home care (which would be a good thing) there will be, presumably, much less reliance on apprehensions and, as a result a much easier and gentler court process.

[42] See transcript of evidence from 5 July 2011 at page 127.

The adversarial system and court culture

When talking about an adversarial culture, it needs to be remembered that workers (or experts or anybody else) are not required to give evidence at the Children's Court very often. This submission has already highlighted that once parties start talking to each other at court, many of the placement decisions are agreed without the need for submissions time.[43] If an apprehension does go to a submissions contest, the court does not hear evidence and the matter proceeds on submissions from counsel.

Of those matters that then go to an evidence based IAO contest, approximately 80% settle before the contest date or on the contest date. The BCG research confirms that the most difficult cases are those that have commenced by apprehension and yet only 3% of these matters 'run' as contested hearings.

Those cases that do run as contested hearings have been through ADR and through a directions hearing. They are the hardest cases. The parties have been unable to resolve the case and some or all of the facts are not agreed. Because they are the hardest cases those who give evidence in them must expect to have their views and assessments scrutinised. The outcome of the cases will be of profound importance to the child and the future of the family unit.

All parties have the right to a proper hearing of the evidence and the right to challenge the evidence. In these cases, those who are representing families or children will often strongly challenge evidence given by important and central witnesses such as the child protection worker or an expert witness. The court understands how a young and inexperienced child protection worker – poorly trained for court, overworked, under-prepared and poorly supervised – may find the whole process confronting and overwhelming. In such a case, the process will be resented. Similarly, some experts, particularly those not used to court process and having their professional opinions challenged, resent the process and see it as disrespectful.

The Ombudsman highlighted a child protection service that is under extreme pressure. Some of the significant problems are exposed in cross-examination in a courtroom. Issues such as the compromised capacity of Child Protection to investigate comprehensively the families reported to them, how the critical response to children in need of care is sometimes inappropriate and that case planning for children in care is often inadequate and poorly executed.

In its submission to the VLRC, the court highlighted the range of functions that Child Protection has to perform. Child Protection is:

- the authority charged with the responsibility of delivering assistance to children and families;
- the investigating body for reports made to DHS;
- a party to proceedings in the Children's Court; and
- the agency that generally initiates and conducts the proceedings including initiating proceedings for alleged breach of court orders.

The court believes that this broad range of not entirely complementary functions can make the work of the child protection worker very difficult and does from time to

[43]This is one reason why the VLRC presented its option of structured, early negotiation by way of Family Group Conference.

time result in a lack of objectivity in the way in which matters are litigated in the Children's Court. It sometimes makes it difficult for DHS to perform properly the function of a model litigant.[44] The court agrees with the discussion in the VLRC report that Child Protection should not have to perform all these roles.

The submission of the CPSU to the panel highlighted another problem for the child protection witness that the court observes reasonably frequently; a problem that clearly causes stress. The union submission says –

> *"All caseworkers need to have the right to write notes of their view/assessment on the appropriate file or CRIS record where their recommendations are overturned and they feel the need to do so. They also need to be able to honestly represent their view if asked in court, they cannot be asked to perjure themselves to maintain the Department's position, but must ensure they communicate in addition what the Department's position is."*[45]

It is important however, that we do not confuse the strong challenging of evidence with a view that the court is 'derisory or disrespectful' of child protection workers. The implication seems to be that the court is kind and respectful of parents, children, lawyers, and everyone else in the process but not the child protection worker or witnesses for DHS. The suggestion that judicial officers do not take the judicial oath seriously and do not understand the difference between proper and improper behaviour towards witnesses in court is rejected. In relation to this issue, the President of the Children's Court has received two complaints in the last five years about the conduct of judicial officers at the Melbourne court.

One particular submission to the panel is critical of some judicial officers. The court would be interested in knowing whether the writer based her views on active or inactive research. Put simply, how many contested hearings had she observed? How many judicial officers had she observed in court? It should also be noted that the majority of lawyers who represent families and children at contested hearings are barristers who are bound by the particular ethical obligations imposed upon them by the Victorian Bar. Rarely do the solicitors at Melbourne – who seem to be the lawyers accused of being part of a 'culture' – conduct contested hearings.

As the court observed earlier in this submission, difficulties faced by child protection workers in their dealings with the legal process are not merely a Victorian phenomenon. They are universal. It is worthwhile quoting The Honourable Judge Leonard P. Edwards' opinion about the very similar American experience:

> *"The court system presents problems for child protection agencies that they continue to struggle with today. First, in order to participate in court proceedings, they have had to create and maintain staff familiar with the law. This has meant hiring lawyers to present the agency position in court as well as developing legal expertise among the social worker staff to interpret court orders. Second, to obtain approval for their actions, child protection agencies have been required to learn how legal decisions are made, how evidence must be gathered, and how court procedures dictate*

[44] Refer to Chapter 4.1.6 in Research Materials on the website of the Children's Court of Victoria: www.childrenscourt.vic.gov.au.
[45] See page 36 of the CPSU submission.

> *the presentation of evidence. Third, they have had to learn about the formality of court proceedings, the power of the judge, and the power that attorneys have to shape court proceedings.*
>
> *For the line social worker, the formality of court proceedings and the adversarial process have presented the most difficult problems. Nothing in their training prepares social workers for evidence collection, report writing, and direct and cross-examination under the rules of evidence. Many social workers find the court process to be an overly formal setting, demeaning and inhospitable, where the truth is sacrificed for procedural rules and the free exchange of information and ideas is difficult, if not impossible."*[46]

Conditions at Melbourne Children's Court

The court acknowledges that the experience of many workers (and others) in the waiting areas of the Melbourne Children's Court is difficult and that the conditions are less than ideal. Problems with over-crowding were recognised by the Child Protection Proceedings Taskforce –

> "*The Family Division is now too small to contain the large number of families, lawyers and protective workers who attend the court each day. Child Protection is emotionally demanding and the overcrowding contributes to the distress, anxiety and agitation of those who are at the court. Put simply, there are too many people in too small a space. It is not a good place for a child*" (at p. 27) – and by the VLRC (see the commentary at pp. 354 - 357).

The court has roving security to protect workers from abusive family members. In addition, the court understands how overcrowding could be alleviated by moving some work out of Melbourne. The court supports the principle of decentralisation but notes that there are no suburban courts with the capacity (or facilities) to hear Family Division cases. The President of the Children's Court has made representations to the DOJ Legal Master Plan Working Group on the importance of designing future courts to accommodate the needs of families and child protection workers.

In June 2009 the court moved Southern Region cases to the Moorabbin Justice Centre. Child Protection supported that move. That court does not present the problems that are a feature of the Melbourne court and many of the lawyers from Melbourne attend at Moorabbin. The court intends to move Eastern Region cases to the WCJC as soon as that centre is available for use. The court will also be able to move its Conference Unit off-site when the WCJC is operational. The court also supports the relocation of the Children's Court Clinic to an off-site venue. The court plans to use the space created by these moves to develop more 'user friendly space' at Melbourne.

[46] Judge Leonard P. Edwards, "Mediation in Child Protection Cases". Judge Edwards' impressive background is detailed at footnote 43 of the court's submission to the VLRC.

Behaviour of parties

The court supports the development of a 'code of conduct' to help generate respectful relationships between parties to proceedings. The court understands that VLA and DHS have developed a draft code that has been referred to the Law Institute for comment. The court has worked with VLA and the Law Institute to develop a process for accreditation of lawyers working in the Children's Court. The court is represented on the committee that is advancing this issue.

The court is of the strong view that the panel of lawyers practising at the Melbourne court needs to be expanded. Put simply, there are not enough lawyers representing children and families. When the court moves to the WCJC, there will have to be more lawyers because the court will be operating in three court buildings in the Melbourne metropolitan area. The court will continue working with VLA on this issue. The court is also in discussions with the Women's Legal Service in an effort to encourage their lawyers to be involved in the work of the court.

As far as bullying lawyers are concerned, the court can say that judicial officers are aware of their obligations in running their courtrooms. If there has been bad behaviour outside the courtroom, it should be reported to the judicial officer handling the case, or reported to the President of the court.[47] In addition, bullying behaviour by lawyers can be referred to the relevant professional bodies i.e. the Law Institute, the Legal Services Commissioner or the Bar Council.

Training

As already detailed in this submission, the court is strongly committed to joint training of child protection workers and lawyers as a way of ensuring that each understands the role of the other. Such training should also encourage courteous and respectful behaviour.

When the President of the Children's Court visited Western Australia in 2010 as part of the work of the taskforce, he was impressed by the joint training sessions that Legal Aid were conducting in that state. When the President inquired whether the sessions were successful in changing 'culture' and encouraging mutual understanding of the role of each 'player' in the system, he was told that the training had been successful but that it had taken about three years to 'bite'. There have been some joint training sessions in Victoria and there will be many more. The court is committed to participating in joint training and is represented on the board established by DOJ to develop an ongoing program for child protection workers, lawyers and court staff. This activity is supported by funding and collaboration at the highest level of each of the participating agencies and the court.

Alternative Dispute Resolution (ADR)

Many of the criticisms about the Children's Court being overly adversarial fail to acknowledge the existence of ADR processes within the court.

The court has a longstanding commitment to ADR as a means of assisting a non-adversarial approach to case resolution. Over recent years, the court has led a review of its ADR processes with a view to ensuring that those processes are even more

[47] In the term of the current President, there has not been one written complaint about a lawyer's behaviour in the corridors of the court.

responsive and focused on achieving appropriate settlements at an earlier stage in proceedings.

The court began its reform processes well before the release of the Ombudsman's report in November 2009. In late 2008, the President of the Children's Court asked Mr Neil Twist from the Appropriate Dispute Resolution Unit in DOJ, to chair a working group to review the current approach to ADR in the Children's Court and assess how this approach could be enhanced and improved. The working group convened for the first time on 8 December 2008 and included representatives from DOJ, VLA, DHS, CPLO and the court. The working group met regularly throughout 2009 and developed a model that was endorsed by the taskforce.

The court is now implementing the new model process in Melbourne, as detailed below. The court would like to expand the model throughout the state. Additional resources would be required to support such an expansion.

New Model Conferences (NMCs)

The resources made available following the report of the taskforce enabled the court to implement a new model for conferencing. The NMC model initially commenced as a pilot for all applications from the Footscray office of DHS. This form of conferencing, now applies to all those cases coming to court from the North and West Metropolitan Region of Melbourne. The model is no longer a pilot. NMCs will be used for cases from Southern and Eastern Metropolitan Regions when the WCJC becomes available.

The working group meets regularly to monitor the implementation. It has a sub-committee that will provide advice on the best way for the voice of children to be represented in the NMC process. Ms Robyn Miller, DHS is participating in the work of that committee.

The current legislative framework for conferencing is flawed

In its submission to the VLRC, the court explained its concerns about the current legislative provisions that govern conferencing.[48] In summary, the provisions do not provide effective compliance mechanisms, do not deal with the challenges of child participation and provide for two ADR models, one of which, the 'Advisory Conference', has proved so unattractive to court users that such a conference has only once been held.

The old DRC process had a number of deficiencies. These included –

- limited opportunities for the sessional convenors to access the court files and prepare the conference;
- no funding for such preparation;
- no requirement that the parties prepare or exchange any documentation prior to the conference;
- lawyers focusing on other matters proceeding in the court building;
- DHS not represented by decision makers; and
- no insistence that parties attend.

[48] Refer to p. 36 of the court's submission to the VLRC.

The sessional convenors, as far as the court is concerned, provided an excellent service given the severe limitations of the funding and the legislation. It needs to be acknowledged that until recently, the rate of remuneration for the sessional convenors was not particularly generous, and did not reflect the professional skills of the mediators, the challenges of the jurisdiction and the significance of the issues that are dealt with. The DRC model's effectiveness was a reflection of its poor resourcing.

The NMC model has a number of features that distinguish it from the DRC process and from other ADR processes in protective jurisdictions around Australia. Those features include -

- prescriptive 'Guidelines' that govern procedural matters and describe the court's expectations as to the behaviour of the various participants;
- appropriate risk assessment;
- an expectation that all relevant family members and other significant persons attend;
- holding of an NMC, except where there are security and custody issues, at a venue away from the court to encourage uninterrupted, concentrated participation by all parties in a less crowded, less stressful environment;
- the requirement that each party advise all other parties and the convenor of their position in writing well before the NMC commences;
- the implementation of a rigorous, standardised ADR model based on the Harvard model to achieve uniformity and predictability in terms of ADR processes;
- an intensive intake procedure with a focus on identifying security issues, alternative venue issues and ensuring that the participants are well prepared for the NMC; and
- an expectation that the department be represented for at least the concluding stages of the NMC, if not the whole conference.

As outlined in the court's earlier submission, the court agreed with the VLRC view that convenors of family decision-making processes should have appropriate qualifications and training. The court adopted the recommendation from the taskforce report that all convenors conducting NMCs be trained and accredited in mediation in accordance with the National Mediator Accreditation Scheme (NMAS). However, convenors do not currently have the powers to grant adjournment orders for a further conference or a mention hearing. If convenors did have such powers, this would reduce court time for all parties involved. Judicial registrars in the Magistrate's Court jurisdiction currently have those powers and it is the court's view that convenors need the authority to make such orders in routine and less complex matters.

Evaluating New Model Conferencing

Notwithstanding the geographically limited range of NMC availability, a sufficient number of conferences have taken place for the court to be able to assess the reforms and to consider how the process could be strengthened. Monthly statistics for NMCs are set out on the following page.

Table 2: NMC monthly statistics at Melbourne Children's Court from August 2010 – June 2011

	LISTINGS		CANCELLATIONS		OUTCOMES					
Month	**No. of NMCs Listed**	**No. of NMCs Conducted**	**No. of NMCs cancelled prior to NMC**	**No. of NMCs cancelled at NMC**	**Settled (final order)**	**Settled on interim basis (IPO)**	**Adj for further MNC**	**Adj for further mention**	**Not settled (contest booked)**	**% of NMCs conducted & not settled (contest booked)**
Aug 2010	2	1	1	-	-	-	-	1	-	0.0%
Sept 2010	13	7	2	4	4	1	-	1	1	14.3%
Oct 2010	8	7	-	1	3	1	2	1	-	0.0%
Nov 2010	10	9	1	0	5	-	-	1	3	33.3%
Dec 2010	11	7	3	1	5	-	-	2	-	0.0%
Jan 2011	11	2	9	-	2	-	-	-	-	0.0%
Feb 2011	20	12	2	6	5	1	-	3	3	25.0%
Mar 2011	43	26	5	12	11	-	3	7	5	19.2%
Apr 2011	44	27	7	10	11	1	1	9	5	18.5%
May 2011	51	30	11	10	14	4	4	3	5	16.7%
June 2011	44	32	6	6	16	2	2	9	3	9.4%
TOTAL	**257**	**160**	**47**	**50**	**76**	**10**	**12**	**37**	**25**	**15.6%**

A number of conclusions can be drawn from the above figures:

1. The conferences are producing a significant number of settlements. As at 30 June 2011, 76 out of 160 conferences settled outright, resulting in a 47% settlement rate.
2. A partial settlement rate, (expressed as an IPO, the booking of a further NMC or an adjournment to a mention) applied in 59 out of 160 matters, (36% partial settlement rate).
3. Only 15.6% of matters went straight to a contest on the basis of no resolution.
4. If the court were to adopt the widely accepted national model of assessing ADR process success rates (with success being defined as the achieving of either full or partial settlement) then the NMC overall success rate is 84 %.
5. The cancellation rate for booked conferences (either in the days leading up to the conference or on the day itself) is high. The most recent figures would suggest that close to 40% of booked conferences do not take place on the original listing date. Reasons for NMCs being cancelled prior to the conference include the convenor, a representative from DHS or a party is unavailable, a party is ill, there is a lack of childcare for the family, the case is not ready or a Family Violence Intervention Order prevents the NMC from taking place.

Cancellation rates

The court notes that those conferences which are cancelled with some notice given (i.e. in the week or so leading up to the conference), are re-scheduled, with a new conference listed. Similarly, a significant number of conferences, which are cancelled

on the day, are also rescheduled. Cancellation of a conference on the day usually occurs because a parent(s) does not attend.

The court (and the working group) is concerned at the number of conferences that do not proceed. The court is trialling different methods of addressing this problem including diverting some resources to allow the conference intake officer to focus on risk assessments and engagement with parents, and the sending of SMS reminders to conference participants. The court has not conducted any research to verify whether SMS reminders have a positive impact on attendance.

The court has raised with the working group a potential solution that involves listing a directions hearing one week prior to the conference date to ensure the conference will be ready to proceed on the due date.

Comparisons between the New Model Conferencing process and other Alternative Dispute Resolution processes

Some comparisons can be made with other ADR models in other jurisdictions to assess the value of the NMC process. The court's initial comparison has been with the Western Australian Signs of Safety Pilot.

The Final Evaluation Report (June 2011) of the Western Australian model indicated that:

- of the 74 conferences scheduled, 68 took place and 11 resulted in a complete settlement, a settlement rate of 16%. By comparison, the NMC settlement rates are approximately three times that figure;
- of the 68 conferences that took place, 50 involved a partial settlement. If we adopt the definition of a settlement as including a partial settlement, then the Western Australian model achieves an 89% settlement rate; and
- the Signs of Safety model operates outside the court system and as such does not have quite the same focus on ensuring that all relevant family members are present. Out of the 68 conferences conducted, only 42 had both parents in attendance. If our NMC convenors were to accept such a level of absenteeism then the cancellation rates for Victoria would be significantly lower.

Other ADR models that might be worth examining to assess the efficacy of the NMC process include the various schemes established by state and territory Legal Aid bodies to deal with disputes under the Family Law Act. The schemes were subject to evaluation by KPMG in 2008[49]. The settlement rates of the various schemes (settlement being defined as being both full and partial settlement) are summarised below:

- Queensland: 1,846 matters out of 2,391 settled (78% settlement rate)
- New South Wales: 1,962 matters out of 2,449 settled (80% settlement rate)
- Victoria: 772 matters out of 925 settled (83% settlement rate)
- South Australia: 304 matters out of 370 settled (82% settlement rate)
- Western Australia: 283 matters out of 349 settled (81% settlement rate)
- Northern Territory: 80 matters out of 102 settled (78% settlement rate)
- Tasmania: 305 matters out of 491 settled (80% settlement rate)

[49] Attorney-General's Department Family Dispute Resolution Services in Legal Aid Commissions Evaluation Report (December 2008)

- ACT: 83 matters out of 102 settled (81% settlement rate)

The NMC settlement rate of 84% compares very favourably with the various ADR processes undertaken in Family Law Act matters. The Children's Court NMC success rate exceeds the figures from each state or territory even though Children's Court matters have a number of complicating aspects not present in family law cases. These include the involvement of the state as a party, multiple parties, parties with multiple chronic health, disability, substance abuse issues, parties with no financial incentive to settle and the frequent involvement of children as participating parties.

Unlike the Western Australian model, the Children's Court NMC process is not a pilot. It is an established part of the court's procedures, supported by the court's judicial officers and staff. In addition, an NMC is effectively a compulsory part of the court's procedures; only in appropriate circumstances will the parties be excused from participating in an NMC. In Western Australia, conferences can only take place with the consent of each party, a factor that may also in part explain the low cancellation rates in that state. The focus on very young children in the Western Australian pilot also means that children are rarely involved as parties in the process; indeed, the court notes that of the 68 conferences held, only one involved a child participating.

In Victoria where every child over the age of seven is treated as a party, the majority of NMC's will involve at least one child participating. In addition, the Victorian legislation provides that step-parents have a right to participate, thereby further adding to the complexities involved in listing, preparing and holding an NMC.

In conclusion, the Children's Court submits that its established, innovative ADR processes are not only extremely successful but demonstrate the court's leading role in developing and implementing less adversarial processes within the existing legislative framework.

Other aspects of New Model Conferencing

The Children's Court of Victoria is determined to continue to work with DHS, VLA, and other court users in advancing two important matters.

Aboriginal co-convenors
The court supports the principle of having Aboriginal co-convenors in those conferences that involve Aboriginal families. This is currently being advanced with DOJ and the Aboriginal community. There would need to be appropriate training for those who are willing (and qualified) to participate.

Children's participation
Children over the age of seven are treated as parties in the Children's Court and, for the most part, their lawyers operate on an instructional basis. This is in contrast to how children are represented in other jurisdictions.

The nature of ADR processes and in particular, the expectation that the participants will identify issues and develop resolution options, usually involves intensive participation. In the case of children, such an expectation is at odds with the court's often-stated view that children need (as far as possible) to be kept away from the court and its processes.

However, the nature of ADR is such that at the very least the legal representatives of any party need to be able to update their instructions during the conference. Facilitating such instruction taking may involve having the child at the conference (in appropriate cases with mature children), having the child near the conference or ensuring that the child can be contacted by telephone. Such arrangements require considerable liaison between lawyers, protective workers and parents. They also involve dealing with fundamental issues such as transport, child care (i.e. who will care for the child who has attended the conference venue but may not be actually participating in the conference itself) and liaising with a school (if the child is to be contacted by telephone during the conference).

Recognising the challenges involved, the court has established a specialist subcommittee to review arrangements for the participation of children in the NMC process. Members of the sub-committee are considering appropriate reforms.

In Summary

- The court resolved close to 7,000 secondary applications in 2008-09. Between 75%-81% of these cases resolved within three mentions. Only 1% of secondary applications proceeded to final contest. Only 1% of applications by notice proceed to final contest.
- Cases that commence as apprehensions take longer to resolve and are more likely to proceed to contest. The court is trying to manage these cases efficiently by early referral to conferencing and, in the case of applications from the North and West Metropolitan Region, by the use of NMCs.
- The number of cases where workers are required to give evidence is very small. The court supports conferencing as a way of assisting parties to resolve disputes without the need for a contested hearing. Within the constraints of the current legislation, the court has led measures to improve ADR and develop problem-solving approaches.
- The court acknowledges that the experience for workers appearing in court can be difficult. This is in part because their training does not adequately prepare them for the experience of court. The pressures of their own workplace and caseloads further compound this. The court acknowledges that the conditions at the Melbourne court are also less than ideal and create stress for those required to attend court.
- The court is committed to implementing measures to assist in addressing these issues including moving some further matters out of the Melbourne court, participating in collaborative training and encouraging measures designed to improve collaborative practice.

SECTION FIVE

Responses to Other Themes and Issues

The importance of a unified system – the harm of a fragmented system

The court submits that the system should not be fragmented. The court has already referred to views expressed about the Scottish system that the existence of different decision-making arenas for child protection was cumbersome. The VLRC did not support a fragmented approach. Indeed it recommended expanding the Children's Court jurisdiction to enable it to have concurrent jurisdiction in relation to hearing caseplan reviews. This was desirable "for reasons of both efficiency and accessibility for participants".[50]

It is sensible to recognise the strengths of the current system, including the fact that very few cases actually require a final contest. Currently, the court event initiates the 'informal bargaining' that results in a resolution of the case. The VLRC properly noted that a better approach is to encourage the parties to "use supported and child centred agreement-making processes in order to reach negotiated outcomes".[51] This approach recognises the importance of moving along a continuum from non-adversarial conferencing through to judicial conferencing to a court hearing that is inquisitorial or conducted in accordance with LAT principles. In its earlier submission to the panel, the court endorsed that approach while proposing its NMC process as a good model for 'front end' conferencing.

It has been suggested that the court should not have a role in determining the conditions on particular orders. The suggestion arises most frequently in relation to court orders on frequency of child contact. The court would make the following comments on this suggestion –

- If ADR is to be an important first step in a process of less adversarial determination, independent mediators must be able to discuss all the significant matters that are relevant to a case. To exclude discussion about the conditions on a proposed order would cripple the conferencing process and lead to a significant increase in the number of contested cases. This is contrary to everything the court has been doing to enhance its ADR processes.
- In contested cases, the court hears evidence that enables it to make an appropriate decision about what is in the best interests of the child. At the end of a contested hearing, the court provides an independent and informed decision about the whole case, including the conditions on an order that would best protect the child. The court submits that it would not be a sensible process for the court to determine proof of an application and, upon proof, the most appropriate order to be made, but then allow one of the parties to determine what the conditions attached to an order should be. Nor, in the court's view, is such a process in the best interests of children generally. Would this 'administrative' decision-making, if introduced, be subject to appeal to the Victorian Civil and Administrative Tribunal (VCAT)? If so, the matter will become the subject of further litigation. If

[50] See VLRC report at page 344.
[51] See VLRC report at page 214.

not, how does a parent or child challenge decisions that have been made on improper grounds? Regrettably, there have been a number of cases where the court has heard evidence (or had submissions made) on frequency of child contact that focus on the ability of DHS to facilitate a particular frequency of access (i.e. resources available) and less often on the impact of a particular level of access on the subject child.

- In some cases, parents will consent to proof (and to an order) but seek to have the court rule on the frequency of child contact. This is because there is no agreement on that issue. The contest is about a clearly defined issue. If there is no independent assessment of this issue, many parents are likely to contest both proof of the application and the order that should be made.

Reducing the range of orders

The court has been asked to comment on whether the range of orders available in Victoria should be reduced. The court submits that generally the current range of orders is appropriate. Two particular orders, Custody to Third Party Orders and Temporary Assessment Orders are used sparingly and do not seem to serve any current purpose. On the other hand, the court submits that the Supervised Custody Order has been a valuable addition to the range of orders available to the court. If that order was not available, it is likely that there would be more contested hearings. The court also submits that the Long-term Guardianship Order has been beneficial for those young people placed on such an order.

Child as a party

The court agrees that a child or young person should be a formally recognised party to the proceedings before the court. The court has also indicated in its earlier submission to the panel that all children should be represented and the basis upon which they should be represented. As a matter of principle, the court agrees that a child should not be required to attend court unless the child has the capacity to understand the proceedings and has expressed a wish to be at court. This will require legislative amendment. It may also require a change to the VLA fee structure.

A court of record

The court is not opposed to being a 'court of record'. In the overwhelming majority of final contests, the court already provides detailed written reasons. Proceedings in the court are recorded and copies of recordings are made available to parties on the payment of a fee ($50). The court has published some de-identified decisions on its website. The cases published are those that raise a point of principle as opposed to those determined on the facts. The recent Court of Appeal decision in *R v Smith* [2011] VSCA 185 at [32] to [33] is relevant to this issue with the court stating -

> [32] "*As is apparent from the reasons of Lasry AJA, this appeal and application give rise to no point of principle. When the proposed new arrangement for non-publication comes into force, a decision of this kind will no longer be published generally but only to parties. The intent of the new arrangement is to reduce the volume of fact specific decisions which judges and practitioners are obliged to review. A decision which is stated as involving no point of principle will not be able to be cited without leave*

> *of the court."* [33] "*It is expected that those arrangements will come into force, with proper notice to practitioners, in the near future.*"

Like the Court of Appeal, the Children's Court sees no benefit in publishing every decision. However, if the court were required to do so, it would need substantial administrative assistance as every decision would need to be de-identified.

Specialist lists

The court is involved in developing a specialist list for Koori cases in the Family Division. A first step in that process is the appointment of a Koori Support Program Manager. The court sought funding for this grade 5 position through budget and revenue retention processes but was not successful. The court has applied for funding through the Justice Finance Committee, and is currently awaiting their decision.

Magistrate Gregory Levine has recently been awarded a Churchill Fellowship to research family drug treatment courts in the USA and UK and develop a model for introduction of such courts into Australian jurisdictions.

The President of the court is keen to continue a discussion with the CEOs of QEC, Tweddle and Mercy on the establishment of a specialist zero to three-year old list.

Obviously, the development of these lists would depend on the court being supported with appropriate resourcing.

The court is also establishing a specialist list for sex abuse cases. This will be discussed under the next heading.

Sex abuse cases

Professor Cathy Humphreys has indicated in her submission to the panel that the Children's Court is requiring evidence 'beyond the balance of probabilities' in sex abuse cases and that "*Until recently, child protection workers had virtually stopped substantiating child sex abuse and only putting cases forward on the basis of emotional abuse or physical abuse*." The court would be interested to see the research that supports both those propositions. The court submits that both assertions are incorrect.

The Children's Court Research Materials (available on the court's website) have a thorough discussion of the proof required in sexual abuse matters. In section 4.8.4 it is stated –

> "It follows that the *Briginshaw* formulation does not give rise to a third standard of proof. It simply stands for the proposition that where a civil case involves allegations of criminal conduct, fraud or moral wrongdoing, which may lead to grave consequences for the impugned party, the judicial approach should be a closer scrutiny of the evidence. Mc Hugh J put it pithily in an exchange with the NSW Solicitor General during argument in *Witham v Holloway* (1995) 183 CLR 525 [Transcript of proceedings 10/2/1995]:

> "There are only two standards of proof: balance of probabilities and proof beyond reasonable doubt. I know *Briginshaw* is cited like it was some sort of ritual incantation. It has never impressed me too much. I mean it really means no more than 'Oh, we had better look at this a bit more closely than we might otherwise', but it is still a balance of probabilities test in the end."[52]

The court understands the test to be applied.

On the second point made by Professor Humphreys, the court has prepared a table that shows the assertion is incorrect. The table indicates notifications, investigations and substantiations at various times over the last twenty years. It shows no recent change in practice. It does show how remarkably consistent the numbers have been over time.

Table 3: Notifications, investigations and substantiations (1992-2010)

Year	Notifications	Investigations	Substantiations
1992-93	2,450	1,679	577
1997-98	4,480	2,031	607
2002-03	4,390	1,694	562
2006-07	3,877	1,482	479
2009-10	N/A	N/A	522

The court submits that the problem with low rates of notification and substantiation is a community problem. Victoria has historically had very low rates of notification, investigation and substantiation in this area. This is not some fault of the court.

However, the court appreciates the need for appropriate management of these cases. The court already has a sex offenders list in its Criminal Division. The success of that list has inspired the court to look at developing a similar specialist list in the Family Division. A multi-disciplinary working group supports the court in advancing this important reform. Membership of the working group includes – the President of the Children's Court, Magistrate Jennifer Bowles, Magistrate Belinda Wallington, Ms Robyn Miller, Principal Practitioner, Child Protection, Professor James Ogloff, Monash University, Associate Professor Rosemary Sheehan, Monash University, Dr Darryl Higgins, Australian Institute of Family Studies, Jenny Wing, Child Protection Society, Tom Nairn (SOCIT) Victoria Police, Di Garner, Adolescent Forensic Mental Health and Dr Carmel Fahey, Children's Court Clinic.

Members of the Committee have developed an application for a research grant to study the best model for the specialist list and the resource implications for its establishment. The court is committed to this reform. The work of this committee is one of the many examples of the court, DOJ, VLA, DHS and other agencies working strongly together.

High frequency child contact

The court refers to the discussion of this issue at pages 97 and 98 of its submission to the VLRC. The court also refers to the full discussion of this matter in the 'Research

[52] See the full discussion in the Research Materials, chapter 4.8.4.

Materials' on its website.[53] These materials contain a reference to the 2009 American Judge's Guide. A copy of the Guide has been provided to the panel as Appendix 3 to this submission. The Guide was prepared by both lawyers and social scientists. The project was overseen by an advisory committee consisting of some of the most respected scientists and judicial officers, including Dr Joy Osofsky, Professor of Public Health, Psychiatry and Paediatrics at Louisiana State University Health Sciences Centre. The discussion on frequency of child contact occurs at pages 72-73; 97-98 and 105-106.

In Summary

- The court does not support fragmenting decision-making or limiting its ability to determine the conditions on any particular order.
- The court submits that the current range of orders is generally appropriate but notes that two particular orders do not seem to serve any current purpose.
- The court agrees that a child or young person should be a formally recognised party to the proceedings before the court and that a child should not be required to attend court unless the child has the capacity to understand the proceedings and wishes to attend the proceedings.
- The court is committed to establishing specialist lists for Koori families and sex abuse cases but requires appropriate resources to do so.

[53] Refer to Research Materials chapter 4.14.

SECTION SIX

The Children's Court Clinic

In a small minority of cases in the Family Division - usually the most difficult and most heavily contested – the court can call on expert evidence from the Children's Court Clinic to assist in its deliberations.[54]

In 2009-10, the clinic accepted 725 child protection referrals from the Family Division of the Children's Court. In the same year 9,915 applications were initiated in the Family Division.

Benefits of the Children's Court Clinic

The Children's Court Clinic can offer a judicial officer psychological or psychiatric assessments of children and families involved in child protection proceedings (in addition to material provided by DHS). The report of the clinician engaged by the clinic will often constitute the only independent expert evidence before the court.

In 1997, the Australian Law Reform Commission noted that the clinic was well regarded and operated efficiently. The commission recommended that similar clinics be attached to children's courts nationwide, and adequately resourced to provide the court and legal representatives with expert advice on the best interests of the child.[55] New South Wales established a clinic based on the Victorian model in 2001.

Challenging clinicians at court

It has been asserted that there is no process for challenging a clinic assessment. This is not correct. A clinician submitting a report must be available for cross-examination when subpoenaed by a party or required to attend by notice given by the child, a parent, the Secretary of DHS or the court (section 550 CYFA).

The Clinic and its independence

It has also been suggested that the court attaches too much weight to clinic reports. The court understands that it is alleged that there is a high degree of alignment between clinic recommendations and court orders and that this shows some sort of partiality towards 'one side over another.' The court makes the following points in response to this allegation:

- It is a most serious allegation to make against a court that its decision-making is partial or governed by influences apart from the evidence that is presented to it. The court suspects that people who make such claims have limited experience of the court, rarely, if ever, observe contested cases and would appear not to have read the reasons for decision in any given case. Those who do have standing to institute appeals very rarely do so.
- It is appropriate to ask those who make such allegations, how they are able, so confidently, to assert that there is a strong alignment between clinic recommendations and court decisions. Where is the research to support such an assertion?
- The court strongly encourages research. Associate Professor Jeanette Lawrence from the University of Melbourne has been involved in significant and on-going research in the Children's Court for the past four years. The

[54] The court is also able to call on the clinic to assist in cases before the Criminal Division.
[55] Seen and heard: priority for children in the legal process (ALRC Report 84), p. 154.

court has supported Associate Professor Lawrence's research, which has expanded into research on the Children's Court Clinic. The court has encouraged this additional research. The court is able to provide an interim report on a comparison of clinicians' recommendations and Children's Court orders. The results are instructive. The interim report is attached as Appendix 4. In summary, it reveals that in relation to final substantive orders, judicial officers made orders that were consistent with recommendations made by the clinic in 57% of cases. The report confirms the importance of acting on research rather than anecdote or assertion.

The court submits that there are four important issues in relation to the clinic for the Department of Justice to address. They are –

- a proper model of governance; (This would involve the creation of a "board" that would be responsible for overseeing management of the clinic, the appointment of staff (including sessionals), professional development, clinical performance appraisals, and complaints. The board would have appropriate representation from the fields of forensic psychology/psychiatry, family and children's law and management. Funding for the clinic would not come from the budget of the Children's Court.)
- locating the clinic out of the court building at a venue nearby;
- paying appropriate rates for clinicians (full-time and sessional); and
- properly supporting the Clinic to better serve country courts.

The Children's Court Clinic (funded from the Children's Court budget) continues to be under-funded annually, to a significant degree (39% deficit in 2010-11). The total workload of the Family Division of the Children's Court has increased 9% annually since 2004. The additional judicial and registry resources have not been matched by investment in the Children's Court Clinic. A budget sustainability strategy will need to be considered to support the additional resources required.

In Summary

- ❖ The Children's Court Clinic provides reports that inform the decision-making of the court. The clinic provides professional assessments of children and families involved in child protection.
- ❖ Recent research shows that the orders made by judicial officers are consistent with recommendations made by the clinic in 57% of cases.
- ❖ The clinic requires additional resources to maintain its ability to provide high-quality services to the court.

CONCLUSION

The court has a crucial role in the child protection system. It makes decisions regarding the removal and placement of children, as well as the provision of services for families, in an open forum, according to legal standards and based on the evidence presented. The court provides reasons for decision and is accountable through an appeal process.

In every state and territory in Australia and in England, Wales, New Zealand and the majority of American states, a court is regarded as the most appropriate body to review a decision by a child protection agency to intervene in the life of a family.

The court actively supports and has been actively involved in developing less adversarial trials, a better model of conferencing and the development of specialist lists.

The court confirms the reforms to the child protection system recommended in its original submission to the panel, namely –

- a strong investment in prevention and early intervention;
- an enhanced family care conference process;
- a new way of commencing applications;
- investment in court resources to strengthen the court's capacity to conduct NMCs throughout the state, engage in problem solving approaches and adopt a less adversarial trial model;
- investment in court infrastructure to enable better decentralisation of cases throughout metropolitan Melbourne; and
- investment in court resources to enable stronger support to regional venues of the Children's Court.

OPTION 4 – COURT, PANEL OR TRIBUNAL?

Changing the nature of the body which decides whether there should be State intervention in the care of a child so that it includes non-judicial as well as judicial members.

4.1 Is the function of deciding whether 'a child is in need of protection' an exercise of judicial power?

4.2 Is it desirable to change the composition of the Family Division of the Children's Court to include people other than judicial officers in decision-making panels?

4.3 What people other than judicial officers should comprise decision-making panels?

4.4 What qualifications, if any, should they have?

4.5 Upon what terms should any non-judicial members of the Family Division of the Children's Court be appointed?

4.6 If some or all of the functions currently performed by the Family division of the Children's Court are to be performed by panels of people should those functions be retained by the Children's Court or should they be exercised by a tribunal?

4.7 If these functions are to be exercised by a tribunal should that tribunal be a division or specialist list of VCAT?

4.8 If these functions are to be exercised by a tribunal should a new Protective Tribunal be established to deal with a range of matters where the state intervenes in the lives of people for their protection?

The Court submission will deal with this option in a global way instead of responding to each question separately.

IS THE FUNCTION OF DECIDING WHETHER A 'CHILD IS IN NEED OF PROTECTION' AN EXERCISE OF JUDICIAL POWER?

The Court engaged Senior Counsel to provide an opinion regarding this question. In his opinion dated 23 March 2010, Mr Peter Hanks QC drew three conclusions.

Conclusion 1:

- *The function, conferred on the Children's Court, of deciding whether "a child is in need of protection" falls within the paradigm of judicial power.*

In support of the conclusion, Senior Counsel stated:

The function conferred by the CYF Act on the Children's Court, of deciding whether "a child is in need of protection", lies at the heart of judicial power.

- *The function will involve the determination of a controversy between the Secretary to the Department of Human Services, on the one hand, and (typically) the parent or parents of a child, on the other hand. The controversy is likely to involve disputed questions of law and disputed facts.*

- *The determination of that controversy has immediate consequences relating to the rights of the child and the child's parents.*

- *The decision, once made, is binding and authoritative (even if subject to appeal).*

- *The decision is made by reference to defined criteria (as set out in s 162(1) of the CYF Act).*

Conclusion 2:

- *That characterisation has no constitutional implications, because the State can confer judicial power on a body that is not a court.*

Conclusion 3:

- *If it is seen as desirable that the Children's Court remain a State court in which the Commonwealth can vest federal jurisdiction (that is, the judicial power of the Commonwealth), it is important to ensure that the Children's Court retains the basic characteristics of a court – performing only those functions that are compatible with the exercise of judicial power and being constituted principally by judicial officers with protected tenure and remuneration.*

In relation to the third conclusion, it is important to note that the Family Division has jurisdiction to hear and determine applications to make, vary, revoke or extend an intervention order under the *Family Violence Protection Act 2008* (FVPA). As a result the Children's Court has Commonwealth jurisdiction to vary Family Court orders that conflict with intervention orders made under the FVPA, provided that the jurisdiction is exercised by a magistrate (section 68R of the *Family Law Act 1975*) (Cth).

Senior Counsel has advised, "that if the Children's Court were to be constituted otherwise than by judicial officers (of the kind that presently constitute the Court), the Children's Court would cease to be a permissible recipient of any part of the judicial

power of the Commonwealth. That is, the Children's Court could no longer exercise the powers that are currently conferred on it by provisions in the *Family Law Act 1975* (Cth)."

The Family Division of the Children's Court deals with applications under the FVPA where there are child complainants or child defendants. In 2008-09, the Children's Court finalised 1,836 of these applications. Cases from suburban courts are often adjourned into Melbourne where the parties would benefit from the services available at the Melbourne Children's Court or where proceedings will be contested and the expertise of a specialist Children's Court magistrate is required.

There is a strong connection between family violence and child protection. It is not uncommon in the Children's Court for there to be concurrent proceedings in both the child protection list and the family violence list, with common facts and allegations. It is particularly helpful for families in this position and those charged with assisting them to have their matters dealt with by one judicial officer at one hearing. The need to maintain the close integration between child protection applications and family violence applications supports the preservation of both jurisdictions within the Children's Court. If child protection is moved out of the Court, family violence matters will – because of their possible connection to associated Family Court orders - inevitably remain within the Court.

It is difficult to see any rationale for families to be involved in two separate yet similar litigious matters before different bodies. The parties would be required to attend different venues on a greater number of occasions, unlike the current situation in which, wherever possible, the Children's Court adjourns and determines the matters on the same date. In addition, separate hearings before different bodies would require witnesses to give evidence on more than one occasion with the potential for inconsistencies to emerge within the separate proceedings. Furthermore, now that the Department is able to apply for intervention orders on behalf of family members, the creation of a separate tribunal for child protection matters would mean that protective workers would be pursuing parallel, concurrent and factually similar applications in two separate jurisdictions.

WHAT IS THE POLICY OR EVIDENCE BASE FOR DEPARTING FROM THE CURRENT CHILDREN'S COURT MODEL?

In 2000, the *Children And Young Persons (Appointment of President) Act 2000* was enacted which created the office of President of the Children's Court and established the Children's Court as an independent court, separate from the Magistrates' Court of Victoria. The Act reflected the importance of increasing the specialisation and authority of the Children's Court and elevated the status of the Court by creating a separate court from the Magistrates' Court.

As noted by the Attorney General during the introduction of the legislation:

> *The bill is good legislation…. Having a stand-alone Children's Court constitutes an upgrading of the status of the Children's Court and allows for the best possible expertise to sit in judgment on Children's Court matters. The proposal has been argued in this state for 17 years and has finally been introduced by the Bracks Labor government.*

In 2003 and 2004, there was an extensive review of the primary legislation that governs child protection in Victoria. This review, overseen by the Department of Human Services, led to the proclamation of the CYFA which, among other things, governs the operation of the Children's Court of Victoria. In the second reading speech in support of the CYFA, the then Minister said – "*The Children's Court will remain central to the statutory system of child protection."*

The CYFA has as one of its main purposes - "*to continue the Children's Court of Victoria as a specialist court dealing with matters relating to children*."

This recent decision to maintain a specialist Children's Court for child protection cases was an appropriate acknowledgement of the importance of judicial decision-making in the area of child protection. It also recognised that a decision concerning the removal of a child from his or her family is a decision of such profound importance to a child's future and the future of a family unit that it ought to be made by a court.

Given the broad consultation which occurred during this most recent review, the Court is struggling to understand the policy or evidence base that supports a substantial departure from the current court based model. Nor has the Court during meetings with court users, heard any person or agency express a view that it would be desirable to move away from a court based model. As noted throughout this submission however, the Court is constantly working to refine the process to enable it to be responsive to the needs of the community and to continue to produce outcomes which are in the best interests of children.

The Ombudsman's report has been influential in suggesting there may be a need for an alternative framework to a court-based model. The Court has already detailed the problems and failings in the Ombudsman's report and yet it is on the basis of that flawed report that there comes a suggestion that the Court model should be departed from.

If the concern is about the legalistic or formal nature of the Court process, the conclusions of the Leyton Review in SA are relevant: "*it is not necessary to change the system in order to discourage an inappropriate or excessively formal approach in the court*."

As noted at page 30, the Court recognises the environmental pressures created by the Melbourne building and its associated legal culture and is keen to continue to address the situation. However, it is important to note that these are "environmental" issues that are not reflected at the Family Divisions in Victorian rural locations or the Family Division at the Moorabbin Court. It is not the Court model that needs to be addressed but the problems at Melbourne. This is a critical distinction.

It is, of course, essential that the Victorian community be convinced that there is a sound policy and evidence basis to make fundamental changes to a long-standing court model. It is only when this is established that consideration of non-court based models can be entertained.

The Court's decision-making – appeals

The Court is, of course, accountable for every decision that it makes. In the 2008-09 year, the Children's Court made 5,691 interim accommodation orders. These are orders that provide where a child will live pending the final determination of the matter. If a party considers that the Court has made an order that is not in the best interests of the child that party may seek an immediate appeal hearing before the Supreme Court. Such appeals are very rare. In the last 12 months, the Court is aware of one appeal by the Department. It was dismissed.

Similarly, the Court is accountable for every final order it makes. If it is considered that the Court has made an error of law in its decision-making, a party can appeal to the Supreme Court of Victoria. In addition, if a party is aggrieved by the decision of the Children's Court, it can appeal to the County Court of Victoria. In the latter case, a judge of the County Court will re-hear the matter. Such appeals are rare. When they do occur, it is just as likely to be an appeal by a family member as it is to be by the Department of Human Services.

Certainly, there is no evidence to support the suggestion that the judicial officers of the Children's Court are regularly making incorrect decisions. The evidence, in fact, supports the contrary proposition.

The Court's decision-making – high frequency contact orders for infants and cumulative harm

Some people have commented on these two aspects of the Court's decision-making.

Below is a summary of the Court's position on "high frequency contact orders for infants" and "cumulative harm". For a full and detailed discussion of these two issues, the reader is referred to the Research Materials on the Children's Court website. [178]

High frequency contact orders for infants[179]

The Court is of the view that there is no unanimity among professionals as to what is an optimal frequency of access between an infant and a non-custodial parent. It is clear that every case must be considered independently and on its facts. A case which demonstrates this view is *DOHS v Ms B & Mr G*[180] in which a respected child psychiatrist, Dr P, said that *"there certainly is evidence that a prolonged period out of the care of your primary carer in the first months of life can be quite disruptive to your sense of self-organisation"*. He also expressed the view that there was no one answer which applied across the board but one ought be guided by how the particular infant reacted to a particular frequency of access: "*I'd give it a period of trial*."

A study by Professor Cathy Humphries and Ms Meredith Kiraly entitled "Baby on Board" includes some criticism of Children's Court orders involving "high frequency access" between an infant and a parent. The authors acknowledged that one of the

[178] The Children's Court website: www.childrenscourt.vic.gov.au. (Research Materials 4.14 and 4.15).
[179] The Court's response in relation to a commission having authority to fulfil functions relating to issues such as access in response to Question 3.7.
[180] [2008] VChC 1.

limitations of their research was that they were not able to gain the views of any parents. A full analysis of this research work is included in the Court's Research Materials previously referenced. The Court does note that whilst the authors concluded that a period of court-ordered high frequency parental contact did not improve the rate of family reunification, it considers that the ultimate aim of contact should generally be to develop the best possible parent-child relationship, whether reunification is ultimately achieved or not. This is consistent with paragraphs (a), (b) and (k) of section 10(3) of the CYFA. Of course, that will not mean high frequency contact in every case. Every case depends on its own particular facts.

The Court is aware of the view expressed in the American Judicial Guidelines 1999 which, *inter alia*, provide as follows[181]:

> *Because physical proximity with the caregiver is central to the attachment process for infants and toddlers, an infant should ideally spend time with the parent(s) daily, and a toddler should see the parent(s) at least every two to three days. To reduce the trauma of sudden separation, the first parent-child visit should occur as soon as possible and no later than 48 hours after the child is removed from the home*."

As previously noted, these guidelines were prepared by both lawyers and social scientists and overseen by an Advisory Committee consisting of some of the most respected American social scientists and judicial officers, including Dr Joy D. Osofsky, a world authority on child development.[182]

While the Court understands the pressure that facilitation of high-frequency access places on the system, a proper determination of access frequency must be child-focussed. Given the divergence of professional views on this issue and given that decisions about a child's welfare ought be made holistically and on a case by case basis, the Court is of the view that it is currently giving proper attention to all relevant considerations as part of its decision-making.

Cumulative harm

"Cumulative harm" was introduced into legislation by section 162(2) of the *CYFA* which provides that for the purposes of proving harm pursuant to subsections (1)(c) to (1)(f), the harm may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances. From the Court's perspective, this legislation was hardly necessary as it had long been part of the common law and therefore applied by this Court. It had expression, *inter alia*, in dicta of Lord Nicholls of Birkenhead (with whom Lord Goff of Chiefly & Lord

[181] At p.72 of "Healthy Beginnings, Healthy Futures: A Judge's Guide", a publication compiled in 2009 by a team of six professionals drawn from (i) the American Bar Association Center on Children and the Law, (ii) the National Council of Juvenile and Family Court Judges and (iii) the Zero to Three National Policy Center.

[182] Dr Osofsky is Professor of Public Health, Psychiatry & Paediatrics at Louisiana State University Health Sciences Center. She is also President-elect of one of the organisations which produced the guidelines, Zero to Three, a non-partisan, research-based resource for American federal and state policy makers and advocates on the unique developmental needs of infants and toddlers. Shortly prior to the storms that devastated New Orleans, Dr Osofsky had accepted an invitation – we believe from the Victorian child protection authority - to visit Victoria and speak to interested persons about her specialist subject but unfortunately she had to cancel her plans as a consequence of the New Orleans disaster.

Mustill agreed) in *In re H. & Others (Minors)(Sexual Abuse: Standard of Proof)*[183] in interpreting very similar English child protection legislation:

> "*Facts which are minor or even trivial if considered in isolation, when taken together, may suffice to satisfy the court of the likelihood of future harm*."

Ms Robyn Miller[184] when explaining the rationale for the inclusion of section 162(2) in the CYFA said as follows:

> "*One of the unintended consequences of the practice, which developed from the Children and Young Persons Act 1989, is that intake and initial investigations were increasingly based on episodic assessments, which were focused on immediate risk and safety, and less focussed on the developmental wellbeing of children, and patterns of abuse and neglect over time.*"[185]

The Court submits this is the correct analysis. The legislative provisions were not introduced because of some problem with the Court's application of the principle but because child protection workers were not applying the principle in their daily work.

THE REQUIREMENT FOR NEW MODELS TO BE CONSISTENT WITH THE CHARTER OF HUMAN RIGHTS AND RESPONSIBILITIES ACT 2006

The *Charter of Human Rights and Responsibilities Act 2006* (the Charter) provided a new framework for the protection and promotion of human rights in Victoria. The Charter is based on the notion that all arms of Government should contribute to the protection and promotion of human rights in Victoria.

Section 17(2) of the Charter affords special protection to children in recognition of their vulnerability due to age. Under the Charter, children are entitled to the enjoyment of all rights, as human beings except where they do not meet the eligibility criterion.

In addition, section 17(1) recognises *that families are the fundamental group unit of society and are entitled to be protected by society and the State*. Section 13 also provides that a person has the right *not to have his or her privacy, family, home or correspondence unlawfully or arbitrarily interfered with*. [186]

Consistent with the Charter therefore, any removal of a child from a family unit must be carried out only where it is lawful and where it is not arbitrary.

Further, section 24 of the Charter requires that a party to a civil proceeding has the right to have the proceeding decided by a competent, independent and impartial court or tribunal after a fair and public hearing. The Court understands that the purpose of the right to a fair hearing is to ensure the proper administration of justice and is

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[183] [1996] AC 563,591.
[184] The Principal Child Protection Practitioner in the child protection authority.
[185] "*Cumulative Harm: A Conceptual Overview*" (December 2006) at p.11.
[186] Article 3 of the United Nations Convention on the Rights of the Child provides similar protections. See Appendix 6

concerned with procedural fairness. What constitutes a fair hearing will of course depends on the facts of the case and will require a weighing of a number of public interest factors.

The fair hearing obligation will also require that the institution of the court or tribunal as well as each of the individual members of the court or tribunal must be competent, independent and impartial.

Policy makers and the VLRC will therefore need to give careful consideration to matters raised under the Charter in any proposal to create a new model for dealing with the Family Division jurisdiction (including creating a new court or tribunal; altering the jurisdiction of a court or tribunal; amending the way evidence is presented in a court or tribunal etc.).

Any new model must consider whether it adequately takes into account the best interests of the child as a paramount consideration and that processes are fair and transparent.

The European Court of Human Rights has stressed the central importance of a fair trial in matters that separate children from the family unit. (Article 6 of the Convention for the Protection of Human Rights and Fundamental Freedoms):

> *There is the importance of ensuring the appearance of the fair administration of justice and a party in civil proceedings must be able to participate effectively, inter alia, by being able to put forward the matters in support of his or her claims. Here, as in other aspects of Article 6, the seriousness of what is at stake for the applicant will be of relevance to assessing the adequacy and fairness of the procedures.*

A few examples of orders and conditions in the Family Division which affect human rights include:

- an interim accommodation order placing a child outside the family unit (section 17);
- a condition requiring a child or parent to undergo medical treatment. Such a condition would interfere with the right to not be subjected to medical treatment without consent (section 10);
- a condition limiting contact between family members might also be seen as an interference with not only the right to family life but the right to freedom of movement (section 12);
- those cases where substantive orders such as therapeutic treatment orders (TTO) or therapeutic treatment placement orders (TTPO) are made, the rights affected are significant. For example, a TTO can require that a child aged 10-14 who has exhibited sexually abusive behaviours participate in an appropriate therapeutic treatment program (medical treatment without consent); and
- finally, as part of an order, where the Court finds there is a substantial and immediate risk of harm to a child, the Court can place a child in a secure welfare service. This is a serious matter which raises a child's fundamental right to liberty (section 21).

In contested matters in the Children's Court, it is not unusual for families to have an extensive protection history stretching back several years or for there to be several parties participating. In addition, it is common for at least one of the parties to suffer

from an impediment that limits their ability to fully participate in the litigation, eg, immaturity (in the case of children), physical disability, intellectual disability, mental illness or substance abuse issues.

The Family Division of the Children's Court deals with serious and complex matters. It also deals with our most vulnerable citizens. It is difficult for the Court to analyse alternative models, without appropriate details of those models being outlined. However, it is the Court's view that weighing relevant public interest factors and with the best interests of children as a paramount consideration, a court remains the most appropriate forum for the determination of Family Division matters in Victoria.

THE SCOTTISH CHILD PROTECTION MODEL

The Court has taken some time to examine Scotland's Children's Hearings system which commenced on 15 April 1971. This system is a dual model which deals with both child protection and criminal law matters.

In relation to child protection cases, it appears that under the relevant legislation the local authority (probably similar to our local councils), has a general responsibility for promoting social welfare in an area and specifically it has a duty to inquire into and tell the Reporter of cases of children who may be in need of compulsory care measures, to provide reports on children for children's hearings and to implement supervision requirements imposed by children's hearings.

The Reporter is an official employed by the Scottish Reporter Administration. Included in the Reporter's duty is to decide whether a case should be referred to a children's hearing and arranging such hearings. It is understood that the Reporter also provides support, legal advice and input to the children's hearing and to panel members.

Children's hearings decide whether a child requires compulsory measures of care and, if so, which measures are appropriate. A children's hearing consists of a chairman and two other members drawn from the children's panel. It must not be wholly male or female. Scottish ministers appoint a children's panel for each local authority area. The members hold office for such period as the minister specifies; they may be removed by him or her at any time, but only with the consent of the most senior judge in Scotland. The children's panel comprises a group of people from the community who come from a wide range of backgrounds, are unpaid and give their time voluntarily. Children's hearings may also appoint a safeguarder for the child.

Hearings are usually conducted in the child's home area and the layout is relatively informal with the participants usually sitting around a table.[187]

Under Scottish law a children's hearing is regarded as a tribunal. Its members are considered to enjoy judicial immunity from proceedings for wrongful detention and defamation, in the same way as judges of their lower courts.

[187] The Court also notes that current Children's Court hearings are heard closest to a child's home and are required to be conducted with as little formality as possible.

The children's hearing may only consider the case of a child where it has been referred to them by the Reporter and where certain "grounds of referral" are established, either by agreement with the child and his parent or by a decision of the Sheriffs Court. Therefore, in the absence of agreement, a decision by a judge on the grounds of referral, after hearing appropriate evidence, is essential before the children's hearing can consider the case.

The Sheriff, who is any judge of the local Sheriffs Court, has the following main roles in the process:

(a) to grant a warrant for continued detention of a child in a place of safety, pending a hearing, in certain circumstances;

(b) to adjudicate on whether the grounds of referral to the children's hearing are established, where the child or his parent does not accept them;

(c) to hear appeals against decisions of children's hearings.

The Court makes the following observations regarding the Scottish model. That:

- it is based on what appears to be a localised model, with panels based in regions who are responsible for its operations;
- it is based on a model which combines child protection with criminal matters;
- the panel members are unpaid volunteers;
- without agreement as to the facts, a children's hearing will not proceed;
- a court model is retained with a judge to determine the facts;
- urgent orders for removal are authorised by a court comprising of a judge; and
- the Scottish model is currently under review (discussed below).

The Scottish children's hearing process is currently undergoing reform *in order to protect the system from emerging European Convention of Human Rights challenges*[188]. It also appears that their equivalent child protection authority is in crisis[189] and the Scottish panels have struggled to cope with significant increases in referrals. [190]

The Court also understands that the Government introduced a Bill on 23 February 2010, (which creates a new national body called the Scottish Children's Hearings Tribunal, provides better access to legal representation and makes changes to the role of the reporter) after delaying its introduction as the previous iteration was the subject of strong divergent views from stakeholders. The Policy Memorandum supporting the new Bill notes that there *has also been recognition for a number of years now, including amongst the Hearing's system's strongest supporters that it is not working*

[188] 'Whitewash' Fear Over Child Abuse Review, news.scotman.com, 5 March 2010, Children's Hearing Rethink Urged, BBC News, 17 August 2009, Row As Controversial Children's Bill Put Back To Next Year, Herald Scotland, 28 August 2009, Shake-Up For Children's Panel System, Scotland-on-Sunday, 2 August 1998

[189] Failings 'Put Children At Risk', BBC News, 26 November 2009, Brandon Muir Child Protection Services Still Failing, TimesOnline, 23 June 2009, Child Protection 'Overstretched', BBC News, 13 July 2009, Moray Child Protection Condemned, BBC News, 12 February 2009, Aberdeen Child Protection Slated, BBC News, 13 November 2008, Resignation After Care Criticism, BBC News, 1 February 2007, Child Services 'Need Improvement', BBC News, 25 January 2007

[190] Care Reaches Highest Level for Almost 30 years, The Scotsman, 25 February 2010

as effectively as it might or should. Key concerns include: inconsistency within the Hearing system…limited opportunity for the child to participate effectively...and the potential for challenges to the system under the European Convention on Human Rights."

The Court notes the following in relation to the Scottish model:

- that the current ADR model is preferred as it can operate without the need to settle facts; and it doesn't require a decision to be made by a third party – it is worked out between the parties – adopting an ADR philosophy;
- it still requires the retention of a court structure;
- referring part of the decision-making unnecessarily fragments the system; and
- as noted above, it is premised on conditions that don't exist in Victoria.

THE ENGLISH CHILD PROTECTION MODEL

The Court has examined the English child protection model and makes the following observations:

- child protection proceedings are usually held in the Family Proceedings Court, which is essentially a court-based model;
- the Family Proceedings Court, not only hear cases of child welfare, but also child custody, visiting rights for parents who no longer live in the family home, reclaiming maintenance and divorce hearings - similar to Australia's Family Court;
- matters are heard by a bench of three **lay** magistrates, collectively called a Bench; and
- The Bench is supported by a legally qualified Court Clerk. One magistrate has been trained to take the chair and the other two are referred to as 'wingers'. Although the chair speaks on behalf of the bench, all three magistrates have equal decision-making responsibility.

In the Court's view, a positive feature of the UK model is the fact that the local authorities have a duty to continue to promote the welfare of children until the age of 21 years. Apart from this feature, the Court notes that the UK model appears to retain a court based approach using lay magistrates based on the old *justice of the peace* system.[191] The use of lay magistrates is not unique to their child protection courts. The English legal system uses lay magistrates across their justice system including criminal hearings.[192]

Victoria abolished a similar justice of the peace system (aside from the execution of documents), many years ago.

The Court further notes that the English child protection system has been subject to high level review many times since World War II.

[191] They are not paid but may claim expenses and an allowance for loss of earnings and do not usually have any legal qualifications.

[192] Magistrates hear criminal matters but cannot normally order sentences of imprisonment that exceed 6 months (or 12 months for consecutive sentences), or fines exceeding £5000.

THE PROPOSAL FOR NON-JUDICIAL MEMBERS TO PARTICIPATE IN DECISION-MAKING REGARDING CHILD PROTECTION

Other Australian reviews of Children's Court Models

There have been two recent reviews of child protection systems in Australia. One in New South Wales and the other in South Australia.

The NSW inquiry (Wood Commission) looked at the "Scottish model". In its submission to the NSW inquiry, the Department of Community Services (DOCS) submitted:

> *"Research suggests that tribunals, particularly those not involving legally trained personnel can fail to provide procedural fairness due to lack of proper reasoning, lack of proper representation, failing to apply legal principles, perceptions of bias and formation of views prior to the hearing. Anecdotal evidence and research findings in the first decade of the operation of the Scottish Children's Hearing system indicated that informality led to procedural laxity as well as wide variations in practice between hearings. This is supported by 2007 research into the relationship between social work recommendations to Scottish Children's Hearings and the decisions taken, which found that widely different policies and practices operated between different regional localities throughout Scotland. There is a risk that a failure to provide procedural fairness can lead to complex, costly and formal appeal processes*."

The NSW Inquiry did not favour a model of decision-making that included lay, volunteer panels because they "*often lack the rigour and experience in decision-making that is necessary in such a sensitive and complex area*".

The NSW Inquiry also concluded that it did not consider it necessary to replace the existing model of decision-making by their Children's Court.

THE PROPOSAL TO REPLACE THE CHILDREN'S COURT WITH A TRIBUNAL BASED MODEL

The Family Court and adoption cases

In Australia, it is accepted that private law cases involving children should be dealt with by the Family Court. In 2004, the former Chief Justice of the Family Court, (Nicholson CJ) was asked for his views on a tribunal system to hear family law cases. He replied:

> *"I think tribunals don't have the independence that courts have and they're very much subject to the possibility of appointments not being renewed if the tribunal's not following the line that that particular government wants, so you take away an essential aspect of independence with a tribunal."* [193]

[193] Transcript of interview on Radio National, "The Law Report" – 6 April 2004.

The former Chief Justice was even clearer in 1995 when asked to comment on whether child protection matters should proceed before a tribunal rather than a court:

> "….. *I view the suggested solution of a tribunal as no solution at all. Experience suggests that tribunals are no better and may well be worse than courts in performing the decision-making function. Their drawbacks include liability to political interference, either indirectly or by the removal of the tribunal if its approach is disapproved of by government, expense (three decision makers instead of one), lack of security of tenure and a lack of independence resulting from concerns about re-appointment."* [194]

The Children's Court adopts these views and notes the critical importance of independent and fearless decision-making in the area of child protection.

The Court also adopts the comments to the NSW inquiry made by Magistrate Mitchell (the then Senior Children's Court magistrate in NSW):

> *"Although it is possible to find some jurisdictions where the tribunal model is followed – Norway and Denmark which are cited in the Green Paper along with a couple of African States, most jurisdictions with which New South Wales associates itself follow the judicial model. These include England and Wales, New Zealand, most of the United States and every State and Territory of the Commonwealth. It is submitted that ours is a society in which it is expected that such fundamental rights and interests as are involved in care cases should be dealt with by the Courts."*[195]

Child protection adjudication requires determination of issues between a powerful government agency, and a number of different parties including, parents (often two competing parents), each child (often with separate representation if mature enough to give instructions), and frequently a grandparent or competing grandparents. Over the last few years the Children's Court has heard difficult and complicated cases involving multiple parties and complex issues. For example, in 2006, the Court had one case that proceeded for 80 days. In 2008, another case proceeded over 50 days. A court is the appropriate place for these complex and difficult matters to be determined.

There is no evidence to suggest that a tribunal would manage these cases in a "less adversarial manner" as tribunals have jurisdiction to hear contested matters in the same way as a court.

Cases in the Children's Court involve a very wide spectrum of factual disputes. The Court is required to determine whether the child is in need of protection and if so, what orders the Court should make to ensure the child is protected. The Court may be required to make findings on issues as complex as whether a baby has been shaken; whether a child has been sexually abused; whether a particular type of parenting is excusable in terms of culture; whether a particular regime of drug rehabilitation is likely to meet with success; whether a parent's particular mental health deficit is likely to be inconsistent with "good enough" parenting.

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[194] Law Institute Journal, April 1995 at page 309.
[195] See Magistrate Mitchell's submission at para 53, p. 20.

As noted by Magistrate Mitchell in NSW:

> *"These are the types of issues that in many comparative jurisdictions are dealt with by superior courts such as the Family Court of Australia and the High Court of England and Wales. It is submitted that care cases are not primarily administrative matters to be dealt with extra judicially."*[196]

Child protection cases can either be straight forward or complex. They can be quickly conceded or heavily contested. In every case, the outcome of the case will have profound implications on the future lives of children, young people and families. Some cases before the Children's Court will involve orders that change guardianship. Some cases will result in permanent care orders. In either case, the decision is of such importance it must be made by a Court.

In Victoria, the importance of judicial involvement in, and oversight of, adoptions is accepted. These matters are heard and determined in the County Court of Victoria. It is the Court's view that the same approach should be maintained for child protection cases. [197]

THE CONNECTIONS BETWEEN CHILD PROTECTION, FAMILY VIOLENCE AND THE CRIMINAL DIVISION

As noted above, the Scottish child protection system deals with most alleged criminal offenders under the age of 16 years.[198] The system is an integrated one that treats offending behaviour as indicative of family problems to be addressed.

The New Zealand model is different to the Scottish model in a number of ways. Importantly, it deals with child protection in a court-based system. Nevertheless, it is similar to Scotland in the way it adopts an integrated family based approach to alleged offenders. In New Zealand, alleged offenders under 14 are not processed as criminal offenders but referred to Family Group Conferencing. This integrated response recognises the interconnections between criminal behaviour and child protection.

Victoria deliberately moved away from an integrated hearing approach but has maintained physical co-location of the Divisions (as well as joint administration of the Divisions). In recognition of the interconnections between the two Divisions, the Court has been given power to refer a defendant in the Criminal Division for investigation by the Secretary of the Department of Human Services if:

- it considers that there is prima facie evidence that grounds exist for the making of a protection application in respect of the child;[199]
- it considers there is prima facie evidence that grounds exist for an application for a therapeutic treatment order (TTO) in respect of the child.[200]

Generally, referrals in the first category have not resulted in intervention by the Secretary.

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[196] See Magistrate Mitchell's submission at para 54, p. 21.
[197] Permanent care orders are effectively Children's Court adoptions.
[198] See footnote 10
[199] s.349 (1)(b) of CYFA
[200] s.349 (2)(b) of CYFA

The second category of referral has resulted in a number of cases where the Secretary has intervened. If a young person is assessed as suitable to undergo a TTO (or the related therapeutic treatment placement order), the criminal proceedings are adjourned pending the determination of the application in the Family Division. If that Division grants the application, the charge/s in the Criminal Division are adjourned until the therapeutic treatment is completed. The charges will be struck out if the young person successfully completes the order.

It is the Court's view that any proposal to sever the Family Division from the Court and locate it in a tribunal will inevitably disrupt the interaction between the two Divisions. This disruption will be even more profound in the area of family violence.

There is a strong correlation between family violence and child protection. As noted previously, under the CYFA, the Family Division has jurisdiction to hear and determine applications to make, vary, revoke or extend an intervention order under the *Family Violence Protection Act 2008* or the *Stalking Intervention Orders Act 2008*, when either the respondent or an affected person is a child. As a result the Children's Court has Commonwealth jurisdiction to vary Family Court orders that conflict with intervention orders made under the *Family Violence Protection Act 2008*, provided that the jurisdiction is exercised by a magistrate (section 68R of the *Family Law Act 1975*)(Cth). Only a body with the basic characteristics of a Court can be the repository of Commonwealth judicial power. This inevitably means that family violence matters – because of their possible connection to Family Court orders -will be heard in a court. We have already explained the difficulties with having child protection matters dealt with at a venue away from the Children's Court while family violence matters are being dealt with in the Children's Court.[201] The need to maintain the close integration between child protection applications and family remedies under the FVPA supports the preservation of both jurisdictions within the Children's Court.

CHILDREN'S DECISION-MAKING FUNCTIONS AT VCAT

The Children's Court of Victoria - a strong statewide system

The Children's Court of Victoria operates a statewide system across Victoria. Country magistrates deal with urgent apprehensions and manage matters with a high level of competence. If a matter is to proceed to a contested hearing of four or more days duration, the Melbourne Court will assist by providing a magistrate to conduct the directions hearing and hear the final contest.

All magistrates assigned to regional areas have spent at least three months working in the Melbourne Children's Court, participated in regular professional development, have access to resource materials and the support of the President or magistrates at Melbourne at any time.

The Children's Court operates an integrated and efficient system that relies on close cooperation and understanding between the Children's Court and the Magistrates' Court. It is hard to imagine how a panel system or a tribunal system could possibly match the quality service that is currently provided to country Victoria.

[201] See the discussion at page 94 and 95

In addition, the Court has recently established two Family Division courts at Moorabbin. It did so by working with the Chief Magistrate. These Courts service the Southern Region offices of Child Protection at Cheltenham, Frankston and Dandenong. The initiative has received strong support from Child Protection. The establishment of the Court at Moorabbin is an example of the flexibility, efficiency and strength of our current court based system.

It is clear from the Taskforce report that Child Protection would prefer further decentralization of the Children's Court with the use, where possible of local courts, rather than bringing families and workers into Melbourne. The Taskforce committed in principle to decentralisation and recommended contingency plans to ease the pressure at Melbourne in the short term. The Court is prepared to move Eastern Region cases to the old County Court building as soon as government agrees to this. Again, it is the current Court based system that offers the best opportunity for achieving a responsive, efficient and, if appropriate, decentralised system.

In addition, if a matter is to be fully litigated -some matters are incapable by their very nature of a negotiated settlement - then it is the Court's strong view that overly informal, fast-tracked procedures, with an emphasis on cost-effectiveness, are not in the best interests of the child or the community. Properly safeguarding the interests of the participants in child welfare proceedings, whose participants include some of the most marginalised members of the Victorian community, requires a Court to be the decision maker not a tribunal.

The importance of a statewide service is relevant in the discussion of VCAT and any alternative model.

One VCAT President's Review of VCAT

The former President of the Victorian Civil and Administrative Tribunal (VCAT), Justice Bell, reviewed VCAT at the request of the Attorney-General and released his report *One VCAT President's Review of VCAT* in March 2010. As noted in that report, VCAT was established in 1998 as a 'super tribunal' with its purpose to provide fast, cheap, efficient and fair access to justice.

The main areas of tribunal jurisdiction are residential tenancies, civil claims, guardianship and planning. Apart from the Human Rights Division which includes the Guardianship and Administration List with powers to make orders appointing a guardian or administrator for a person aged 18 years or over who has a disability, the VCAT underlying operating philosophy appears to be the antithesis of the approach required for Child Protection matters.

As part of the review, Justice Bell conducted community consultations across Victoria with a wide range of community, industry and professional stakeholders. Whilst he found the Tribunal improved access to justice and equitable outcomes (and there was virtual unanimity about the tribunal being a necessary feature of Victoria's justice system), he also found there were serious deficiencies in the accessibility of justice to the Victorian community. Criticisms identified in the consultation include:

- excessive delays in being listed and getting a decision. This was noted as *strong across the board;*

- inappropriate behaviour by some members;
- inconsistency in procedure and result. This was noted as *a strong point of criticism*; and
- people in outer-suburban and country Victoria have relatively poor access to the tribunal. This was noted as *a very strong criticism revealed in the community consultations*.

There is also no existing evidence suggesting that ordinary litigants found VCAT to be less adversarial than other courts in Victoria.

The Court submits that, there is no evidence to show that a tribunal model would provide the necessary statewide service; or provide a consistent approach to decision-making; or result in a timely approach to the resolution of matters; or provide a less adversarial approach.

The Court is also concerned at the findings of Justice Bell regarding the poor utilisation of the tribunal by culturally and linguistically diverse (CALD) communities and Koori communities:

> *There is poor utilisation of the tribunal by CALD and Koori communities. A number of access barriers appear to stand between these communities and the tribunal. A major cause is disengagement between these communities and the institutions of government generally. Part of the solution involves greater engagement between the tribunal and such communities, which is hard to achieve with the present metro-centric model of the tribunal's service delivery. The tribunal's record of engagement with the Koori community is particularly disappointing, despite the conspicuous efforts of some members to do something about it.*

The Mental Health Review Board

The Court would oppose any proposal to move Family Division matters currently in the Children's Court towards a board type model, similar to the Mental Health Review Board. It would be difficult to draw any comparisons between systems, as the jurisdictions are so different, but the Court notes:

- the Board exercises administrative decision-making powers;
- Board hearings area carried out at a patient's location;
- Board hearings are closed to the public[202];
- there are usually few parties present;
- the panel comprises three members;
- Board hearings are relatively short and vastly less complex than child protection proceedings can be; and
- evidentiary matters differ widely.

[202] Children's Court hearings are currently open to the public unless otherwise ordered by a magistrate. Also note Section 24 of the Charter and the requirement for a public hearing.

A FINAL COMMENT

In every State and Territory in Australia, and in England, Wales, New Zealand and the majority of American States, a Court is rightly regarded as the most appropriate body to review a decision by a child protection agency to intervene in the life of a family.

In 1993, Justice Fogarty prepared a report on the child protection system in which he concluded:

"In my view the Children's Court must maintain its position of independence and integrity and if anything that position should be reinforced rather than diminished."

With respect, that conclusion was correct then and is correct now.

FORM 37

Rule 60 (1)

REDACTED FINDING INTO DEATH WITH INQUEST

Section 67 of the ***Coroners Act 2008***

Court reference: 1430/08

In the Coroners Court of Victoria at Melbourne

I, JUDGE JENNIFER COATE, State Coroner

having investigated the death of:

Details of deceased:
Surname:
First name: AARON
Address:
AND having held an inquest in relation to this death on 9, 10 and 11 August, 2010
at 250 William Street, Melbourne
find that the identity of the deceased was AARON
and death occurred on 8th April, 2008

at 1 Surrey Road, South Yarra, Victoria 3141

from
1a. INJURIES SUSTAINED IN FALL FROM HEIGHT

in the following circumstances:

Introduction

1. Aaron was the eldest of the three children of his mother ML. Tragically, on 8 April, 2008, he took his life at the age of 14 years and 9 months old by jumping from an 11th floor balcony of a Ministry of Housing multi-storey complex at 1 Surrey Road in South Yarra. At the time of his death, he was living with his mother and two younger siblings in emergency housing premises in Albert Park.

2. At the time of his death, Aaron was enrolled as a student at Malvern Central School. According to the evidence of Ms Wendy John,[38] Assistant Principal, Aaron was an intelligent boy who was popular amongst other students and teachers although he was not the most diligent of students. Ms John painted a picture of a troubled boy who, although often at odds with the teachers, had a strong friendship network and found school to be a haven. Ms John described

[38] Exhibit 8 : Statement of Wendy John

Aaron as kind with younger students, a boy who loved animals and enjoyed spending time with his friends.

3. Aaron's father, JE, lived in Heidelberg. He does not appear to have had any contact with Aaron for about the last three years of Aaron's life. The reason for this is not clear. He has had no involvement with these proceedings and made no statement to police.

4. During Aaron's life he was the subject of 14 separate notifications to child protection ("DHS") over 12 years, being from the time he was 22 months old. At the time of Aaron's death, he was not on any formal child protection orders but DHS were still actively involved in his life.

5. The recurring nature of the child protection notifications was that Aaron had a lack of any or any appropriate adult supervision, was being exposed to many incidents of domestic violence, psychiatric illness, environmental neglect, exposure to substance abuse by his father, mother and mother's partner, lack of school attendance, homelessness of himself and his family and that his emotional and psychological wellbeing was either actually being harmed or at risk of being harmed by all of the above.

6. The material produced supports a finding that for a number of years of Aaron's life, his mother worked nights as an escort. The evidence is that this lifestyle often resulted in the children being left unattended overnight, or inappropriately placed and, as Aaron got older, reports that he was required to care for his younger siblings whilst his mother worked, began to emerge. ML's interaction and co-operation with DHS over the years was unpredictable and erratic. It was often characterised by short periods of responsiveness and engagement at the time of intervention, but these periods were not sustained as is apparent from the 12 year history.

7. On surveying Aaron's child protection history, it was not surprising that during the last few years of Aaron's troubled life, as he reached his adolescence, his behavior and attendance at school became problematic and concerning. He was suspended on a number of occasions for fighting and failing to respond to teachers' instructions. It is apparent that he was often not staying at home overnight, and not apparently eating or sleeping properly and consuming alcohol. In the last 12 months of his life he engaged in several apparently overt acts of self-harm until the final tragic act which took his life.

8. ML was approached to make a statement for the inquest but declined to do so. Thus, it was not possible to get her response to any of the material contained in the inquest brief. She attended at the first Directions Hearing for this inquest. She sought an adjournment to engage legal representation. This adjournment was granted. However, she did not attend for the adjourned Directions Hearing. She did not attend at the Inquest and thus her responses or views about the evidence or the circumstances surrounding Aaron's death could not be taken into account.

General comments as to the role of the coronial investigation

9. The fact finding role of the coronial investigation has often been stated as one focused on establishing the truth of what happened as best the evidence allows, to establish the circumstances surrounding the death. At times, in the course of investigating and establishing the circumstances surrounding the death, opportunities for improvement in systems of public health and safety which may contribute to a reduction in preventable deaths are identified. When this occurs, the Coroner has the power[39] to comment on any matter connected to the death including matters that relate to public health and safety and the administration of justice. The Coroner's investigation should not be seen as an exercise in apportioning blame against individuals or agencies, even though it is acknowledged that the process of the investigation and inquest may well be perceived by those individuals involved in the investigation as such an exercise. However, sometimes to achieve improvements to our systems of public health and public safety, it may be necessary to put under scrutiny the actions of individuals trained and working inside those systems to highlight the need for improvement.

10. Aaron's death was a reportable death pursuant to s.3 *Coroners Act 1985* (at the time at which it was reported) and s.4 Coroners Act 2008, the law applicable at the time at which it went to inquest.[40]

Circumstances of Aaron's last day alive

11. Aaron was still enrolled at Malvern Central School at the time of his death, although on the last day of Term 1 he had told his school friends Alina and Isabelle and the Assistant Principal Ms John that he did not intend to return to the school for Term 2. He had been enrolled at the school since February 2007.

12. In the wake of Aaron's death some of Aaron's school friends spoke with police. It is clear from their statements that they had spoken with Aaron previously about his thoughts of killing himself. When Aaron told Alina and Isabelle on the last day of Term 1 2008 that he would not return to school in Term 2, he would not tell the girls why that was so. However, Isabelle told police that on the last day of Term 1 Aaron "again mentioned that he was going to kill himself as he didn't want to be at home on the holidays and had nothing else to do."[41]

13. The girls told the police that one of them had removed a knife she found in Aaron's bag when they were together on that last day of Term 1 2008. According to Isabelle they spoke to Aaron at some stage on the last day of Term 1 about the knife they found in his bag. In the course of the

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39 See S.67(3) **Coroners Act 2008**

40 See Schedule 1 **Coroners Act 2008** for the transitional provisions. No issue was taken with the 2008 Act being the applicable Act for this inquest.

41 Statement of Isabelle P.35 Inquest Brief

discussion they stated they told Aaron he should not kill himself with the knife, implying that Aaron had previously spoken to them about taking his own life. The girls stated that in response to this, Aaron said that he would just jump off a building instead. Isabelle stated that he indicated towards the commission flats as he said this.[42]

14. Alina and Isabelle were with Aaron the day he died. They told the police they had previously been with Aaron in that same building in Surrey Road during the Term 1 school holidays. The building was being renovated and the upper floors were not intended for public access. They told the police that Aaron had gone to the 11th floor and had been walking around close to the opening. On that occasion they had managed to talk him into coming downstairs with them. Isabelle stated they told him how much they cared about him and how he had his whole life in front of him.

15. Tuesday 8 April 2008 was the second day of Term 2. Aaron had not been at school on the first day of Term 2 which was Monday 7 April. On 8 April 2008 at the end of the school day Aaron spoke to Alina and Isabelle about not being at school the next day. Indeed Isabelle recalls that he had been telling them during the day that he was not going to be at school the next day but would not say why as you "try and get me out of it". Isabelle noted that he did not appear to be any different to normal other than "being happier and talking to us." She noted that he was giving out his money and yearly tram tickets which had seemed strange.

16. The girls described how the group left school together and traveled on the tram to the stop near Surrey Road where they got off. After they got off the tram, Aaron took off quickly towards the same building they had been in during the holidays. The group all pursued him believing that he was "doing the same thing as last time, trying to grab our attention".[43] Alina stated to police that when some of the group with Aaron followed him into the building and saw him trying to force the temporary door into the 11th floor, she said he was telling them to go away and that when asked why he needed to do this he stated "I just do". His friends made various endeavours to try and get him to come back down but he kept telling them to go away.

17. Alina and Isabelle returned downstairs believing at that stage that sooner or later he would get bored and come back down. They watched him for 20 to 30 minutes. They saw Aaron looking out from what appeared to them to be the 11th floor, sitting on the ledge, throwing various items over the edge.

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[42] Both Alina and Isabelle made statements to the police. Given their young ages and the trauma of their experience, they were not required to attend court to give evidence. The evidence attributed to them is derived from the statements they made to police and included in the inquest brief.

[43] Statement of Alina P.31 Inquest Brief

18. Alina and Isabelle then tried hiding from Aaron in the belief this may cause him to come down and look for them. After about 10 minutes of this strategy, both girls went back up to where Aaron was and saw him sitting on the window ledge of the 11th floor.

19. Again they asked Aaron why he was doing what he was doing and he replied that he had to do what he was doing. He momentarily got off the ledge, apparently looking around for something and telling the girls to go away. Aaron went back and looked out of the window and then said to the girls "The cops are downstairs". The girls hoped that he would follow them down, but as they went out past the temporary ply board door, Aaron locked it behind them so they could not regain entry.

20. They walked back down the 11 flights of stairs and by the time they got there, they could see that Aaron was on the ground.

21. Ms Amanda Wastell was working nearby that day. She stated that at about 5.10pm her attention was drawn to a man on the edge of a building with two girls "trying to talk him down". She went outside her building and saw him standing on a "tiny ledge" about 9 floors up the building. She saw no other person near him and could see him looking down. She dialled 000 and a few minutes later she met police who had arrived. They gathered proximate to the base of the building.

22. When the police arrived, they could not see Aaron. The police commenced to obtain details from Ms Wastell about what she had seen and where she had last seen Aaron and then asked her to wait where she was as they moved towards the building.

23. It was Ms Wastell's evidence that very shortly after the police moved off towards the building she saw Aaron come and go from view in an area where there was no glass in the window area of an upper storey apartment in the building. She stated that she then saw Aaron fly out of the window looking like he "was diving into an Olympic swimming pool" with his arms outstretched.[44] Ms Wastell screamed and looked away before Aaron hit the ground. She stated that the police returned to where she was standing a couple of minutes later.

24. Four police responded to the call from Police Communications to attend the Surrey Road flats where a male could be seen on the ledge of an open window near the top floor of the building. LSC Page stated that he attended with Constable Hammer within four minutes of getting the call. LSC Page stated that when he arrived LSC Berwick and Constable Konomas were already present.[45] LSC Page stated that about two minutes after arriving at the scene he saw a male come "flying out of an open window head first". He stated that it looked as if the male had taken

[44] Exhibit 1 Statement of Amanda Wastell
[45] Exhibit 2 Statement of LSC Page

a run before he jumped. The account of LSC Berwick is consistent with the other eye witness accounts of how Aaron jumped and landed.

25. LSC Page and LSC Berwick immediately went to where Aaron was lying, felt for a pulse, found none and assessed that he was deceased and called for an ambulance.

Issues raised in the course of the investigation

26. A Coroner investigating a death must find the identity of the deceased person, the cause of the person's death and the circumstances in which the death occurred.[46] In the course of this investigation and inquest, no issue was raised as to Aaron's identity or the cause of his death. There were issues raised about the circumstances in which his death occurred and it is this area that was the focus of this inquest.

27. The circumstances surrounding Aaron's death require attention to the role of the State in three separate categories; they are the police, the school and the Department of Human Services in its child protection role. There was also an issue raised on the material about the safety and security of the building the children were in.

Death in police presence

28. As described above, Aaron's death occurred in the presence of the police. In any case where this is so, given the role of the police in our state, it is necessary for a Coroner to address any issues about the actions or non-actions of the police in connection with the death.

29. In this case, the evidence is that Amanda Wastell called 000 after seeing Aaron in a perilous position on the outside ledge of the building. Ms Wastell's evidence was that the police then made contact with her on her mobile to get her exact location and then arrived "a few minutes" later.[47]

30. Ms Wastell stated that she was between 200 and 300 metres from the building when the police arrived, in a nearby car park.[48] She stated that the police spoke to her to confirm that she was the caller and then walked towards the building. Further, she stated that from the time the police arrived to the time Aaron jumped was shorter than five minutes but no more than that and maybe as brief as two minutes.[49]

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46 See Section 67(1) **Coroners Act 2008**
47 Statement of Amanda Wastell: p.2
48 Transcript p.8
49 Transcript p.7

31. Leading Senior Constable Kane Berwick stated that he had about a one minute conversation with Ms Wastell, to try and establish Aaron's location. He then spoke with his partner Constable Konomas and two other police members who had also arrived to develop a plan of action in response to the situation.

32. LSC Berwick stated that he then walked across the road to the footpath outside the estate fence. He looked up to where Ms Wastell had indicated Aaron was and at that time saw Aaron leap from the building. LSC Berwick described Aaron as having been "outstretched" like he had been running rather than just dropping from the ledge.

33. LSC Berwick stated that he ran to where Aaron had fallen and felt his neck for a pulse, but could not find one. He also noted that LSC Page had already called for an ambulance by the time he had felt for a pulse.

Conclusion as to police involvement

34. The evidence demonstrates that the police who attended this scene, led by LSC Berwick had arrived within several minutes of the call from Ms Wastell and acted quickly to attempt to execute a plan. Sensibly, they sought information about the situation they were responding to and then attempted to put a plan into action. I am satisfied that, in these circumstances, there was no action that the police should have or could have taken to prevent Aaron's death. He jumped before the police had any opportunity to make contact with him or attempt any form of interception.

Building

35. The investigation and brief raised some issues about the state of the building and whether or not young people should have been able to access the area where Aaron and the girls had entered.

36. Clearly, there were extensive renovations going on inside the building and in particular on the 11th floor which is where Aaron had entered. The windows had been removed and new ones had not yet been fitted. There were temporary barriers erected, intended to keep people out of the area. The evidence is that Aaron had forced the temporary door at the end of the stairwell to the 11th floor of the building. The group responsible for the safety and security of the building was Arrow International.

Conclusion as to building safety and security

37. The area was clearly "out of bounds". It was being patrolled by a security presence. Aaron put considerable effort into getting into the area where he wanted to be.

38. In the wake of Aaron's death, WorkSafe, Arrow International, DHS and Victoria Police met with the contractors performing the renovations on the building. New safety and security measures were put in place which included erecting mesh grills over the windows and replacing the plywood doors with more secure doors.[50] This action was both sensible and appropriate and requires no further investigation or comment.

School

39. As stated above, Aaron had enrolled at his current school in February 2007 and was still enrolled at the school at the time of his death. The circumstances surrounding his death raise issues as to whether or not there was anything the school generally could have or should have done to contribute to Aaron's safety and wellbeing and potentially prevent his death.

40. Ms John stated that Aaron was suspended numerous times for a range of incidents including physical fighting and lack of work and failure to comply with teacher's instructions.

41. Ms John said that the school started to become concerned about Aaron in Term 2 of 2007. She gave evidence about some particularly serious incidents of concern as well as a more general picture of observations and ongoing concerns about Aaron.

42. For example, she stated that on 17 August 2007, Aaron was observed in class to have slashed his diary with a blade and to have cuts on his knees and to have a blade in his mouth. This behaviour was the subject of a notification to DHS.[51]

43. In September 2007, Aaron was located in a classroom with a group of students. He had a can of deodorant and a lighter and was assessed by his school to be self-harming and acting destructively. Further, it was the school's assessment that Aaron had been cutting himself and leaving visible scars, although he denied this behaviour when confronted with it.[52]

42. This behaviour was also brought to the attention of DHS.[53]

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50 Exhibit 7: Statement of Costa Petropolous
51 This was the 14th notification to DHS about risk to Aaron's safety and well being.
52 Exhibit 8: Statement of Ms John, Assistant Principal
53 Exhibit 8: p.1

44 On 1 November 2007, according to Ms John, Aaron attended school in an apparently intoxicated state. It was not clear whether he was drunk or drug affected. He was observed in his classroom to lapse into apparent unconsciousness and an ambulance was called which conveyed him to the Royal Children's Hospital. The school was not made aware of what the cause of that collapse was or the outcome of any hospital assessment. DHS attended the hospital.

45. Ms John stated that throughout Aaron's problems at school his mother was difficult to contact and engage. She noted that it was also difficult to get Aaron to open up although she noted that Aaron had apparently been more open with a couple of his friends at school and in particular Alina and Isabelle. The girls would sometimes inform the teachers of Aaron's problems but Ms John stated that Aaron would deny anything was wrong when questioned.

46. She also stated that he would sometimes come to school out of uniform but in the same clothes for a few days in a row and she suspected he was not going home. She also stated that Aaron would regularly fall asleep at school. Ms John stated that she eventually found out that Aaron would sometimes stay out all night rather than go home. Ms John stated:

> *"When I asked about this, he stated he would ride the trains and trams until they stopped running and would then find a park to sleep in. From this and information received via other kids, that he was not happy at home and that there were issues which caused him to not want to be at home, I was unable to contact his mother to find out these issues. Aaron would always turn up to school though, yet sometimes without food or his uniform".*[54]

47. Carum another 13 year old junior school student also spoke with police. He described Aaron as "often hurting himself by cutting his wrists". He also stated that Aaron was always saying "bad things" about his mother and was often engaged in "attention seeking" behaviour.

48. These same sorts of sentiments were expressed by Alina and Isabelle to the police in the wake of Aaron's death. Isabelle stated that about a month before Aaron's death he had been talking about killing himself saying he had not been sleeping, was under a lot of pressure at home and that he had been drinking.

49. As to Aaron's state of mind, Ms John gave evidence that when she spoke to Aaron about his behaviour and how things were for him, he would close up. She recalled that once he said to her:

> *"What's the point . ..... nothings going to happen .... Nothing can make anything better and that's all."*[55]

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[54] Exhibit 8: p.2
[55] Transcript p.43

She stated that she asked some of his friends how he was going and if everything was all right and was told, "things aren't great at home, but he's handling it".[56]

50. In oral evidence Ms John painted a picture of doing the best she could to try and find out what was happening in Aaron's life to help support him better at school, but generally not making much headway with his mother or his friends or Aaron. The evidence is that, sadly in the wake of Aaron's death, Ms John learned considerably more about Aaron's life. She stated that it appeared that school was Aaron's "haven."

51. Ms John also gave evidence that she was "imploring" DHS to get involved. She stated that she felt she did not get a lot of "feedback" from DHS and felt it was somewhat frustrating as she wished to be in a relationship with DHS in which the school and DHS were working together for the benefit of Aaron.[57] Ms John felt that she lacked a lot of information about Aaron's situation and that more information may have assisted them to support him in a more successful way.[58] She also felt she would have benefitted from advice and guidance from DHS about how to deal with Aaron.

52. Ms John did state that Aaron had "seemed a lot happier" in 2008. She stated that he seemed enthusiastic to be at school and was being more productive. However, on the last day of Term 1, 28 March 2008 Aaron got into some trouble with a teacher and when spoken to by Ms John, he told her that he would not be back at the school after the school holidays.

53. As stated above, Aaron did not attend school on the first day of Term 2 (April 7, 2008) but Ms John saw him at his locker on the morning of April 8, although not in uniform. It would appear that he participated in school that day and his spirit and upbeat mood were apparently so notable that a couple of teachers who spoke with Ms John at lunch time on that day told her that Aaron told them he was "great" and he was noted to "be co-operative, participating and seemed happy". It was that evening that Ms John received a telephone call advising her of Aaron's death.

Conclusion as to school involvement in Aaron's life

54. Ms John's evidence paints a picture of a compassionate and engaged school community that tried to accommodate Aaron's behaviour and lifestyle and keep him engaged with and attending school, aware that his peer support was a great comfort to him. Ms John gave evidence that Aaron's friendship group was "the most important thing for him".[59]

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[56] Transcript p.38
[57] Transcript p.72
[58] Transcript p.74
[59] Transcript p.51

55. There is little evidence that DHS gave much in the way of tangible support, guidance and advice to the school in its efforts to keep Aaron engaged and attending. School was Aaron's haven and ongoing connection to community and peer support. Whilst he kept attending school, this gave DHS a real opportunity to work with him and the school, to support and protect and understand what life was like for him. Sadly, that opportunity was not capitalised upon.

DHS

Overview

56. As stated above, Aaron had been the subject of 14 notifications to DHS over a 12 year period beginning from when he was 22 months old.[60] Seven of the notifications were not proceeded with beyond the initial assessment stage. The other seven notifications resulted in investigations which were closed at the "intake" phase. The evidence from Lucas Ford, the last DHS worker allocated to Aaron for notification 14, is that once Aaron was provided with a youth worker, the plan was again to withdraw from Aaron's life.

57. The evidence is that only one report of the 14 notifications over 12 years resulted in DHS taking any court action. Even that one court application resulted in DHS withdrawing before any findings or final orders mandating child protection intervention were made to protect Aaron. Aaron and his brother were made the subject of one interim accommodation order into the care of their maternal grandmother.[61] At that time, ongoing concerns were identified based on ML's current and past suicide attempts and frequent mood changes. Following further assessment of ML's parenting capacity, the protection applications were withdrawn on August 29, 1996 on the basis that ML agreed to work with a range of services and her extended family would support her and her family.

58. There were 9 further notifications to child protection after this time.

59. In summary, as stated above the nature and range of the notifications related to Aaron's exposure to domestic violence, neglect, exposure to his mother and father's substance misuse and his mother's partners violence, poor school attendance and his mother's mental health functioning.[62] There were also issues of concern raised about the family's transience, Aaron's mother's avoidance of DHS and the children's lack of schooling. The last couple of notifications contained concerns that Aaron was expected to provide primary care for his younger siblings while his mother worked nights. There was also evidence that Aaron's relationship with his mother was often very strained, that he was sad and self-harming and staying out at nights to avoid being at home.

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60 Written submissions of DHS filed November 12, 2010
61 The DHS file was provided to the Coroner together a summary of DHS interventions.
62 Statement of John Daniliuc 20.7.2010

60. At the time of Aaron's death he was not the subject of any formal orders pursuant to the *Children Youth and Families Act 2005 (Vic)* but DHS still considered itself to be actively involved in "case managing" Aaron.

The last notification (Number 14)

61. The last formal notification to DHS for Aaron came to the Southern Metropolitan Region of DHS in August 2007. Concerns were raised about Aaron's behavioral and mental health issues including self-harming and aggressive behaviour, cutting himself, erratic school attendance, falling asleep in class, conflict at home between Aaron and his mother and her absence from home overnight.

62. I have had the benefit of reading the comprehensive and extensive summary of the history of DHS involvement in Aaron's life set out in the Child Death Inquiry report provided by DHS.[63] With the benefit of that knowledge, I shall turn only to the last notification for Aaron and the wake of that notification to examine the effectiveness or otherwise of the State's protection in this case.

63. Mr Lucas Ford, the team leader of the Adolescent Team responsible for the management of Aaron at the time of his death provided a statement to police for this investigation and gave evidence at the inquest. In his statement[64] he noted he was aware of the 13 notifications dating back to when Aaron was 22 months old. He then went on to describe the history of the most recent intervention from August 2007 as follows:

> *"While Child Protection was involved with the family, Aaron's mother fluctuated between seeking assistance from the Department and refusing to engage. On numerous occasions, ML was non-contactable or not willing to discuss the situation with protective workers. ML was always afraid her children would be removed from her care. During child protection involvement, the concerns in relation to Aaron appeared to subside. It is believed that this occurred as Aaron and his mother improved their relationship. Aaron was residing at home with his mother and attending school when he was not suspended. Moreover, he had not self-harmed since the beginning of the child protection involvement (August 2007). During involvement, child protection staff offered counselling/mental health support to Aaron but he did not wish to engage with such a service ....."*

64. This statement is to be contrasted with the material in the DHS file which appears to lead to conclusions to the contrary. On a number of grounds, the above conclusions of Lucas Ford do not appear to be sustained by the evidence.

63 See commentary in "Comments" section with respect to the production of this report.
64 Exhibit 9: Statement of Lucas Ford

65. For example, by mid October 2007, Aaron had not attended school for a month and had apparently been reported by his mother to police as a missing person. Aaron was subsequently located and had apparently been staying with his aunt. Early in December he was found sleeping at the Shrine of Remembrance and by mid December ML was indicating to DHS that Aaron could not live with her. During December 2007 and January 2008 he was staying at the houses of friends and relatives. This evidence does not support a conclusion that Aaron was residing at home and getting along with his mother. This information was either known by DHS at the time or should have been known by DHS.

66. During a meeting on 24 October, 2007, three months after the August notification, Aaron's mother presented to DHS as "chaotic and running on adrenaline". She stated she was not coping and that she and Aaron needed a break. She also stated she believed all of her children were suffering from depression. She would not let DHS representatives speak separately to Aaron. However, during her absence from the room, Aaron stated that he was "sick" of looking after his siblings and could not handle living with his mother. He stated he was happy living with his aunt and wanted that arrangement to continue. This evidence does not support a conclusion that Aaron was living at home and getting along with his mother.

67. On 1 November, 2007 DHS were made aware that Aaron had been found unconscious at school and taken to hospital. The DHS investigation revealed an array of serious concerns about Aaron's home life including his mother's apparent precarious mental health. DHS spoke to Aaron at his school on November 20, 2007 during which time Aaron told them he did not want to live at home with his mother as she did not love him, he did not have a positive role model in his life or an adult that he felt close enough to talk to about his problems; he was suffering from insomnia and waking up every two hours; he had not seen his mother happy in a long time and she neither smiled, nor talked to him any more and he had not had any contact with his father since the beginning of 2007. This evidence does not support a conclusion that Aaron had not self-harmed since August 2007. Nor does it support a conclusion that he was getting along with his mother and that his relationship with his mother had "improved". This information was recorded in DHS files as at November 2007.

68. On 30 November, 2007 a meeting was held with DHS and Aaron and his mother and it was decided that DHS would remain "voluntarily" involved on the basis that various supports would be engaged for the family and they would co-operate with them.

69. On 7 December, police contacted DHS in the early hours of the morning advising they had found Aaron at the Shrine of Remembrance and he was stating that he did not want to go home as he did not get along with his mother. The police arranged for him to stay with his aunt.

70. On 11 December, 2007 Aaron's school was again providing information to DHS that he was staying on the streets at night and attending school in a tired and disheveled state and appearing substance affected. Further, the school was reporting that it was unable to engage with either Aaron's mother or aunt. This evidence does not support a conclusion that Aaron was not engaging in self-harming behaviour and that he was getting along with his mother and living at home.

71. When Aaron returned to school in February 2008, the school set a range of conditions which were made clear to DHS. During February 2008, Aaron was suspended twice and the school advised DHS that Aaron may be better off at another school that had a higher staff student ratio.

72. Leaving to one side the accuracy of the statement of Lucas Ford in light of these facts, notwithstanding all of the above, DHS appear to have placed weight on a meeting Lucas Ford had with Aaron on 14 March, 2008 in which Aaron stated that he would try and stay out of trouble and that the situation at home was "going well". Mr Ford became the allocated DHS worker for Aaron and met him for the first time on March 14 2008.

73. The evidence of his friends from school was that this was the period in which Aaron was talking to them about ending his life.

74. In the meeting of 14 March, Mr Ford noted that Aaron was initially shy but then engaged well.[65] Mr Ford went on to note that during this meeting Aaron stated to him that he did not want a mental health worker but that he would engage with a youth worker. Mr Ford stated that Aaron was not presenting as suicidal as he was talking about future goals and aspirations and appeared very interested in engaging with a youth worker. Mr Ford's case note for 14 March, 2008 indicates that he advised Aaron that he would organise a youth worker with a view to ceasing DHS involvement. He went on to say that Aaron seemed very excited by the idea of having a youth worker and very excited about the prospect of playing grid iron. When asked about the follow up from this meeting, Mr Ford stated that he found a grid iron team and then wrote a letter to Aaron and his mother and told them he had found a team in Nunawading.[66]

75. On the issue of DHS continuing to place weight on ML's representations that she would co-operate with DHS and engage with support services when her history spoke loudly to the contrary, Mr Ford stated that (DHS) were used to parents being upset and aggressive with the DHS involvement and basically DHS should just keep trying to engage and "stick with it".[67]

76. Mr Ford sought to clarify why he stated that Aaron was not displaying any significant "risk taking behaviours" as at 14 March, 2008. He stated in evidence that he meant Aaron wasn't

65 Statement of Lucas Ford: p.4
66 Transcript p.127 (See comments section (2))
67 Transcript p.137 (See comments section (3))

engaging in *"chronic absconding... he wasn't using substances all the time... He wasn't substance affected all the time ..... he wasn't self-harming all the time ..... compared to other young people in the adolescent program his issues were not that visible.*[68]

77. Mr Ford gave evidence that he was an experienced youth worker who had been trained to look for concerns about suicidality in youth. Mr Ford was asked by me as to what he made of the information that Aaron had been found at school, a few months earlier, to have been drinking "White Out", cutting himself, creating fireballs with aerosol cans and a cigarette lighter and assessed by the Assistant Principal to have been engaging in self-harming behaviour? He answered:

> *"I guess it made me think something - there is something that is bothering him, something that is on his mind."*[69]

78. Mr John Daniliuc, a very experienced and senior child protection practitioner currently employed in DHS as assistant manager at the Southern Metropolitan Region Child Protection program gave oral evidence in this Inquest. He did not have any involvement with the management of Aaron but had reviewed the DHS file and prepared a statement for the inquest brief. He impressed as a thoughtful and measured witness. When asked about the quality of the assessment of Aaron's state of mind in the months before his death, he stated with considerable candour that he did not consider that DHS had had a lot of direct contact with Aaron and were not in a position to really know who he was. In this context he stated:

> *"Can I just say Your Honour, that over the whole life of this case we didn't know Aaron and I think that's one of the saddest things. We've been involved with him since he was 22 months old and we had no idea what this boy was about."*[70]

79. Mr Daniliuc was of the view that Aaron had social skills and could have engaged well with a skilled worker. He agreed that, given Aaron was voicing intentions to kill himself to his friends, that information may have been made available to somebody who actually had made a connection to Aaron. Mr Daniliuc also agreed that as at October 2007 when Aaron was saying he couldn't handle living with his mother and he wanted to live with his aunt, that DHS could have responded in a more timely way and been an advocate and a support for him.

80. Mr Daniliuc agreed that DHS could have given more assistance to support the school and thereby assist Aaron to stay engaged: He stated: "I*n my experience schools are incredibly committed to their students".* He gave evidence about the new protocol introduced in May 2010 as between DHS and the Department of Education and Early Childhood Development to assist in

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68 Transcript p.149 (See comments section (4))
69 Transcript p.152
70 Transcript pp.182-206

the development of more collaborative practices regarding the safety and wellbeing of young people including information sharing.[71]

Conclusions re DHS involvement

No Assessment of Aaron

81. In the 12 years of engagement with Aaron there was no proper in depth assessment of Aaron's mental and emotional health made by DHS. This is difficult to explain in the context of the information DHS had from Aaron's school about his behaviour, his history of self-harming and what DHS knew of Aaron's history accumulated in 12 years of notifications of protective concerns from infancy to adolescence. To fail to make the connection between Aaron's documented history with DHS, and the most recent descriptions of his range of behaviours including expressing concerns that he does not wish to live at home, that his mother does not love him, that he has been staying out on the streets, engaging in behaviour described by his school as self-harming does no credit to the Victorian child protection system. To fail to try and assess what Aaron was actually experiencing was to fail him.

Lack of Action to Assist Aaron

82. Given there was no proper in depth assessment of Aaron's state of mind, thus, it was not possible to say what Aaron's state of mind was and what was distressing him. Mr Daniliuc agreed that whilst the file revealed various actions and activities on the part of DHS staff, after 8 months of DHS involvement (from August 2007 to April 2008) nothing concrete eventuated for Aaron, through his eyes, in terms of even a supportive adult to whom he could connect. The allocated DHS worker appears to have changed at least three times throughout these 8 months as his case moved through DHS processes. Whilst the material reveals that a number of ideas and proposals were discussed with Aaron, such as joining sporting groups and getting a mentor, none of it had happened for him at the time of his death.

Episodic Responses/Lacking Analysis

83. The DHS material reveals years of serious reports of child protection concerns for Aaron. The DHS interventions are characterised, at best, by a few months of involvement, some apparent level of "settling" of the issues and then a withdrawal with no apparent ongoing monitoring of Aaron's safety or well being. The "episodic" nature of DHS intervention into and withdrawal from Aaron's life over the years without a more strategic and planned involvement

[71] Transcript pp.191-200 (See comments section (5))

was not desirable and failed to take into account the need to look at Aaron's history and assess his behaviour and risks to his emotional and psychological safety in the context of his own history, rather than against some bench mark of "high risk adolescents" generally.

Lack of Evidence of Comprehension of Cumulative Harm

84. Whilst it is not difficult to understand how and why this may happen a few times, by the time DHS are receiving notification 6, 7, 8, 9 and beyond, it is simply unacceptable that, with all of the expertise available to a child protection authority, it does not, at the very least comprehend the likely risk of cumulative harm for Aaron from years of exposure to the disruptions and issues detailed above.

Failed to Seek Statutory Intervention

85. When Aaron was 5 to 6 years old he was the subject of his 7th child protection notification. This notification was not from a concerned member of the public, this notification came from the Family Court of Australia pursuant to its statutory powers. The end result of that report was that the concerns were "not substantiated". Aaron acquired 7 more notifications after this. One cannot help but wonder at what point a reasonable child protection worker, looking at Aaron's history might have considered that, given the extraordinary number of notifications about this boy's risk of harm inside his family and the increasingly concerning nature of those reports as he reaches adolescence, that the patterns inside his family were not amenable to on-going voluntary involvement?

No Skilled Worker Linked to Aaron

86. Understandably, Aaron's death came as a shock to his mother and to the school and to DHS and to his friends. He had not spoken of taking his own life to an adult. However, there is no evidence that Aaron had developed a relationship with a skilled adult who could assist him to reveal his feelings. There is no evidence that Aaron had had any mental health assessment at all, despite some very overt self-harming behaviour in the last few months of 2007 and a troubling set of circumstances at home.

87. It is not possible now to conclude what was in Aaron's mind that caused him to feel like there was "no point" as he told Ms John on more than one occasion. But it might have been possible had more successful work been done on making a link between Aaron and a skilled youth worker or mental health worker who had maintained a skilled and stable presence in his life. This may have enabled a rapport and trust to be built with Aaron to assist in engaging him with the supports he needed. The tragedy is we will not know how successful this might have been.

CONCLUSION:

88. I find that Aaron, intentionally propelled himself from the outer ledge of the 11th floor of 1 Surrey Road South Yarra, dying instantly from his injuries when he hit the ground below. I further find that Aaron did this with the intention of taking his own life.

89. There appears to be little controversy on the evidence of the experts that making an accurate assessment as to the risk of suicide to a person is a very difficult task. This task of assessing risk is especially difficult in circumstances where that person is a 14 year old boy. Further, it is also a difficult task for a Coroner to conclude whether, on the balance of probabilities, there is evidence sufficient to find that a 14 year old boy has sufficiently understood the ramifications of his actions such that one can find he has intentionally taken his own life.

90. Sadly, in Aaron's case, as stated above I have come to that conclusion. This is based on the following evidence:

(a) At the end of Term 1 Aaron was disengaging with his school community by announcing he did not intend to return in Term 2

(b) Over the Term 1 holidays he was "rehearsing" his plan by visiting the building and even the location inside the building

(c) In the month before his death, he was talking to his friends about killing himself

(d) On the day he died he was giving away his money and his tram tickets

(e) On the day he died he appeared happier than normal and more engaged and talkative (a common retrospective finding in the immediate hours before suicide)

(f) When asked by his friends to come down and stop his behaviour he told them to go away and explained to his friends that he "needed" to do what he was doing

(g) The eye witness accounts of the circumstances of his "jump" leave no equivocation about the intentional nature of it rather than an accidental slip or fall

91. For the reasons set out above, I find that Aaron was showing strong signs of a significant level of disturbance by August 2007. His conduct in the months after this was responded to appropriately by his school by endeavouring to obtain assistance for Aaron from his home, his school and DHS as the child protection agency.

92. Whilst various referrals for assistance for Aaron were made in the last few months of his life, there is no evidence formal counselling or supports were put in place for Aaron. No mental health assessment was made of Aaron to make a professional assessment of his state of mind. No co-ordinated effort was launched by DHS to engage with Aaron's school to endeavour to keep him supported and connected to the one place where Aaron appeared to have a sense of belonging and comfort. From August 2007 to March 2008 there were at least three different workers allocated for Aaron as his case was moved through the DHS case management structure. This resulted in no continuity for Aaron, no capacity to build rapport and trust with him and no apparent understanding of the impact of this upon Aaron.

93. In its final written submissions, DHS submitted that the Court should find that its actions were appropriate having regard to the information available to it at the time of Aaron's death.[72] DHS added that, in any event, it would be speculative to draw conclusions about what the catalyst was for Aaron's final actions when he jumped from the building.

94. I accept that, on the evidence it is not possible to make a causal link between Aaron's suicide and the shortcomings of DHS as set out above. However, it is possible and appropriate to conclude that had a more timely and substantive and engaged response been made to Aaron's situation as at August 2007, it would at least have increased his chances of surviving the tragic state of mind which caused him to take his life on April 8, 2008.

COMMENTS:
Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

For Alina and Isabelle

1. Not surprisingly, Alina and Isabelle were shocked and deeply distressed and traumatised by Aaron's death. They were both 13 years old at the time. The evidence is that they were a great support and comfort to Aaron and he deeply valued their friendship. Whilst the girls may reflect many times throughout their lives on whether there was anything they could have or should have done differently, they must accept they were just barely into their teenage years and not equipped to handle the complexities of such a situation.

[72] DHS final written submissions: p.7

The school

2. The perseverance of Ms John and the staff at Malvern Central should be noted for their efforts on behalf of Aaron. Ms John consistently reported her concerns to DHS and endeavoured to get assistance for Aaron.

Form of supports offered by DHS

No Mental Health Professional

3. (a) The evidence is that DHS did not engage the services of a mental health professional to make a proper risk assessment of Aaron and that it did not appear to be identified as necessary by DHS. It is not suggested that this is always an easy task, but given the evidence of Aaron's willingness to engage with a youth worker, it should not have been a difficult task for a skilled professional to have Aaron engage with an appropriately trained adolescent mental health worker.

No apparent understanding of reality of Aaron's capacity or his mother's capacity to support him

(b) At Aaron's last engagement he had with DHS, he was promised assistance to engage in a grid iron club. He was noted to be very excited about this prospect. What he experienced at most, in the wake of this promise was a letter telling him and his mother of the existence of a club in Nunawading. Bearing in mind Aaron was a 14 year old school boy, with no independent means, living in Albert Park with a mother who had a poor history of following through for Aaron, this appears to be a very poor piece of practice. It would seem almost cruel to excite a young person in Aaron's circumstances into believing assistance is going to be given to him to join a sporting club, to find that the assistance he gets is a letter telling him where the club is located. It does not pass the commonsense test and was likely to leave Aaron with the feeling that the intervention of DHS in his life was likely to achieve little.

Assessing the ability and likelihood of a parent to act protectively

4. This comment comes in the context of Mr Ford's evidence that he was well used to parents being upset and aggressive in the face of DHS involvement in the family's life and that basically it was required to just persevere and work through this. Whilst this sounds like a laudable sentiment from a child protection authority, is it an appropriate one after 14 notifications in the life of a child over 12 years of the child's life? That is, a reasonable professional making constant assessments of the capacity of a parent to sustain the necessary changes to maintain minimum standards for a child in his care, has to ensure that the "perseverance" is not futile. There simply must come a point where the decision has to be made to increase the capacity to obtain on-going

mandated compliance with child protection by using the *Children Youth and Families Act* to support the State's intervention for the benefit and proper protection of the child (see comment 7 below).

Assessment of Aaron based on behaviour of high risk" adolescent generally

5. This comment flows from the evidence of Mr Ford about how he assessed whether or not Aaron was a "high risk" adolescent. The assessment appeared to be based around where Aaron fitted on the **scale** of high risk adolescence, rather than an assessment of his state and his needs. The danger of "bench marking" Aaron's behaviour against the worst end of the disturbed adolescent spectrum is to risk not "seeing" or knowing Aaron. The system should be one which makes a thorough assessment of the young person and their life and circumstances before deciding what "stream" they should be placed in. If this does not happen, there are multiple risks. One is that the "skew" of the system is to wait until the young person's behaviour deteriorates into significant chronic dysfunction before he warrants significant intervention and, sadly, the intervention is less likely to be positive. Another risk is that the young person who is not "acting out" in a dramatic way will be more likely to be overlooked by the system. DHS through Mr Daniliuc advised that since Aaron's death the system has put considerably more emphasis on developing an understanding inside DHS on the significance of multiple reports to child protection and that child protection workers are trained to actively understand and consider the possibility of cumulative harm rather than looking only at the report to hand.[73] This is a good development and DHS are to be commended for it. Seen in this context, however, it must always be based on a thorough assessment of the child or young person who is the subject of the notification.

Information sharing between DHS and Department of Education

6. This issue was raised in the evidence of Ms John who was firm in her view about what would have assisted her in trying to cope with keeping Aaron at school and engaged with his school community. She was disappointed in what she perceived as a lack of support and guidance and collaboration including information sharing from DHS. Mr Daniliuc for DHS gave evidence about a new published protocol between DHS and the Department of Education addressed at improvements in this area. This is a good initiative and the parties involved are to be commended for this achievement.

Schools should be seen by the child protection system as crucial 'allies' for obvious reasons. Schools are full of trained and committed teachers who spend more time with the children and young people in those schools than any child protection worker or any other professional could achieve short of in-patient or residential care. School staff observe the students in social and

[73] Transcript p.201

academic settings. Schools also regularly interact with families. The insights, observations and advice from school staff available to child protection workers for the benefit a child is invaluable for this reason alone. The capacity to monitor, assist and support a child or young person who maintains a connection to school cannot be understated. Quite simply schools are an invaluable resource for the ongoing protection of children in this state. To maximise the benefit to a child who is being managed, assisted or cared for by DHS, DHS should ensure that it provides support, guidance, information and advice to the school of a young person to maximize the chances of that young person staying connected to school.

Value of formal application/mandated intervention

7. Our State has a regime in place to provide for the intervention of the state into the life of a child if the State, through its child protection authority, forms the belief on reasonable grounds that a child is at risk of a range of possible harms inside his or her family. The Department of Human Services (DHS) is the body which has the responsibility for the operation of the child protection regime in Victoria. DHS is given a range of powers and responsibilities housed in the *Children Youth and Families Act 2005 (Vic)* to carry out its child protection functions. Included in that range of powers is the capacity to bring a "protection application" before the Children's Court of Victoria to use the authority of the State to support and protect a child at risk of harm inside his or her family. Such form of State intervention into the family is considered to be a last resort to protect a child, but sadly necessary in circumstances such as where repeated attempts to work voluntarily with a family to ensure the safety of a child have clearly not been or are unlikely to be successful based on the history to date.

8. After the close of evidence and submissions and with the assistance of the Coroners Prevention unit, I have been provided with further information from the Department of Human Services advising that it is currently reviewing the content of the training material relating to adolescent mental health with the assistance of Dr Neil Coventry. I commend this initiative. I have also been advised that the Department of Human Services has recently developed a specialist practice resource titled "Adolescents and their Families" published by the Department of Human Services in collaboration with the Australian Institute of Family Studies. I commend this initiative. I am also advised that work is progressing between Children, Youth and Families Division of the Department of Human Services and the Mental Health, Drugs and Regions Division of the Department of Health regarding the priority access of child protection clients to Child and Adolescent Mental Health Services. I also commend this initiative.

Production and distribution of the Child Death Inquiry Report

9. (a) The *Child Well Being and Safety Act 2005* requires the Child Safety Commissioner to conduct an enquiry and prepare a report to the Minister in relation to a child who has died whilst

a client of child protection. The report prepared is known as a Child Death Inquiry Report ("CDI report").

(b) A very comprehensive Child Death Inquiry (CDI) report was provided to the court by DHS at the commencement of the Inquest. The issue of its production to the court and its distribution or publication was the subject of some controversy in these proceedings. Indeed, the production of the Child Death Inquiry reports to Coroners generally has been the subject of some tension and controversy. For this reason, I thought it worthy of some comment in this case.

(c) In this case, both DHS and the Child Safety Commissioner resisted the court's request to produce the CDI report to the Coroner. Through Ms Gardner of Counsel representing both, the concerns of both of her clients were that, in essence, persons who willingly participate in their inquiry will cease to do so if it is understood that this information will be provided to the Coroner. This lack of willingness will be a detriment to the stated aim of the Child Death Inquiry which is to promote continuous improvement in policies and practices in child protection.

(d) When a child dies whilst a client of DHS, a Coroner is required to investigate to establish, amongst other things, the circumstances surrounding the death. If appropriate, a Coroner may use the investigation into the circumstances surrounding the death to make comments or recommendations addressed to public health and safety issues, in particular, for the purpose of contributing to the reduction in preventable death. The *Coroners Act* also makes clear that Coroners in the conduct of their investigations should liaise with other investigative authorities to avoid unnecessary duplication of inquiries and investigations and to expedite the investigation.[74] Ms Gardner submitted that it is necessary to give meaning to the word "unnecessary" in this context. That is, that given the two different purposes of DHS and the Coroner, the duplication might be illusory. That is, DHS are engaged in a much broader exercise than the Coroner and thus it is not a duplication for each to conduct their own separate enquiry at public expense. That submission is accurate as far as it goes in that DHS may be engaged in a much wider enquiry than the Coroner, but there will be a considerable overlap.

The question of how the public interest is best served in this context is a balancing exercise. On the one hand, the public interest seems well served by the Coroner having the report. The public interest is also served in having DHS respond as quickly and fully as possible to a fatality to ensure the on-going protection of children is as thorough and as immediate as possible and to address any identified public health or safety issues in a more timely way than a coronial investigation can achieve.

The Coroner provided with the internal report or review can be greatly assisted in the conduct of his or her investigation and can provide a more timely completion to his or her own

[74] See section 7 **Coroners Act 2008**

investigations and reduce the amount of public time and money used to re-investigate issues or have to compel witnesses into court to be cross examined. On the other hand, DHS submit that the public interest is best served by the provision of frank and open disclosures which are protected.

(e) Ms Gardner also submitted that the report contains the opinion of the chosen CDI investigator and writer and thus does not alleviate the Coroner of his or her functions to investigate "independently". It is accepted that the opinion of the writer or the findings of the writer of the CDI report do not bind a Coroner. Clearly, DHS select extremely senior and competent persons experienced in child protection matters to prepare and provide those reports, thus, their opinions are very helpful.

(f) In directing the production of the report, I was confident that the contents of the report were likely to address an extensive range of systemic issues in this case in considerable detail and thus reduce the need to pursue these issues in the coronial enquiry. That is, the production of the CDI report was likely to mean that not only would I not have to spend days reading 12 years of DHS files, but I would not require the attendance of numbers of workers and other witnesses as it was likely they had all been interviewed in depth during the Child Death Inquiry and a summary of what had happened would be contained in the report. This will not always alleviate the need for the calling of witnesses, but it often will.

(g) Ms Gardner accepted that s.40 of the *Child Well-Being and Safety Act 2005* **does not protect** or **prohibit** the report from production to the Coroner. There is then the issue of its distribution and publication that requires consideration.

(h) There is a distinction between the **production** of the report to the Coroner and the **publication** of the report, both to the interested parties and to others beyond the interested parties. In making decisions for any dissemination or publication, Coroners are always mindful of balancing the public interest being served by the frank and open disclosures encouraged by the promise of confidentiality and/or anonymity and the public interest in not prolonging an investigation and getting the best information available to the Coroner's investigation.

In this case, there were no other interested parties. No other person or party was seeking a copy of the report. In balancing the tensions, I was satisfied it was appropriate to require the production of the report to the Coroner to meet community expectations that the Coroner would be satisfied that a thorough investigation had been completed and appropriate recommendations made, and then assess whether or not any publication limited or otherwise was necessary. As a general observation, it would seem to be in very rare and exceptional circumstances that even limited publication of a Child Death Inquiry report would be warranted. Whilst interested

parties may need to be provided with some information from the report, consistent with the rules of natural justice, appropriate constraints on its further use or dissemination can be made.

(i) Ms Gardner for DHS sought to rely on *D v National Society for the Prevention of Cruelty to Children* [1978] 171 as authority for the proposition that the greater public interest to be served in a case such as this is absolute confidentiality of the Child Death Inquiry report. However, in my view that is not the effect of this decision. The decision relates to a consideration of whether or not a protected notifier who makes a disclosure of suspected child abuse should be protected from disclosure in a civil suit arising out of that notification. In short compass, these circumstances are completely distinguishable. The request for the production of the report to the Coroner investigating the same death, does not breach the prohibition on identifying notifier details. DHS usually provides its file to the Coroner and keeps the notifier details in a separate sealed clearly marked envelope. In my view, this is sound practice. It would be perfectly proper to produce a Child Death Inquiry report to the Coroner in the same way. Further, notifier details should be protected during or in the wake of a coronial enquiry unless the interests of justice demand otherwise.

(j) In my view, the public interest is best served by ensuring that the Coroner gets as much frank information as possible from the agency under scrutiny, be it Victoria Police, a government department such as DHS or a major public hospital. I accept that there is a real risk that reviews which obtain the frank co-operation of agencies and individuals involved in the death may be compromised if routinely made public in the course of a coronial enquiry.

(k) I consider the production of the Child Death Inquiry report to be a very valuable aid to my investigation and consistent with requirements of s.7 of the **Coroners Act 2008.** However, I am also satisfied that it is in the public interest to protect the contents of the report from general dissemination or publication. In this way, I am satisfied this strikes the correct balance between protecting the public interest in ensuring that candid reviews, performed by highly qualified senior people for public agencies whose actions are under scrutiny by the Coroner are provided to the Coroner whilst protecting the identities of those who have given information to assist in the continuous improvement of our public systems and to help identify any systemic concerns in a timely way.

Based on the reasoning set out above, I am satisfied that it is contrary to the public interest to make public the Child Death Inquiry report produced in this case and have already made an order suppressing its contents.

RECOMMENDATIONS:

Pursuant to section 72(2) of the **Coroners Act 2008**, having made the above findings of fact and conclusions, together with the above comments, I make the following recommendation:

To enhance the opportunities to identify early intervention for children at risk of harm, I recommend:

1. That the Department of Human Services give serious consideration to imposing a mandatory practice standard for Victoria that requires a unit manager or above to review the proposed DHS response to any child protection notification once that child's history accumulates three notifications, but has not resulted in a response beyond voluntary intervention. If a response beyond voluntary intervention is not deemed appropriate the unit manager (CPW5) should record an explicit rationale for this decision on the file.

To develop and maintain skills in identifying adolescent mental health risks and issues, I recommend:

2. That the Department of Human Services child protection practitioners (CPW 2/3), team leaders (CPW4), and unit managers (CPW 5) working primarily with adolescents, undertake mandatory training at commencement and then every two years thereafter to develop and maintain staff skills in identifying and addressing adolescent mental health issues.

To enhance knowledge and understanding of appropriate use of services for assessment and support of adolescents I recommend:

3. That the Department of Human Services develop clear and detailed guidelines outlining when child protection practitioners should make a referral to a specialist mental health professional or service to ensure timely mental health advice and treatment is received when necessary. These guidelines should be incorporated into all the current practice advice within the Child Protection Practice Manual relating to adolescence and mental health issues

Signature:

Judge Jennifer Coate
State Coroner
Dated: 16 May 2011

I **direct** that this Finding be distributed to the following for their action:
Secretary, Department of Human Services

I also **direct** that this Finding be distributed to the following for their information:
The Hon. Attorney-General
The Hon. Minister for Health
The Hon. Minister for Education
Ms Wendy John, Assistant Principal, Malvern Central School
S/C Antolini: Coroner's Assistant
LSC Berwick: Investigating Member
ESD, Victoria Police
Ms ML
Parents of Isabelle and Alina
The Hon. Philip Cummins, Chair Protecting Victoria's Vulnerable Children Inquiry
Mr John Daniliuc, Department of Human Services
Robyn Miller, Principal Practitioner, Department of Human Services
Mr Bernie Geary OAM, Office of Child Safety Commissioner

APPENDIX 2A

The Scottish Government

Statistics

Statistics Publication Notice: Children Looked After Statistics 2007-08

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Table 1.8: Children looked after at 31st March 2008 by type of accommodation

Type of accommodation	Age Group					Total
	Under 5	5-11	12-15	16-17	18-21	
In the community:-						
At home with parents	1,039	2,167	2,347	695	111	**6,359**
With friends/relatives	647	1,102	503	133	13	**2,398**
With foster carers provided by LA	965	1,448	834	262	70	**3,579**
With foster carers purchased by LA	115	290	200	53	6	**664**
With prospective adopters	137	84	12	3	1	**237**
In other community	-	-	-	28	8	**36**
Residential Accommodation:-						
In local authority home	3	50	408	214	20	**695**
In voluntary home	0	12	25	17	4	**58**
In residential school	0	83	403	141	22	**649**
In secure accommodation	-	1	55	37	0	**93**
Crisis care	0	10	18	7	0	**35**
In other residential	5	8	52	15	3	**83**
Total looked after children	**2,911**	**5,255**	**4,857**	**1,605**	**258**	**14,886**

Note: Figures are provisional and may be revised in 2008-09.

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Page updated: Tuesday, November 25, 2008

Children on care orders/looked after (0-17 years) 2007-08

Source: Table 1.8 Children looked after at 31 March 2008 by type of accommodation, Scottish Government

	Scotland
Total looked after	14,886
Total 18-21 years	258
Total looked after 0-17 years (under 18)	14,628
Population 0-17 years	1,045,693
Rate per 1,000 0-17 years	14.0

Defn: Children looked after are children or young people who have the legal status of being looked after by local authorities. This can include a range of living placements, including those children under supervision orders still placed with parents.

Children in OOHC/looked after (not with parents) (0-17 years) 2007-08

Source: Table 1.8 Children looked after at 31 March 2008 by type of accommodation, Scottish Government

	Scotland
Total looked after	14,886
Total at home with parents	6,359
Total looked after away from home	8,527
18-21 years looked after away from home	147
0-17 years looked after (not with parents)	8,380
Population 0-17 years	1,045,693
Rate per 1,000 looked after (not with parents) 0-17 years	8.0

Defn: This figure is for children and young people who have the legal status of being Looked After by the Local Authority but who are not living with/placed with parents.

Scotland:

The Scottish Government (2008). *Statistics Publication Notice: Health and Care Series: Child Protection Statistics 2007/08*, web only publication, http://www.scotland.gov.uk/Publications/2008/09/23090901/18. Accessed 9th Feb 09.

Population: General Register Office Scotland (2009), *Mid 2008 Population Estimates Scotland.*

The Scottish Government (2008). *Statistics Population Notice: Children Looked After Statistics 2007-08*, web only publication, http://www.scotland.gov.auk/Publications/2008/11/25103230/0.

APPENDIX 2C

The Scottish Government

Statistics

Statistics Publication Notice: Children Looked After Statistics 2007-08

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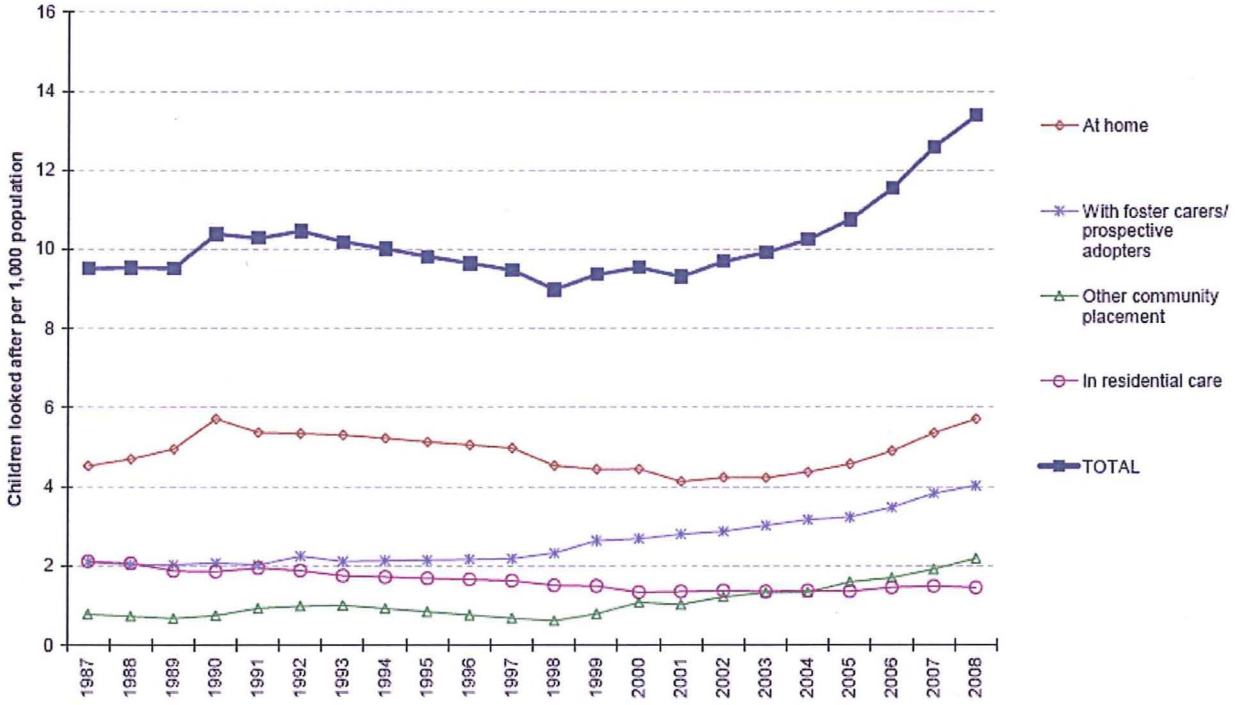
Chart 1: Children looked after per 1,000 of 0-18 population by type of placement, March 1987-2008



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Page updated: Tuesday, November 25, 2008

APPENDIX 2D

The Scottish Government
Riaghaltas na h-Alba

Legal definitions

Children (Scotland) Act 1995

Looked after children and young people: a brief summary

This is a brief summary of the legislation about looked after children and young people - it should not be taken as a comprehensive statement of the law. People should consider seeking their own legal advice as they consider appropriate.

The majority of children and young people who are considered to be **looked after** will come into one of the following two categories.

- **Looked After at home**, where the child or young person is subject to a **supervision requirement *with no* condition of residence** through the Children's Hearing system. The child or young person continues to live in their normal place of residence (i.e. often the family home).

- **Looked After away from home** (i.e. away from their *normal* place of residence), where the child or young person is subject to a **supervision requirement *with a* condition of residence** through the Children's Hearing system, or is provided with accommodation under section 25 (voluntary agreement) or is the subject of a Parental Responsibility Order (section 86). The child or young person is cared for away from their normal place of residence, e.g. in a foster care placement, residential/children's unit, a residential school, a secure unit or a kinship placement.

The undernoted is a brief guide to the main parts of the **Children (Scotland) Act 1995** which governs many areas of a local authority's duties, powers and responsibilities in relation to looked after children and young people and care leavers.

Section	Provision
17	This section imposes a **duty** on local authorities towards children who are **'Looked After'** by them by ensuring that they safeguard and promote the child's welfare, promote contact with those who have parental responsibilities, whilst taking into account the views of the child. A further duty is the provision of advice and assistance with a view to preparing a child for when the child is no longer looked after - often referred to as 'throughcare'.
21	This section sets out details regarding co-operation between authorities and other bodies to help in the exercise of their functions.
22	This section imposes a duty on local authorities to provide a range of services to children who are 'in need'. Such services should be offered to safeguard and promote the welfare of the child and to prepare young people for when they are no longer looked after.
25	This section imposes a duty on local authorities to provide accommodation for children, if: • No one has parental responsibility for them; • They are lost or abandoned; or • The person who has been caring for them is prevented from providing suitable accommodation/care.
29	This section (entitled Aftercare) sets out the main local authority responsibilities, both duties and powers, to young people who leave the **'Looked After'** system following their school leaving age. Section 29 was amended on 1 April 2004 by the Regulation of Care (Scotland) Act 2001.
30	This section sets out when local authorities may give financial assistance towards the education or training expenses of those who have ceased to be looked after following their school leaving age.
31	This section ensures that each child who is **'Looked After'** by the local authority has their case formally reviewed at regular intervals.
53	This section imposes a duty on local authorities to make initial inquiries, if information is received suggesting compulsory measures of supervision may be necessary for the child, i.e. a Children's Hearing report.
55	This provides a local authority with the power to apply to a Sheriff for a **Child Assessment Order**, where access to a child for the purposes of gathering information is denied.
56 (4)	This section provides the Reporter with the power to refer any case to

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Legal guide for your reference:
Word file: Brief guide to the Children (Scotland) Act 1995 (57.5KB)

(b)	the local authority for advice, guidance and assistance to a child and/or their family. This is commonly referred to as **'Voluntary Supervision'.**
57	This section allows a Sheriff to make a **'Child Protection Order'** where there are grounds to believe that a child is being ill-treated, neglected or will suffer harm. Whilst any person may apply for such an order, this is normally pursued by Social Work Services.
70	This section covers the disposal of a **'supervision requirement'** by a Children's Hearing, the two main sub-sections being: **70 (1).** The supervision requirement would, in most circumstances, stipulate that the child continues to reside in the family home. The child would be deemed to be **'Looked After at home'** by the local authority, and **70 (3).** The supervision requirement would require the child to reside outwith their normal place of residence (i.e. place a condition of residence), e.g. a foster care placement, residential/children's unit, a residential school, a secure unit or a kinship placement. This child would be deemed to be **'Looked After away from home'.**
71	This section imposes a duty on a local authority to give effect to the supervision requirement of a child decided by a Children's Hearing and to any conditions contained within the requirement.
73	This section ensures that 'no child shall continue to be subject to a supervision requirement for any period longer than is necessary in the interests of **promoting or safeguarding his welfare'.** Section 73(2) ensures that no requirement will remain in force for a period longer than one year without that requirement being reviewed by a Children's Hearing.
86	This section provides the power for the local authority to apply to the Sheriff Court, to transfer parental rights and responsibilities to the local authority

Appendix 3

Healthy Beginnings, Healthy Futures

A Judge's Guide

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National Center for Infants, Toddlers, and Families

Healthy Beginnings, Healthy Futures

A Judge's Guide

ABA Center on Children and the Law
Eva J. Klain, JD
Lisa Pilnik, JD, MS
Erin Talati, JD, MD

National Council of Juvenile and Family Court Judges
Candice L. Maze, JD

Zero to Three National Policy Center
Kimberly Diamond-Berry, PhD
Lucy Hudson, MS

Edited by Claire S. Chiamulera

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AMERICAN BAR ASSOCIATION
Center on Children and the Law

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National Center for Infants, Toddlers, and Families

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Contents

Foreword

Janet, who just turned 18 last week, is on the phone for a shelter hearing from the Birthing Center at the hospital. She had her first baby, Mariah, yesterday. Janet is crying hard. The state wants to place Mariah in foster care. The state says Janet is unstable, has used methamphetamine in the past, and is too immature to safely parent. The state explains that Janet was abused and neglected as an infant. She grew up in foster care, in numerous placements, and was, until recently, an out-of-control teenager. Janet says she has put that past behind her. She has her own apartment. She is clean now and the baby was born clean. She says she wants the chance to parent her baby because she wants a family, her own family, something she never had.

The judge considers: What can be done to help Janet be a successful parent? How can the judge give her a chance without risking that the same thing happens to her child as happened to her? And if foster care occurs, what can the judge do to ensure the baby is not injured further by being a ward of the court?

Judges make decisions like this every day. On average, infants and toddlers comprise about one third of our national abuse and neglect caseload. Infants and toddlers—our most vulnerable and precious wards—present an opportunity for judges to do the most harm or to provide the most help. The science of early child development now gives us a clear understanding of the ways we can improve developmental outcomes for infants and toddlers at a time when the rapid rate of brain development provides the best chance for effective intervention. If we know the science and act on it, we can ensure healthy growth and development. This guide gives us those tools. This guide gives us the science in one comprehensive volume so we can usher in a new way to do business when it comes to infants and toddlers in dependency court.

We need a new way to do business. Very young children develop within the context of their primary relationships. They are hurt and healed within that context. Science teaches us that the quality and reliability of those first relationships forms the actual physical architecture of the baby's brain. Since first relationships are primary, we must take a relational approach to case planning for infants and toddlers, by helping parents learn how to have a reciprocal loving relationship with their child. Since first relationships are primary, we must not allow multiple placements of infants and toddlers and find more permanent placements sooner. Since first relationships are primary, we must reframe visitation. Visitation should be a therapeutic opportunity to promote, enhance, and shape the bond between parent and child and not just a "right" of the parent to spend time with the child.

This guide helps ensure that as a nation, we equip the bench to do better by babies every day. Judges can be key players in breaking the intergenerational cycle of abuse and neglect. Read the guide and pass it along to a fellow judge. Push for a relational approach in every case. Let's act now. Let's usher in a new future now, one baby at a time. Mariah—and Janet—can't wait.

Judge Pamela L. Abernethy
Marion County Circuit Court
Salem, Oregon

Preface

A recent explosion of research on early brain development highlights how crucial the early years are in the health and development of infants, toddlers, and preschoolers. The foundation laid early in life affects their childhoods, adolescence, and adult lives. This very young population is especially vulnerable to the effects of abuse and neglect that set the stage for their long-term health outcomes.

As legal professionals dedicated to the safety and well-being of children in foster care, it is important to educate ourselves not just about the laws and regulations that govern what happens in the courtroom, but also learn from other disciplines about the health needs of this population. Safe, permanent homes for very young children must also mean healthy attachment to nurturing families and caregivers, up-to-date immunizations, a medical home, and comprehensive oral health care.

This guide provides you, in one easily accessible resource, a comprehensive source of information about the health needs of very young children in care within the context of permanency decision-making. We hope it will help you ask the right questions, require the necessary health-related information, and make the life-altering decisions that meet the unique health needs of very young children in the child welfare system.

You can promote the health of the infants, toddlers, and preschoolers who come before you in the courtroom and help them achieve their full potential. Their healthy beginnings can lead to healthy futures.

Eva J. Klain

Acknowledgements

There are many people without whom this judge's guide would not be possible. The authors would like to thank the members of the ABA Center on Children and the Law's Improving Understanding of Maternal and Child Health (IUMCH) project advisory committee for their staunch support of this endeavor and for all their time and efforts in reviewing drafts of the manuscript. Their invaluable guidance and wealth of knowledge and experience in responding to the health needs of court-involved infants, toddlers, and preschoolers enriched the content.

We are grateful for the support of the leadership and staff of the three organizations that partnered to develop this guide. The ABA Center on Children and the Law, the National Council of Juvenile and Family Court Judges, and the Zero to Three Policy Center each brought diverse expertise and unique insights to the project, ensuring its broad coverage and interdisciplinary perspective.

We are especially grateful to Moira Szilagyi, MD, who lent her extensive knowledge of the medical needs of children in foster care to the physical health chapter. Special thanks also to Jessie Buerlein and Burton L. Edelstein, DDS, of the Children's Dental Health Project for their careful review and contributions to the section on dental homes and dental care for very young children.

Thanks to ABA Center intern Allison Green for her research, cite checking and overall support.

Thanks also to Audrey Yowell, our federal project officer, for her unwavering support, insights, and encouragement throughout the development of this guide. And thank you to our Alliance for Information on Maternal and Child Health (AIM) partners who reviewed various chapters and provided valuable feedback.

And finally, a special thank you to Claire Chiamulera for her extraordinary editing talents, constant support, and timely encouragement. Claire's substantial guidance throughout the development of this guide ensured its comprehensiveness and accessibility.

Advisory Committee

The Honorable Pamela L. Abernethy
Marion County Circuit Court
Salem, OR

Jessie Buerlein, MSW
Children's Dental Health Project
Washington, DC

The Honorable Constance Cohen
Polk County Juvenile Court
Des Moines, IA

Sheryl Dicker, JD
Albert Einstein College of Medicine
New York, NY

The Honorable Stephanie Domitrovich
Erie County Juvenile Court
Erie, PA

Mary R. Haack, PhD, RN, FAAN
University of Maryland
School of Nursing
Baltimore, MD

Sheri L. Hill, PhD
Early Childhood Policy Specialist
Seattle, WA

Brenda Jones Harden, PhD
Institute for Child Study,
University of Maryland
College Park, MD

Anne Kellogg, JD
National Association of
Counsel for Children
Denver, CO

The Honorable Cindy S. Lederman
11th Judicial Circuit of Florida
Miami, FL

The Honorable Katherine Lucero
Superior Court, Santa Clara County
San Jose, CA

Candice L. Maze, JD
Maze Consulting, Inc.
Miami, FL

Joy D. Osofsky, PhD
Louisiana State University
Health Sciences Center
New Orleans, LA

JoAnne Solchany, PhD
Seattle University
University of Washington
Bothell, WA

Kelly Towey, MEd
Parent Education Consultant
Downers Grove, IL

Understanding Federal Laws and Programs

The following federal laws and grant programs support judges' efforts to meet the health care needs of very young children in foster care.

Medicaid

The Medicaid program is jointly funded by the federal and state governments and administered by states according to federal guidelines. Most foster children can receive Medicaid because program requirements are tied to eligibility for state reimbursement for foster care expenses under Title IV-E of the Social Security Act. The federal government requires that "mandatory" services, such as physician and hospital services, family planning, and laboratory and x-ray services be included in all states' Medicaid programs, while other, "optional" services, such as prescription drugs, vision, dental, home-based care, and physical therapy may be included if a state chooses.[1]

Under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions of Medicaid, however, *children* are entitled to all of the services in the federal law's "optional" list, whether or not the state chooses to offer those benefits to adults.[2] EPSDT requires that state Medicaid programs provide a comprehensive set of screening, diagnosis, and treatment services to children under age 21 enrolled in Medicaid. This includes periodic screenings at established age-appropriate intervals for mental and physical health issues, as well as additional screenings if a problem is suspected. The screening component "includes a comprehensive health and developmental history, an unclothed physical exam, appropriate immunizations, laboratory tests, and health education."[3] Despite the broad reach of this benefit, studies show it is underused, causing many children's health needs to go unidentified. Courts can ensure that such services are provided to children in care by routinely asking about screening results.

Two services available for children under EPSDT may be particularly helpful for children in foster care:

- **Targeted Case Management (TCM):** Thirty-eight states use TCM services to provide coordinated care and access to needed medical services for children in foster care.[4] Using these case management services makes it more likely for children to receive physician, prescription drug, hospitalization, rehabilitative, and mental health services than those who do not receive TCM.[5] In states where TCM is used, judges should routinely ask if TCM is being provided for children in care.

- **Rehabilitative Services:** Rehabilitative services may include services to reduce physical or mental disabilities and ensure optimal functioning. The services can also include certain specialized placements including therapeutic foster care and other family support services that improve children's functioning. This option is sometimes used to permit a child in care to remain in the least restrictive setting while receiving essential mental health services.

Children's Health Insurance Program (CHIP)

Through the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA),[6] CHIP continues to provide health insurance to low-income children whose families earn too much to qualify for Medicaid.[7] In combination with Medicaid, CHIP aims to decrease the number of uninsured children. The program is an essential source of health insurance for children in the child welfare system who are not eligible for Medicaid or who are transitioning out of care and therefore losing their eligibility for Medicaid. Judges should ensure that foster children will have health insurance when they are no longer in care by requiring that caseworkers and reunifying or adoptive families address this issue while the child is still under the court's jurisdiction.

Title V Maternal and Child Health Block Grant to States Program

This program provides funding for a range of health-related services, such as respite care for families caring for special needs children, or outreach to educate low-income families about food stamps.[8] States have wide discretion on what to fund with these grants. Some families in your court may benefit from services your state has chosen—check with your state's Title V director. (A list is available at https://perfdata.hrsa.gov/mchb/mchreports/link/state_links.asp.)

Healthy Start

Healthy Start grants fund local programs that address infant mortality, low birthweight, and racial disparities in infant health. Services offered include case management to help families access health care and other resources, peer mentoring for parents, and postpartum depression screening. Efforts are also made to connect families to other services to address their specific issues, including housing

or employment barriers, substance abuse, domestic violence, or mental health problems. Encourage caseworkers, attorneys and families to look into the services offered by a local Healthy Start program for infants and/or pregnant women. For more information and to access a list of local programs, visit www.healthystartassoc.org/ and click on "Directory."

Health Insurance Portability and Accountability Act (HIPAA)[9]

Enacted in 1996, HIPAA prevents the use or disclosure of protected health information (PHI) by certain entities, including child welfare agencies *if* they are considered health care providers. (The Department of Health and Human Services provides a tool to determine when an entity is a health care provider at www.cms.hhs.gov/apps/hipaa2decisionsupport/.) PHI includes any health information that could reasonably be used to identify an individual.

Several exceptions may apply in child welfare proceedings, however. PHI may be used or disclosed when:

- reporting abuse or neglect; and
- the information relates to judicial or administrative proceedings if the request is made through a court order or administrative tribunal.

The exceptions under HIPAA provide for sharing of information between the child welfare agency, courts, and health providers for children, although questions still remain about its application in practice, including the ability of parents to access the records of their children in care.[10] Respecting the privacy rights of even the youngest children in care now can protect them against future discrimination.

Child Abuse Prevention and Treatment Act (CAPTA)/Individuals with Disabilities Education Act (IDEA) Part C

CAPTA requires that states refer children under age three who have a substantiated case of child abuse or neglect for screening for early intervention services funded by Part C of IDEA.[11] This federal grant program helps states implement a comprehensive system for early intervention referrals and services. States have some discretion in setting evaluation criteria, therefore eligibility definitions vary significantly from state to state. Once a child is deemed eligible for early intervention services, an Individual Family Services Plan (IFSP) must be developed within 45 days of referral.[12] IDEA Part C can help ensure that very young children's

developmental needs are met through services such as occupational and speech therapies, counseling, nursing services, transportation, and more. Ask if each infant and toddler in your courtroom has been evaluated and has received recommended services.

Fostering Connections to Success and Increasing Adoptions Act of 2008 (Fostering Connections Act)[13]

The Fostering Connections Act addresses many issues that promote permanency and affect the health and well-being of very young children in foster care, including:

- making it easier for relatives to care for children;
- increasing adoption incentives and support;
- increasing resources that help birth families stay together or reunite;
- placing greater priority on keeping siblings together;
- helping students stay in the same school or promptly transfer when they enter care;
- providing more direct support to American Indian and Alaskan Native children; and
- increasing support for training of staff working with children in the child welfare system.

The Fostering Connections Act also requires states to develop plans to coordinate and oversee health services for children in foster care, in consultation with health care and child welfare experts. Each state's plan must include a coordinated strategy to identify and respond to children's health care needs, including mental and dental health.

State plans must address:

- schedules for health screenings;
- monitoring and treatment of identified needs;
- sharing and updating of health records;
- continuity of care;
- monitoring of prescription medications; and
- collaboration between the state and health professionals for assessment and treatment of health issues.

Endnotes

1. *Medicare: A Primer*. Menlo Park, CA: The Henry J. Kaiser Family Foundation, January 2009. Available at www.kff.org/medicaid/upload/7334-03.pdf.

2. Ibid.

3. *EPSDT Program Background*. Rockville, MD: Health Resources and Services Administration. Available at www.hrsa.gov/epsdt/overview.htm#1.

4. Geen, R., A. Sommers and M. Cohen. "Medicaid Spending on Foster Children." Urban Institute Child Welfare Research Program, Brief No. 2, August 2005. Available at www.urban.org/UploadedPDF/311221_medicaid_spending.pdf.

5. Ibid.

6. P.L. 111-3.

7. Klain, E. "What Passage of CHIPRA Means for Child Advocates." *Child Law Practice* 28(1), March 2009, 12.

8. *Block Grant Program*. Rockville, MD: Health Resources and Services Administration, Maternal and Child Health Bureau. Available at https://perfdata.hrsa.gov/mchb/mchreports/LEARN_More/Block_Grant_Program/block_grant_program.asp.

9. P.L. 104-191.

10. Klain, E. "Federal Confidentiality Laws and Dependency Courts: Managing Competing Interests." *The Judges' Page Newsletter*, February 2006. Available at www.nationalcasa.org/download/Judges_Page/0602_mental_health_issue_0036.pdf.

11. U.S. Department of Health and Human Services, Administration for Children and Families. *Child Welfare Policy Manual*. Available at www.acf.hhs.gov/j2ee/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=354. 20 U.S.C.A. § 1437.

12. Child Welfare Information Gateway. *Addressing the Needs of Young Children in Child Welfare: Part C—Early Intervention Services*, 2007. Available at www.childwelfare.gov/pubs/partc/partc_a.cfm.

13. P.L. 110-351.

chapter 1

Meeting the Needs of Very Young Children in Dependency Court

Early experiences and relationships significantly impact a child's development.[1] From birth to five years old, children develop the foundation for their future linguistic, cognitive, emotional, social, regulatory and moral capabilities.[2] The science of early child development clearly shows the importance of parenting and regular, consistent caregiving to a child's healthy growth and development.[3] The health and well-being of children's parents or primary caregivers are also crucial to a child's early development.[4]

The growth and development of very young children are profoundly affected by abuse, neglect and removal. As the largest group to enter the child welfare system, very young children who become the subject of dependency court proceedings face multiple disadvantages, traumas, and losses during a critical time of early brain development.

As a judge who handles child welfare cases, the cumulative effect of harmful early life experiences likely challenges your efforts to seek positive developmental and permanency outcomes for children birth through five years old. However, this stage of development can also provide opportunities to intervene early and pursue strategies to clear the path for healthy growth and development. You can take advantage of this opportunity by collaborating with health care professionals, child welfare workers, and others to implement proven interventions and use science to inform your decision making.

How Very Young Children Experience the Child Welfare System

Age is strongly associated with (1) the likelihood of a child entering the child welfare system; (2) how long children remain in out-of-home placements; (3) how children exit the system; and (4) the likelihood of reentry.[6] Even considering other factors such as economics, policy, administrative structure, and method of service delivery, age largely determines what happens to children in foster care.[7]

A baby's social-emotional development, specifically attachment to a primary caregiver, is affected by removal from his parent and multiple placements while in care.[8] Research shows that young children, even newborns and infants, experience long-lasting sadness, grief, loss, and rejection.[9] Separations occurring between six months and approximately three years of age are even more likely to cause later emotional disturbances.[10] These findings stress the need to consider the social-emotional development of very young children when making judicial decisions about removal, placement, and permanency.

Key Terms

- **Very young children** and **infants, toddlers, and preschoolers**: used interchangeably to describe children from birth through age five
- **Infants**: children from birth to one year old
- **Toddlers**: children between the ages of one and three years old
- **Preschoolers**: children ages three through five
- **Court-involved children**, **dependent children**, and **children in care**: very young children under the jurisdiction of a judge or court system that oversees dependency matters (civil child welfare proceedings), irrespective of a child's physical placement.[5] This book applies to all infants, toddlers, and preschoolers who are or have been the subject of a dependency petition, whether they are living with their biological parents, relatives, nonrelatives, or in a licensed foster home or group home.
- **Foster caregivers and foster parents**: includes kinship caregivers and relative and nonrelative caregivers

Entering Care

Of the 311,000 children who entered care across the United States in 2005, those from birth through five years old represented 38% of new admissions.[11] This was largely because 15%, or 46,954, of the new admissions were infants less than one year of age.[12] More recently, a national study found that 91,278 babies in the United States under age one were victims of nonfatal child abuse or neglect between October 2005 and September 2006.[13] Of these babies, 29,881 were victims of neglect (70%) or physical abuse (13%) before they reached *one week* of age.[14]

Very young children who enter the child welfare system are disproportionately children of color. Although African American children make up only 15% of the U.S. population of children, they represent approximately 37% of the children in the system.[15] In 2005, the placement rate of infants in foster care was 18.8 for every 1,000 African American children in the United States.[16]

A primary reason that very young children enter care is identified maternal drug and alcohol abuse.[17] This is especially true for newborns identified as exposed to drugs or alcohol through a toxicology report in the hospital.[18] Increased reporting and economic pressures facing families may also contribute to the high number of very young children entering care. Our ever younger child population overall, as well as wider use of early interventions, are likely related to the influx of infants, toddlers, and preschoolers into the child welfare system.[19]

Time in Out-of-Home Care

Once removed from homes and placed in foster care, infants and toddlers are more likely to stay in foster care for more than one year.[20] According to the 2006 Adoption and Foster Care Analysis and Reporting System (AFCARS) report for fiscal year 2005, of those children with a goal of adoption and/or whose parental rights had been terminated, 59% entered care at age five or younger.[21] Of the 59% of children 'waiting' for adoption as of September 30, 2005, 23% had entered care before their first birthday.[22] Another study underscored the challenges facing these 'waiting' children, finding that 50% of the children who were first placed as infants with a permanency plan of adoption took more than 39 months to be adopted, with nearly 17 of the 39 months accruing *after* becoming legally free for adoption.[23]

Challenges for Very Young Children in Out-of-Home Care

Because of their exposure to conditions that are not conducive to healthy development, many very young children in care have a mixture of physical, developmental, and emotional challenges. Factors such as low birth weight and lack of prenatal care are closely related to long stays in care.[24] These deficits often cause the child to have multiple needs that may complicate attaining positive and permanent placements. Additionally, infants and toddlers are more likely to be neglected and abused while in care than older children, especially babies who enter care between birth and three months of age.[25]

Exits from the Child Welfare System

Although the probability of adoption is much higher for children entering out-of-home care before their first birthday than for older children, the likelihood for reunification is much lower.[26] Only 36% of infants who enter care between birth and three months of age are reunified with their parents, and 56% of infants who enter care between 10-12 months of age are reunified with their parents.[27] Poor reunification rates for the very youngest children partly relate to the physical, emotional and/or developmental needs resulting from limited prenatal care, unhealthy living situations or abuse and neglect.[28] Also, because substance abuse is common among mothers of very young children in care, many addicted parents cannot become clean and sober within the constraints of the Adoption and Safe Families Act's (ASFA) timelines.

As with entry into foster care, disproportionality is evident when looking at exits of children of color from foster care. Like older children of color in care, very young children of color spend longer periods in care than their white counterparts and are less likely to be adopted once parental rights are terminated.[29]

Reentry

One-third of infants discharged from the child welfare system reenter care.[30] Evidence shows that infants who return to foster care experience much longer stays in care upon their return.[31] Reentry rates for infants discharged to relatives are lower than those for infants reunified with biological parents (this is also true for older children).[32]

How the Bench Can Make an Impact

Courts, in partnership with multiple systems, can reduce the number of very young children in out-of-home placements and minimize the effects of maltreatment and removal on their development. As the judge, understanding the unique needs of young maltreated children can help you ensure their needs are met on all levels (developmental, physical health, mental health) by promoting appropriate screening, assessments and interventions; ensuring regular contact with biological families; making appropriate placements; and expediting permanency.

By understanding how health, early child development, attachment, placement and safety interrelate, you can better promote positive and permanent outcomes for very young children. This is a compelling endeavor because decisions in dependency court often influence whether a baby develops into a securely attached, healthy, well-functioning child, or takes a different course in her development.

Many judges across the country have taken the lead in elevating the needs of babies, toddlers, and preschoolers in their jurisdictions through court-run projects, interventions, publications and collaborative models. The elements that underlie the success of these efforts are detailed in the final chapter of this book. By incorporating them into daily practice judges can shape policies and practices that identify and address the multifaceted needs of very young children in care.

This book serves as your guide to the wide array of health needs of very young children in care. By sharing current research on physical health, child development, attachment, infant mental health, and early care and education, the authors provide tools and strategies to help you promote better outcomes for babies, toddlers, and preschoolers who enter your courtroom. Specific goals are to:

- Underscore the sense of urgency for the youngest children in care and build consensus among judges who work with this population that a special focus is necessary to ensure the child protection system and courts take care of these vulnerable children.
- Synthesize extensive research about young children in general and specific research related to young children in care that apply to judges' daily decision making.

- Provide strength-based, holistic tools and techniques to support judges in achieving positive outcomes for this population, including strategies to reduce the harm caused by removal and long stays in care, and mediate the impact of maltreatment and resulting developmental delays and impairments.
- Offer information about evidence-based programs and interventions that can aid judges and other child welfare professionals in building community-based supports for very young children.

How This Book Is Organized

Entire volumes are devoted to the topics presented in the following chapters. Reducing decades of research and practice into a succinct and useful resource is challenging. Moreover, human development is complex and influenced by many factors. Genetics, environment, trauma, and support systems impact each other and interact with overall child development and well-being. Discussing attachment and mental health independently from physical health and development for very young children presents logistical challenges, which become more complex when the child has been maltreated and exposed to multiple caregivers and environments. Thus, while divided into discrete topical chapters, this book should be viewed as an integrated resource for making decisions for very young children under the jurisdiction of the dependency court.

- **Chapter 2 examines physical health needs** of infants, toddlers and preschoolers as well as special health-related considerations for very young children under dependency court jurisdiction. Special health needs and medical issues that arise for these children are explored. Comprehensive health assessments, specific health-related screenings, and immunizations are reviewed.

- **Chapter 3 examines mental health and developmental needs** of very young children in care within the context of essential relationships. This chapter discusses the very young child's social-emotional development, the basic need for secure and stable attachments, and the impact of trauma on the mental health of the very young child in dependency court. The cognitive and developmental needs of infants, toddlers, and preschoolers in care are described, with a focus on screening and intervention to address and prevent delays. The chapter shares practices that support the healthy cognitive and social-emotional development of very young children in dependency court.

This chapter also **explores early care and education settings** for infants, toddlers and preschoolers in the child welfare system. Many very young children involved with the dependency court process are not only in out-of-home living arrangements, but also in child care centers, family group care settings, or early education programs such as Early Head Start/Head Start and prekindergarten programs. This chapter describes these programs, discusses the importance of quality early care environments, and examines the potential added value these settings may have in the developmental process of a very young child in care.

- **Chapter 4 focuses on permanency planning strategies and postpermanency supports** for very young children. It places the information in the preceding chapters into the context of the dependency court process and the overarching systemic goal of timely permanency for very young children in care. This chapter uses the *RESOURCE GUIDELINES: Improving Court Practice in Child Abuse and Neglect Cases*[33] as a framework for discussing key decisions for infants, toddlers, and preschoolers at each required hearing. A significant portion of Chapter 4 discusses permanency outcomes and options from a very young child's perspective and strategies for preventing postpermanency reentry into care.
- **Chapter 5 concludes with a brief Call to Action** for judges and other child welfare system partners to explore and make meaningful systemic changes for very young children in care. It focuses on judges as change agents who can advance policies and interventions that minimize the harm to young children of long stays in care and support their healthy development while under the jurisdiction of the dependency court.

Endnotes

1. Shonkoff, J.P. and D.A. Phillips, eds. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. National Research Council and Institute of Medicine Committee on Integrating the Science of Early Childhood Development. Washington, D.C.: National Academy Press, 2000, 1-2.

2. Ibid., 5.

3. Ibid., 7.

4. Ibid.

5. Recognizing that many family courts and courts of general jurisdiction oversee child welfare proceedings, 'dependency court' is used to refer to children under the jurisdiction of any court or judge authorized to hear civil cases involving child maltreatment or abandonment.

6. Wulczyn, F., K.B. Hislop and B. Jones Harden. "The Placement of Infants in Foster Care." *Infant Mental Health Journal* 23(5), 2002, 463.

7. Ibid.

8. Wulczyn, Hislop and Jones Harden, 2002, 454-475, 457.

9. Shonkoff and Phillips, 2000, 28.

10. Cohen, J. and V. Youcha. "Zero to Three: Critical Issues for the Juvenile and Family Court." *Juvenile and Family Court Journal* 17, Spring 2004, 15-28.

11. U.S. Department of Health and Human Services, Administration for Children and Families. *The AFCARS Report*. Washington, D.C.: Administration on Children, Youth and Families, Children's Bureau, 2006. Available at www.acf.hhs.gov/programs/cb.

12. Ibid.

13. 905,000 children in the U.S. during this period had substantiated allegations of maltreatment, thus infants, those under one year of age, represented 19% of the total number of children.

14. Centers for Disease Control and Prevention. "Nonfatal Maltreatment of Infants – United States, October 2005 – September 2006." *Morbidity and Mortality Weekly Report* 57(13), 336-339, April 2008. Available at www.cdc.gov/mmwr/preview/mmwrhtml/mm5713a2.htm.

15. Wulczyn, F. and B. Lery. *Racial Disparity in Foster Care Admissions.* Chicago: Chapin Hall Center for Children at the University of Chicago, September 2007, 4.

16. Ibid., 12-14.

17. Lewis, M.A. et al. "Drugs, Poverty, Pregnancy and Foster Care in Los Angeles, California, 1989-1991." *The Western Journal of Medicine* 163, 1995, 435-440.

18. Ibid.

19. Centers for Disease Control and Prevention, 2008.

20. Wulczyn, F. and K.B. Hislop. "Babies in Foster Care: The Numbers Call for Attention." *Zero to Three Journal*, April/May 2002, 14.

21. U.S. Department of Health and Human Services, Administration for Children and Families. *The AFCARS Report*. Washington, D.C.: Administration on Children, Youth and Families, Children's Bureau, 2006. Available at www.acf.hhs.gov/programs/cb.

22. Ibid.

23. Kemp, S.P. and J.M. Bodonyi. "Infants Who Stay in Foster Care: Child Characteristics and Permanency Outcomes of Legally Free Children First Placed as Infants." *Child and Family Social Work* 5, 2000, 101.

24. Wulczyn, F. "Status at Birth and Infant Foster Care Placement in New York City." In *Child Welfare Research Review* 1. Edited by R. Barth, J.D. Berrick and N. Gilbert. New York City: Columbia University Press, 1994, 146-184.

25. Wulczyn and Hislop, 2002, 14.

26. Wulczyn et al, 2002, 466-468.

27. Ibid.

28. Kemp and Bodonyi, 2000, 102-104.

29. Jones Harden, B. *Infants in the Child Welfare System: A Developmental Framework for Policy and Practice*. Washington, DC: Zero to Three, 2007, 56-57.

30. Wulczyn, F. and K.B. Hislop. *The Placement of Infants in Foster Care.* Chicago: Chapin Hall Center for Children, University of Chicago, 2000.

31. Ibid.

32. Kemp and Bodonyi, 2000, 99; Wulczyn et al., 2002, 466.

33. *RESOURCE GUIDELINES: Improving Court Practice in Abuse and Neglect Cases.* Reno, NV: National Council of Juvenile and Family Court Judges, 1995.

chapter 2

Promoting Physical Health

Promoting Physical Health

Initial Health Information Gathering

- Ensure detailed health histories are obtained from the birth parents and other caregivers at placement.
- Ensure medical information is obtained when a newborn enters care from the hospital.
- Ensure the child receives an initial health screen within 24 hours of entering care.
- Ask the child welfare agency to report health screen results at the initial hearing and ensure the child welfare agency is keeping all of a child's medical records on file.
- Request additional health assessments to address missing information.

Comprehensive Physical Assessment

- Require a comprehensive health assessment within 30 days of placement.
- Ensure necessary health care records and consents are available.
- Ensure the comprehensive assessment includes developmental and mental health screens by a qualified provider.
- Request assessment results and ensure services are in place.

Immunizations

- Ensure the child has been properly immunized.
  - Ask about immunization at the first hearing.
  - Ensure immunizations are complete and up-to-date for the child's age.
  - Require catchup immunizations if necessary.

Routine Medical Screening

- Ensure the child has received all appropriate screenings.

chapter 2

Coordinated Medical Care

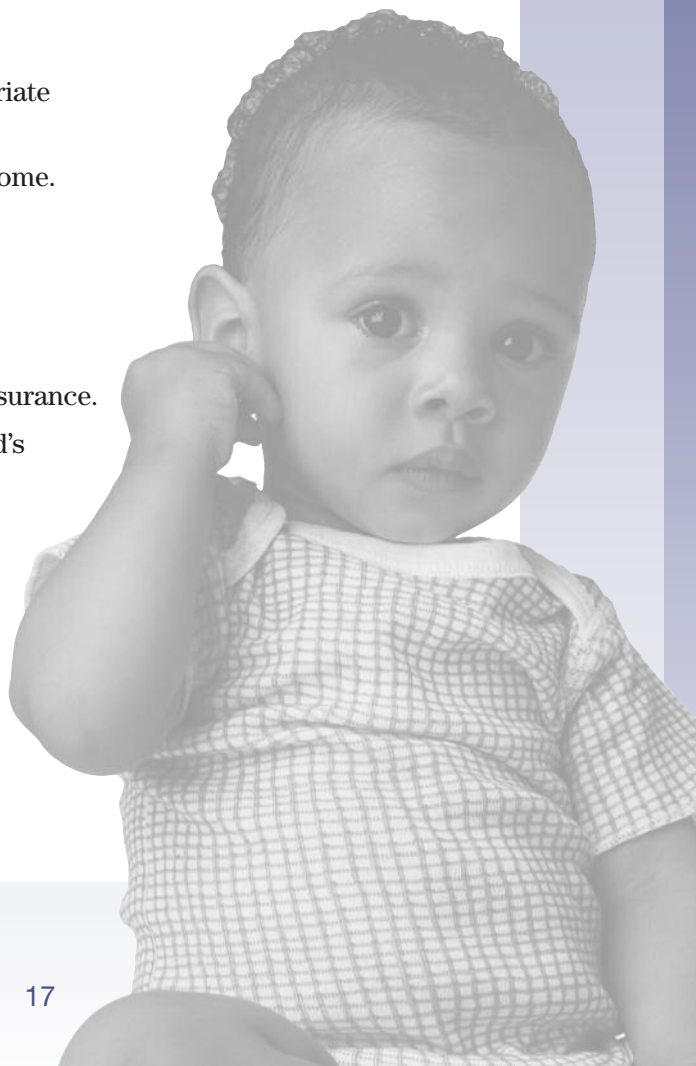
- Require a medical home.
- Address barriers to using a medical home.
  - Make placement decisions with continuity of health care in mind.
  - Ensure the initial placement for a child in care is carefully selected and work to maintain the integrity of this placement.
  - If a change is needed, try to keep the child in the same geographic area and make sure caseworkers and foster parents understand the importance of the medical home.
- Ask if the child has a health passport.

Oral Health

- Ensure the child receives appropriate dental services.
- Help each child access a dental home.
- Remove barriers to dental care.

Barriers to Health Care Access

- Find out if the child has health insurance.
- Identify other barriers to the child's access to medical services.



Many infants and young children enter foster care with complex physical health needs. Acute illnesses, diseases, infections and compromised bodily organs or systems often result from the child's maltreatment and inadequate health care. As the judge, you can affect these young lives when they are most vulnerable and when services and supports can have the greatest impact.

Becoming familiar with the physical health needs and characteristics of each child in your court can help you make the best decisions for these children and their families. You play a key role by:

- ensuring information about the child's physical health is gathered at the start of the case;
- requesting a comprehensive medical assessment to identify gaps in knowledge about the child's physical health;
- asking specific questions about the child's physical health and medical needs (including whether she has a medical home or regular source of routine medical care);
- ensuring birth parents and foster caregivers receive education and training to meet the child's special health needs; and
- securing medical services and supports to treat the child's physical health issues.

Initial Health Information Gathering

When a very young child enters foster care, an opportunity exists to identify and address any unmet physical health needs. Seeking health information as early as possible after placement helps ensure that immediate and long-term health needs of young children are met. To get a complete picture of a young child's physical health upon entering care, take the following steps.

Ensure detailed health histories are obtained from the birth parents and other caregivers at placement.

The child's health history before entering care lays the foundation for services she will receive while in care, so it is essential to obtain this information as soon as possible. As time passes, it may become harder to secure this information. Encourage the agency to follow the American Academy of Pediatrics' (AAP) recommendations by gathering critical information when removing the child, including:

- where the child has been receiving health care;
- immunization record or history;
- any chronic medical conditions (e.g., asthma, sickle cell disease, epilepsy);
- past surgeries or past hospitalizations;

- medications the child takes;
- medical equipment the child uses (e.g., glasses, hearing aids, nebulizers, wheelchairs, epipens);
- any allergies;
- the child's birthplace (so birth records can be obtained);[1] and
- a family health history (particularly hereditable or communicable diseases).

Any additional medical or immunization records in the home, as well as medications and medical equipment, should also be obtained when the child is removed. Agency staff should ensure that the medical records travel with the child. Caseworkers can obtain a more complete health history by using a comprehensive health history form to interview parents. The AAP is developing one and will post it on its Healthy Foster Care America Web site (www.aap.org/advocacy/HFCA/). Daycare providers, grandparents, and others who regularly care for the child can also be rich sources of information.

Ensure medical information is obtained when a newborn enters care from the hospital.

Many infants are placed into care directly from the hospital.[2] When newborns enter care from the hospital, it is important for the agency or caregiver to obtain from the hospital staff:

- instructions for immediate care (e.g., treatment for existing health conditions, signs and symptoms requiring urgent health care);
- information about where the infant will receive follow-up care—primary care and referrals to specialists, if any;
- results of any state-mandated screenings to identify conditions for which the infant will need follow-up care (e.g., genetic defects, metabolic problems);
- a list of immunizations given at the hospital;
- results of the newborn hearing screen;
- any information about risks to later healthy development, such as prematurity, low birth weight, prenatal substance exposures, and lack of prenatal care;[3] and
- birth records and the hospital discharge summary.

Ensure the child receives an initial health screen within 24 hours of entering care.[4]

This initial evaluation:

- screens for acute illnesses;

- identifies chronic diseases;
- documents signs of abuse, neglect, or infectious diseases; and
- assesses any hygiene or nutritional concerns.

These preliminary observations should inform the placement decision and follow-up for health problems. Ask whether the initial health screen identified lower than expected height, weight, or head circumference measurements or obesity. If so, order further evaluation since these findings may suggest growth delays, poor nutrition, or poor general health. (See sidebar, page 46, for an in-depth discussion of failure to thrive.) Having baseline measures of the child's health can help detect disruptions in growth over time. The health screen also allows the clinician to share age-appropriate strategies to help caregivers support children who are experiencing acute grief associated with removal.

An initial health screen can help detect significant physical, mental health, and developmental problems of children when they enter foster care. Initial placement provides a chance to identify, treat and refer infants and young children with unmet needs. Because children placed in care may return home within 30 days, an initial health screen should be conducted promptly to identify any significant medical needs. Failure to identify these needs places the child at risk for poor health outcomes. It also affects placement adjustment, as potentially serious behavioral, developmental, and physical health problems compromise placement stability and may impact permanency options.

Ask the child welfare agency to report health screen results at the initial hearing and ensure the child welfare agency is keeping all of a child's medical records on file.

Caseworkers should come to court ready to summarize and discuss the results of a child's health assessment. If a child has not yet been assessed, or the results are not yet available, find out why. Ask the caseworker to obtain the information and file a supplemental report. Set clear expectations for agency caseworkers and attorneys for what health information you expect every time they are in your courtroom.

Request additional health assessments to address missing information.

If the health screening report was incomplete, or indicated a need for urgent follow-up, evaluation, or care, require the caseworker to address those gaps and file a supplemental report within a set period.

Comprehensive Physical Assessment

Require a comprehensive health assessment within 30 days of placement.

The AAP recommends that all children undergo a comprehensive health assessment within 30 days of placement in care.[5] Children who lacked routine health care before entering the child welfare system are vulnerable to medical, mental health, and developmental conditions that are normally detected during routine health evaluations.

As part of a comprehensive health assessment, a health care provider gathers information to learn about risks for ongoing health problems. These include:

- chronic conditions
- hospitalizations
- past surgeries
- medications
- allergies
- immunizations
- behaviors and emotional health
- developmental skills
- adjustment to foster care and visitation[6]

The child's prenatal and birth histories are critical as the health provider needs to know about circumstances such as:

- substance exposure during pregnancy
- birth weight
- problems at delivery
- infectious risks for the child
- family health problems that could affect the child
- newborn screening results

This information helps medical providers make care decisions, including recommendations about treatment, referrals, and follow-up, and also helps judges, lawyers, and caseworkers plan for placement and permanency. In addition, the clinician can provide caregivers problem-specific health information, child care recommendations, and strategies to promote the child's emotional and behavioral health.

Ensure necessary health care records and consents are available.

The child welfare agency must provide all relevant records so the health professional can conduct a complete health assessment. These include all past and current records from primary and specialty care providers, hospital records, and agency records containing relevant medical, social, and family health information. Additionally, each state has requirements for obtaining consent to health care of children in the child welfare system. Become familiar with your state's requirements so you can ensure that proper consents for routine and emergency care are secured and a child's care is not delayed. This includes ensuring that birth parents cooperate in signing consents, providing health histories, and attending health visits, when appropriate.

Ensure the comprehensive assessment includes developmental and mental health screens by a qualified provider.

A comprehensive health assessment includes several screenings for problems common to children in the child welfare system, including developmental delays and some mental health concerns. Ensure that these initial screens have occurred for children in your courtroom. (See Chapter 3 for more information, including early intervention services under Part C of the Individuals with Disabilities Education Act.)

Request assessment results and ensure services are in place.

At early hearings, ask the agency if a comprehensive health assessment has occurred (or is planned). Require a summary of the results be given in court or submitted within one week after the assessment occurs. Ask the agency to provide any missing information in a supplemental report to the court before the next scheduled hearing. Any necessary services should begin before the next scheduled hearing if they are not already in place.

As the case continues, ensure that parents have had regular contact with health professionals (medical, mental health, developmental, and dental) and understand their child's care before approving unsupervised visits, and certainly before approving overnight visits or permitting the child to return home.

Children in foster care with communication delays and problems with personal-social and cognitive development should also be screened for autism, as discussed in Chapter 3.

Immunizations

Ensure the child has been properly immunized.

Immunizations protect children against potentially devastating diseases, and are critical for children who have received inadequate health care. Proper immunization decreases a child's susceptibility to many illnesses, some of which have potential long-term effects. Incomplete immunization also generally means a child lacks medical care from a regular provider. An unimmunized child should be considered at risk for many medical problems.

Ask about immunization at the first hearing.

At the initial hearing, ask if a child's immunization records are available and if the child is up-to-date for recommended immunizations. If the child is missing immunizations, require the agency to work with the child's health provider to obtain missing information or provide needed immunizations. Also ask about the immunization status of caregivers. For conditions the child cannot be immunized against because of age or health status, it may be especially important that caregivers are immunized.

Ensure immunizations are complete and up-to-date for the child's age.

All children new to foster care should have a health screen followed by a comprehensive medical evaluation. To achieve this goal, be sure to ask the caseworker to collaborate with health providers to obtain immunization records or begin "immunization catchup" for children at the time of the comprehensive health screen.

Order that the child receive immunizations consistent with the most recent nationally recommended immunization guidelines published jointly by the Centers for Disease Control and Prevention (CDC), the Advisory Committee on Immunization Practices (ACIP), and the AAP, available at www.cdc.gov/vaccines/recs/acip/. Federal law requires that state Medicaid programs use these guidelines, so payment should not be an issue for most children.[7]

Require catchup immunizations if necessary.

Allow about 30 days for caseworkers and health providers to investigate immunization history by exploring avenues such as old health records, immunization registries, and school and child care records. This avoids repeating immunizations the child has already had. Also require that doctors treating children in foster care use the national immunization information system (www.cdc.gov/vaccines/programs/iis/default.htm) to ensure children are not overimmunized. If any necessary

immunizations have not been given, order catchup immunizations according to CDC, ACIP and AAP combined guidelines, beginning at or shortly after the comprehensive health assessment.

Children entering foster care as unaccompanied refugee minors may have inaccurate and incomplete immunization records and may need blood tests before beginning catchup immunizations. Their health screenings should address health risks specific to their countries of origin. Children with immune problems (e.g., due to chemotherapy, treatment with steroids, or HIV infection), should not receive live virus vaccines, so it is essential that health care providers have complete information on the child's health status before administering these vaccines.

Routine Medical Screening

Ensure the child has received all appropriate screenings.

Catching problems and starting services early gives children a better chance of healing or achieving optimal control of health problems. Fortunately, most children in foster care are Medicaid eligible, and therefore eligible for Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The EPSDT program provides essential preventive health services to at-risk children. As part of a comprehensive health assessment, children are eligible for a variety of screening procedures, including evaluation for:

- hearing and vision problems
- lead exposure
- communicable diseases
- nutrition status
- anemia
- growth problems
- mental health issues
- medical problems

For any problems identified by screenings or assessments, order that birth parents and foster caregivers receive assistance to properly care for the child (e.g., training on how to use a nebulizer, education about managing diabetes).

Hearing, speech and language

Ask the agency if the child received a hearing screen at birth and regular speech, language, and hearing screenings thereafter. If not, require that they be done before the next court date. Also ask if any reports from parents or caregivers raise hearing or language concerns. If so, require an assessment and any indicated services.

Normal hearing is essential to a young child's speech and language acquisition, adjustment, and emotional development. Failure to detect hearing loss hampers development in these areas and can impair later learning and academic achievement. Detecting hearing loss and intervening within the first six months of life helps prevent or reduce these outcomes.[8] Annual hearing screening should be conducted for any child with a family history of hearing impairment, and those with syndromes that place the child at risk for hearing impairment (e.g., Down syndrome, Usher syndrome, Treacher Collins syndrome).

Hearing loss can result from congenital diseases, infections such as ear infections and meningitis, head injury, neglect of health problems, or use of medications that damage hearing.[9] In addition, a number of factors put children at risk for developing a hearing problem later in life, including structural abnormalities of the ear or face, certain exposures in the newborn or late gestational period, and speech and language delays.

All states but one provide hearing evaluations for newborns.[10] These screens detect most hearing loss due to congenital problems. Many children referred for follow-up hearing exams after the initial screen never go back for those evaluations, however, so it is important to ask if necessary follow-up has occurred.[11] The AAP also recommends a formal objective hearing screen at four years of age in addition to screenings for all newborns.[12]

Speech and language disorders may occur from hearing loss, early neglect and deprivation, or a variety of genetic or medical conditions. Speech disorders may include problems with how speech sounds are pronounced (articulation), the rhythm of speech (fluency or stuttering), the quality of voice or some combination of problems.[13] Language disorders stem from a problem understanding and/or using spoken or written words or sign language.[14] Swallowing disorders, feeding problems, or cognitive impairments may also signal speech-language issues.

A child's speech and language development follows a predictable pattern throughout the first five years of life, beginning at age two months. During the first 18 months, children should be able to imitate sounds, form simple words, point, and use two-word phrases.[15] An important sign of normal social and language development is a child's ability to expand their use of language to convey thoughts and feelings and to show increasing comprehension of the world around them through such actions as pointing, gesturing, or responding to simple commands.[16]

Older children, through age two, should begin to use two-to-three word phrases and understand questions. Children aged two to three years should be able to form short sentences (four to five words or more) and tell brief stories.[17] As children get older and their speech and language develops, their words become more intelligible to adults who do not regularly spend time with them; for three

Speech, Language, and Hearing Milestones for Young Children

	Hearing and Understanding	Talking and Communicating
Birth–6 months	Startle to loud sounds. Respond to changes in tone of your voice.	Cry differently for different needs. Babbling sounds more speech-like with many different sounds, including p, b and m.
7–12 months	Enjoy games like peek-a-boo and pat-a-cake. Recognize words for common items like "cup," "shoe," "book," or "juice."	Imitate different speech sounds. Use gestures to communicate (waving, holding arms to be picked up).
12–24 months	Follow simple directions and understand simple questions ("Roll the ball," "Kiss the baby," "Where's your shoe?"). Point to pictures in a book when named.	Say more words every month. Put two words together ("more cookie," "no juice," "mommy book").
24–36 months (2–3 years)	Understand differences in meaning ("go-stop," "in-on," "big-little," "up-down"). Follow two requests ("Get the book and put it on the table.").	Use two or three words to talk about and ask for things. Speech is understood by familiar listeners most of the time.
36–48 months (3–4 years)	Hear you when you call from another room. Answer simple who, what, where, and why questions.	People outside of the family usually understand child's speech. Use a lot of sentences that have four or more words.
48–60 months (4–5 years)	Pay attention to a short story and answer simple questions about it. Hear and understand most of what is said at home and in school.	Communicate easily with other children and adults. Use sentences that give lots of details (e.g., "The biggest peach is mine.").

Source: Adapted from American Speech-Language-Hearing Association. *How Does Your Child Hear and Talk?* Available at www.asha.org/public/speech/development/chart.htm (last accessed February 18, 2009). View the online chart for a complete list of milestones and ways to help children who are not reaching them.

year olds, 75% to 80% intelligible speech is a good guideline.[18] Children aged three to four should have a vocabulary of over 1,000 words and should ask "why" and "how" questions.[19] The American Speech-Language-Hearing Association lists more hearing, understanding, and talking milestones for different age ranges at www.asha.org/public/speech/development/chart.htm. The absence of certain behaviors (pointing and showing, eye contact with caregiver, limited speech) merits screening for autistic spectrum disorder (see Chapter 3) or other speech-language and developmental problems.

Very young children may also be evaluated for hearing problems when adults observe hearing difficulties, inattention, or erratic responses to sound. Most hearing deficits are uncovered when a parent has concerns and requests an assessment. Parents often identify hearing problems up to a year before a physician would,[20] and can also be essential in catching speech and language delays. Since children in foster care often lack a consistent caregiver who can detect subtle abnormalities or delays, they may be less likely to be identified early. Children in care should undergo regular screenings for deficits in hearing, speech, and language development to ensure their healthy development. Whenever *any* caregiver suspects hearing, speech, or language problems, a formal evaluation should occur.

Vision

Ask if the child's eye exam was abnormal *as a newborn* and at *later checkups*. For children older than three, ask if a vision screen has been completed. (Until age four, children may not cooperate in identifying shapes reliably, so they are not ready for vision screens. They can still receive eye exams that check for expected reflexes, responses to light, and range of eye movements.) If not, require a vision screen before the next hearing. Require the agency to report the results of vision screenings, and to start any recommended services. If a child has impaired vision, ensure he has current prescription glasses.

Vision problems are the fourth most common disability for children in the United States,[21] and are more prevalent among children in foster care. Screening for vision problems detects conditions that can result in serious visual impairment, including blindness. It also detects other diseases that can affect the body.[22] Undetected vision problems can lead to poor school performance and can be life threatening if they lead to a more serious disease.

The AAP recommends all children have a vision exam as newborns and at all routine health visits. A formal vision screen should be attempted at age three (if the child is uncooperative, a repeat screen should be attempted in six months).[23] If screening is unsuccessful despite repeated attempts, the child should be referred (by age four years) to an ophthalmologist trained in examining children.[24]

Screening and Placement Can Decrease Lead Levels

A study[1] of children in foster care, their siblings, and the general population found:

- before entering foster care, children were twice as likely as other children to have elevated blood lead levels; and
- after placement, the children were less than half as likely to have high lead levels.

Practice Tips:

- **Ensure children receiving services in their own home or in kinship care**, as well as children entering care, are screened for lead exposure.
- **Consider environmental and behavioral factors** that may lead to increased lead exposure when making placement decisions. Of particular concern are houses built prior to 1979, especially if they have peeling paint, and children who have the eating disorder pica (which involves regularly ingesting nonfood items).

Source:

1. Chung, E., Webb, D. et al. "A Comparison of Elevated Blood Lead Levels Among Children Living in Foster Care, Their Siblings, and the General Population." *Pediatrics* 107(5), 2001, e81-85.

Lead exposure

Ask if the child had a lead screening at *nine to twelve months* of age and *annually thereafter*. If not, require a screening for lead exposure by a pediatric health professional as soon as possible. If the screening reveals an issue, order an investigation into the source of the lead.

A prior history of abuse and neglect, developmental delay, behavior problems, failure to thrive, and poverty are all associated with an increased risk for lead exposure and poisoning.[25] Children living in poverty are at high risk for lead poisoning, but only 20-30% of this group is screened for exposure. Because most children entering foster care have many of these risk factors, including poverty, they should be considered at high risk for lead exposure.

Lead poisoning harms a child's health and development, and can lead to impaired learning, lower academic achievement and intelligence, abnormal behavioral development, decreased growth and hearing, and damage to the brain, kidney, and blood-forming process. For children in foster care, the AAP recommends blood lead screening at nine to twelve months of age, with yearly screenings through age six.[26] For children with elevated lead levels, the pediatric health

professional should follow the CDC guidelines for more frequent screening and/or treatment.[27]

If the child's current home (or the home the child is expected to move to when case plan goals are reached) has dangerous lead levels, the court should order that lead hazards be reduced to safe levels through abatement or other methods. Some jurisdictions have federal Department of Housing and Urban Development funding to reduce lead hazards, but if your jurisdiction does not (or there are long waiting lists), order the agency to pay for the work (or help the family find new housing) as part of their required reasonable efforts.

Communicable diseases

- **Sexually transmitted infections:** Many young children in foster care have birth parents whose sexual histories are unknown and who struggle with substance abuse. These exposures place children entering care at high risk for infection with HIV, hepatitis B, hepatitis C, syphilis, and congenital herpes. Children with a history of sexual abuse are also at risk for other sexually transmitted diseases.[28] Ask if the child has been screened for *HSV (herpes)*, *syphilis*, *hepatitis B*, *and hepatitis C*.

- **HIV:** A risk assessment for HIV exposure should be conducted,[29] and, if positive, the child should have a blood test to screen for HIV infection once consent is obtained (states vary on who may give consent for testing children in care and the procedures for obtaining consent). Some states' newborn screens also include an HIV test. Order any necessary screenings before the next hearing, and ask the agency to file a supplemental report with the screening results. Early screening and treatment for these conditions promotes the long-term healthy development of children in foster care.

  For young children, detecting HIV is also critical to ensuring an infected child receives modified immunizations to maximize the protective effect of vaccination, while avoiding harm.[30]

- **Tuberculosis:** Tuberculosis (TB) exposure is more common among certain groups, and occurs through exposure to the respiratory droplets of an infected person (e.g., droplets expelled through a cough or sneeze). Those who are or have been incarcerated, live in crowded conditions, or immigrate from certain countries are at high risk. Testing for TB exposure is recommended for all children placed in foster care beginning at 12 months of age. Children should be re-screened every three-to-five years while in foster care or whenever an exposure is suspected. A positive

Data Supports HIV Testing for Infants and Young Children

Children in foster care at all ages are at increased risk for HIV infection. Studies have shown:

- Inner-city newborns placed directly in foster care were eight times more likely to be born to an HIV-positive mother than other newborns.[1]
- Health care providers did not detect infection in 17.7% of HIV-infected children studied until four years of age.[2]
- 36 out of 42 children who acquired HIV during the perinatal period did not display symptoms of infection until after age four.[3]

Practice Tips:

- **Assess HIV status of all children in foster care** since symptoms are not always apparent. Some risk factors include maternal substance abuse, multiple sexual partners, unprotected sex, the presence of other vertically transmitted infections, and sexual abuse. For children who enter foster care secondary to sexual abuse, HIV testing should be done at the time of the incident, and then at six weeks, three months, and six months after the incident.[4]
- **Obtain consent for HIV screening.** If the mother's HIV status was not determined during pregnancy, the HIV exposure status of the newborn or infant should be determined. The AAP recommends discussing testing the newborn with the mother after birth to obtain consent. If the mother refuses consent, or if the authority to consent for medical care has been transferred to the foster care agency, the agency or the court should give consent.[5]
- **Older children, including toddlers and preschoolers, should also be assessed.** The factors that led to foster care placement often correlate with increased risk for HIV infection. Children may display no or only mild symptoms of infection for several years.
- **Know the risk factors.** Understand the risk for HIV infection in infants and other young children in foster care and order necessary evaluations when risk factors are present.

Sources:

1. Nicholas, S., et al. "Maternal Newborn Human Immunodeficiency Virus Infection in Harlem." *Archives of Pediatric and Adolescent Medicine* 148, 1994, 813-819.

2. Persaud D. et al. "Delayed Recognition of Human Immunodeficiency Virus Infection in Preadolescent Children." *Pediatrics* 90, 1992, 688-691 (study not specific to children in foster care).

3. Grubman S. et al. "Older Children and Adolescents with Perinatally Acquired Human Immunodeficiency Virus Infection." *Pediatrics* 95, 1995, 657-663 (study not specific to children in foster care).

4. American Academy of Pediatrics, Task Force on Health Care for Children. *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2005.

5. American Academy of Pediatrics Committee on Pediatric AIDS. *Identification and Care of HIV-Exposed and HIV-Infected Infants, Children and Adolescents in Foster Care*, 2000.

TB screening test requires evaluation by a specialist in TB (local health departments can identify these specialists).

- **Parasitic diseases:** The small population of refugee minors in foster care often come from countries in which parasitic disease is prevalent. Refugees from certain areas of the world, such as Africa and Southeast Asia, should be screened for parasitic disease and treated according to AAP Redbook or CDC guidelines.

Malnutrition

Malnourished children may not meet recommended growth parameters (weight, length, and head circumference) or may have hair, skin, teeth, or mouth abnormalities.[31] Any of these findings on a screening exam should prompt questions about the child's nutritional health.

The special dietary needs of infants and young children (who cannot eat most "adult" foods and instead require formula, baby cereal, and other foods high in vitamins, minerals, and protein) can be costly and difficult for some foster caregivers to maintain. Infants and children up to their fifth birthday may be eligible for nutrition assistance services under the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).[32] WIC benefits include supplemental nutritious foods, nutrition education and counseling at WIC clinics, and screening and referral to other services.

To ensure the nutritional needs of infants and children in care are met, ask whether their nutrition status has been evaluated and whether their growth parameters are normal for their age. Also ask whether a child is being fed an age-appropriate diet as this shows a caregiver's awareness of and attention to a child's needs. For example, children less than one year should not receive regular milk and children less than two should receive a diet with adequate calories and fat for brain development. Consider barriers to food access that may contribute to suboptimal dietary practices. Require the agency to refer caregivers to resources that provide nutritious options for children in their care (e.g., WIC and its "Farmers Market Nutrition Program"). Be sensitive to the fact that dietary choices may be influenced by cultural beliefs and practices.

Many children in foster care have feeding difficulties. Some were premature infants with medical complications that delayed the start of oral feeding. Others have developmental delays, sensory problems or behavioral issues that interfere with feeding. Food insecurity before foster care may lead to behaviors such as hoarding of food, gorging, eating spoiled or discarded food, pica, or strong but unhealthy food preferences.

How the Court Can Support Breastfeeding

Infants who are breastfed have 21% lower mortality rates, and may be less likely to develop diabetes, asthma, leukemia, obesity and other diseases later in life.[1] Breastfeeding also protects against or minimizes the severity of many infectious diseases including bacterial meningitis, respiratory tract infections, and ear infections.[2]

Practice Tips:

- **Order daily visitation** to support breastfeeding when safety is not an issue.
- **Ensure the mother has the equipment she needs** to preserve milk for her child when they are not together (e.g., a breast pump).
- **Order a consultation with a pediatric or obstetric health professional** if a mother's medical condition or other life circumstance raises questions about the appropriateness of breastfeeding. Although breastfeeding may not be in the child's best interest in some situations (e.g., the mother is abusing drugs, has HIV, or is receiving chemotherapy), breastfeeding is the healthiest choice for most infants.[3]
- **Ensure the agency knows about local resources** to support breastfeeding, and has educated the mother on this topic. (La Leche League International maintains a list of resources in each state at www.llli.org/WebUS.html.)

Source:

1. American Academy of Pediatrics, Section on Breastfeeding. "Breastfeeding and the Use of Human Milk." *Pediatrics* 115(2), 2005, 496-506.
2. Ibid.
3. Ibid.

The other form of malnutrition is obesity, which is now more prevalent in children new to foster care than failure to thrive or growth failure. Almost all obesity results from consuming too many calories, lack of activity, and inadequate nutrients in the diet. This problem is compounded when foster parents have difficulty "limiting" access to food in the foster home because it upsets the child or they fear being accused of neglect.

During the first year, regular feeding helps the child trust that his needs will be met. This promotes healthy attachment to caregivers, which is important for healthy emotional and mental development (see Chapter 3). Older children should have a diet rich in vegetables, fruits, whole grains, low fat dairy foods, and protein sources. Desserts, unhealthy snacks, and processed foods should be minimized. Meals should occur at predictable times, at the table, in a pleasant context that engages family members. Portions should be appropriate to the child's age.

Children with Chronic Health Care Needs Benefit from Specialized Nutrition Services

Compared to other children from the same socioeconomic background, children in foster care have much higher rates of chronic physical disabilities.[1] Children with such special health care needs experience greater rates of nutrition-related health problems because their chronic condition may alter their appetite or food intake.[2] Environmental factors may also affect access to or acceptance of food.[3]

Nutrition-related special health needs may include:

- delayed growth
- difficulty feeding and eliminating
- interactions between foods and medications
- altered appetites
- unusual eating habits
- early childhood dental problems
- difficulty maintaining a healthy weight (either overweight or underweight)

Practice Tips:

When chronic illness and nutrition concerns arise:

- **Ask whether the child's nutrition status has been assessed.** If not, order an assessment.
- **Order an assessment for early intervention services.** Early intervention services provide access to dietitians, occupational therapists, physical therapists, and speech and language pathologists who are trained to address nutrition and feeding issues.

Sources:

1. American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care. "Health Care of Young Children in Foster Care." *Pediatrics* 109(3), March 2002, 536-541.

2. Hagan J.F., J.S. Shaw and P.M. Duncan, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3d ed. Elk Grove Village, IL: American Academy of Pediatrics, 2008.

3. Ibid.

Coordinated Medical Care

The average stay in foster care is roughly 28 months,[33] and approximately two-thirds of children in care for 24 months or longer have three or more different placements while in care.[34] For this reason, children in foster care are less likely to receive ongoing care by the same provider than other children. Having contact with a single health care provider is crucial for children who are slowly adjusting to separating from a primary caregiver and adapting to a new placement.

Preventive Health Care Schedule

Age	Recommended Frequency of Visits
Birth to six months	Monthly
Six months to one year	Every two months
One to two years	Every three months
Two years through adolescence	Every six months

In addition to age-based visits, AAP also recommends supplemental visits at critical child welfare junctures, including:

- system entry;
- placement transitions;
- significant changes within the home environment (health issues or death of a caregiver, disruption of sibling from a home, etc.);
- when significant issues arise around visitation;
- when any concern is raised regarding potential child abuse or neglect;
- deterioration in child behavior or developmental skills;
- deterioration in health; and
- system exit—either based on discharge, termination of parental rights, or adoption.

Source: American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care. "Health Care of Young Children in Foster Care." *Pediatrics* 109(3), March 2002, 539 (supplemental examples provided by Moira Szilagyi, MD, PhD, FAAP, Vice-chair of the AAPs Task Force on Foster Care).

Ideally that health provider is familiar with the impact of complex trauma, separation, and loss on the emotional and developmental health of children in foster care. Since the harmful experiences of children in care can negatively impact their health and well-being, the AAP recommends an enhanced preventive health care schedule for these children. Regular contact with a knowledgeable medical home provider (discussed below) helps detect subtle changes in the child over time, and supports and educates foster parents, who are the primary therapeutic intervention for the child in care. The AAP recommends an increased preventive health care schedule for children in foster care (see above).

To help ensure adequate health care:

- Ask at each hearing when the child's last medical appointment was, and when the next one is scheduled.
- Require that additional appointments be scheduled at critical points in the child's case or according to the AAP age-based recommendations above.

- Ask the caseworker to obtain a health update after each well-child visit and to incorporate that information into the permanency plan in a meaningful way (e.g., for the child with asthma, all current and potential caregivers should have asthma education and understand the signs and symptoms, which medications the child needs, how and when to administer them, and when to seek help).
- Ensure all current and potential caregivers know the child's doctor's name and number.

Require a medical home.

Ask if the child has a medical home, a single source of coordinated health care and if the caseworker receives health updates from that resource. A medical home ensures a child is being seen frequently (because records will accurately show the last visit) and allows health care providers to develop a relationship with the child.

A "medical home" offers coordinated, comprehensive, compassionate health care that is continuous over time. Continuity of care in the medical home promotes better outcomes for children, including increased immunization rates, fewer emergency department visits, decreased hospitalization, and improved perceptions of quality of care. This continuity can be especially important to children in care, who have greater health and social needs. The medical home may be essential to timely identify health care needs and deliver appropriate health services for children in foster care.

Other advantages of the foster care medical home are it maintains a detailed health record for the child in foster care, develops care plans for children with special health care needs, assumes responsibility for care coordination, and exchanges health information with child welfare at regular intervals. Recognizing this, the AAP stresses that children in foster care should receive continuity of care through a medical home.[35]

A medical home is centrally located, accessible, and accepts a variety of insurance. It is family-centered and offers culturally effective care. One practitioner acts as a single point of contact for a child and knows the needs of children in the foster care system. The practitioner oversees primary care and periodic reassessments of the physical, developmental, and emotional health of the children under her care.[36] The primary care practitioner for the child in foster care can facilitate access to all other mental health, developmental, and dental health care services, and maintain uninterrupted treatment and health information for the child.

Another benefit of a medical home is its cost-effectiveness. Children who use emergency departments, walk-in clinics, or urgent care facilities for regular

medical care receive services that cost more and are less effective, particularly for children with special health care needs.[37]

A medical home can also reduce the duration of inpatient hospitalization and medical errors, because the child's provider knows her health history. Care by a skilled pediatric health professional in the context of a medical home helps the courts and child welfare agencies' efforts to support caregivers, improve health outcomes, create stable placements, and promote permanency for children.

Address barriers to using a medical home.

For the system's most medically needy children, meeting the medical home recommendation will be difficult. Finding health providers familiar with the impact of complex trauma on children and families, willing to accept Medicaid and to spend the extra time for the poor reimbursement Medicaid offers, is a challenge. Maintaining continuity of care with a single provider for children experiencing multiple placements or moving into and out of foster care is difficult. To address these concerns and support medical home use, take the following steps:

- **Make placement decisions with continuity of health care in mind.** Reducing multiple placements for children in foster care promotes medical home use, which reduces placement instability.
- **Ensure the initial placement for a child in care is carefully selected** and work to maintain the integrity of this placement. For children with complex health care needs, a medical home provider who knows the foster care agency and foster parents in the area can help select placements for children.
- **If a change is needed, try to keep the child in the same geographic area** and make sure caseworkers and foster parents understand the importance of the medical home. This also promotes educational stability and maintains the child's other connections within the community.

Ask if the child has a health passport.

Continuity of health care services is particularly challenging for children in foster care whose placements change frequently. Besides establishing medical homes, health data-sharing efforts can help ensure continuity of services. Several states have developed a health passport for children in foster care. Health passports are snapshots of a child's health history that provide useful information to the child's health providers, caseworkers, and caregivers and help ensure appropriate health care is received while minimizing medical errors and duplicated services. The health passport may be in electronic or paper format, or a combination, and

Health Disparities and Culturally Effective Health Care

Black infants have more than twice the infant mortality rate of White infants, and are almost twice as likely to have low birth weights.[1] Black children are also more likely than White children to have asthma, to be hospitalized for asthma, and to die from asthma.[2] They are also more likely to be uninsured, have elevated lead levels in their blood, be overweight, and be diagnosed with type-2 diabetes.[3]

In response to these disparities and other factors, the AAP believes all children should receive culturally effective pediatric care.[4] It encourages increased training for health professionals on cultural diversity, and increased institutional efforts and government funding to support culturally effective care.[5]

Practice Tips:

- **Be aware of cultural and racial differences in your communities** that may be affecting health service delivery and use.
- **Learn about health disparities or cultural attitudes towards health** common among people in your jurisdiction.
- **Partner with local medical organizations to address health disparities** (e.g., by serving on a task force addressing the issue, or testifying on the issue, along with medical professionals, to local or state government).

Sources:

1. Disparities in Children's Health and Health Coverage, Children's Defense Fund Healthy Child Campaign. Available at www.childrensdefense.org/child-research-data-publications/data/childrens-health-disparities-factsheet.pdf.
2. Ibid.
3. Ibid.
4. American Academy of Pediatrics Committee on Pediatric Workforce. "Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy." *Pediatrics* 114(6), 2004, 1677-1685.
5. Ibid.

summarizes essential health information including medical problems, allergies, chronic medications, and immunization data, as well as social service and family history. The passport can also be used to record behavioral health, dental, hearing, and vision services.

The passport is available to all of the child's health providers, regardless of placement changes. Paper passports alone are less successful because they get lost or forgotten or are not filled out. Some states have better success with Web-based secure health passports which maintain data on a specific child from multiple data systems and can include immunization, EPSDT, lead, WIC, and other

data. However, there are often no requirements or incentives for providers to fill them out and passports are only useful if updated regularly. Health passports are more useful where medical homes dedicated to the care of the child in foster care do not exist.

Encourage agencies to use health passports and ensure the foster parent has access to a health passport when the child is first placed. Instruct the foster parent to bring the record to all health evaluations, and make sure the record goes with the child if placement changes. When electronic records are available, ensure confidentiality protections are applied.

Oral Health

Ensure the child receives appropriate dental services.

Early childhood caries (previously known as baby bottle tooth decay) is a common infectious disease among children, according to a U.S. Surgeon General's report, more common even than asthma or hay fever. Although this disease is chronic, transmissible and *progressive*, it can also be prevented, and is manageable once acquired. It affects infants from all racial and socioeconomic backgrounds, but low-income children are especially at risk.[38] More than 40 percent of children show signs of tooth decay before reaching kindergarten.[39] Tooth decay and cavities cause pain and potentially life-threatening swelling. They also affect learning, communication, behavior, mental health, and nutrition and are linked to lower body weight and lost time in school. Often, tooth decay and other dental problems are overlooked.

Children may also experience dental neglect, defined by the American Academy of Pediatric Dentistry (AAPD) as the "willful failure of parent or guardian to seek and follow through with treatment necessary to ensure a level of oral health essential for adequate function and freedom from pain and infection."

Promoting children's oral health from birth can prevent the onset and delay the progression of dental caries. Doing this takes ensuring children have the proper exposure to fluoride, adequate nutrition and limited exposure to sugar, and regular access to oral health professionals. Proper dental care helps children gain nutrition from their food, develop language skills, and improve their overall health. To ensure the healthy development of infants and young children, access to routine dental services should be included in an overall health plan for every child in care.

Ask about children's brushing and flossing habits. Children should brush three times a day and floss at least once, especially at the end of the day. They should be using nonfluoride toothpaste until the child can spit toothpaste out,

since swallowing large doses of fluoride can be unhealthy. Ask if children age six months or older have been seen by a dentist and are having regular visits. The AAPD recommends that a primary care physician or health provider refer a child to a dental home as early as six months and by no later than 12 months of age.[40] A referral should also be provided as soon as the baby's first tooth erupts. Ask the agency to report on the initial visit and any recommended follow-up care, as routine follow-up decreases the risk of preventable dental disease. When physical or sexual abuse involving the mouth or dental neglect is suspected, ask whether the child was referred to an appropriate specialist.

The National Council of Juvenile and Family Court Judges encourages judges to ask specific dental health questions during hearings and to coordinate agency efforts to ensure each child's access to a dental home.[41] Relevant questions include:

- Does the child have a dental home and/or access to preventive and treatment services?
- Has the child had a dental exam? When?
- What dental health needs does the child have?
- How are the child's dental health needs being met?
- How often does the child brush? Floss?
- How does the child receive fluoride?
- When is the child's next dental exam scheduled?[42]
- Has the child received sealants?

In addition to health benefits, early preventive care is a sound financial investment. Low-income children who receive their first dental visit by age one are not only less likely to have subsequent restorative or emergency room visits, but their average dental costs are almost 40% lower over a five-year period than those for children who receive their first preventive visit after age one.[43] Communities that fluoridate their water save $38 in dental treatment costs for every $1 spent and giving children sealants reduces treatment costs by preventing cavities.[44] Children who lack periodic preventive dental care are more likely to wait until symptoms (i.e., toothache) become so severe that a visit to the emergency room is warranted. Managing symptoms in an emergency room costs approximately 10 times more than preventive care in a dental office.[45]

Help each child access a dental home.

A "dental home" refers to the ongoing relationship between a patient and a licensed dentist. All aspects of oral health care are delivered in a comprehensive, coordinated, and family-centered way. Like a medical home, the dental home brings together patients, parents, and dental professionals to deliver continuous,

Low-income Children and Dental Health

Low-income children and children of color are at greater risk for tooth decay and untreated cavities:[1]

- Poor children are almost twice as likely to have untreated cavities.
- Poor children have more severe tooth decay than higher-income youth.
- 54.9% of Mexican-American, 43.3% of Black non-Hispanic, and 37.9% of White non-Hispanic children aged 2-11 had untreated tooth decay in their primary teeth.

Source:
1. Beltrán-Aguilar, Eugenio D. et al. *Surveillance for Dental Caries, Dental Sealants, Tooth Retention, Edentulism, and Enamel Fluorosis—United States, 1988–1994 and 1999–2002, 2005*. Available at www.cdc.gov/MMWR/preview/mmwrhtml/ss5403a1.htm.

cost-effective and high-quality oral care. Tooth decay, cavities, and other oral health issues are easily prevented when routine services are provided by a dental home.

A dental home will:

- provide comprehensive oral health care services, including acute and preventive treatment that follow accepted practices and timelines for pediatric dental health;[46]
- conduct an oral disease risk assessment and provide an individualized program for preventive care;
- offer caregivers guidance about growth or development issues (teething and bite development), behavior modification techniques, dietary counseling, and plans in case of emergency dental trauma;[47]
- provide referrals to adult oral care providers when needed, and to other dental specialists, such as endodontists, oral surgeons, orthodontists, and periodontists, when care cannot be provided directly within the dental home.[48]

A referral to a pediatric dentist or a family dentist is the first step in accessing a dental home. It helps to give families a list of providers who participate in the Medicaid program. In addition, local Head Start programs, dental associations, and Internet resources (such as www.aapd.org) are all useful for locating a dental home.[49] Many communities have low-cost dental clinics for low-income children and families.

Innovative Oral Health Programs

- **Prevent Abuse and Neglect through Dental Awareness (PANDA) Program**
  This program, which started in Missouri but is now running in most states, trains dentists to identify child maltreatment.
- **I Smiles**
  www.idph.state.ia.us/hpcdp/oral_health_ismile.asp
  This statewide program links children to a dental home and is a good example of a coordinated system of care.
- **BEST Oral Health Program**
  http://baystatehealth.com
  (type "Oral Health" in the search box, then click on "BEST Oral Health")
  This Massachusetts program addresses oral health issues among vulnerable infants, toddlers, and preschoolers through Early Care & Education Centers.
- **Klamath County (Oregon) Early Childhood Cavity Prevention Program**
  www.oregon.gov/DHS/ph/oralhealth/programs/klamath.shtml
  This initiative links mothers and children to dental care through referrals to local WIC programs.
- **Cincy Smiles**
  www.cincysmiles.org/
  CincySmiles Foundation runs a well-coordinated mobile dental care program in Cincinnati, Ohio, along with several other school- and community-based programs.
- **AAP Oral Health Initiative**
  www.aap.org/commpeds/dochs/oralhealth/index.cfm
  Prepares pediatricians to provide oral health screenings and referrals for young children.

Remove barriers to dental care.

Oral health awareness

Caregivers often lack awareness of the importance of oral health for young children and may be unaware of the need for early and regular oral health care. The priority of oral health can vary due to social, cultural, and economic factors. Dietary practices specific to certain cultures may promote the onset or development of dental caries, while other factors may discourage some groups from pursuing care. Without proper dental care referrals, caregivers may miss the importance of dental care for offsetting and managing dental caries.

There is often a misconception that primary teeth are unimportant since they

Safety Net Providers of Dental Care

Where can low-income children in your community turn for dental care when few dentists will take Medicaid? Safety net providers and services, such as mobile dental programs, community health centers approved by the state or federal government, or dental schools, may fill this need.

Safety net facilities and programs include:

- **State-Recognized Safety Net:** These providers include hospitals, diagnostic and treatment centers, community health centers, school-based health centers, and county health departments approved to operate by the state department of health. They receive public funding for oral health services. Dental schools and dental hygiene training programs may also be state-recognized safety net providers if they have explicit policies regarding care for vulnerable populations.
- **Federally Recognized Safety Net:** These facilities have been approved as safety net providers by federal agencies such as the Health Resources and Services Administration or Center for Medicare and Medicaid Service. Each agency sets its own administrative and/or service requirements, and recognition provides access to federal funding.
- **Community Hospitals:** Although local hospitals and their emergency departments provide medical treatment regardless of ability to pay, these hospitals rarely have the capacity to address routine dental complaints. Young children who come to the emergency room with severe acute dental pain and infection are usually given antibiotics and pain medications to ease their symptoms but may not receive treatment for the underlying disease. Their parents must then take them to a dentist suggested by the hospital, or locate dental care on their own.
- **Community & School-Based Centers:** Facilities supported by public and private funders, including school-based (onsite) or school-linked (offsite) health centers, freestanding voluntary health centers, and city and county health centers.
- **Head Start and WIC:** Head Start and Early Head Start are required by federal regulation to give clients oral health education, screening, and referrals for treatment. Head Start and the American Academy of Pediatric Dentistry are also working to establish "dental homes" for all children in Head Start.

  WIC nutrition programs also provide counseling on oral health and childhood caries prevention and are often co-located in health centers. Local programs that target young at-risk children with health education and social services may also provide oral health services or education.
- **Mobile Dental Programs:** Like school-based health centers, mobile programs bring care to children where they are during the day rather than bringing children to care.

Mobile programs include both self-contained vans, and satellite-site programs that bring mobile dental equipment onsite to gyms, auditoriums, and function rooms. Mobile programs may also be used to screen children and identify those who require additional care in a traditional dental setting.

- **Medicaid-Focused Private Practices:** Some private practices focus on children on Medicaid. They are easily accessed by public transportation and schedule flexible appointments that accommodate clients' constraints and adjust for high rates of missed appointments. They may engage in more flexible appointment management (e.g., filling in missed appointments by providing more care for children who are present). These practices may provide comprehensive care or limited services.
- **Training Programs:** Dental schools, postdoctoral dental residencies, and dental hygiene programs also support the dental safety net.

Source:
Adapted from Edelstein, B.L. *Maximizing Public Dollars in the Provision of Dental Care in New York State*. The Community Health Foundation of Western and Central New York, January 2009.

will eventually fall out, yet they are essential for: biting and chewing food, assisting in speech development, developing jaw bones and facial muscles, reserving space for permanent teeth, and developing self esteem. Additionally, tooth decay in primary teeth is the most reliable predictor of dental caries in permanent teeth.[50]

Access to dental care

Medicaid covers a quarter of all children in this country, but only one-third of enrolled children see a dentist annually. Children enrolled in Medicaid must receive comprehensive dental coverage under EPSDT. Comprehensive dental care is also provided to low-income children through the state Child Health Insurance Program (CHIP). However, dentists' participation in these programs is limited, and access is severely inadequate in many areas.[51]

Fewer than 5% of all U.S. dentists are pediatric dentistry specialists, dentists uniquely trained to manage the behavioral and treatment complexities of children who experience the most severe dental disease. These specialists are commonly located in suburban areas. While more pediatric dentists participate in Medicaid than general dentists, their suburban location is often a barrier for inner-city and rural children. A national survey suggests that fewer than one-in-five dentists participate in Medicaid and far fewer participate significantly.[52]

Due to these barriers, low-income children may need to access dental care through "safety net"[53] providers and services, such as mobile dental programs,

community health centers approved by the state or federal government, or dental schools. (See "Safety Net Providers of Dental Care" box.)

Judges can work on several levels to expand access to dental care for children:

- Order that each child in your courtroom have a dental home.
- Advocate for increased Medicaid reimbursement rates for providers.
- Engage state and local dental associations to develop referral and care programs for children in the child welfare system.
- Strengthen relationships with, and state support for, the various safety net providers.

Barriers to Health Care Access

Find out if the child has health insurance.

Many young children in foster care will not receive the medical, dental, developmental, or mental health services they require because of insufficient health insurance coverage. Most children in care are eligible for Medicaid based on their eligibility for Title IV-E foster care funds. Some states also cover non-Title-IV-E eligible children in foster care as an optional category. Children in foster care who are not eligible for Medicaid may be eligible for coverage under the state Children's Health Insurance Program (CHIP). Ensuring all children in care are covered by health insurance will help to maintain continuous health care.

Ask whether the child has health insurance (e.g., Medicaid, private coverage). If the child is uninsured, ask if she is eligible for any programs (e.g., Children's Health Insurance Program) and require that she be enrolled as appropriate. If the child is insured, ask if the coverage is adequate (e.g., does it cover mental health and dental care in addition to routine pediatric care)? If necessary, ask the agency to look into switching to better health insurance, or paying for medical costs that aren't covered by insurance (e.g., broken or lost glasses which Medicaid won't replace, or a wheelchair or ventilator that could take months to procure through Medicaid). Require a supplemental report be filed with the court discussing eligibility, enrollment, and payment of burdensome medical costs before the next court hearing.

Under Medicaid, children are eligible for EPSDT services, which include recommended assessments, screens, and treatment services. Because only Medicaid requires EPSDT services, children without Medicaid coverage may or may not receive such services.

Guidelines for Health Care for Children in Foster Care

This chapter summarizes research and best practices for meeting the health needs of children in care. Two national publications provide additional guidelines:

- **Fostering Health: Health Care for Children in Foster Care**
  American Academy of Pediatrics (AAP)
  Describes practice guidelines for primary care, developmental and mental health care, management of health care, and approaches to child abuse and neglect.
- **Standards for Health Care Services for Children in Out-of-Home Care**
  Child Welfare League of America (CWLA)
  Provides a comprehensive framework to organize physical, developmental, and mental health services for child welfare organizations.
- **Additional resource:**
  Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates, and Child Welfare Professionals
  New York State Permanent Commission on Justice for Children
  Asks questions related to the above standards developed by the AAP and the CWLA and gives recommendations for how to meet them. Available at: www.courts.state.ny.us/ip/justiceforchildren/PDF/ensuringhealthydevelopment.pdf.

Identify other barriers to the child's access to medical services.

The lack of qualified providers who accept Medicaid, or who have experience and knowledge about the health care needs of children in foster care, and the fact that many jurisdictions do not require comprehensive exams, are additional barriers to health care. The high mobility of children in foster care can cause interruptions in insurance when a child moves out of a plan's coverage area. Agencies must make reasonable efforts to meet children's medical and dental health needs. As a judge overseeing the agency's efforts, you can ensure children receive necessary care by ordering the agency to pay the full cost of a visit to a provider outside the child's health insurance plan if there are no qualified providers, or to insure the child under a different health plan with more providers.

Reduced Medicaid spending also prevents many children from accessing services despite insurance coverage. Many states have shifted from a fee-for-service-based Medicaid reimbursement system to a managed care plan, which raises

Red Flags for Health Concerns

The following health conditions are common in young children in foster care. Be familiar with them to quickly identify when a child requires more attention.

Failure to Thrive/Malnutrition:

Failure to thrive (FTT), or growth failure, occurs when a child does not receive sufficient nutrition for proper physical growth and development. FTT is often associated with poverty and may have multiple causes, such as difficulty feeding or underlying medical conditions, including three of the health problems described below (Fetal Alcohol Spectrum Disorders, vertically transmitted infections, and lead poisoning). FTT can also result when a caregiver does not have the means to provide adequate nourishment or does not use available resources. Sometimes, maternal or paternal neglect of a child's nutritional needs stems from mental health and cognitive issues that result in a failure to supply adequate nutrients (nonorganic FTT). Malnutrition in children with FTT not only results in poor growth, but also in long-term deficits in intellectual, social, and psychological functioning. Although not directly linked to FTT, attachment disturbances often accompany the condition, especially nonorganic FTT. Therefore, infants with FTT should be referred for an early childhood developmental and mental health evaluation. Their parents should also be referred for mental health evaluation.

Practice Tips:

- Ensure caregivers meet medical recommendations and adhere to treatment plans for children with FTT.
- Mandate education for birth and foster parents on the importance of feeding and close social interaction to promote healthy growth and strong attachments.[1]
- Mandate a mental health evaluation for the birth parents.

Fetal Alcohol Spectrum Disorders (FASD):

FASD is an umbrella term for three outcomes that can result from a mother drinking during pregnancy (fetal alcohol syndrome, fetal alcohol effects, and alcohol-related neurological disorder).[2] Fetal alcohol syndrome is most known and may be characterized by specific facial features. The other symptoms are common in all the disorders in the FASD spectrum: growth deficits, mental retardation, heart, lung, and kidney problems, chronic ear infections, hyperactivity and behavior problems, attention and memory problems, poor coordination or motor skills delay, difficulty with judgment and reasoning, and learning difficulties.

Practice Tips:

- Screen for FASD in all children in foster care.
- Require birth parents and foster caregivers to be trained to recognize signs of these disorders.

- Ensure an assessment is completed in suspected cases, preferably one conducted by a developmental or behavioral pediatrician or a geneticist. If the assessment reveals a problem, ensure the child's caregiver has the knowledge and support to meet his needs, and the child is receiving early intervention services.
- Visit the federal FASD Center for Excellence Web site to learn more about FASD: www.fascenter.samhsa.gov/index.cfm

Because FASD affects learning, especially for young children, assessment is critical to identify services to help a child get ready for school. Obtaining information about a mother's drinking history while pregnant is also vital, since an accurate history of maternal alcohol use is the key to the most conclusive FASD diagnosis.[3]

Vertically Transmitted Infections:

Vertically transmitted infections are infections that a mother passes to her baby, either through the placenta or when the baby passes through the birth canal. Infants can contract viruses, including HIV, hepatitis B, hepatitis C, herpes, HPV (genital warts) and syphilis, among others. A mother may not experience symptoms related to the infection and may unknowingly pass the infection to her child during pregnancy or child birth.

Vertically transmitted infections can be difficult to diagnose because the effects of the infection may not be seen at birth. Complications associated with these infections include damage to the developing brain and other body systems.

- Hearing loss may be associated with vertically transmitted infections and may be present at birth or progressively develop and present later in childhood.
- Visual problems are also common.
- Brain damage can be mild or severe and may cause mental retardation, learning and behavioral disorders, and autism. Special education is frequently required, and early intervention services should also be accessed.

Practice Tip:

- Because of the varied effects of vertically transmitted infections, early and periodic hearing, vision, and developmental screens are essential. Make sure screens occur and are repeated at recommended intervals. If necessary, ensure special education or other services are in place.[4] Poor growth is also an early sign of vertically transmitted infections, and calls for screening.

Shaken Baby Syndrome (SBS):

SBS, also called shaken impact syndrome, describes the effects of violently shaking an infant or young child. Children, especially infants, have weak neck muscles, which cannot fully support their heads. When a baby is shaken his brain moves back and forth inside his skull. This movement can cause severe injuries including blindness or eye damage,

Red Flags for Health Concerns (continued)

developmental delay, seizures, paralysis, brain damage, and sometimes death. SBS often occurs in children under two years old, but has been reported in children up to age five.

Although severe cases of SBS may present with signs of head injury, less serious cases may result in symptoms mimicking colic or a viral infection—poor feeding, vomiting, lethargy and irritability—and may delay early attention. Outcomes for children who do not receive medical attention are unknown but they may have learning, motor, or behavior problems later in life with no known cause. When severely injured children survive, they may experience blindness, seizure disorders, severe cognitive impairments, and other serious brain defects.[5]

Practice Tips:

- If SBS is suspected, ask if a head injury evaluation has been performed. If not, order one. An adequate assessment of a child with a suspected shaking injury includes a head MRI or CT, an ophthalmology examination to look for retinal hemorrhages, and a skeletal survey to look for subtle fractures of the ribs and long bones that occur with shaking and chest compression. A "babygram" (which gives a single image of the entire infant) is not sufficient; ordering a full range of tests helps establish whether or not the child was the victim of abuse and confirm a diagnosis of SBS.
- At the initial hearing, order a thorough investigation of who cared for the child during the seven days before the onset of symptoms.

Lead Poisoning:

Usually caused by environmental lead exposure, lead poisoning can have many long-term effects including decreased intelligence, impaired behavioral development, short stature, hearing problems, and learning difficulties. Children living in poverty, and those in foster care, are at risk for elevated lead levels. Blood screening for elevated lead is the most common way to detect lead poisoning.

Practice Tips:

- Ask about lead screening results for all children under age six years or a developmentally delayed child of any age who has a history of pica. Require a lead evaluation if these results are not available.[6]
- If the home the child currently lives in (or will live in if case plan goals are met) contains lead-based paint hazards, order lead remediation services.

Respiratory Illness:

Respiratory illnesses are the most common medical problem among children in care. One study reported 19% of children in care as having a respiratory illness. Ear infections make

up a large percentage of these infections and can result in long-term problems in hearing, speech, and language development. Asthma and chronic respiratory diseases, such as cystic fibrosis may be less common, but more dangerous for children in care. Respiratory illnesses can also cause breathing difficulties.

Practice Tip:

- Make sure any young child with a respiratory illness is evaluated by a medical provider.[7]

Hearing and Vision Problems:

Hearing impairments can hamper a child's speech and language development, personal-social adjustment, and emotional development. As a result, later learning and academic achievement may be limited. Similarly, vision problems may impair school performance, and can signal more significant disease.

Practice Tips:

- Hearing, language, and vision should be periodically evaluated in children in foster care because caregivers may be less likely to report subtle abnormalities in these areas. Ask if such screens have been completed regularly coinciding with well-child care visits.
- Ask if there is information about the child's newborn hearing screen.
- Ask if there is a family history of hearing impairment and ensure this information is relayed to the child's medical home.
- Eye exams occur at each well-child visit beginning at birth, but formal visual acuity screening begins successfully around age four.

Sources:

1. Block, R. and N. Krebs. "Failure to Thrive as a Manifestation of Child Neglect." *Pediatrics* 116(5), November 2005, 1234-1236.

2. Hudson, L., L. Burd and K. Kelly. *Recognizing Fetal Alcohol Spectrum Disorders (FASD) in Maltreated Infants, Toddlers and Parents*. Washington, DC: American Bar Association and Zero to Three, forthcoming.

3. *FASD: What Everyone Should Know*. Washington, DC: National Organization on Fetal Alcohol Syndrome. Available at www.nofas.org/resource/factsheet.aspx.

4. Simon, N.P. *Congenital Infections*, Available at www.pediatrics.emory.edu/divisions/neonatology/dpc/conginf.html.

5. American Academy of Pediatrics, Committee on Child Abuse and Neglect. "Shaken Baby Syndrome: Rotational Cranial Injuries—Technical Report." *Pediatrics* 108(1), July 2001, 206-210.

6. Chung, E. et al. "A Comparison of Elevated Blood Lead Levels Among Children Living in Foster Care, Their Siblings, and the General Population." *Pediatrics* 107(5), May 2001, e81-85.

7. Takayama, J., E. Wolfe and K. Coulter. "Relationship Between Reason for Placement and Medical Findings Among Children in Foster Care." *Pediatrics* 101(2), Feb. 1998, 201-207.

concerns about access to comprehensive services, especially mental health services.[54] Many communities lack enough providers who accept Medicaid, and these shortages will worsen as Medicaid cutbacks deepen. Furthermore, continuity of care, which is important for ensuring the healthy development of young children in foster care, may not happen in a managed care system[55] (unless a case manager is assigned).

Closely watching the needs of this population and whether necessary medical care is provided can help counter difficulties that funding restrictions create for public health programs that serve children.

Conclusion

Infants and toddlers in foster care are more likely to have physical health problems than other children. Identifying these problems and intervening early to treat and prevent them is key. Ensuring access to high-quality, consistent health care promotes their optimal physical health and development. You can help ensure that each child in your courtroom achieves optimal physical health by following the guidelines set out in this chapter including each child having a medical and dental home that has all of her relevant medical history and records and provides assessments, indicated follow-up, and preventative and routine care on the schedules advised by the AAP or AAPD. You can also help reduce barriers to good health by ensuring that all children in your courtroom are enrolled in Medicaid or another health insurance program. With effective oversight, court-involved infants and toddlers can grow into healthy children, adolescents, and adults.

Endnotes

1. American Academy of Pediatrics, Task Force on Health Care for Children in Foster Care. *Fostering Health: Health Care for Children and Adolescents in Foster Care*, 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics, 2005.

2. Dicker, S. and E. Gordon. *Ensuring the Healthy Development of Infants in Foster Care: A Guide for Judges, Advocates and Child Welfare Professionals.* Washington, DC: Zero to Three Policy Center, 2004.

3. Ibid.

4. American Academy of Pediatrics, Task Force on Health Care for Children in Foster Care, 2005.

5. Ibid.

6. Ibid.

7. Dicker and Gordon, 2004.

8. Cunningham, M. and E. Cox. "Hearing Assessment in Infants and Children: Recommendations Beyond Neonatal Screening." *Pediatrics* 11(2), February 2003, 436-440.

9. Ibid.

10. Kaye, C. and American Academy of Pediatrics, Committee on Genetics. "Introduction to the Newborn Screening Fact Sheets." *Pediatrics* 118(3), September 2006, 1304-1312. In most states, hearing screens for newborns are required by law or rule; in all but one of the remaining states, the newborn hearing screen is universally offered, but not required. The remaining state offers the test to a select population or upon request.

11. National Institute on Deafness and Other Communication Disorders. "How Medical and Other Health Professionals Can Help Increase the Number of Infants Who Return for a Follow-Up Evaluation." *NIH Pub. No. 98-4291*, August 2003.

12. American Academy of Pediatrics Committee on Practice and Ambulatory Medicine and Bright Futures Steering Committee. "Recommendations for Preventive Pediatric Health Care." *Pediatrics* 120(6), December 2007, 1376.

13. American Speech-Language-Hearing Association. *Speech Sound Disorders: Articulation and Phonological Processes*. Available at www.asha.org/public/speech/disorders/SpeechSoundDisorders.htm; American Speech-Language-Hearing Association. *Childhood Apraxia of Speech*. Available at www.asha.org/public/speech/disorders/ChildhoodApraxia.htm; American Speech-Language-Hearing Association. *Stuttering*. Available at www.asha.org/public/speech/disorders/stuttering.htm; American Speech-Language-Hearing Association. *Vocal Fold Nodules and Polyps*. Available at www.asha.org/public/speech/disorders/NodulesPolyps.htm.

14. American Speech-Language-Hearing Association. *Language-Based Learning Disabilities*. Available at www.asha.org/public/speech/disorders/LBLD.htm.

15. Hagan J.F., J.S. Shaw and P.M. Duncan, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3d ed. Elk Grove Village, IL: American Academy of Pediatrics, 2008.

16. Ibid.

17. Ibid.

18. Ibid.

19. Ibid.

20. American Academy of Pediatrics, Task Force on Newborn and Infant Screening. "Newborn and Infant Hearing Loss: Detection and Intervention." *Pediatrics* 103(2), February 1999, 527-530.

21. American Academy of Pediatrics. "Children's Health Topics: Vision and Hearing." Available at www.aap.org/healthtopics/visionhearing.cfm (last accessed January 30, 2009).

22. American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine and Section on Ophthalmology. "Eye Examination in Infants, Children, and Young Adults by Pediatricians." *Pediatrics* 111(4), April 2003, 902-907.

23. American Academy of Pediatrics Committee on Practice and Ambulatory Medicine and Bright Futures Steering Committee, 2007.

24. American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine and Section on Ophthalmology, 2003.

25. Chung, E. et al. "A Comparison of Elevated Blood Lead Levels Among Children Living in Foster Care, Their Siblings, and the General Population." *Pediatrics* 107(5), May 2001, e81-85.

26. American Academy of Pediatrics Task Force on Health Care for Children in Foster Care, 2005.

27. Ibid.

28. American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care. "Health Care of Young Children in Foster Care." *Pediatrics* 109(3), March 2002, 536-541.

29. American Academy of Pediatrics Task Force on Health Care for Children in Foster Care, 2005.

30. Osofsky, J.D. et al. "Questions Every Judge and Lawyer Should Ask About Infants and Toddlers in the Child Welfare System." *Technical Assistance Brief*. Reno, NV: National Council of Juvenile and Family Court Judges, 2002.

31. Story, M., K. Holt and D. Sofka, eds. *Bright Futures in Practice: Nutrition*, 2d ed. Arlington, VA: National Center for Education in Maternal and Child Health, 2002.

32. United States Department of Agriculture, Food & Nutrition Services. *WIC at a Glance*, 2005. Available at www.fns.usda.gov/wic/aboutwic/wicataglance.htm.

33. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. *The AFCARS Report: Preliminary FY 2006 Estimates as of January 2008 (14)*. Available at www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report14.htm.

34. U.S. Department of Health and Human Services. *Child Welfare Outcomes 2002–2005: Report to Congress.* Available at www.acf.hhs.gov/programs/cb/pubs/cwo05/cwo05.pdf.

35. American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care, 2002.

36. Ibid.

37. American Academy of Pediatrics, Medical Home Initiatives for Children With Special Needs Project Advisory Committee. "Policy Statement: The Medical Home." *Pediatrics* 110(1), July 2002, 184-186.

38. Edelstein, B.L. "Dental Care Considerations for Young Children." *Special Care Dentist* 22(3), May/June 2002. 11S-25S.

39. American Academy of Pediatrics, Section on Pediatric Dentistry. "Oral Health Risk Assessment Timing and Establishment of the Dental Home." *Pediatrics* 111(5), May 2003, 1113-1116.

40. American Academy of Pediatric Dentistry. *Policy on the Dental Home*. Available at www.aapd.org/media/Policies_Guidelines/P_DentalHome.pdf.

41. Largent, B., C. Lederman and E. Whitney Barnes. "Children's Dental Health: The Next Frontier in Well-Being." *Technical Assistance Brief*. Reno, NV: National Council of Juvenile and Family Court Judges. 2008.

42. Ibid.

43. Savage, M.F. et al. "Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs." *Pediatrics* 114(4), October 2004, e418-23.

44. Sinclair, S.A. and B.L. Edelstein. *Policy Brief: Cost Effectiveness of Preventative Dental Services*. Washington, DC: Children's Dental Health Project, 2005. Available at http://cdhp.org/downloads/CostEffect.pdf.

45. Pettinato, E., M. Webb and N. Seale. "A Comparison of Medicaid Reimbursement for Non-Definitive Pediatric Dental Treatment in the Emergency Room Versus Periodic Preventive Care." *Pediatric Dentistry* 22(6), November/December 2000, 463-468.

46. American Academy of Pediatric Dentistry. *Policy on the Dental Home*. Available at www.aapd.org/media/Policies_Guidelines/P_DentalHome.pdf.

47. Ibid.

48. Ibid.

49. Largent, et al., 2008.

50. An eight-year study of children ages three-to-five found that children with tooth decay in their primary teeth were three times more likely to develop decay in their permanent teeth. Lil., Y. and W. Wang. "Predicting Caries in Permanent Teeth from Caries in Primary Teeth: An Eight-year Cohort Study." *Journal of Dental Research* 81(8), August 2002, 561-566.

51. Edelstein, 2002.

52. Only a fraction of the dentists surveyed provided more than $10,000 in Medicaid billings per year. Children's Dental Health Project. *Survey of State Medicaid Oral Health Departments on Payment Rates to Dentists, Dentist Participation Levels, Dental Program Administrative*

Issues and Contracting Issues. Washington, DC: Children's Dental Health Project, 1998 (Produced with the National Conference of State Legislatures Forum for State Health Policy Leadership).

53. The Institute of Medicine defines the health care safety net as "Those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients" (Institute of Medicine, 2000). Weinick, R.M. and J. Billings. *Introduction: Tools for Monitoring the Health Care Safety Net.* Rockville, MD: Agency for Healthcare Research and Quality, November 2003. Available at www.ahrq.gov/data/safetynet/intro.htm.

54. 42 U.S.C. §1396(a)(10) and (43)(2000); 42 U.S.C. §1396(d)(a)(4)(B) (2000); 42 U.S.C. §1396(r).

55. DiGiuseppe, D. and D. Christakis. "Continuity of Care for Children in Foster Care." *Pediatrics* 11(3), March 2003, e208-e213.

chapter 3

Addressing Early Mental Health and Developmental Needs

Addressing Early Mental Health and Developmental Needs

Factors that Influence Social-Emotional Development of Young Children

- Understand how child maltreatment affects children's development.
- Ensure placements for very young children provide long-term stability and promote healthy attachments.

Mental Health Assessment and Services

- Order an immediate screening of the child's mental health issues.
- Require a screening to identify developmental delays and disorders.
- Ensure the comprehensive mental health assessment is initiated within 30-60 days of placement.
- Order a reassessment of the child's mental health status during placement.
- Ensure a continuum of services is offered to each child.
- Ensure frequent parent-child contact.
- Ensure frequent sibling contact.
- Ensure the mental health and emotional needs of the parent(s) are assessed and appropriate services are provided.
- Order a determination of the intensity and type of services required to meet the family's needs.
- Order an assessment to determine whether the child and parent would benefit from Child-Parent Psychotherapy.

- Order an assessment of whether the child and parent would benefit from Parent-Child Interaction Therapy (PCIT).
- Ensure services respond to the needs of different ethnic and cultural groups.

Early Care and Education

- Ensure children participate in positive early childhood learning experiences.
- Carefully consider the availability and quality of early care and education settings.

From birth, babies look to trusted adults to meet their needs. When their needs are met, babies thrive. When their needs are not met, their social-emotional development (mental health) is compromised. In either case, babies' brains are learning what to expect from the world, and whatever happens during the first three years becomes part of the brain's hard wiring. The zero-to-three age range is the time when the greatest amount of development occurs in the brain.

Even though the brain is constantly growing, changing, and forming new connections during early childhood, recovering lost connections becomes much harder with age. Babies are born with just a portion of the connections they will later develop. Through their relationships with caregivers and trusted adults who talk to, play with, and comfort them, the brain will build many connections. In fact, a newborn's brain produces many more connections than will be needed during childhood. The connections that are not used or needed become weaker and are eventually tossed away, or pruned from the brain.

Research shows that removing a child from a neglectful home after age four offers little opportunity to recover the initial attachment.[1] That is why early maltreatment is potentially so damaging. The sooner a child is able to develop a consistent, positive attachment with a primary caregiver, the more likely he will develop the confidence and intellectual curiosity to succeed throughout childhood and as an adult. The key to healthy social and emotional development is positive and consistent early experiences with loving caregivers. Supportive interventions for children and their parents and quality early child care and educational experiences are also important to promoting children's positive mental health.

As a judge, you can guard the mental health of very young children by making sure that:

- placement decisions are made wisely at the outset that promote long-term stability and healthy child-caregiver attachments,
- ties are maintained with birth parents and siblings through frequent quality visits, and
- permanency decisions respect the bonds children have forged in out-of-home care.

Factors that Influence Social-Emotional Development of Young Children

Understand how child maltreatment affects children's development.

In very young children, the terms *social-emotional development* and *infant mental health* are used interchangeably. Social-emotional development describes "the

Common Mental Health and Developmental Disorders of Infancy and Early Childhood

The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3) was first published in 1994 by Zero To Three to address the need for a systematic, developmentally based approach to the classification of mental health and developmental disorders in the first four years of life. The DC:0-3R was published in 2005 and builds on the tradition of the first version. DC:0-3R uses a multiaxial system with five major classifications of disorders and they are:

- **Axis I:** The infant's primary diagnosis. Examples are posttraumatic stress disorder, affective disorders and eating behavior disorders.
- **Axis II:** Disorders related to the caregiver-child relationship. Examples of categories include angry/hostile, over-/underinvolved, verbally, physically, or sexually abusive relationship disorders.
- **Axis III:** Medical and/or developmental conditions including developmental language disorder, failure to thrive, and cerebral palsy.
- **Axis IV:** Acute and chronic stressors in the child's environment. Examples are parental psychopathology and parental conflict.
- **Axis V:** The young child's current functional and emotional level of adaptation.

Source:
Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3). Washington, DC: Zero to Three Press, 1994; *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R).* Washington, DC: Zero to Three Press, 2005.

developing capacity of the child from birth through five years of age to form close and secure adult and peer relationships; experience, regulate, and express emotions in socially and culturally appropriate ways; and explore the environment and learn—all in the context of family, community, and culture."[2]

Healthy emotional and psychological development of infants and young children requires that the child have a relationship with a nurturing, protective adult who fosters trust and security. This is an **attachment relationship**. A young child forms attachments during the period of early brain development, which sets the framework for emotional development. The professional literature[3] identifies four types of attachment relationships:[4]

- **Secure attachment:** The child trusts that her parents are consistently available. When the child is frightened or unsure about something, she

Autism Spectrum Disorders

What are Autism Spectrum Disorders?

Autism Spectrum Disorders (ASD), most commonly diagnosed in young children, fall in the category of difficulty in relating and communicating.[1] An estimated 1 in 150 children are on the autism spectrum, which has prompted researchers to describe the disorder as "an urgent public health issue."[2] Typically diagnosed by three years of age, ASD can be recognized in children as young as two years. Although symptoms present differently in individual children, many will manifest problems in social interaction, verbal and nonverbal communication, and repetitive behaviors or interests.[3]

General Indicators of ASD

- **Social Indicators:** Typically, developing infants are born ready to be in relationships with adults and primary caregivers. The parent-infant relationship helps form the foundation for healthy infant and toddler social-emotional development. Some very young children with ASD have difficulty interacting and sustaining eye contact with parents and caregivers. As these young children grow and develop, their passiveness, self-isolation, and resistance to human affection often becomes more pronounced. They may also become attached to a particular toy or object to the point that if the toy or object is moved or lost the child will become very upset, lose control, and have difficulty calming down. These children may:
  - not smile very often,
  - seem hearing impaired,
  - lose social skills apparent earlier in development, and
  - crave rituals and/or order to their activities.

- **Communication Problems:** One of the first sounds very young infants make is babbling. By the first year babbling typically develops into words. Some children diagnosed with ASD never speak, others babble for the first few months and then stop. Still others are delayed in developing language. Some children develop echolalia, a language disorder in which the young child parrots everything he/she hears. Although many children repeat everything they hear, this phase usually ends around three years of age. Many ASD children:
  - do not respond to their names, and
  - lose language skills apparent earlier in development.

Any parent or foster caregiver who suspects a problem with a young child should seek Early Intervention screening and a diagnosis as soon as possible. The American Academy of Pediatrics recommends autism-specific screenings at 18 months with a follow-up at 24 months, and whenever a concern is raised (in addition to general developmental screenings at 9, 18, and 30 months).[4] Judges should ask whether such screening has

occurred. Early screening and diagnosis is important for ASD children because the sooner a child is diagnosed, the sooner services can begin to support them.

Sources:

1. *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R).* Washington, DC: Zero to Three Press, 2005.

2. Johns Hopkins Bloomberg School of Public Health. "CDC Releases New Data on the Prevalence of Autism Spectrum Disorders: First and Largest Multi-site Study Provides Baseline for Future Comparisons." *Public Health News Center*, 2007. Available at www.jhsph.edu/publichealthnews/articles/2007/lee_autism.html.

3. U.S. Department of Health and Human Services. *Autism Spectrum Disorders: Pervasive Developmental Disorders.* National Institutes of Health, National Institute of Mental Health, NIH Publication No. 08-5511, 2004. Available at www.nimh.nih.gov/health/publications/autism/complete-publication.shtml.

4. Hagan J.F., J.S. Shaw and P.M. Duncan, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3d ed. Elk Grove Village, IL: American Academy of Pediatrics, 2008, 226.

looks to her parents for reassurance. If the parent is calm, the child is no longer frightened. She may move closer to the parent to touch base but then will return to whatever activity she was engaged in before the threat.

- **Anxious-ambivalent attachment:** The child cannot count on his parents to respond consistently. Sometimes the parent is nurturing and sometimes she is not. The child uses two coping strategies interchangeably—clinginess and feigned independence—to demonstrate his insecurity.
- **Anxious-avoidant insecure attachment:** The child has learned that the parent is not there for her. She behaves as though she has no need for the parent's attention.
- **Disorganized attachment:** This form of attachment is associated with children who have been physically abused and is the most difficult to treat. Such a child has no strategy for dealing with his parents' failure to protect and nurture him. He attempts proximity with his parent in odd ways such as approaching her backwards or simply falling in a heap near her.

Insecure attachment underlies later mental health problems, substance addiction, homelessness, and criminal activity.[5] Especially for children in foster care, who often have unstable relationships with adults, understanding and promoting attachment is critical to ensuring healthy emotional and mental development.

Infants and toddlers living with families dealing with substance use disorders are also at risk for developing mental health disorders.[6] For example, they may cry for long periods, seem unable to soothe themselves or be soothed, have trouble sleeping and eating, and withdraw from adults and peers. These children find

Biological Factors Affecting Social-Emotional Development

- **Premature Birth:** Any birth that occurs before the 37th week of pregnancy is considered preterm. The more prematurely a baby is born the greater the health risks. Babies born very prematurely often have breathing, digestive, and brain problems and are at high risk for death in the first few days of life. Premature babies may continue to have developmental delays and learning problems that will affect them throughout their lives.
- **Low Birth Weight and Small for Gestational Age:** Infants weighing under 5½ pounds at birth are *low birth weight* and are at increased risk for other health problems and developmental delays.[1] *Small for gestational age* infants have birth weights below the third percentile for gestational age. Very small infants have great difficulty regulating their behavior in response to changes in emotional stimulation. A fussy baby is normally soothed when a parent gently holds him and rocks, or talks softly to her and gently rubs her back, but very small infants are not able to benefit from these soothing techniques and their emotional distress continues unabated. This early regulatory difficulty may be linked to the later diagnosis of attention deficit hyperactivity disorder.[2]
- **Neurobehavioral Problems:** During the first few days of life, drug-exposed infants experience tremors and irritability.[3] They may also have diarrhea, vomiting, and even seizures. Some newborns are lethargic, and many are easily distracted and overstimulated. Others display poor quality of movement and self-regulation.

Sources:

1. Bada, H. S. et al. "Gestational Cocaine Exposure and Intrauterine Growth: Maternal Lifestyle Study." *Obstetrics & Gynecology* 100, 2002, 916–924.

2. Committee on Integrating the Science of Early Childhood Development, National Research Council and Institute of Medicine. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Edited by Shonkoff, J.P and D.A. Phillips. Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, DC: National Academy Press, 2000, 349.

3. Lester, B. M. et al. "Methamphetamine Exposure: A Rural Early Intervention Challenge." *Zero To Three* 26(4), 2006, 30–36.

it difficult to develop and sustain strong connections with adults and others, leading to attachment disorders that may affect their ability to form relationships, take risks, explore the world around them, and learn.[7]

Researchers estimate that 30 to 70% of the children witnessing domestic violence also experience child abuse as a result.[8] The impact on young children can be devastating, as many never learn to expect their parents to protect them and ensure their well-being.[9] Because the parents cannot make the child safe, and indeed, contribute to the child's insecurity, the child is caught in a terrible dilemma: try to stay away from parents who might harm him or seek parental comfort and

protection when it is unclear whether the parents will provide them. Children exposed to this kind of stress are likely to have a disorganized attachment relationship with their parents.[10] The child's response to this violence can lead to a clinical diagnosis of traumatic stress disorder, which includes these symptoms:

- experiencing the traumatic events over and over through ritualistic play, flashbacks, and nightmares;
- becoming distressed when exposed to anything that reminds the child of the trauma;
- losing previously acquired skills (e.g., a child who had been toilet trained has repeated accidents);
- blunting personality: the child stops expressing emotion, interacting with people, or carrying out normal play activities;
- becoming hypervigilent: the child is easily startled, cannot relax or fall asleep, and wakes up frequently at night;
- displaying behavioral symptoms that appear after the traumatic events (e.g., aggression toward people or animals, separation anxiety, other new fears).

We would like to believe it is never too late to rehabilitate a child who has suffered harmful early childhood experiences. However, the science of early childhood tells us that the initial attachment is critical to protect against future inadequacies in relationship building and behavioral control. When children experience long periods without forming this initial attachment, or repeatedly begin and end relationships, they become less and less likely to achieve it.

Ensure placements for very young children provide long-term stability and promote healthy attachments.

Stable placements with loving adults and predictable nurturing routines promote healthy attachments for very young children. By the time child protective services (CPS) intervenes, these essentials are likely to be lacking. Helping the child overcome the maltreatment that brought CPS into the picture requires careful planning, and the child needs to be protected from multiple moves between caregivers. To do this, extended family members need to be identified as close to the removal as possible, ideally before the child is removed. Ask caseworkers to describe efforts to identify extended family caregivers in the first week after the case comes to them.

In the event that extended family members are not available or not appropriate as caregivers at the time of removal, a foster-to-adopt home should be selected. Placements should be evaluated to ensure that they support the mental health

Red Flags[1]

Children who are too young to speak communicate in other ways. Even very young infants tell us when they are suffering. In their first year of life, children react to trauma through the disruption of normal biological rhythms and sensorimotor responses outside of what would typically be expected.[2] Mental health problems are often reflected in physiologic responses to stress and a pattern of behavior that includes multiple episodes or symptoms. They should be treated seriously.

An infant under chronic stress may respond with:

- apathy—lose interest in the world (caregivers cannot elicit a smile);
- poor feeding—refusal to eat or an insatiable appetite (failure to thrive and morbid obesity are possible outcomes);
- develop symptoms like vomiting or skin rashes for which there is no detectable diagnosis;
- withdrawal.

More acute stress may lead to various responses:

- inconsolable crying;
- temper tantrums;
- aggressive behaviors;
- inattention and withdrawal.

A young child's response to stress may include:

- excessive day dreaming;
- disengagement;
- opposition;
- defiance.

Repeated experiences can lead to dysregulation of the areas of the brain that control motor activity and anxiety. Children can consequently display:

- motor hyperactivity;
- out-of-control and accident-prone behavior, or overly cautious movements and activities;
- anxiety;
- mood swings;
- impulsive behavior;
- sleep problems;
- caring for self, siblings, or parent beyond what is expected for such a young child;
- taking responsibility for abusive behavior in play ("If only I hadn't skinned my knee, Daddy wouldn't have hit Mommy."); and

- oversexualized behavior (excessive masturbation, inappropriate touching, or body rubbing).

Sources:

1. Adapted from American Academy of Pediatrics, Committee on Early Childhood, 2000.

2. Lieberman, A.F et al. "Violence in Infancy and Early Childhood: Relationship-Based Treatment and Evaluation." *Interventions for Children Exposed to Violence.* Edited by A.F. Lieberman and R. DeMartino. New Brunswick, NJ: Johnson & Johnson Pediatric Institute, 2006, 65-83.

needs of young children. However, foster parents need special training to understand their dual roles as coach to the parents when reunification is the permanency goal, and as adoptive parents if the biological parents are not able to overcome the problems that led them into the child welfare system. Ask about the training provided to the foster parents to prepare them to care for very young children and about supportive services to help the family address the child's emotional needs.

Make sure all parties understand that placement decisions are being closely examined and any changes in placement will be reviewed in court. Also ensure concurrent permanency planning begins on day one to engage both parents and other potential permanency resources in supporting the child's healthy development. Cases should progress without delay when a permanency plan changes.

Effect of Cognitive and Developmental Delays on Young Children's Mental Health

While the effect of insecure attachment on the social-emotional development of very young children is significant, cognitive and developmental delays are other factors that can play a major role. Before children are born, their parents are already influencing their lives. If their mothers drink alcohol, take drugs (either recreational or prescription), smoke cigarettes, fail to eat enough healthy food, are exposed to chronic stress, or are victims of violence or environmental toxins, the children are at an elevated risk for several developmental challenges that affect their social-emotional development. Common biological problems in babies that often lead to developmental delays are premature birth, low birth weight, and neurobehavioral problems. Cognitive problems in toddlers and young children such as autism can lead to difficult or insecure attachments with caregivers and other trusted adults. For parents who have looked forward to nurturing a

relationship with their infant or toddler, these signs can be very upsetting and cause parents and very young children much tension and stress. Parents who expected to bond with an infant or toddler who appears nonresponsive may feel deeply disappointed and at a loss as to how to respond.

Mental Health Assessment and Services

Order an immediate screening of the child's mental health issues.

The initial mental health screening should occur within 24 hours of removal. The primary purpose is to identify and provide services for any emergency mental health needs. Any biological factors affecting very young children's mental health should be evaluated during the initial mental health assessment and follow-up screenings. Young children who are removed from their caregivers may require an immediate intervention to address acute separation issues. Early efforts to prevent, identify, and support mental health issues are crucial for young children entering foster care. Whenever removal occurs, responding to the child's needs first requires a comprehensive evaluation of their social-emotional health and development. Quality assessments are key to uncovering early signs of emotional and mental distress so that services can begin to address them. Treatment and interventions should be trauma-informed and evidence-based.

The American Academy of Child and Adolescent Psychiatry (AACAP) and the Child Welfare League of America (CWLA) recommend an immediate mental health screening followed by a comprehensive mental health evaluation for all children who are removed from their primary caregivers due to suspected abuse, neglect, or caregiver impairment.[11] A qualified mental health professional, such as a psychiatric nurse practitioner, who uses recognized clinical tools and has training and experience with very young children should conduct the evaluation.

Require a screening to identify developmental delays and disorders.

The Child Abuse Prevention and Treatment Act of 2003 (CAPTA) requires that children who are the subjects of substantiated child maltreatment complaints receive a screening to identify developmental delays. If the child has developmental delays, she is eligible for a wide range of services authorized by Part C of the Individuals with Disabilities Education Act (IDEA) (see Part C box). Part C screening provides a thorough picture of a child's developmental status. Evaluating the child's social-emotional health is one important component of that assessment that may be overlooked if the agency responsible for implementation lacks

Part C of the Individuals with Disabilities Education Act[1]

Congress established the Part C program under the IDEA in 1986 to address an "urgent and substantial need." The purpose of Part C is to:

- enhance the development of infants and toddlers with disabilities;
- reduce education costs by reducing the need for special education through early intervention services;
- minimize the likelihood of institutionalization; and
- enhance the capacity of families to meet their children's needs.

Amendments to the Child Abuse and Prevention Treatment Act (CAPTA) from 2003 require states to develop procedures to ensure that all children under age three who are involved in a substantiated case of abuse or neglect are referred to Part C services.

The IDEA amendments of 2004 require Part C services for all children who have been maltreated or exposed to prenatal substance and alcohol use or domestic violence. This legislation opened a window of opportunity for getting developmental assessments and treatment for infants and toddlers who have been abused or neglected. However, although Part C is a federal requirement, many local jurisdictions are not yet aware of the Part C program in their states.

For eligible children, Part C services include:[2]

- family training, counseling, and home visits;
- nursing, health, and nutrition services;
- service coordination;
- medical services for diagnostic or evaluation purposes;
- occupational and physical therapy;
- psychological and social work services;
- vision, orientation and mobility services;
- speech-language pathology services;
- transportation services; and
- age-appropriate special education instruction.

To learn more about Part C of the IDEA, visit:
www.childwelfare.gov/systemwide/service_array/development/childwelfare.cfm

Sources:

1. Hudson, L. et al. *Healing the Youngest Children: Model Court-Community Partnerships*. Washington, DC: American Bar Association Center on Children and the Law & Zero to Three Policy Center, 2007.

2. Santucci, R. et al. *Special Education: Grant Programs Designed to Serve Children Ages 0-5*. Washington, DC: United States General Accounting Office, 2002, 8. Available at www.gao.gov/new.items/d02394.pdf.

expertise in infant mental health. If a thorough Part C assessment is available, a separate mental health assessment may not be necessary.

The American Academy of Pediatrics (AAP) recommends that pediatricians screen all children for developmental disorders at every pediatric visit.[12] When developmental risks are identified, the health care provider should administer a developmental screening tool and determine whether referrals for further evaluation or services are necessary. In addition to routine surveillance, the AAP recommends all children, irrespective of risk for developmental concerns, undergo formal developmental screening at 9, 18, and 30 month visits. Whenever any screening tool identifies potential issues, referrals for further evaluation and services should be made.

Children receiving common early intervention services (e.g., speech, information processing, and other cognitive and motor functions) have a higher risk for behavioral and mental health disorders.[13] When mental health services are provided under Part C, "relationship-based and family-focused intervention strategies [should be used] by early intervention personnel, regardless of professional discipline or the service being provided."[14] Strategies include:

- working with the parent and child together;
- educating parents about things they can expect in their child's behavior;
- building on parents' strengths to enhance their ability to care for their child;
- offering opportunities for the parent and child to interact positively; and
- helping the parent explore their feelings about the child and about being a parent.[15]

Ensure the comprehensive mental health assessment is initiated within 30-60 days of placement.

Typically, when a child is removed from the caregivers and placed in out-of-home care, he is suddenly separated from all things familiar—his home, community, educational setting, caregivers, family, and friends. This experience causes grief that can impair new attachments and the success of the out-of-home placement. Ensuring an early and comprehensive evaluation of a child's mental health needs by a professional familiar with the social and emotional needs of children in care will help address the young child's distress. Ask about the results of the mental health screening that was done before placement. If one has not been completed, order one.

A comprehensive assessment should occur within 30-60 days of placement. The timing of this evaluation should be guided by any mental health needs identified in the initial screening. The initial evaluation and the comprehensive assessment

should focus on the potential psychological consequences of removal, with or without the presence of symptoms that support a psychiatric diagnosis.

While the focus of this chapter is mental health, it bears repeating that a full assessment should include a thorough physical exam and developmental evaluation. Delays in cognitive and motor functioning can be clues to previous maltreatment. For example, an infant who cannot track objects with her eyes may have suffered an eye injury.[16]

Learning about infants and toddlers occurs most successfully in conditions that create the least stress for them. Assessments of very young children should occur in familiar settings, whenever possible. The child should never be separated from the primary caregiver (e.g., foster parent, birth parent, kinship care provider) during the evaluation. A thorough assessment should be conducted over two or three sessions to accommodate the child's rapidly changing moods, health, and comfort.

Many instruments and procedures are used to evaluate young children. These instruments are used together to paint a complete picture of the child's mental health. The differing approaches highlight:

- infant development and functioning
- the social-emotional domain
- the child's adaptive skills
- parent-child interaction

Order a reassessment of the child's mental health status during placement.

During placement, the emotional and mental health needs of children in foster care will change, varying with the child's age, developmental stage, and circumstances. For this reason, children's emotional and mental health status should be periodically reassessed during placement. For children with particular mental health needs, reassessment should occur at appropriate intervals. An assessment occurring very soon after placement may portray the child as having very different behaviors than one conducted after the child has had time to adapt to the changed situation.

Consistent surveillance is required to detect developmental delays early. Health providers who know about the developmental needs of children play a key role in identifying potential problems for maltreated children. Young children who have been maltreated should receive a full mental health evaluation no later than one month after entering care[17] and every six months thereafter. These assessments should address the effects of maltreatment and the quality of the child's placement experience. The evaluators should be looking at how the child

Commonly Used Developmental Screening Tools

Developmental Screening Tools Using Information from Parents

- **Ages & Stages Questionnaires (ASQ) Second Edition**
  The ASQ uses drawings and simple directions to help parents elicit and indicate children's language, personal-social, motor, and cognition skills. The ASQ is tied to well-child visits. A newly developed Ages and Stages Questionnaire: Social Emotional (ASQ:SE) helps screen for emotional and behavioral problems in children 6–60 months of age.

- **Parents' Evaluation of Developmental Status (PEDS)**
  PEDS is a 10-question screening and surveillance tool designed to detect and address a wide range of developmental issues including behavioral and mental health problems. Parents can complete it in just a few minutes, and it promotes parent-provider collaboration and family-centered practice. PEDS identifies when to refer, screen further or refer for additional screening, or monitor development, behavior, and academic progress. Research shows use of PEDS improves positive parenting practices and satisfaction with services.

- **PEDS: Developmental Milestones (PEDS:DM)**
  PEDS:DM uses six-to-eight items per well-visit that address different developmental domains: fine motor, gross motor, expressive language, receptive language, self-help, social-emotional, and for older children reading and math. The PEDS:DM can be used with or without PEDS but in combination better helps meet the AAP's 2006 policy statement on early detection.

- **Infant-Toddler Checklist for Language and Communication**
  Parents complete 24 multiple-choice questions that focus on social aspects of their child's language development. Scores are produced for the child's social, speech, and symbolic communication skills. It does not screen for motor milestones.

Developmental Screens Requiring Direct Elicitation of Children's Skills

- **Bayley Infant Neurodevelopmental Screener (BINS)**
  The BINS assesses neurological processes (reflexes and tone); neurodevelopmental skills (movement and symmetry); and developmental accomplishments (imitation, and language).

- **Brigance Screens-II**
  Separate forms each cover a 12-month age range to screen speech-language, motor, readiness, and general knowledge skills, and for the youngest age group,

social-emotional skills. All screens use direct elicitation and observation except the Infant and Toddler Screen, which can be administered by parent report. This screen is widely used in educational settings.

- **Battelle Developmental Inventory Screening Test (BDIST)**
  BDIST uses a combination of direct assessment, observation, and parental interview to screen receptive and expressive language, fine and gross motor, adaptive, personal-social, and cognitive/academic skills.

Behavioral/Emotional/Mental Health Screening Tools

- **Eyberg Child Behavior Inventory (ECBI)/Sutter Eyberg Student Behavior Inventory Revised (SESBI-R)**
  The ECBI consists of 36 short statements of common acting-out behaviors. Parents rate each item for frequency of occurrence (referred to as intensity) on a one–to-seven scale and then indicate whether the behavior is a problem for them. A single score is produced to suggest the presence of disruptive, externalizing behavior problems (e.g., disorders of attention, conduct, oppositional-defiance). The SESBI-R works in a similar way but uses teachers as the informant.

- **Pediatric Symptom Checklist (PSC)**
  The PSC consists of 35 short statements of externalizing (conduct, attention, etc.) and internalizing (depression, anxiety, adjustment, etc.) problem behaviors.

Sources:

Smith, P.K. "Chapter 3: Early Intervention Using Standardized Developmental Screening Tools." *Enhancing Child Development Services in Medicaid Managed Care; A Best Clinical and Administrative Practices Toolkit for Medicaid*. Hamilton, NJ: Center for Health Care Strategies, Inc., 2005. Available at www.chcs.org/usr_doc/Toolkit.pdf;

Frances P. Glascoe, MD. "Commonly Used Screening Tools." *Developmental Behavioral Pediatrics Online* (AAP). Available at www.dbpeds.org/articles/detail.cfm?textid=539.

expresses emotions, his ability to regulate himself (e.g., Can he calm himself after a disappointment?), his self awareness, and his relationships with the primary caregivers in his life.

Ensure a continuum of services is offered to each child.

Identifying mental health needs is the first step in promoting the emotional and mental health of young children in care. Given their complex prior experiences, and the diversity of placement options, children's needs are best met through a complement of mental health services. Services should permit the child to remain in the least restrictive, but also safe, community-based environment and should encourage *voluntary* family participation at all stages.[18]

All children should receive individualized service planning to address all their needs including their mental health and emotional needs. Plans should include:

- services that focus on the interests, values, and goals of the child and family;
- targeted assessment of the mental health needs of the child and services and supports to help the family support the child;
- a concurrent permanency plan to reduce the need for multiple placement changes by preparing foster parents to serve as adoptive parents if reunification is not possible;
- informal and formal services such as visit coaching or child-parent psychotherapy, and opportunities to participate in community activities (e.g., Early Head Start, faith-based organizations);
- assessments of progress toward identified goals.

Review the child's individualized service plan to ensure it incorporates supports that meet identified needs. Services should continue when a child is reunified with his family or another permanency plan is implemented. If no services have been required while the child is in care, his needs should be reassessed at each hearing and any necessary services should begin at that time.

Ensure frequent parent-child contact.[19]

Professionals working with very young children in foster care often do not understand the extent of the child's distress over being removed from the parent and placed in a strange environment. Remember that very young children grieve the loss of a relationship. Even though the parent has maltreated the child, she or he is the only parent the child has known, and separation evokes strong and painful emotional reactions.[20] The younger the child and the longer the period of uncertainty and separation from the primary caregiver, the greater the risk of harm to the child.[21] Maintaining consistent contact between the child and his or her parents and siblings is critical unless visits would harm the child.[22] In fact, parent-child contact is the number one indicator of reunification.[23] Family contact and interaction is important and the relationship between the foster family and biological family can be crucial.

Because physical proximity with the caregiver is central to the attachment process for infants and toddlers,[24] an infant should ideally spend time with the parent(s) daily, and a toddler should see the parent(s) at least every two to three days.[25] To reduce the trauma of sudden separation, the first parent-child visit should occur as soon as possible and no later than 48 hours after the child is removed from the home.[26]

Visits should promote parent-child attachment and be an opportunity to model good parenting skills. The length and frequency of visits should reflect the child's developmental stages and gradually increase as the parent shows she is able to respond to her child's cues in consistent and nurturing ways, soothe her child, and attend to her child's needs. During the initial phase, limiting visits to one-to-two hours allows the parent to experience small successes without becoming overwhelmed. By the transition phase, as the family approaches reunification, unsupervised all-day, overnight, and weekend visits should be completed.[27]

A young child's emotional dysregulation following a visit does not necessarily mean the parent did something harmful during the visit.[28] Visitation can be extremely upsetting for children, and it is important to understand the developmental context of their feelings and behaviors. Very young children cannot understand the separation, and they tend to respond with bewilderment, sadness, and grief. During visits, they may cling or cry, act out, or withdraw from their parent. At the end of a visit, when another separation is imminent, they may become confused, sad, or angry. Following visits, infants and toddlers may show regressive behaviors, depression, physical symptoms, or behavioral problems. Foster caregivers may need information to help them understand and support young children who are distressed after a visit.

Parents also find visits to be a time of emotional upheaval, particularly during the first phase of placement. Parents often experience pain and sadness resulting from the separation. They may feel shame, guilt, depression, denial that there is a problem, anger, and/or worry about the child. During the first visits, the parent is likely to be awkward, tense, and uncertain. Visit coaches, caseworkers, and foster parents should help the parent process her emotions and help her interact with her child.[29]

Ensure frequent sibling contact.

The Fostering Connections to Success and Increasing Adoptions Act of 2008[30] addresses many issues that promote permanency and affect the health and well-being of very young children in foster care, including placing greater priority on keeping siblings together. While placements that can accommodate a very young child's siblings should be sought, it may be necessary to separate siblings due to the special needs or circumstances of the very young child. When siblings are not placed together, the importance of siblings to the young child should not be minimized, especially if there is an established bond. Ensure frequent sibling visits and opportunities to maintain the sibling bond, especially for toddlers and preschoolers who may perceive their older siblings as caregivers.

Ensure the mental health and emotional needs of the parent(s) are assessed and appropriate services are provided.

Because children's early social-emotional development depends on their parents' health and well-being,[31] issues that undermine the parents' sense of safety and belonging will harm the young child's mental health. Infants react to trauma as it is manifested through their parents' lack of availability to provide them nurturing care.[32] Promoting a family-centered approach to mental health assessments and services will uncover many family needs that can be addressed early in the child welfare case.

Children thrive to the extent that their parents provide consistent nurturing care. Parents whose lives are consumed by substance abuse, mental illness, domestic violence, a history of childhood trauma, compromised cognitive functioning, or poverty cannot provide the care their very young children need because they are often distracted by their own issues. With proper interventions and support, they can address these problems and work toward resuming care of their children.

Substance Abuse

Parents with addiction problems may be unable to provide consistent emotional and psychological attention to infants and toddlers because they are preoccupied by their chemical addiction. Primary caregivers who are chemically dependent are likely to have experienced maltreatment as children.[33] They are often unable to provide the comfort, security, and consistent care infants and toddlers need to regulate their behaviors and emotions. Parents with addiction issues are also likely to have been exposed to alcohol in utero which brings with it a host of possible disabilities (e.g., fetal alcohol spectrum disorders; neurobehavioral problems). Parents with addiction problems should complete a parenting course focused on these issues.

Mental Illness

Parents with mental illnesses run the gamut. Many are competent and manage their parenting responsibilities appropriately and without help, while others are good parents with some assistance. Some lack sufficient parenting skills and others are abusive, neglectful, or both.[34] Psychopathology among parents of young children is often linked to maltreatment. For new parents, postpartum depression, post traumatic stress disorder, depression, and anxiety can interfere with their ability to care for their newborns. Maternal depression and other psychiatric problems (e.g., hostile personality, explosiveness) are linked to abuse of infants.[35] Research documents high rates of psychopathology among biological parents who

maltreat their young children. Children of psychotic parents often experience confusion over reality. If no other caregiver is available, they can get lost in the psychotic world of the one available parent. More recently, high rates of psychiatric illness have been identified among foster and kinship parents.[36]

Infants with chronically depressed mothers will often withdraw from social interactions, jeopardizing their social-emotional development. As they get older, these children are likely to lack self control, behave aggressively towards other children, and experience school difficulties that can lead to grade retention and dropping out of school.[37]

If services to the parents have not begun, order them to begin before the next court hearing to comply with ASFA's reasonable efforts requirements. When reunification is planned, ask whether the parents' mental health needs are being successfully addressed as part of the case plan.

When evaluating the ability of parents struggling with mental illness to safely parent their young children, ask the following questions and refer to *A Judicial Checklist for Children and Youth Exposed to Violence*:[38]

- Does the parent demonstrate poor reality testing (a person's ability to differentiate between the external and internal worlds) or worrisome patterns of denial?
- Does the parent have a mental illness, including a character disorder, such that the capacity to nurture is severely impaired?
- If there is a psychotic diagnosis: what is the need for treatment, the ability to benefit from treatment, and the effect of medication?
- Is the parent willing to be treated?
- If the parent has a mental illness, is this worsened by close contact with the infant or by demands to meet parental responsibilities (e.g., delusional thinking centering on the infant)?
- If the parent has a history of psychosis, is the infant at the center of the parent's delusional thinking or do the infant's needs trigger difficulty for the parent?[39]

Family Violence

Parents facing personal violence (or the threat of it) from an intimate partner are often distracted from caring appropriately for their young children. They have low self-esteem and tend to suffer from depression. Researchers estimate that as many as 75% of the parents who abuse or neglect their children were themselves maltreated in childhood.[40] Their experiences as children impair their ability to appropriately care for their own young children because they never learned to form healthy attachments. Child-parent psychotherapy, discussed later in this chapter,

attempts to uncover the parent's own childhood trauma as the therapist works with both parent and child to broker a mutually enjoyable relationship.

When domestic violence is a factor in the child protection case,[41] case plans must address the unique needs of each family member, including the batterer and the adult and child victims.[42] In determining placement, respect the autonomy of the nonoffending parent and support her ability to provide a safe and nurturing home for the children.[43] Batterers must be held accountable for their actions. They should have a separate case plan that requires them to stop all forms of abuse toward any family member, abide by all court orders, and participate in counseling and educational programs designed for domestic batterers.[44]

Low Cognitive Functioning

Parents with low IQs face challenges caring for their children. If their intelligence is too compromised, they may not be capable of understanding and supporting their children's needs.[45] They also may not receive the support they need themselves to parent effectively. In assessing a parent's ability to care for an infant, questions about their ability to provide responsive caregiving help determine their ability to support their infant's mental health. An important consideration for parents with diminished cognitive functioning is FASD, the single greatest cause of nongenetic mental retardation. The IQ deficit is compounded by other neurological deficits that impair the victims' ability to follow directions or learn from their mistakes.[46] Proper diagnosis can lead to developing a case plan for the parent and child that permits them to live safely together.

Poverty

Poverty is the single most important predictor of neglect.[47] Living in poverty adds tremendous stress and interferes with the parents' ability to care for their young children. Poverty puts mothers at high risk for depression, post traumatic stress disorder, and for difficulties establishing nurturing relationships with their very young children.[48] Among these mothers' greatest challenges are creating a safe environment, and providing food and a place to live for themselves and their children.

Order a determination of the intensity and type of services required to meet the family's needs.

Case plans should refer parents to parenting programs that have been evaluated and found effective. Whenever possible, programs that target parents' special needs should be used. Programs exist for parents with substance abuse issues, parents of young children, and fathers. Avoid parenting classes taught by instructors who lecture parents about parenting. Rather, seek programs that allow

Incredible Years and the Strengthening Families Program

The following two programs meet established criteria for effectiveness in helping families address their special needs:

- **Incredible Years** offers training to help parents and teachers intervene in children's conduct problems when they are very young and develop their social competence. Curricula are available that address children in the general population, children experiencing behavior problems, and children with mental health diagnoses like attention deficit hyperactivity disorder. The experience of the teachers is related to the intensity of the intervention (e.g., therapists and teachers offer the curriculum for children with mental health diagnoses).
- **The Strengthening Families Program** was developed for families at risk for maltreatment. The program has developed specialized curricula for families with various cultural backgrounds (e.g., Asian and Pacific Islanders, American Indians). Like the Incredible Years, their curricula are specific to children of various ages, including a curriculum for parents and their three-to-five year olds. Although they do not yet have a curriculum for babies and toddlers, it is a model worth considering because of its curricula in Spanish, with cultural sensitivity for a wide range of ethnically diverse populations, and its extensive use with families dealing with child maltreatment.

Source: Substance Abuse and Mental Health Services Administration. National Registry of Evidence-Based Programs and Practices, 2008. Available at www.nationalregistry.samhsa.gov/submit.htm.

parents to practice new skills. The Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services has established a national registry of research-based parenting interventions that may or may not target parents with substance abuse issues (www.nationalregistry.samhsa.gov/index.htm). Programs must show, at a minimum, that:

- they achieve positive outcomes in mental health and/or substance use behavior among individuals, communities, or populations;
- proven program results are documented in a peer-reviewed publication or a comprehensive evaluation report;
- guidance on implementing the program (e.g., manuals, process guides, tools, training materials) is available to the public to aid dissemination.[49]

Among programs listed are the Incredible Years and the Strengthening Families Program. Several others with an established research base have requested

review by the national registry. These include Child-Parent Psychotherapy and the Nurturing Parenting Program. Each intervention focuses on special populations (e.g., families with substance abuse issues, young children).

Effective programs share certain characteristics:[50] (1) regular in-class opportunities for the parent and child to practice the information they are receiving; and (2) assessments of the parent's skills and emotional relationship with the child before the classes begin and again at the end.

Order an assessment to determine whether the child and parent would benefit from Child-Parent Psychotherapy.[51]

This intervention focuses jointly on the parent and infant. Child-Parent Psychotherapy (CPP) for mothers, fathers, and their infants and toddlers (birth to three) helps the parent read, interpret, and respond to the infant's cues. A therapist serves as a guide for the parent, helping her understand what the baby might be feeling and how the parent's needs might influence her responses to the baby.[52] Roleplaying with the infant also allows the parent to uncover traumatic experiences from his own childhood and to look at interactions from the young child's point of view.[53]

Parents also receive concrete assistance, such as transportation to appointments or a school function of an older sibling. The therapist helps with life problems such as housing that interfere with the parent's ability to focus on the clinical aspect of CPP. The therapist's positive regard for the parent in these very tangible ways helps the parent heal negative experiences with attachment figures from his or her own childhood.

Positive outcomes for those who complete CPP include:

- improved perceptions of the baby by the parent;
- improved socioemotional functioning;
- stronger parent-child relationship;
- secure attachment between parent and child; and
- improved mental health of parent.[54]

Order an assessment of whether the child and parent would benefit from Parent-Child Interaction Therapy (PCIT).[55]

This therapy was designed for two-to-six year olds with disruptive behavioral characteristics of oppositional-defiant or conduct disorder, and children with insecure attachment. It is a short-term intervention (10 to 16 weekly sessions). At first it emphasizes improving the parent-child relationship. Once certain therapeutic

goals are reached, the emphasis shifts to implementing consistent discipline with the child.

PCIT is effective except when the mother is highly critical or severely depressed or when the parents are abusing drugs, experiencing severe marital discord or psychopathology.[56] Some evidence suggests that the family's relationship with the therapist is more predictive of treatment outcome than any specific therapeutic techniques. While concrete assistance with life tasks is not part of the therapeutic design, "Prinz and Miller (1994) found that families whose treatment focused exclusively on parent training and child behavior dropped out more often than families who had opportunities to discuss life concerns beyond child management, particularly among families facing greater adversity."[57]

Ensure services respond to the needs of different ethnic and cultural groups.

Little data describes effective mental health interventions for children who are not white and middle class. Ethnic minorities are less likely to begin a mental health intervention or complete treatment once therapy has begun. Practical considerations make it difficult for these families to attend regular sessions (e.g., transportation, cost). Beyond these practical barriers to participation, ethnic minority families often do not perceive services as culturally appropriate for them.[58] Case management, like that provided in CPP, is an important way to help poor and ethnic minority families meet very basic needs like housing and sufficient food.[59]

Some ethnic and cultural groups often have beliefs about child rearing that do not conform to mainstream expectations. Extended family, broadly defined to include people with whom the child has a family-like relationship, play an important role in many cultures.[60] In some cultures the autonomy that is promoted among young middle class white American children is not encouraged; rather children are encouraged to conform to standards established by adults.[61]

In cases involving Native American families, make sure the provisions of the Indian Child Welfare Act are followed. In every case you can ask parents if they feel they have been treated with respect. Ask attorneys and caseworkers to bring cultural factors to the court's attention, such as a family's reluctance to seek a blood transfusion for a severely anemic child. To enhance your ability to respond appropriately to diverse families, organize or participate in judicial training in cultural competence that addresses the diverse cultures represented in your jurisdiction.

Early Care and Education

Ensure children participate in positive early childhood learning experiences.

Early childhood is a time of intense growth and development in all areas, including rapid changes in motor development, cognition, and emotions.[62] All young children need positive early learning experiences to foster their intellectual, social, and emotional development and to lay the foundation for later school success. Infants and toddlers who have been abused or neglected need additional supports to promote their healthy growth and development and overcome adverse outcomes.

Early care and education encompasses nursery schools, prekindergarten programs, family child care homes, preschools, Head Start and Early Head Start, and care provided by families, friends, and neighbors. Care providers include private nonprofit agencies, for-profit companies, faith-based organizations, public schools, and in-home providers.

Early care and education programs and services are used in the child welfare setting for:

- an enrichment experience for the child;
- child care so foster parents or relative caregivers can work outside the home;
- respite care to allow caregivers time away from the children to care for themselves (e.g., when a parent has mental or physical illness issues that need to be addressed);
- oversight to allow the court or child welfare agency to watch for maltreatment in the home (biological or substitute caregiver's);
- a neutral professional setting for visitation with parent coaching;
- an opportunity for the child to be involved in consistent peer relationships and receive sensory and cognitive support that might not be available at home.

Referrals or court orders specifying early care and education programs should weigh the potential benefits and drawbacks.

Benefits:

- **Early relationships.** Early childhood education programs that promote small groups, continuity of caregivers, and individualized care can help young children who have been abused and neglected develop essential early relationships that are associated with adaptive social development.[63]

- **Caregiver support.** High-quality early care and education programs can also support foster, kinship, and biological parents by directing them to other support systems, providing information, and connecting them with other parents who can offer advice and support.[64] Comprehensive early childhood programs like Early Head Start combine home visitation and comprehensive center-based services that also provide opportunities for the parent to learn and model supportive parenting strategies.
- **Specialized services for children.** Early care and education programs can provide the specialized services that very young children in the child welfare system need, including opportunities for enhanced social-emotional health and development. In addition, therapeutic child care programs that address issues faced by abused and neglected children can ensure that these young children are receiving specialized treatment and attention.

Drawbacks:

- **Staff training.** Child care is only as good as the teachers who staff the program.[65] If staff has not received adequate training, children under their care will not receive the quality experiences that promote their healthy development.
- **Quality.** While there has been no definitive study of the quality of care available for infants and toddlers, research shows that much available care is not optimal.[66] Placing a very young child in a low or poor quality child care situation may cause further harm to a child already suffering from developmental or mental health issues as a result of abuse or neglect.
- **Staff turnover.** Even the best programs struggle with staff turnover due to very low wages. High rates of staff turnover—nearly 40% per year, nationally—mean that the warm, caring relationship between a child and teacher is frequently disrupted. The result is poor quality care and children who show lower language and social skills.[67] This instability prevents babies and toddlers from developing secure attachments to their child care providers.[68]

Carefully consider the availability and quality of early care and education settings.

Consider the following factors when deciding to place a child in an early care and education setting:

- **Can the foster parent stay home with the child?** This is typically a better option for very young children if the foster parent provides nurturing, developmentally appropriate care. Opportunities for enriched

learning experiences can be sought through facilitated play groups, museum programs, and in-home services for developmentally delayed children. The foster parent should receive training in developmental milestones and in appropriate ways to engage young children from birth and beyond so they can enrich the home environment.

- **If not, what type of program would best meet the child's needs?** Early Head Start focuses on the child in the context of his family and works to involve families. Traditional child care programs may play no role in families' lives beyond providing care for the child each day. Care provided by a neighbor may give the foster parent flexibility and provide the child with individualized care, assuming the quality of the neighbor's care is closely examined and verified (e.g., proper licensing, training, and experience).
- **How many hours per day and days per week should the child attend?** Limiting the number of hours away from the child's primary caregiver will make the transition easier for the child within a regular schedule (e.g., Monday, Wednesday, and Friday from 9:00 until 12:00).
- **Will the child be assigned to one specific primary teacher who is present most of the child's day in care?** Expanding the circle of primary caregivers to include one teacher in a safe and engaging learning environment is positive for maltreated children. Less than this level of personalized attention has the potential to add to the child's existing confusion and sense of powerlessness.
- **Does the program provide in-home services where the child and parent receive individual attention and guidance?** This training helps parents apply loving strategies to their relationships with their children.
- **Can the child care program be used as a location for visits between noncustodial parents and their young children?** Holding visits in a familiar setting makes the experience less stressful for the child. Depending how child care staff handles the visits, parent and child can engage in supported interactions and classroom activities that will strengthen their relationship and better equip the parent to care for the child.
- **Who pays for the care?** Some of the most significant issues regarding early care and education relate to access and capacity of the programs to enroll children. For example, Early Head Start is a federal entitlement program. Families whose incomes fall below the federal definition of poverty are eligible to enroll. However, due to limited funding only 3%

of eligible infants and toddlers are able to participate.[69] Public preschool programs are part-day programs that are typically offered free to children living in the school's community. Some states grant eligibility for state subsidized child care when children come into contact with the child welfare system. State child care subsidy programs are administered by multiple agencies across the 50 states. Eligibility requirements differ as do state funds available to support children in care.

Conclusion

During infancy and early childhood, the child's brain develops its capacity for trust, self-esteem, conscience, empathy, problem solving, focused learning, and self control.[70] While research continues to reveal what a child needs for healthy development throughout this period, much is already known:[71]

- All children have the capacity to learn and experience feelings from birth.
- Creating nurturing and secure early environments is essential to healthy development.
- Parental health and well-being affects children's development.
- Early and focused interventions can increase the chances of positive developmental outcomes when early childhood is disrupted.

Well-conceived interventions can minimize or even reverse the effects of damaging early childhood experiences. By arming yourself with the science of early childhood and learning about effective interventions, you can improve the outcomes for the children under your court's jurisdiction.

Endnotes

1. Perry, B.D. "Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us about Nature and Nurture." *Brain and Mind* 3, 2002, 79-100.

2. Foulds, B. et al. *Infant Toddler Module 1: Social Emotional Development with the Context of Relationships*. Washington, DC: Center on the Social and Emotional Foundations for Early Learning, 2008.

3. The field of attachment research began with the work of British psychoanalyst John Bowlby. Mary Ainsworth tested and corroborated Dr. Bowlby's theory through "strange situation" experiments where very young children and their parents were observed at separation and reunion and during the introduction of a stranger. Dr. Ainsworth documented the quality of the attachment between young children and their parents in multiple settings in the U.S. and abroad. She identified three types of attachment. Years later a student of Dr. Ainsworth's, Mary Main, identified a fourth category.

4. Karen, R. *Becoming Attached: First Relationships and How They Shape Our Capacity to Love*. New York: Oxford University Press, 1994.

5. Tartar, R.E. "Etiology of Adolescent Substance Abuse: A Developmental Perspective."

American Journal of Addiction 11(3), 2002, 171-91. Available at www.ncbi.nlm.nih.gov/pubmed/12202010?ordinalpos=33&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DefaultReportPanel.Pubmed_RVDocSum; Whitbeck, L.B. and D.R. Hoyt. *Nowhere to Grow: Homeless and Runaway Adolescents and Their Families.* New York: Aldine de Gruyter, 1999; Irving, B. and C. Bloxcom. *Predicting Adolescent Delinquent Behavior and Criminal Conviction by Age 30; Evidence from the British Birth Cohort.* London, England: Police Foundation, 2002.

6. Infant mental health disorders are defined as emotional and behavioral patterns that interfere significantly with very young children's capacity to meet age-appropriate, cultural, and community expectations for managing emotions, forming close and secure interpersonal relationships, and exploring the environment. Zeanah, C.H., ed. *Handbook of Infant Mental Health*, 2d ed. New York: Guilford, 1999; U.S. Department of Health and Human Services. *Pathways to Prevention: A Comprehensive Guide for Supporting Infant and Toddler Mental Health*, 2004.

7. Diamond-Berry, K. and L. Hudson. *Intergenerational Chemical Addiction: Improving Outcomes for Maltreated Infants, Toddlers, and Their Families.* Washington, DC: American Bar Association Center on Children and the Law & Zero to Three Policy Center, in press.

8. Lieberman, A.F. et al. "Violence in Infancy and Early Childhood: Relationship-Based Treatment and Evaluation." *Interventions for Children Exposed to Violence.* Edited by A.F. Lieberman and R. DeMartino. New Brunswick, NJ: Johnson & Johnson Pediatric Institute, 2006, 65-83.

9. Ibid.

10. Siegel, D. "The Mindful Brain: Healing in the Face of Trauma." A Conference on Childhood Trauma: Integrating Research and Practice. Mentor, OH: Crossroads, Lake County Alcohol, Drug Addiction and Mental Health Services Board, 2008.

11. "AACAP/CWLA Policy Statement on Mental Health and Use of Alcohol and Other Drugs, Screening and Assessment of Children in Foster Care." American Academy of Child and Adolescent Psychiatry, 2003. Available at www.aacap.org/cs/root/policy_statements/aacap/cwla_policy_statement_on_mental_health_and_use_of_alcohol_and_other_drugs_screening_and_assessment_of_children_in_foster_care.

12. American Academy of Pediatrics, Council on Children With Disabilities. "Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening." *Pediatrics* 118, 2006, 405-420.

13. Infant & Toddler Coordinators Association. *Infant Mental Health Approaches and IDEA Part C.* Indianapolis, IN: Infant & Toddler Coordinators Association, 2005. Available at www.ideainfanttoddler.org/ITCA_infant_Mental_Health_7_05.pdf.

14. Ibid., 7.

15. Ibid., 6.

16. Jones Harden, B. *Infants in the Child Welfare System: A Developmental Framework for Policy and Practice.* Washington, DC: Zero to Three, 2007, 169-184.

17. AACAP/CWLA Policy Statement, 2003.

18. Ibid.

19. This section includes excerpts from Smariga, M. *Visitation with Infants and Toddlers in Foster Care: What Judges and Attorneys Need to Know.* Washington, DC: American Bar Association Center on Children and the Law & Zero to Three Policy Center, 2007.

20. Goldsmith, D.F., D. Oppenheim and J. Wanlass. "Separation and Reunification: Using Attachment Theory and Research to Inform Decisions Affecting the Placements of Children in Foster Care." *Juvenile and Family Court Journal* 55(2), 2004, 1–13.

21. American Academy of Pediatrics Committee on Early Childhood, Adoption and Dependent Care. "Developmental Issues for Young Children in Foster Care." *Pediatrics* 105(5), 2000, 1146.

22. American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care. "Developmental Issues for Young Children in Foster Care." (Policy Statement) *Pediatrics* 106(5), 2000, 1145-1150.

23. Ginther, N.M. and J.D. Ginther. "Family Interaction: The Expressway to Permanency—Facilitating Successful Visitation." Presentation prepared for Western Training Partnership at the University of Wisconsin River Falls, 2005, 12-13.

24. Ohio Caseload Analysis Initiative. *Visitation/Family Access Guide: A Best Practice Model for Social Workers and Agencies*, 2005, 14.

25. Ginther and Ginther, 2005, 10, 21.

26. Wright, Lois E. *Toolbox No. 1: Using Visitation to Support Permanency.* Washington, DC: CWLA Press, 2001; Ohio Caseload Analysis Initiative, 2005, 16.

27. Wright, 2001; Ohio Caseload Analysis Initiative, 2005.

28. Goldsmith et al., 2004, 2; Wright, 2001, 28–32.

29. Wright, 2001, 23–28; Haight, W.L. et al. "Making Visits Better: The Perspectives of Parents, Foster Parents, and Child Welfare Workers." *Child Welfare* 81(2), 2002, 173–202.

30. P.L. 110-351.

31. Committee on Integrating the Science of Early Childhood Development, National Research Council and Institute of Medicine. *From Neurons to Neighborhoods: The Science of Early Childhood Development.* Edited by Shonkoff, J.P and D.A. Phillips. Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, DC: National Academy Press, 2000, 390.

32. Schuder, M.R. and K. Lyons-Ruth. "'Hidden Trauma' in Infancy: Attachment, Fearful Arousal, and Early Dysfunction of the Stress Response System." In *Young Children and Trauma: Intervention and Treatment.* Edited by J.D. Osofsky. New York: Guilford Press, 2004, 70.

33. Jones Harden, B., 2007, 56-57.

34. Boger, R.P. and A.B. Smith. "Developing Parental Skills: An Holistic, Longitudinal Process." *Infant Mental Health Journal* 7(2), 2006, 7.

35. Jones Harden, B., 2007, 46.

36. Jones Harden, B., 2007, 187.

37. Onunaku, N. *Improving Maternal and Infant Mental Health: Focus on Maternal Depression.* Los Angeles, CA: National Center for Infant and Early Childhood Health Policy, 2004, 4.

38. Office of Juvenile Justice and Delinquency Prevention. *A Judicial Checklist for Children and Youth Exposed to Violence.* Reno, NV: National Council of Juvenile and Family Court Judges, 2006. Available at www.safestartcenter.org/pdf/childandyouth_tabrief.pdf.

39. Boger and Smith, 2006, 26.

40. Larrieu, J.A. and S.M. Bellow. "Relationship Assessment for Young Traumatized Children." In *Young Children and Trauma: Intervention and Treatment.* Edited by J.D. Osofsky. New York: Guilford Press, 2004, 156.

41. Edwards, L. *Domestic Violence and the Child Protection Court.* Reno: NV: National Council of Juvenile and Family Court Judges, The Greenbook Initiative. Available at http://thegreenbook.info/documents/l_edwards_col.pdf.

42. Fitzgerald, R. "Reasonable Efforts Determinations in Co-Occurrence Cases: A Policy Discussion." *2003 Judges' Toolbox Meeting Executive Summary.* Reno, NV: National Council of Juvenile and Family Court Judges, The Greenbook Initiative, 2003. Available at www.thegreenbook.info/documents/JT_Exec_Summ.pdf.

43. Ibid.

44. Schechter, S. and J.L. Edleson et al. *Effective Intervention in Domestic Violence & Child Maltreatment Cases: Guidelines for Policy and Practice, Recommendations from the National Council of Juvenile and Family Court Judges.* Reno, NV: National Council of Juvenile and Family Court Judges, 1998.

45. Jones Harden, B., 2007, 186.

46. Hudson, Lucy, Larry Burd and Kay Kelly. *Recognizing Fetal Alcohol Spectrum Disorder (FASD) in Maltreated Infants and Toddlers and Their Parents*. Washington, DC: American Bar Association Center on Children and the Law & Zero to Three Policy Center, in press.

47. Jones Harden, B., 2007, 57.

48. Committee on Integrating the Science of Early Childhood Development, National Research Council and Institute of Medicine, 2000, 353.

49. Substance Abuse and Mental Health Services Administration. "Submissions." *National Registry of Evidence-Based Programs and Practices*, 2008. Available at www.nationalregistry.samhsa.gov/submit.htm.

50. Katz, L. "Parenting Classes: The Good, The Bad, and the Ugly." Presentation to Zero to Three Court Teams for Maltreated Infants and Toddlers Project Staff and Consultants, 2007.

51. Lieberman, A.F., R. Silverman and J.H. Pawl. "Infant-Parent Psychotherapy." In *Handbook of Infant Mental Health*, 2d ed. Edited by C.H. Zeanah, Jr. New York: Guilford Press, 2000, 432.

52. Carter, S.L., J.D. Osofsky and D.M. Hann. "Speaking for Baby: Therapeutic Intervention with Adolescent Mothers and Their Infants." *Infant Mental Health Journal* 12(4), 1991, 291-302.

53. University of Miami Linda Ray Intervention Center, Eleventh Judicial Circuit of Florida. *Miami Safe Start Initiative Replication Manual*, 2005, 14-15.

54. Lieberman, A.F. et al., 2006, 76-79.

55. Herschell, A.D. et al. "Parent-Child Interaction Therapy: New Directions in Research." *Cognitive and Behavioral Practice* 9, 2002, 9-16.

56. Ibid.

57. Ibid.

58. Lewis, M.L. and C.G. Ippen. "Rainbows of Tears, Souls Full of Hope: Cultural Issues Related to Young Children and Trauma." In *Young Children and Trauma: Intervention and Treatment*. Edited by J.D. Osofsky. New York: Guilford Press, 2004, 11-16.

59. Ibid., 33.

60. Ibid., 28.

61. Ibid., 30.

62. Committee on Integrating the Science of Early Childhood Development, National Research Council and Institute of Medicine, 2000.

63. Ibid., 309.

64. Dicker, S., E. Gordon and J. Knitzer. *Improving the Odds for the Healthy Development of Young Children in Foster Care.* New York: National Center for Children in Poverty, 2001.

65. Shonkoff and Phillips, 2000, 310.

66. See generally Vandell, D.L. and B. Wolfe. *Child Care Quality: Does It Matter and Does It Need to be Improved?* Madison, WI: Institute for Research on Poverty, University of Wisconsin-Madison, 2000. Available at http://aspe.hhs.gov/hsp/ccquality00/ccqual.htm#1.

67. National Association for the Education of Young Children. "Where Your Child Care Dollars Go." Washington, DC: National Association for the Education of Young Children, 2008. Available at www.naeyc.org/ece/1997/07.asp.

68. Committee on Integrating the Science of Early Childhood Development, National Research Council and Institute of Medicine, 2000, 235.

69. Schumacher, R. and L. DeLauro. *Building on the Promise: State Initiatives to Expand Access to Early Head Start for Young Children and Their Families.* Washington, DC: Center for Law and Social Policy/Zero to Three, 2008, 7.

70. American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care. "Health Care of Young Children in Foster Care" (Policy Statement). *Pediatrics* 109(3), 2002, 536-541.

71. Shonkoff and Phillips, 2000.

chapter 4

Achieving Permanency

Achieving Permanency

Timely Permanency and Healthy Child Development

- Plan for permanency from day one.
- Consider the rapid and multifaceted development of a very young child when determining permanency goals.

Preliminary Protective Hearings

- Determine the relative harm of nonremoval versus the potential psychological harm of removal.
- Determine if the child-placing agency has made reasonable efforts to prevent removal.
- If the child will be removed, identify appropriate caregivers.
- Seek the least disruptive, most family-like setting.
- Evaluate child care/early education options for the child.
- Devise a plan for parent-child and sibling contact.
- Request the child's medical records and order screening to identify the child's health needs.
- Identify services for the parent.

Disposition and Case Planning

- If a placement change is needed, identify the safest, most family-like placement.
- Revisit reunification.
- Identify the child's needs and available family resources.
- Assess caregiver supports.
- Require comprehensive individualized case planning in each case.
- Encourage family group conferencing.
- Ensure concurrent planning begins early in the case.
- Identify the family's service needs.
- Ensure a comprehensive visitation plan is developed.

Review Hearings

- Assess whether the issues that caused the child's removal are being addressed.
- Order additional services or reassessments for the child.
- Evaluate safety and risk factors if the child will return home.

- Determine if the substitute caregiver supports the parent toward reunification.
- Assess the visitation plan and whether changes are needed.

Permanency Hearings

- Determine if reunification is a viable permanency plan.
- Identify how reunification will affect the child in the short term.
- Ensure transition planning is part of a reunification plan.
- Determine if adoption is a viable permanency plan.
- Determine if the current caregiver can adopt the child.
- Consider ordering mediation to resolve adoption-related concerns.
- Determine if legal guardianship is a viable permanency plan.
- Determine if relative placement is a viable permanency plan, only after exploring more desirable options.
- In most cases, APPLA should not be a permanency goal for very young children.
- Hear the child's views regarding the permanency plan.
- Observe preverbal children in court to inform your decision making.
- Consider the child's developmental stage during courtroom observations.
- Determine if there is cause to extend the goal of reunification.

Postpermanency Support for Young Children and Their Families

- Ensure supports are in place to sustain reunification.
- Identify adoption disruption factors.
- Identify postadoption supports.
- Ensure postadoption supports and services are equally available to permanent guardians or long-term relative caregivers.
- Maintain family connections.

Very young children in the child welfare system require stable and nurturing caregivers and environments to encourage their healthy development. As the judge, you can promote permanency and healthy development for these children by ordering placement, services, and visitation arrangements that support their primary attachments and relationships.

Research reveals that very young children, especially infants, enter care in greater numbers than older children. Very young children are less likely to reunify with their parents, are more likely to be adopted, and experience longer stays in care.[1] Moreover, very young children reenter the child welfare system after reunification in higher numbers, especially within the first 90 days.[2]

Your leadership from the bench is essential to:

- achieve timely permanency,
- decrease foster care reentries, and
- enhance overall well-being outcomes for very young children in the child welfare system.

Timely Permanency and Healthy Child Development

The Adoption and Safe Families Act of 1997 (ASFA)[3] shortens the timeframes for making permanency decisions for children in foster care. It also requires termination of parental rights proceedings for those children in foster care for 15 out of 22 months and includes special protections for abandoned infants. Permanency is a focal point, requiring heightened reviews by judges and less opportunity for foster care drift. ASFA's push for timely permanency responds to the very young child's sense of time—especially for infants under one year old—by supporting key attachments and relationships during early child development. ASFA's requirement to advance the multiple goals of permanency, child safety, and child well-being is best approached by focusing on the child's specific developmental and emotional needs.[4]

ASFA emphasizes child well-being and the Child and Family Services Review (CFSR) measures states' performance in this area.[5] This focus on well-being is critical for very young children in the child welfare system. You can meet ASFA's requirements by using the court process to ensure early intervention and infant mental health services are provided that promote child well-being and timely permanency from the onset of the case.

Resources on Cultural Competence

Cultural competence within the dependency court allows judges, attorneys, court personnel, social workers and other stakeholders to work effectively with people from different cultures to improve decision-making and services designed to meet the needs of children and families. The cultural context of a case is more than race and ethnicity, but also includes economic status, education level, gender, age, sexual orientation, language, immigration status, disabilities, and many more factors. Cultural competence enables individuals to expand the scope of what they view as relevant facts to include the total life experiences of the children and families before the court.

Resources that can help you consider culture when making decisions for children and families include:

- **Courts Catalyzing Change: Achieving Equity and Fairness in Foster Care**
  www.ncjfcj.org/content/blogcategory/447/580/
  The National Council of Juvenile and Family Court Judges' Courts Catalyzing Change Initiative brought together judicial officers and other systems' experts and set a national agenda for court-based training, research, and reform initiatives to reduce the disproportionate representation of children of color in dependency court systems.

- **National Center for Cultural Competence**
  www11.georgetown.edu/research/gucchd/nccc/
  The National Center for Cultural Competence at the Georgetown University Center for Child and Human Development seeks to increase the capacity of health care and mental health care programs to design, implement, and evaluate culturally and linguistically competent service delivery systems to address growing diversity, persistent disparities, and to promote health and mental health equity.

- **Child Welfare Information Gateway: Cultural Competence**
  www.childwelfare.gov/systemwide/cultural/
  This site offers resources to help professionals in the child welfare system better understand and enhance their cultural competence. It provides information on working with children, youth, and families; disproportional representation of minority groups in the child welfare system; culturally competent services; training for child welfare staff; and the specific role of cultural competence in child maltreatment, out-of-home care, and adoption.

- ***Making Differences Work* (ABA Center on Children and the Law, 1996)**
  www.abanet.org/abastore/ (Search product code 5490051)
  This book by Karen Aileen Howze seeks to help attorneys and judges question the assumptions and perceptions that play an important role in how determinations about the best interests of children in the dependency court are made.

Plan for permanency from day one.

When determining permanency goals and approaches, consider the rapid and multifaceted development of a very young child discussed in Chapters 2 and 3, as well as the prevailing research about permanency outcomes and length of time in care for very young children. Your decisions at key points and hearings during the child's time in care are essential to promoting positive permanent outcomes that consider the very young child's cognitive, physical, and social-emotional development, and well-being.

The National Council of Juvenile and Family Court Judges' *RESOURCE GUIDELINES: Improving Court Practice in Child Abuse & Neglect Cases*[6] (*RESOURCE GUIDELINES*) identify key decisions and questions that judges should focus on at each stage of the court process. The following discussion about permanency for very young children looks at these and other key decisions and how they affect infants, toddlers, and preschoolers involved with the dependency court process.[7]

Preliminary Protective Hearings

Key decisions and questions for the judge:[8]

- Should the child return home immediately?
- What services will allow the child to remain safely at home?
- Will the parties voluntarily agree to participate in such services?
- Has the agency made reasonable efforts to avoid protective placement of the child?
- Are responsible relatives or other adults available?
- Is the placement proposed by the agency the least disruptive and most family-like setting that meets the needs of the child?
- Is the child placed with adults who could become the child's permanent caregivers if reunification efforts fail?
- Will the service plan and the child's continued well-being be monitored on an ongoing basis by a guardian ad litem (GAL) or court appointed special advocate (CASA)?
- Are restraining orders, or orders expelling an allegedly abusive parent from the home appropriate?
- Are orders needed for examinations, evaluations, or immediate services?
- What are the terms and conditions for parental visitation or family time?
- What are the financial support needs of the child?

Removal & Placement

Determine the relative harm of nonremoval versus the potential psychological harm of removal.

Because they are physically defenseless and in a state of rapid development, very young children are at great risk of suffering harm from maltreatment. Even so, removal from biological parents, even when fully justified and necessary, forever alters a young child's life.[9] Thus, both the maltreatment *and* the resulting removal can disrupt the very young child's development and overall well-being. When determining the need for removal, always balance safety concerns with the potential psychological and developmental harm of removal.

Determine if the child-placing agency has made reasonable efforts to prevent removal.

When removal is being recommended or has occurred, determine whether reasonable efforts to prevent the removal were made. For the very young child, these efforts should include intensive, in-home, or residential services that promote an infant's safety while allowing him to remain in the care of his parents. For families with substance abuse issues, some communities have residential drug treatment programs for mothers and their young children that support a mother's recovery and the parent-child relationship, while providing the structure and supervision to protect the child. Domestic violence shelters and transitional housing programs are often designed for a mother and her young children. These programs may have child care centers on-site or an affiliated center so mothers can work on their recovery and self-efficacy. Although less common, some jurisdictions also offer residential services for fathers and their children.[10] In these cases, the court can still take jurisdiction and closely monitor the parent's compliance with treatment and the well-being of the infant.

If the child will be removed, identify appropriate caregivers.

If reasonable efforts have been made to prevent removal or if a child's safety requires removal, finding an appropriate caregiver is essential. Whether a relative, nonrelative, or licensed foster parent, the caregiver must be physically and emotionally prepared to care for the special needs of an infant.

Ensuring Substitute Care Meets the Needs of Infants

Infants who enter foster care are vulnerable due to the maltreatment and trauma they have experienced. The type of substitute care in which they are placed, often for long periods, creates added risks when the caregivers are physically, psychologically, or financially unprepared to provide quality care. Kinship caregivers have high levels of psychosocial challenges such as stress, depression or trauma, and may face greater problems than nonrelative foster parents.

Opportunities exist to enhance the skills and understanding of caregivers and tailor caregiving environments to each infant's needs. This approach emphasizes promoting infant development through their relationships with their caregivers. Even when those caregivers are temporary, they can positively or negatively affect the infant's development.

Family foster parents and kinship caregivers should:

- Understand infant and child development and the infant's developmental needs.
- Develop infant-centered home environments.
- Partner with the child welfare agency by participating in planning meetings and advocating for the infant's needs.
- Empathize with infant experiences, past and present, and understand that infants remember and respond to memories of past trauma.
- Respect, honor, and support the multiple familial connections that infants have to their parents, former foster parents, and others. Acknowledge that these connections may affect their ability to attach to new caregivers (especially if the infant has endured multiple moves).
- Be willing to reflect on their attitudes and behaviors about children and be open to developing new skills and challenging previous assumptions and beliefs.
- Be flexible enough to adapt to an infant's irregular eating and sleeping schedules and be physically capable of lifting, carrying, feeding, diapering and bathing an infant.
- Be able to handle *dysregulated* infants (excessive crying and feeding challenges, typical of maltreated infants) and be able to respond when the infant is in need.
- Be willing to play with the infant and follow her lead and nonverbal cues.
- Be supportive of the infant's placement in a permanent home.
- Take advantage of available resources to support placement.

Child welfare agencies should:

- Provide caregivers with specific infant-oriented support to ensure an infant-centered home environment (e.g., age-appropriate toys, care items, books).

- Engage caregivers as advocates and partner with them in seeking services and interventions through other social service systems.
- Develop foster parent training that teaches how to meet the multiple needs of infants in their care and addresses knowledge, attitudes, and beliefs.
- Select foster parents based on their ability and willingness to meet the requirements in the above list. Screenings and home studies should look carefully at their ability to care for infants.
- Provide intervention programs to support the caregiver-infant relationship when they experience challenges, rather than instantly moving the infant to another foster home.
- Provide ongoing caregiver education programs that address parenting infants, with special attention to supporting maltreated or traumatized infants and creating developmentally appropriate environments for each child in their home.
- Clearly assess the substitute caregiver's ability to support reunification or become an adoptive parent or permanent guardian if reunification becomes untenable.
- Support smooth and thoughtful transitions between caregivers if such transitions become necessary for the child's ultimate permanency.

Source:
Adapted from Jones Harden, Brenda. *Infants in the Child Welfare System: A Developmental Framework for Policy & Practice*. Washington, DC: Zero to Three, 2007, 223-240. This section focuses on infants, those children birth to 12 months of age. Infants four months and younger are more likely to enter foster care and stay in care longer than any other population.

On a practical level, *all caregivers of very young children* must have:

- a crib or safe bed for the child;
- a safety-proofed home—especially for infants who are crawling and walking;
- appropriate food/formula;
- infant-safe bathing and changing areas;
- appropriate clothing and diapers;
- age-appropriate toys and books; and
- ability to meet the demanding physical and emotional needs of very young children.

Caregivers for *infants* must be prepared to:

- be woken up at night;
- change many diapers;
- wash a lot of laundry; and
- tolerate long periods of crying.

Caregivers for *toddlers and preschoolers* must:

- be able to keep up with physically active and emotionally unpredictable children;
- support toddlers' language development;
- provide safe environments in which children can exercise their new skills; and
- monitor health and behavioral signs necessary to appropriately identify potential developmental delays.

Seek the least disruptive, most family-like setting.

Early in the case, a plan for the child's 24-hour care must be laid out. A typical infant in care, especially those in kinship care, will spend some of the day with relatives, child care center staff, and/or parents. Never underestimate the importance of siblings to very young children. Thus, placement arrangements that can accommodate the very young child's siblings should be sought, especially if there is an established bond and the siblings do not act in ways that harm the infant.

Shelter or group care is not recommended for infants who have been taken into care. Not only is it not *the most family-like* setting, the shelter environment is contrary to the emotional and developmental needs of very young children.

If a relative is being considered:

- Determine from the onset whether the relative:
  - knows about the needs of very young children;
  - can manage the physical demands of caring for an infant;
  - will facilitate visitation and the parent-child bonding and attachment process;
  - is aware of the parents' challenges and any limitations placed by the court;
  - is able and willing to become a permanent caregiver if the need arises.
- Ensure the relative has help obtaining the financial support (i.e., relative caregiver funds) and/or child care services they will need to meet the infant's needs.
- Explore the possibility of the relative taking in a teen parent and the infant, especially in cases in which the parent lacks parenting skills but is interested in the infant and wants to learn how to be a responsible parent.
- Ensure a home study is completed if required. Some jurisdictions require a preadoptive home study of any relative being considered to provide substitute care to a child under age three.

- Ask about the number of children in the home, their ages, and any potential risks they may pose to the infant or toddler. While having many children in a home is not necessarily a cause for concern, be sure the caregiver can care for the intensive needs of a young child on top of other obligations.
- Assess the noncustodial parent, often the father and/or the child's paternal relatives, as potential caregivers for a very young child. Involving the noncustodial parent and his/her relatives early is an important step towards ensuring future permanency.

If foster parents are being considered:

- Assess their ability to care for very young children and their potential as long-term adoptive parents.
- Find out about the number of children in the home, their ages, and any potential risks they may pose to the infant or toddler.
- Determine the foster parent's ability to provide frequent visitation to the biological parent(s).
- Get assurance from the child-placing agency that the foster parent will support and involve the biological parents, to the extent possible, in reunification efforts. Experienced foster parents can be strong parent educators if they have the right mindset towards the biological parents.
- If the parent is a youth in care, explore whether the foster caregiver will accept the youth together with her infant.

Evaluate child care/early education options for the child.

At the preliminary protective hearing, assess the quality of any proposed child care setting and early education programs. Many jurisdictions use county or state quality rating systems with Web-based access to a child care center's rating. (See Chapter 3 for more information.)

Devise a plan for parent-child and sibling contact.

Maintaining contact between very young children and their parents helps them develop attachments during the child's first year of life. While frequent contact between a child and parent may be perceived as a burden by caseworkers and foster parents, it is one of the best predictors for successfully reunifying very young children.[11] If a very young child is not placed with his or her siblings, consider sibling visits and opportunities to support the sibling bond, especially for toddlers and preschoolers who may perceive their older siblings as caregivers.

Consider requiring an immediate 'contact conference' or meeting where parents, caregivers, family members, child care providers, service providers, GALs/CASAs and case managers develop a plan for visitation and family time that spreads the supervision and transportation responsibilities among multiple individuals. This plan should also account for preexisting formal or informal visitation agreements between the child and his noncustodial parent, siblings, and relatives.

Research shows breastfeeding can enhance the bond between mother and child and has some health benefits. Nursing mothers should be encouraged to continue nursing their infants, if possible. Parent-child contact and placement arrangements should support their efforts to breastfeed, if the safety of the infant is not jeopardized. Additionally, nursing mothers who wish their infants to have breastmilk should be able to provide it to the substitute caregiver and expect it to be fed to the infant when feasible and safe unless it is not advised for medical reasons.

Request the child's medical records and order screening to identify the child's health needs.

Many infants and young children enter the child welfare system with significant medical and/or developmental delays and challenges, or such issues emerge while they are in the system. Achieving permanency requires addressing these needs early. As discussed in Chapter 3, all states have early intervention systems that identify and address developmental needs of very young children.

At the first point of contact with a very young child, order:

- records of all screenings performed at birth as well as a Part C screening for children ages zero to three (see Chapter 3 discussion of developmental screenings);
- screenings for fetal alcohol spectrum disorders and any other effects of in utero substance exposure; and
- medical and dental screenings and oral health care for the child (see Chapter 2).

Identify services for the parent.

As the *RESOURCE GUIDELINES* suggest, services to address a parent's most pressing issues should be offered from the onset of the case. Typically, substance abuse, mental illness and/or domestic violence cause the need for removal. Often, these issues co-occur, requiring intensive, sometimes residential, interventions. Once a parent is screened and engaged in treatment to address specific needs, he or she may require further skill building or support related to parenting their very young child. Parenting courses, support groups, or parent coaches/mentors can help.

Disposition and Case Planning

Key decisions and questions for the judge:[12]

- What is the appropriate statutory disposition of the case and long-term permanency goal for the child?
- Is the child placed with adults who could become his permanent caregivers?
- Does the agency-proposed case plan reasonably address the problems and needs of the child and parent?
- Has the agency made reasonable efforts to eliminate the need for placement or prevent the need for placement?
- What, if any, child support should be ordered?
- When will the case be reviewed?

Placement

If a placement change is needed, identify the safest, most family-like placement.

Ideally a very young child will remain in the same placement while in care, and beyond if reunification is not achieved. However, sometimes it is necessary to change a child's initial placement at the disposition hearing or at other points during the child's time in care. Assess why the placement is changing. Is the change for convenience or to better meet the child's needs? Could the placement be preserved if the child and/or caregiver received more support or services?

Revisit reunification.

Before moving an infant or toddler to another foster or relative placement, assess whether reunification is safe. Evaluate whether the parent is engaged in services, consistent and attentive during visitation, and capable of caring for the child's daily needs. Also assess the special needs of the child—does he have multiple treatments or therapies and/or special medical needs? Can the parent handle these needs now or does the parent need further training, support, or services? Have the safety issues and risks been significantly reduced or eliminated?

Identify the child's needs and available family resources.

Determining the best placement depends on the specific needs of the child and the family resources available. For infants, toddlers, and preschoolers, any placement in a 24-hour group setting is not appropriate.[13]

One tool for identifying family resources is *family finding*. In this intensive process, caseworkers and/or dedicated staff search for family members or family-like connections for children in foster care. This process often involves reading every paper in a child's file and performing targeted internet searches to identify relatives. Meetings between family and the children are arranged to develop family connections. Often, these family members did not know the infant existed and are willing to step forward as potential permanent caregivers or to support the biological parents. Even when placement does not take place, the contacts are critical for young children in care and may be key to maintaining connections to their family and cultural heritage and traditions.[14]

Assess caregiver supports.

Because very young children have intensive needs, substitute caregivers will need supports. Ask these questions:

- Does the caregiver need time away from the child and respite care?
- If available, have relative caregiver funds been applied for?
- Is the infant receiving all entitlements for which she is eligible?
- Are parents providing financial assistance or support in other ways (e.g., purchasing diapers, infant care products, furniture, and clothing)?
- Is child care needed and/or established?

These supports help maintain a very young child's placement and enhance her ability to form healthy attachments, feel safe, and receive consistent and positive care.

Case Planning

Require comprehensive individualized case planning in each case.

Effective case planning achieves positive outcomes for all children in the child welfare system, especially very young children who are likely to have long stays in care. The more comprehensive and inclusive the case planning, the more likely the plan will address the family's deficits and improve its strengths.[15] For parents of very young children in care, many of whom are just becoming adults themselves, full engagement in the process is essential to achieving reunification. Assessments and screenings should be the starting point for what a child and family need, but the case plan embodies the family's strengths, behaviors, needs, conditions and contributing factors.

Encourage family group conferencing.[16]

Family group conferencing (FGC) or another structured process often aids successful reunification and speeds permanency for very young, vulnerable children. FGC brings together extended family, friends, and others to help the parents develop a plan to protect children and strengthen their caregiving abilities.

Benefits of FGC include:

- increased parent motivation and buy-in to the service planning and implementation process;
- more stable placements;
- improved case-processing times;[17]
- fewer children living in out-of-home care; and
- increased kinship placements.

Although special skills and efforts to engage the family and community are required for effective FGCs, the investment in training and expertise often speeds permanency outcomes for very young children.[18]

Ensure concurrent planning begins early in the case.

ASFA encourages concurrent case planning in permanency planning practice. Originally developed for younger children who were at risk for foster care drift, concurrent planning replaces the sequential approach to case planning.[19] An alternative permanency goal is pursued at the same time as reunification. In some jurisdictions, foster parents are specially trained to serve as *resource parents*—able to support the biological parents' efforts towards reunification, but also able and willing to become adoptive parents if reunification efforts are unsuccessful.[20]

Concurrent case planning works well with young children.[21] Resource parents of very young children are often positioned to become role models for the biological parents, serving as parenting coaches and mentors. Because the lines of communication and interaction are much more open, parents can be more involved in the daily lives of their infants and can learn from more seasoned foster parents. When reunification is not possible, the foster parent or relative is prepared to care for the child long term and essential attachments to primary caregivers are not interrupted by a change in permanency goal. Additionally, the relationship between substitute caregiver and parent may diminish the need for litigation and increase voluntary relinquishments. Optimally, when reunification is not feasible, this less acrimonious process allows the infant to maintain relationships with the key people in his life, even after adoption.

How Concurrent Planning Benefits Very Young Children[1]

Very young children are the least likely to be reunified and the most likely to be adopted. They also remain in care longer than their older counterparts. Concurrent planning, encouraged by ASFA, can support timely permanent outcomes while reducing young children's time in care. For concurrent planning to succeed, foster/adoptive families (also called resource families), must understand and distinguish between their multiple roles. They must be willing to make a long-term commitment to the child and mentor the birth family toward reunification. Two successful approaches to concurrent planning are discussed below.

Increasing Timely Permanency

Colorado's concurrent planning model began in the early 1990s and involves caseworkers who are intensively trained on concurrent case planning. Legislation supports expedited permanency, and state procedures and financial supports encourage frontloading services to families. Some jurisdictions use these supports to implement family group conferencing, family team meetings, or to purchase substance abuse or mental health services. Some jurisdictions assign two caseworkers to each family—one for the child and one for the parents.

Outcomes are favorable:

- 82% of children served attain permanency in one year.
- An additional 18% of children achieve permanency in around 15 months.
- Of 522 children for whom placement data was available:
  - 77% were permanently placed within their family system, with more than 41% returning to the parent from whom they were removed;
  - 9% were placed with another parent; and
  - 26% were placed permanently with relatives.[2]

Decreasing Length of Stay

San Mateo County, California's concurrent planning practices developed from a family preservation model that the county began in 1980. Recognizing the growing numbers of very young children who were not being reunified, the county began using the foster/adoptive parent model. This model emphasizes identifying permanency resources early, fully involving the birth family, and committing to strong reunification efforts, including assessing the family's prognosis for reunification.

Data show that San Mateo County attains permanency for its children faster than the state as a whole:

- 74% of children were reunited within 12 months, compared with 65% statewide during 2003-2004.
- Equally important, 47% of adopted children achieved permanency within 12 months compared with 27% across the state.

The success of this model is attributed to buy-in from the child welfare administration and staff, the courts, and the community. Program managers stress that involving court and agency staff when designing and implementing the process is key.[3]

Sources:

1. This discussion was drawn from Child Information Gateway. *Concurrent Planning: What the Evidence Shows*, Washington, DC: U.S. Department of Health and Human Services, April 2005. Available at www.childwelfare.gov/pubs/issue_briefs/concurrent_evidence/index.cfm.
2. For more information about the Colorado model, contact the Child Welfare Division of the State Department of Human Services, 303/866-3278.
3. For more information about the San Mateo County model, contact San Mateo County Human Services, Children & Family Services—East Palo Alto Office, 650/363-4185.

Services

Identify the family's service needs.

Families and young children in the child welfare system have different strengths, challenges, and support systems. Thus, services will vary and should be tailored to each family's circumstances. Most very young children and their families involved with the child welfare system need services beyond those for substance abuse, domestic violence, or other critical needs. Such services may include child development and trauma reduction services, and treatments or interventions for the child. Because infants develop within the context of their primary relationships, interventions related to bonding and attachment, such as Child-Parent Psychotherapy, may be necessary for both the infant and parent. Many services for very young children are discussed in other chapters of this book.

Assessment-driven services

As with case planning, service needs should be driven by early assessments and screenings. It should be clearly stated who is responsible for taking an infant to therapies, treatments, doctor appointments, etc. The primary substitute caregiver and/or the parent should be required to support the infant during treatments and procedures and provide the treating professional with up-to-date information about the child.

Parenting courses

Once a parent has begun engaging in services to address the issues that brought the child into care, she can benefit from a comprehensive evidence-based parenting course. Parenting programs come in many shapes and sizes. Ideally, a parent of a child under age five should be enrolled in an evidence-based parenting program that includes a parent-child interactive component. Structured preservice and postservice behavioral observations and paper/pencil pre/post standardized and validated measures (e.g., the Adult Adolescent Parenting Inventory—AAPI) are useful tools for determining strengths and weakness and measuring growth over time.[22] Learning how to be a nurturing and safe parent is a dynamic process. An evidence-based parenting program can significantly improve a parent's caregiving abilities. Parents must be aware of basic child development as well as their roles and responsibilities in their child's life.

Features to look for in a parenting program for parents of very young children include that it:

- addresses areas specific to parenting very young children;
- uses a variety of teaching methods to accommodate different adult learning styles;
- emphasizes hands-on experiences (e.g., roleplaying, structured interaction with their child);
- assesses whether a parent is internalizing the information and can put what she has learned into practice rather than simply reporting on parent attendance;
- uses parenting facilitators to identify and build upon strengths and identify where a parent's lack of skills or knowledge can potentially harm a very young child; and
- respects the family's cultural identity.

Parenting programs geared for parents of very young children will target the skills and concepts needed to nurture, care for, and cope with the rapidly changing physical and emotional state of children ages zero to five. If a parent has other children over age five, the professionals in the case should consult and determine whether it is best to refer a parent to a parenting program that addresses the needs of each age range or focuses on younger children. The best programs tailor the course to the individual needs of the parent and his/her children.

Services for parents should target challenges that brought the family into the system and support their ability to connect with and care for their very young child. Despite the constraints of ASFA's timeframes, it is essential that parents of young children are not overburdened with multiple services and case plan

requirements simultaneously. Rather, stagger services and ensure high quality, effective interventions are in place. Meanwhile, encourage parents to focus on quality interactions and visits with their child, and their ability to develop a safe, stable home environment.

Visitation and Family Time

Ensure a comprehensive visitation plan is developed.

Children develop within the context of their relationship with their primary caregivers. Children who are placed in care when they are between birth and three years of age are unable to use words to express their distress over losing their parents and often experience emotional disturbances.[23] Consistent contact between the parent and child increases the possibility of reunification, promotes healthy parent-child attachment, and mediates the negative effects of removal.[24] Visitation, or supervised visitation if appropriate, should be permitted unless the court determines that such visitation would place the child's life, health, or safety at risk. Family visits should take place in the least restrictive, most natural setting that can ensure the safety and well-being of the child.[25]

Quality visitation plans between young children, their parents, siblings, and extended family members directly relate to ASFA's requirement of timely permanency and reasonable efforts requirements. Visitation helps develop and support a parent's ability to care for the child. Consistent and positive interactions between a child and his or her parents indicate that a family is moving towards reunification. Likewise, inconsistent and negative parent-child contact shows a need for further service planning and interventions, addressing barriers to visitation, or reevaluating the permanency goal for the child. A well-crafted and supported visitation plan is essential to achieving permanency.[26]

Contact between parents and young children must be:

- frequent (multiple times a week);
- long enough to allow a range of experiences for the parent and child;
- consistent;
- connected to daily activities;
- in the least restrictive, most home-like setting; and
- conducive to meaningful parent-child interaction.

Because a normal parent-child relationship develops during daily activities such as diaper changes, dressing, bathing, and trips to the grocery store, visitation should not be the only activity to encourage a normal parent-child relationship. Judges should encourage parents to participate in scheduling and attending their child's doctor or specialist appointments and to interact with child care

Visitation and Permanency Planning

Visitation—"the heart of permanency planning"—is a key strategy for reunifying families and achieving permanency. To preserve and strengthen parent-child attachment, promote permanency, and reduce the potentially damaging effects of separation, attorneys who represent very young children in foster care or their parents should make visitation that ensures the child's safety and well-being a focus of their advocacy. Because children in foster care often come from families where the parent-child attachment is unhealthy, visitation should be viewed as a *planned, therapeutic intervention* and the best possible opportunity to begin to heal what may be a damaged or troubled relationship. In addition, visits offer a real-life opportunity to view parental capacity and provide critical information to the court about the parent-child relationship. In this regard, visitation is a *diagnostic tool* to help determine as quickly as possible if reunification is the best permanency option for the child.

Because the term *visitation* does not adequately describe the quality and quantity of time that families need to spend together when children are removed from the home, child welfare experts have begun using other terms, such as *family time*, *family access*, and *family interaction*. Research shows that regular, frequent visitation increases the likelihood of successful reunification, reduces time in out-of-home care, promotes healthy attachment, and reduces the negative effects of separation for the child and the parent.

Source:
Excerpted without citations from Smariga, Margaret. *Visitation with Infants and Toddlers in Foster Care: What Judges and Attorneys Need to Know*. Washington, DC: ABA Center on Children and the Law & Zero to Three, 2007. Available at www.abanet.org/child/policy-brief2.pdf.

providers. This supports reunification and helps the parent develop working relationships with health and child care providers.

When there are concerns about healthy attachment between a very young child and his parent, therapeutic visitation or Child-Parent Psychotherapy (CPP) may be appropriate. CPP is a relationship-based psychotherapy facilitated by a trained infant mental health clinician. It uses a structured therapeutic process to support healthy attachment and reciprocity between a parent and her very young child.[27]

A parent's incarceration should not prevent parent-child contact. If contact is in the child's best interests and can be safely arranged, especially if the parent is not a threat and is a potential long-term caregiver, efforts should be made to promote visitation. Some correctional institutions have units that allow mothers and their infants to stay together or special areas for very young children and their

parents to visit in person. At the very least, photographs should be exchanged. Telephone, video conferencing, or other creative uses of technology may be appropriate depending on the child's age or developmental level.[28]

Visitation plans must be clearly described in the case plan and all involved in the case need to understand one another's roles and responsibilities regarding visitation. Parents, caseworkers, relatives, foster parents, and other providers of family support should be expected to help develop the visiting arrangements and support the plan.

Review Hearings

Key decisions and questions for the judge:[29]

- Is there a need for continued placement of the child?
- Does the court-approved, long-term permanent plan for the child remain the best plan?
- Is the agency making reasonable efforts to rehabilitate the family and eliminate the need for placing the child?
- Do services set forth in the case plan and the responsibilities of the parties need to be clarified or modified due to new information or changed circumstances?
- Is the child in an appropriate placement that adequately meets all physical, emotional, and educational needs?
- Do the terms of visitation or family time need to be modified?
- Do terms of child support need to be set or adjusted?
- Are additional orders needed to move the case toward successful completion?
- What timeframe should be set to achieve reunification or another permanent plan for the child?

Assessing the Permanency Plan

Assess whether the issues that caused the child's removal are being addressed.

The review hearing evaluates whether the parent is sufficiently engaged in remedial and supportive services and if those services continue to be appropriate. Although much focus is on parents and their compliance with the case plan, it is important to assess whether the child-placing agency has offered appropriate services to remedy the problem that caused the child to enter care.

Obtain information from service and treatment providers who have assessed the parent's progress and who can give information about the quality of parent-child interactions. If structured parent-child observations are occurring through therapeutic visitation or CPP, request the professional's assessment of the parent's ability to read the infant's cues, respond to the verbal child's request, or to follow their child's lead during play time. For example, ask case managers or relatives who supervise visits and other contact whether the parent talks to her infant, sets limits for the active preschooler, and responds appropriately and safely to a toddler's temper tantrums. This information will help determine whether the parent has internalized the skills and knowledge from her parenting program, therapy, or anger management course.

Therapists and other service providers should be encouraged to attend the review hearings or to submit a report detailing the parent's progress. At review hearings, directly address the parents and ask them to share what they have learned through their courses and any insights they have gained through their therapeutic interventions about how their choices and behavior affect the well-being of their young child.

Order additional services or reassessments for the child.

At each review hearing, determine whether the child is receiving necessary services and interventions to mitigate the impact of the maltreatment and support healthy growth and development while in care. Specific recommendations regarding these services are covered in previous chapters. An infant who entered care at two months of age is a completely different child at the first review hearing. By this point in the infant's development, he may be sitting up, starting to eat solid foods, or even be crawling. Deficits in performing normal developmental tasks may become more pronounced than when the case plan was first created and the infant was first assessed. Thus, judges can use the review hearing to order another developmental screen—such as the Ages & Stages questionnaire[30]—to identify developmental delays.

Evaluate safety and risk factors if the child will return home.

If reunification is being considered at this stage, safety and risk factors surrounding the return must be evaluated. Some tools to help focus the inquiry when very young children are involved include:

- **Quality observations of parent-child interactions and reports** from substitute caregivers, caseworkers, and service providers about

the parent's ability to respond to the infant's needs and cues are essential. If no structured process for observing parent-child interactions (discussed earlier) exists, consider ordering such an observation by a skilled infant mental health specialist.

- **Observations regarding the parent's knowledge, skills, and ability to put these into practice** from all who observe the parent and child together. Their insights are good indicators of whether the infant will be safe and cared for upon his return to his parent.
- **Information about availability and use of intensive home-based services to support reunification.** A prereunification family group conference (discussed above) can identify and assess the family and community supports a parent can use when feeling overwhelmed or in need of assistance.
- **A clear plan identifying family and community resources that will support reunification** if intensive home-based services are not available.

If risk factors are present at the review hearing, evaluate the family's engagement in services and the kind of support they have been offered.

Seek information about why a parent is not engaged in services:

- Is transportation or logistics an issue?
- Do the services conflict with the parent's employment or education?
- Are the services still appropriate or have the parent or child's needs changed?
- Is the substitute caregiver working with and mentoring the parent or is she impeding the reunification process? If so, what are the substitute caregiver's concerns and suggestions to remedy them?

Parents of young children are also in a constant state of transition—learning new skills and modifying old ones—and they may need different services and supports than those anticipated five or six months ago.

Determine if the substitute caregiver supports the parent toward reunification.

Assuming a concurrent case plan is in effect, the review hearing offers an opportunity to address whether the caregiver supports the parent toward reunification. Seek assurance that the substitute caregiver remains able and willing to be a permanent caregiver if reunification is not likely. Address any service and support needs of the substitute caregiver as well. As an infant grows and develops into an active toddler, a caregiver who enjoys caring for infants may not be able to

Infant Visiting Checklist for Family Court Judges

Visiting Plan

- What is the current visiting arrangement? (Where? How frequent? How long? Who is present? Level of supervision?)
- Is this visiting plan frequent enough to build attachment between the infant and parent?
- Does this visiting arrangement allow the parent to parent? This includes changing and feeding the infant; learning about the infant's cries, habits, and growth; and keeping the child safe in real-life situations.
- Was the purpose of visits clearly communicated to the parent (meet the infant's needs, stimulate the child's growth and development, communicate love for and enjoyment of the child to the child, ease the toddler's adjustment to separation)?
- What are the beginning and the end of the visits like (infant's response, parent's response, source of this information, possible reasons for assessment if any negative reports, changes over time, efforts to ease the transition)?
- If there are other children living separately from the infant, have sibling visits been set up?

Evolution

- How long has this visiting arrangement been in place? If more than three months, why hasn't the arrangement progressed? Answers should be child-related (e.g., safety or developmental concerns) or related to the parent's ability to meet the child's needs—not punitive (e.g., parent has not followed through with referrals or completed service plan, parent relapsed three months ago).

Permanency

- Is this visiting plan moving the court closer to achieving the permanency goal? Whenever possible, are the visits close to real-life situations that will allow the parent to address real-life parenting challenges?

Parental Participation in Child's Life

- Is the parent participating in the infant's medical appointments, early intervention services, and other activities?
- Has attention been paid to arranging visits on birthdays, holidays, anniversaries, and other special occasions that may be important to the child, parent, and family?
- Is mutual communication facilitated between the parent and the foster parent regarding the infant's habits, routines, behavior, preferences, and development/growth?

Limiting, Suspending, or Terminating Visits

Unless there is imminent risk to the infant's safety or well-being or evidence of visit-based harm, before suspending or limiting visits, consider the following:

- What is the basis of this request?
- Has adequate time and explanation of attachment building been given to the parent? Has the parent been encouraged to persistently, actively, and patiently build attachment with the infant? Have efforts to slowly wean the foster parent out of the visits been tried?
- For parents with substance abuse issues: Has the caseworker or substance abuse counselor discussed the expectations, parameters, and purpose of visits with the parent? Have they discussed relapse prevention to address the difficult underlying issues visits may present?
- If due to the parent's inconsistent attendance at visits: What efforts have been made to identify the reasons for irregular attendance? Have there been efforts to engage and support the parent to build an attachment with and parent her/his infant?
- If parental ambivalence toward resuming full-time care of the infant is assessed (including cases where the parent has prior termination of parental rights), has a referral for counseling about options been made?

Source:
Adapted with permission from Dicker, Sheryl and Tanya Krupat. "Permanent Judicial Commission on Justice for Children Infant Visiting Checklist for Family Court Judges." Unpublished draft. New York State Permanent Judicial Commission on Justice for Children, 2006.

supervise or care for a bustling two year old. She may require assistance enrolling the toddler in a quality early care and education program or financial assistance to buy a bed when the crib is no longer safe (especially for those toddlers who like to climb out in the middle of the night).

Modifying Visitation

Assess the visitation plan and whether changes are needed.

Review hearings are a good time to assess the quality of visits and explore whether changes are needed. Suspending visits between a developing infant and the parent when the parent is not participating consistently in visitation may significantly impact the relationship. Unless the child is at risk of harm or the visits have already harmed the child, it is important to understand why a parent is inconsistent with visitation. If a parent is ambivalent towards visitation after efforts to engage, encourage the parent to discuss available options with a therapist and attorney.[31]

If safety issues are not a concern, unsupervised contact or a living arrangement that allows around-the-clock contact (i.e., teen mother living in foster care with her infant; a residential treatment program; or a grandparent who has custody of the child and is allowed to have the parent reside in her home) may be the best way to support the infant's attachment to her primary caregiver while ensuring her safety. However, because many children in the foster care system generally do not experience healthy attachment relationships, visitation is ideally understood as a 'planned, therapeutic intervention' and should be constructed as such.[32]

If parent-child contact must be supervised for the safety of the child, such visits should be in as natural an environment as possible with age-appropriate toys that encourage parent-child interaction.[33] The supervisor should model appropriate parenting when a parent is struggling to interact with the child or behaving inappropriately. Supervisors need to be sensitive to the emotional needs of the infant and the parent related to their separation. If a parent does not understand his infant's needs or does not respond to the infant's cues, CPP should be considered.

Visitation logistics should be reassessed often. Is the parent struggling with visiting three different children in three locations? Is the visitation time interfering with the toddler's nap time? Is the parent able to juggle older children who are seeking her attention and a new infant who needs her focus as well? Because visitation is key to promoting attachment and bonding, extra care and attention should be devoted to ensuring the arrangements are feasible and promote successful parent-child interactions.

Permanency Hearings

ASFA prioritizes permanency options for children as follows:

1. reunification
2. adoption
3. guardianship
4. placement with a fit and willing relative
5. another planned permanent living arrangement (APPLA)

At the 12-month permanency hearing, judges must make key decisions about a child's permanent custody and specific dates for finalizing those arrangements. Judges must also determine whether to extend a child's stay in care for a specific period while continuing to pursue reunification with the parent(s).

Making a permanency determination for very young children after 12 months in care can be difficult. If permanency planning begins at the start of the case, the answer should be clear. For example:

- A parent who has engaged in services, visited intensively with her infant, and participated actively in her infant's early intervention and early care and education services should have already regained physical custody of her child by this stage. If not, the parent should be ready to regain custody at the permanency planning hearing.
- Adoption is optimal when a parent has not engaged in services or visitation or remedied the circumstances that brought the child into care. Ideally, the infant or toddler's substitute caregiver supports reunification and is willing to adopt if reunification becomes implausible. Often in this circumstance, a parent voluntarily relinquishes her parental rights and the adoptive parent allows ongoing contact.

These are the easy scenarios, when things fall into place naturally because planning, services, and supports started early and were reassessed and updated regularly. What is the best decision-making process when it is not as clearcut as these scenarios?

Reunification

Determine if reunification is a viable permanency plan.

Reunification is the preferred permanency option if the parent can keep the child safe and well. There is little research about the decision-making process related to reunification and what contributes to a *successful* reunification, especially when very young children are involved.[34] We do know that infants have the highest rate of postreunification maltreatment, with one in five reentering foster care, usually within 90 days.[35] These findings underscore the need to be careful and clear about carrying out this permanency option.[36] Factors that impact decisions to reunify a parent with a very young child include:

- quality of relationship between the parent and child;
- quality and frequency of parent-child interactions;
- parental compliance with services and benefits attained;
- long- or short-term special medical or developmental needs of the young child;
- parent's demonstrated understanding of the infant's needs;
- parent's capacity to meet the infant's needs;
- family and community supports available to support a parent and child;
- if there are siblings, the parent's track record in assuring the siblings' school attendance, medical appointments, and any required treatment;
- parental mental health and addiction issues;

- length of time out of the parent's care; and
- point at which the infant was removed (e.g., at birth, six months).

Identify how reunification will affect the child in the short term.

Research shows that for infants, changing caregivers is traumatic.[37] Reunification, or any transition, can have harmful short-term effects on the child, especially for those children between the ages of six and 24 months old.[38] Infants often form secure attachments to substitute caregivers who have loved them and have attended to their daily needs. The person an infant trusts most to continue caring for him is naturally the person who has been changing his diapers, feeding him, bathing him, putting him to bed, and so forth. Because an infant cannot understand why things have changed, removal from his substitute caregiver—even to a parent with whom there is a healthy attachment and relationship—may cause distress similar to the initial removal. Removal from substitute care often changes the infant's daily routine—a common source of security for the child. The longer the infant has been in out-of-home care and the more intense the attachment and sense of security associated with that placement, the more psychologically difficult the reunification process.[39] Supportive therapeutic services and transition planning must be considered to promote a successful reunification.

Ensure transition planning is part of a reunification plan.

To avoid another traumatic life event for the infant, *transition planning* should be part of any plan for reunification. Ideally, when reunification is the goal, parents and substitute caregivers will have developed a working relationship, allowing the young child to attach with both caregivers and to observe her primary caregivers connecting with each other.[40]

Any effort to increase the parent's daily caregiving and to nurture the relationship between the child and parent will support a smooth transition. The parent should begin taking on more tasks of daily care through increased visitation or involvement in the substitute caregiver's home. If comfortable, the substitute caregiver could visit the parent's home with the infant on the first few in-home visits, if those have not yet started. Maintaining the status quo in other aspects of the infant's life during the transition phase—child care, therapists, babysitters, doctors—can ease the process and minimize any distress. Finally, ensuring that the parent is aware of the infant's schedule and routine and has a plan to reinforce some of this structure may help the infant better cope with the changes.

Adoption

Determine if adoption is a viable permanency plan.

When a child will not reunify with a parent, adoption is the next best permanency option. In fact, infants represent 48% of adopted children.[41] For an infant who is attached to a foster parent or relative, adoption can formalize this primary relationship in the infant's life. Data on outcomes for infants adopted from the child welfare system are scarce.[42] That said, infants who have been adopted from the child welfare system exhibit better outcomes than their counterparts who remain in care, although this may be due to the instability of foster care rather than the adoptive family.[43]

For infants not already placed with caregivers who are able and willing to adopt (or take some other form of long-term legal guardianship), legally freeing the infant for adoption through a termination of parental rights (TPR) proceeding often extends the time he will spend in care. Once the TPR is finalized, children without an identified adoptive parent may remain in legal limbo while one is identified. One study found that "a surprising number of infants who are placed in child welfare care are neither reunified with their families nor readily placed in alternative permanent homes."[44]

These findings speak to the need to concurrently plan for reunification and possible long-term permanent placement with a specific substitute caregiver from the start of the case. After a TPR, the court should hold frequent review hearings—every two to three months—to determine whether sufficient efforts are being made to identify and secure an adoptive home for a legally free young child.

Determine if the current caregiver can adopt the child.

If adoption is the desired permanency option, confirm that the current caregiver:

- is willing to adopt, and
- would be approved as an adoptive parent.

If concurrent planning was implemented on day one, and if an adoption quality home study was conducted at the start of the case, these critical questions will already be answered. Furthermore, if an extensive search and review of relatives took place early in the case, as some state laws and now federal law require,[45] the child's 'preadoptive' placement should not be disrupted by relatives who step forward after the TPR stage. Remember, there is great psychological risk to disrupting a child's secure attachments without compelling evidence that doing so is clearly in the child's best interest.

If the current caregiver no longer wishes to adopt, determine whether she would be willing to be a permanent guardian through a legal guardianship proceeding (see below). Also assess the caregiver's ability and desire to adequately care for the infant as he grows. If the current caregiver is unwilling or unable to care for the child permanently, require the state to provide a full analysis of other immediate permanency options through adoption or guardianship with family members or nonrelatives.

Consider ordering mediation to resolve adoption-related concerns.

Once a TPR petition is filed, it may be beneficial to order the parties to attend mediation. Mediation can clarify issues in the case, help parents decide whether voluntarily relinquishing their parental rights is in their best interest, and explore whether open adoption will take place. If an infant is with a relative or foster parent who is willing to permit informal or formal (through an open adoption) postadoption contact between the biological parent and/or family, a voluntary relinquishment will speed the TPR process and allow for adoption.

Legal Guardianship

Determine if legal guardianship is a viable permanency plan.

Legal guardianship is defined by the ASFA regulations as "a judicially created relationship between child and caretaker which is intended to be permanent and self-sustaining as evidenced by the transfer to the caretaker" of certain parental rights, "with respect to the child" including "protection, education, care and control of the person and decision making."[46] A relative or nonrelative can become a legal guardian and, according to ASFA, that legal guardianship must be binding beyond the jurisdiction of the court hearing the dependency case. In some states, legal guardianship dissolves the dependency court's jurisdiction altogether.[47]

Legal guardianship is a good alternative to adoption when there are no grounds for TPR and a caregiver is willing to serve in this capacity permanently. Establishing a permanent legal guardianship for a very young child rather than a nonpermanent arrangement with a relative benefits an infant or toddler in the long run. Many relative caregivers prefer this option over adoption because they do not want the parent's rights to be severed or to be a part of an adversarial termination of parental rights process. Judges can ask about the relative's ability—physically and emotionally—to care for a very young child through the age of majority.

Federal law now permits states to enter into kinship guardianship assistance agreements with relatives who are serving as foster parents to their kin using Title IV-E funds.[48] This means that relative caregivers in this circumstance could continue to receive foster care maintenance payments, even after a permanent guardianship is established.

Permanent guardianship may be a good alternative for a developmentally delayed or very young parent. This option supports permanency, but allows a parent who is incapable of change for reasons beyond their control (e.g., cognitive delay) to retain her rights and to actively contribute to her child's upbringing. Additionally, children of parents with disabilities may be entitled to certain benefits, and terminating the legal relationship would end the child's right to receive such benefits (e.g., social security disability payments).

Placement with a Fit and Willing Relative

Determine if relative placement is a viable permanency plan, only after exploring more desirable options.

If neither reunification, adoption, nor legal guardianship is in the best interests of the child, next consider a placement with a fit and willing relative. Although the relative must commit to caring for the child until the age of majority, this option is akin to legal limbo for very young children. In fact, the preamble to ASFA states that "relative placements should not preclude consideration of legalizing the permanency of the placement through adoption or legal guardianship."[49] State statutes typically do not allow this permanency option unless certain conditions are met. States must continue to supervise the placement and the court must review the case regularly (i.e., every six months) and conduct permanency hearings to reevaluate the possibility of adoption or legal guardianship.

For very young children, placement with a fit and willing relative should only be accepted when a more legally permanent arrangement is not in the child's best interest. Judges should require regular updates on efforts to identify an adoptive parent or to help the relative seek a legal guardianship. Additionally, because this option does not preclude a parent from regaining custody, judges should closely consider the same questions that would be asked when assessing reunification.

Another Planned Permanent Living Arrangement (APPLA)

In most cases, APPLA should not be a permanency goal for very young children.

ASFA was developed to prevent children from living their lives in foster or group homes. The preamble advises that long-term placement in a licensed foster home should be the very last resort, and the regulations require the state to document a 'compelling reason' for choosing APPLA as a permanency option.[50] These compelling reasons as applied to very young children may include:

- when a parent and child share a significant bond, but the parent is unable to care for the child due to an emotional or physical disability, or
- when an Indian tribe has identified another planned permanent living arrangement for the child.[51]

APPLA is not a suitable permanency outcome for a very young child. Even when the parent is disabled and unable to care for a child to whom there is a significant bond, the judge should ensure the foster parents are informed of the benefits of becoming the child's adoptive parent and/or legal guardian. Parent-child relationships may be maintained through open adoptions or visitation agreements in a guardianship order. If a foster parent has concerns about covering the costs of a medically fragile or special needs infant and requires the foster care payment to offset certain costs, request that a state and federal benefits and entitlements expert meet with the foster parents and caseworker to secure financial support so a more permanent legal arrangement is possible.

Note that under the Indian Child Welfare Act (ICWA), the permanency preferences of ASFA are not the same. Relatives and *extended families* are preferred over adoption, and many tribes do not value adoption in the same way as ASFA does. Additionally, APPLA can be more easily used as a permanency option for children who are covered by ICWA.[52]

Consulting the Child

Hear the child's views regarding the permanency plan.

The Social Security Act, which includes Title IV-E funding to the states for children in foster care, requires that the court holding a permanency hearing conduct an age-appropriate consultation with the child.[53] This requirement is met when the court obtains the *views of the child in the context of the permanency hearing*.[54] In other words, while it may not be possible for a court to hear testimony from a very young, preverbal child, the court should hear about the child's views on his

or her permanency plan and incorporate this information into the overall decision-making process.

A report written by a nonattorney or CASA, a caseworker's testimony, and communications by the legal representative for the child may present the child's view; however, information relating to the child's best interests alone is not enough to satisfy this 'consultation' requirement.[55] Some states provide guidance to attorneys and other child welfare professionals about determining a child's view on his or her permanency plan. Generally, *age appropriate* means "meeting the cognitive level of a child for their developmental age" unless a child is cognitively delayed.[56]

Observe preverbal children in court to inform your decision making.

Even when a very young child is preverbal, there are many benefits to bringing an infant or toddler to hearings on a regular basis. The information gained from simply observing a child at a court hearing is invaluable. You can gain tremendous insight from seeing the young child interact with her parent and caregivers, and it gives the parent and child an opportunity to visit if the child is placed out of the home. Having a child present in the courtroom can also highlight how quickly she is growing and just how important speedy, decisive action towards permanency is. Courtroom observations can also help inform decisions about placement, visitation, or therapeutic services.

Consider the child's developmental stage during courtroom observations.

It is important to be familiar with developmental milestones when observing very young children. For infants and young children from birth to 12 months old, permanency observations might include:[57]

- How does the child interact and respond to caregivers, parents, and guardians?
- Is the child meeting developmental milestones?
- Does the child appear healthy and well-cared for?

Observations of toddlers and preschoolers in the courtroom might also include:[58]

- How does the child act when answering questions (if verbal)?
- Who does the child look to for help answering questions?
- Is he scared? Anxious? Avoidant?
- Does he look to the caregiver for the "right" answer?

A verbal child's presence in the courtroom also provides an opportunity to ask her questions. Use simple language, speak slowly, and allow the child time to process the question. Younger children can better understand concrete terms and will recognize names better than pronouns. Possible questions to ask might include:

- How old are you?
- Do you like where you are staying now?
- Do you go to preschool or daycare? What things do you like to do at school?
- Do you feel sad or miss anyone? (e.g., brother, sisters, grandparents)
- Have you been to the doctor?
- Do you like the doctor?[59]

Extending the Goal of Reunification

Determine if there is cause to extend the goal of reunification.

It may be that by the time of the permanency hearing a parent is progressing towards reunification, but barriers to taking physical custody of the child are still present (e.g., housing). The federal regulations state that if a child has been placed in out-of-home care for 15 of the preceding 22 months, the state must file to TPR unless there is a compelling reason not to file. While ASFA's reduced timeframes and required permanency hearings stress that time is of the essence for children, overcoming addiction and becoming stable, even when diligently pursued, takes time—often more than 12 months.

When there is cause to extend the timeframe for reunification, evaluate the probability of reunification by assessing a parent's progress with their key services and the consistency and quality of the parent-child interactions. When extending the goal of reunification past the permanency hearing is necessary, the time given to a parent to complete case plan tasks and establish that they have remedied the circumstances that brought the child into care should be consistent with the child's developmental needs.[60] Thus, for an infant placed in foster care, the extension would be short—a matter of weeks. For a preschooler in the care of his grandmother, it may be appropriate to allow the parent several months to finalize reunification-related tasks.

Unless a parent was simply not offered services, refrain from continuing the goal of reunification when a parent has only become engaged in services and visitation in the months or weeks leading up to the permanency hearing. Rather, look for a "genuine, sustainable investment in completing the requirements of the case plan in order to retain reunification as the permanency goal."[61]

Postpermanency Support for Young Children and Their Families

The ability of permanent caregivers to maintain a safe and nurturing environment is critical to achieving sustainable outcomes for very young children exiting the child welfare system. Certain circumstances make infants highly vulnerable to reentry into care for even longer periods. Infants who are reunified in a fairly short period (three months) are more likely to reenter care than older children and other infants who remain in care longer.[62] In addition, infants who return to care a second time stay longer in care than their first experience.[63] Appropriate postpermanency supports can help avoid such reentries. Supports for permanent caregivers should be developed, ideally through a family group conferencing or decision-making process, early in the case and updated regularly as circumstances for the child and her family change.

Sustaining Reunification

Ensure supports are in place to sustain reunification.

Before reunification and during the postplacement supervision period, require case managers and family members to:

- Identify barriers to successful reunification.
- Identify supports to address and overcome reunification barriers.
- Develop a safety or emergency plan to help the parent cope with parenting stressors and challenges that could compromise successful reunification.

Other reunification supports that should be in place before discharge/termination of supervision:

- Connect the birth family with a medical and dental home (as discussed in Chapter 2) and promote the family's *health literacy* (their ability to understand health information).
- Ensure the parents and other family members are aware of the child's special needs and special treatments or appointments. Connections should be made between the parent and the provider well before case closure.
- Develop a visitation plan if only one parent is given custody but the other is permitted to maintain contact with the child.
- Enroll the family in financial assistance programs (e.g., Medicaid, food stamps, Temporary Aid to Needy Families (TANF)).
- Ensure all entitlements and subsidies are in place before case closure.

- Confirm that the parent has identified people or agencies to turn to for respite care, babysitting, and general parenting questions. These should be written down and include specific names and contact numbers.
- Confirm that a parent is linked to neighborhood supports through a community or neighborhood center (e.g., YMCA); link with possible afterschool/summer supports.
- Ensure the parent is engaged in peer support groups for chronic issues such as substance abuse or domestic violence. Some parenting programs offer 'booster sessions' and support groups once a parent completes the program.
- Ensure the child is enrolled in child care or Early Head Start/Head Start and the enrollment package is completed before exiting care. A meeting between the director and child care center caregivers should be facilitated if contact has not already been made.
- Confirm the parent has secured stable housing and employment or a source of income (e.g., child support, Supplemental Security Income) before the case is closed. Make sure he has a backup plan if housing or employment plans do not work out.
- Ensure the parent is connected with the early intervention provider well before reunification and case closure.
- Devise a placement plan if there is a relapse, another incident, or the parent is incarcerated.
- Determine a safety plan for the adult victim and for the child in domestic violence cases.

Sustaining Adoption

Identify adoption disruption factors.

Adoptions are generally highly successful permanency arrangements, although some adopted children and their families confront difficulties.[64] Even so, adopting a very young child from the foster care system can be challenging due to the impact on the child's development by the initial maltreatment, trauma, and resulting stay in foster care.

Research shows several factors increase the risk of adoption disruption:

- **Child's age**—The older the child is when adopted, the higher the likelihood for disruption—an encouraging finding for families who adopt very young children.[65]
- **Alcohol/drug exposure**—Adoptions of children with prenatal alcohol exposure are at risk for placement disruptions because these children are

more likely to experience multiple psychiatric symptoms as they mature. However, low placement disruptions have been found in drug-exposed children adopted early in life (before eight years old).[66]

- **Inexperienced/unknown adoptive caregivers**—Adoptions by strangers or families without adoption or foster care experience are at higher risk of disrupting.[67] Thus it is important for child-placing agencies to be upfront with prospective adoptive parents about a child's special needs and the treatment for those needs. Adoption by someone unknown to a very young child can be frightening. Adoptive parents of very young children should not be lulled into a false sense of security by believing the infant will "just adjust" because she does not understand what is going on. Those adopting very young children must understand early child development and the potential for a very difficult transition phase with a lot of crying, anxiety, rejection, and sleepless nights.

Identify postadoption supports.

Although there is minimal research on postadoption support services, evidence suggests that a family-focused, long-term intervention is a more effective form of postadoption support than short-term interventions.[68] Self-help and adoptive parent support groups fit the needs of many adoptive parents.

Judges should ensure the child-placing agency provides the following postadoption services to families:[69]

Educational/informational:

- full disclosure of information about the infant, including medical, developmental/mental health, social, and genetic history;
- literature related to the infant's specific needs and about adopting very young children;
- lectures, trainings, workshops to help build skills around parenting an infant and about adoption issues;
- support groups and adoptive parent mentors to help them address their child's specific needs;
- Life Book (if available)—a record of an adoptive child's life told through photos, artwork, mementos, and stories that is developed starting when the child enters care.

Clinical:

- couple or family counseling to help cope with the impact of adoption;
- reliable, high quality respite care.

Material:

- adoption subsidies should be applied before the final adoption order (one study found that adoptive families who received higher subsidies were more likely to be maintained than those who received lower subsidies and that families that did not receive any subsidy were more likely to experience a disrupted adoption);[70]
- medical care and a medical home;
- educational opportunities (e.g., Head Start/Early Head Start; child care subsidies).

Permanent Placement with a Relative or Nonrelative

Ensure postadoption supports and services are equally available to permanent guardians or long-term relative caregivers.

Many of the child-focused supports for reunification and adoption apply to sustaining any permanent placement.

Maintain family connections.

The child benefits from maintaining as many connections as possible—to child care, primary care doctors and dentists, infant mental health and early intervention therapists. Nonrelative permanent caregivers should consider the infant's connection with her family of origin and her cultural heritage. A nonrelative should be willing to commit to sibling visits and family contact when feasible and in the infant's best interest. Even very young children benefit from exposure to their cultures of origin. When they grow up and have questions and concerns about where they come from, early exposure to food, music and customs will provide a framework. Contact with the birth family can also support this and maintain important sibling ties.

Conclusion

With ASFA providing the legal framework and the *RESOURCE GUIDELINES* advising on key questions and decisions during each step of the process, you have promising tools to promote timely, stable permanency for very young children in the child welfare system. By understanding early child development principles and research about how very young children experience removal, placement, reunification, and adoption, you can ensure the child welfare system holistically meets their physical, cognitive, and social-emotional needs.

Young children in care should always be viewed through an early child development lens. When possible and safe, keep children with their parent with intensive supports, education, and interventions. If removal is essential, require that every effort is made to ensure the young child's first placement will be the only placement if reunification becomes untenable. Using concurrent case planning is one element of that process. Require thoughtful, comprehensive visitation plans and hold all parties—parents, caregivers and state agencies—accountable for following such plans.

Whether your jurisdiction has a formal family group conferencing structure or not, expect parents, family members, and service providers to participate in case planning, fully support the goals, and increase the potential for successful reunification. Emphasize to parents, family members, and caseworkers that they are all responsible for the very young child's experience in the child welfare system, whether she achieves permanency in a timely manner, and whether her involvement in the system enhances her overall well-being.

Endnotes

1. Wulczyn, F., K.B. Hislop and B.J. Harden. "The Placement of Infants in Foster Care." *Infant Mental Health Journal* 23(5), 2002, 454-475, 456.

2. Jones Harden, B. *Infants in the Child Welfare System: A Developmental Framework for Policy and Practice.* Washington, DC: Zero to Three, 2007, 107.

3. P.L. 108-36

4. Jones Harden, 2007, 17.

5. Ibid.

6. *RESOURCE GUIDELINES: Improving Court Practice in Child Abuse & Neglect Cases.* Reno, NV: National Council of Juvenile and Family Court Judges, 1995. The *RESOURCE GUIDELINES* have been endorsed by the American Bar Association and the National Conference of Chief Justices.

7. For further guidance, the *ADOPTION AND PERMANENCY GUIDELINES: Improving Court Practice in Child Abuse and Neglect Cases*, published by the National Council of Juvenile and Family Court Judges, 2000, is an excellent resource that delves more deeply into considerations for timely permanency and adoption.

8. Ibid., 37. Some questions include changes to reflect a more specific focus on very young children.

9. Lillas, C., Judge L. Langer and M. Drinane. "Addressing Infant and Toddler Issues in the Juvenile Court: Challenges for the 21st Century." *Juvenile and Family Court Journal*, Spring 2004, 92.

10. For example, Promise Home in Tucson, AZ (http://thegivingtreeoutreach.org/id15.html) and the FACT (Fathers and Children Together) Program in Minneapolis, MN provide transitional housing for men and their children, and The Village South in Miami, FL provides residential substance abuse treatment to fathers or mothers with their children (www.villagesouth.com/fit.html).

11. Smariga, Margaret. *Visitation with Infants and Toddlers in Foster Care: What Judges and Attorneys Need to Know*. Washington, DC: ABA Center on Children and the Law & Zero to Three, 2007. Available at www.abanet.org/child/policy-brief2.pdf.

12. *RESOURCE GUIDELINES*, 1995, 57-58. Some questions include changes to reflect a more specific focus on very young children.

13. Jones Harden, 2007, 86.

14. Jurisdictions in California, Florida and Washington have instituted family finding as a standalone program or have implemented some of the tools. Visit www.senecacenter.org for more information about family finding and to request training for your jurisdiction.

15. Buie, J. and G.P. Mallon. "Achieving Permanency for Children & Youth Through Skillful Case Planning: Some Lessons Learned from Child & Family Service Review Final Reports." *Permanency Planning Today*, Summer 2002, 2-3.

16. This is also referred to as family team decision making or family group decision making.

17. Robinson, Judge S.D. et al. "Family Conferencing: A Success for Our Children." *Juvenile and Family Court Journal*, Fall 2002, 43-47, 45-46.

18. Ibid., 43-44.

19. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. "Concurrent Planning: What the Evidence Shows." *Child Welfare Information Gateway Issue Brief*, April 2005. Available at www.childwelfare.gov/pubs/issue_briefs/concurrent_evidence/index.cfm.

20. Ibid.

21. Ibid.

22. This model has been developed in Miami-Dade County, FL as a collaboration between the child welfare community advisory committee, the dependency court (Judge Cindy Lederman), the child welfare system leadership and community parenting program providers in partnership with Dr. Lynne Katz (University of Miami) and Dr. Joy Osofsky (Louisiana State University). For more information about the AAPI, visit www.nurturingparenting.org.

23. Smariga, M., 2007, 5.

24. Ibid., 6.

25. Ibid., 11.

26. Ibid., 8.

27. Child-Parent Psychotherapy is discussed more fully in Chapter 3.

28. "Connecting Children with Incarcerated Parents." *Child Protection Best Practices Bulletin: Innovative Strategies to Achieve Safety, Permanence and Well-Being*. Available at www.f2f.ca.gov/res/pdf/ChildProtectionBPBulletins.pdf.

29. *RESOURCE GUIDELINES*, 1995, 70.

30. The Ages and Stages Questionnaire is a standardized parent report tool used for developmental surveillance for children 4–60 months of age. The parent-completed instruments address children's skills in four domains: language, personal-social, motor, and cognition. D. Bricker and J. Squires. "Ages and Stages Questionnaire." Available at www.brookespublishing.com/tools/asq. For other common developmental screening tools, see www.dbpeds.org/articles/detail.cfm?textid=539.

31. Smariga, 2007, 21.

32. Ibid., 7.

33. Ibid., 13.

34. Jones Harden, 2007, 104.

35. Ibid., 107.

36. U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2006* (Washington, DC: U.S. Government Printing Office, 2008).

37. Jones Harden, 2007, 242.

38. Ibid.

39. Gauthier, Y., G. Fortin and G. Jéliu. "Clinical Application of Attachment Theory in Permanency Planning for Children in Foster Care: The Importance of Continuity of Care." *Infant Mental Health Journal* 25(4), 2004, 379-396, 386.

40. Jones Harden, 2007, 244.

41. Administration for Children and Families, 2006b.

42. Jones Harden, 2007, 108.

43. Ibid., 110.

44. Kemp, S.P. and J.M. Bodonyi. "Infants Who Stay in Foster Care: Child Characteristics and Permanency Outcomes of Legally Free Children First Placed as Infants." *Child and Family Social Work* 5, 2000, 102.

45. Fostering Connections to Success and Increasing Adoptions Act of 2008, P.L. 110-351.

46. 45 C.F.R. § 1355.20(a).

47. Ratterman Baker, D. et al. *Making Sense of the ASFA Regulations: A Roadmap for Effective Implementation*. Edited by D.B. Rauber. Washington, DC: ABA Center on Children and the Law, 2001, 94.

48. Fostering Connections to Success and Increasing Adoptions Act of 2008, P.L. 110-351.

49. 65 C.F.R. § 4060.

50. 45 C.F.R. §§ 1355.20(a) and 1356.21(h)(3).

51. 45 C.F.R. § 356.21(h)(3)

52. Ratterman Baker et al, 2001, 103; Jones, B.J., M. Tilden and K. Gaines-Stoner. *The Indian Child Welfare Act Handbook: A Legal Guide to the Custody and Adoption of Native American Children*, 2d ed. Chicago, IL: American Bar Association, 2008.

53. Social Security Act, § 475(5)(C)(ii).

54. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. *Child Welfare Policy Manual.* Washington, DC, March 21, 2008. Available at www.acf.hhs.gov/j2ee/programs/cb/laws/cwpm/policy_dsp_pf.jsp?citID=58.

55. Ibid.

56. National Resource Center on Family Centered Practice and Permanency Planning. "Age-Appropriate Consultation" (power point presentation). September 2007. Available at www.dphhs.mt.gov/cfsd/.

57. "Engaging Young Children in the Courtroom: Judicial Bench Card." Washington, DC: ABA Center on Children and the Law, 2008. Available at www.abanet.org/child/empowerment/youthincourt.shtml.

58. "Engaging Toddlers and Preschoolers in the Courtroom: Judicial Bench Card." Washington, DC: ABA Center on Children and the Law, 2008. Available at www.abanet.org/child/empowerment/youthincourt.shtml.

59. Ibid.

60. U.S. Department of Health and Human Services, March 2008.

61. Ibid.

62. Wulczyn, F. "Caseload Dynamics and Foster Care Reentry." *Social Service Review*, 65, 1991, 133-156.

63. Kemp and Bodonyi, 2000.

64. Barth, R.P. and J.M. Miller. "Building Effective Post-Adoption Services: What is the Empirical Foundation?" *Family Relations* 49(4), 2000, 447-455, 447.

65. Ibid., 449.

66. Ibid.

67. Ibid.

68. Ibid., 450.

69. Ibid., 452.

70. Ibid.

chapter 5

A Call to Action: Improving the Court's Response

A Call to Action: Improving the Court's Response

How to the Improve Handling of Cases Involving Very Young Children

- Serve as a community leader.
- Convene a court-based group to focus on child welfare cases involving very young children.
- Testify or publicly advocate for policies or legislation.
- Educate the public.
- Participate on committees and other professional groups.

How to Lead Successful Court-Community Collaborations

- Exercise your leadership.
- Seek research-based reforms.
- Seek procedural enhancements.
- Ensure services are child-focused.
- Evaluate, evaluate, evaluate.

The lives of very young children are profoundly affected by the decisions you make every day in your courtroom. This guide shares knowledge about early brain development, healthy attachment, and other health and developmental considerations in cases involving very young children. With this knowledge, you have many opportunities to influence not only the individual cases you see every day, but also systemic changes that will improve outcomes for the youngest children in the child welfare system.

How to the Improve Handling of Cases Involving Very Young Children

Your decision-making role as a juvenile and family court judge is critical to the safety and well-being of very young children, their families, and their communities. You know well your responsibility to ask the right questions, require the right assessments and services, and demand accountability from service providers, child welfare agencies, and the lawyers appearing in your courtroom. What can you do in your role off the bench to advocate for system improvements that will improve outcomes for court-involved families?

The National Council of Juvenile and Family Court Judges has long called on its member judges to serve in a broader role that includes leadership in assessing the needs of children in the court and acting as advocates and catalysts for change in developing resources and implementing policies and procedures:

> Family court judges must take a leadership role to improve the administration of justice for children and families within the courts, in their communities, state capitols, and nationally. It is essential for family court judges to be active in the development of policies, laws, rules and standards by which these courts and their allied agencies and systems function.[1]

Not only can you be a powerful voice within the court system, you are also uniquely positioned to know the problems faced by the children and families who come before you every day. As a prominent and influential member of the community, you can help identify the unmet needs of very young children and their families, which in turn will benefit your community.

You can engage in a variety of activities that promote the administration of justice within your state's judicial code of conduct. These activities benefit the court, the community, and the children and families the court serves:[2]

Serve as a community leader.

Your leadership can help identify unmet needs of very young children in the court system and the services needed to address those needs. For instance, there is growing awareness of the need for early, preventative dental care for very young children in foster care. In your leadership role, you can help raise attention to this issue and reach out to community health centers or local dental care providers to identify services for infants and toddlers in care.

Convene a court-based group to focus on child welfare cases involving very young children.

Many judges have acted as community leaders to establish a variety of court-related services and programs, including court appointed special advocate (CASA) programs, family drug treatment courts, and specialized courts focusing on the unique needs of infants and toddlers in the court system.[3]

Testify or publicly advocate for policies or legislation.

Juvenile court judges have testified before state legislatures on issues such as the value of subsidized adoptions, the benefit of statewide child representation models, and the need for appropriate and sufficient reunification services. You can share your views based on your judicial experience by consulting with or testifying before local, state or national legislative or executive branch officials. You can also encourage support for adequate resources to provide the services needed by very young children in the court system. Many judicial professional organizations provide an avenue for this type of testimony or consultation.

Educate the public.

Share issues related to very young children by speaking before community and civic groups, writing newsletter articles or letters to the editor, and writing articles for scholarly journals that can influence the work of other courts. Educating the public about the need for parent-child psychotherapy or other services that promote positive parenting can bolster support for such programs within the community. If you have established a special court-based program or service for very young children in your court (such as a family drug court for parents of infants and toddlers), describing such efforts through professional journals can help other judges replicate successful programs in their own courts.

Participate on committees and other professionals groups.

You can join professional groups and committees that address the needs of court-involved children. Groups exist at the national level (such as the National Council of Juvenile and Family Court Judges or the American Bar Association's Judicial Division) and the state level. State judicial associations can have a significant impact on legislation and policy impacting the needs of children. Your state supreme court may have a commission or committee on foster care or other related issues where your expertise could help shape the state's response to very young children in care.

How to Lead Successful Court-Community Collaborations

Several courts around the country have implemented special dockets or courtroom procedures in response to the unique needs of infants, toddlers, and preschoolers. Successful approaches apply research to court practice to improve outcomes for very young, maltreated children. If your court has or is considering such a collaboration, your leadership and participation are key.

Healing the Youngest Children: Model Court-Community Partnerships,[4] which describes the court-community collaborations in depth, identifies 13 components that help fuel their success. These components address systems change, a focus on services for very young children, procedural enhancements, and sustainability efforts. You play a vital role in each. Here's how:

Exercise your leadership.

The systems change component depends on a strong, proactive judge who leads the court's efforts focusing on very young children. Therefore, you play an essential role marshaling community services and assistance for young children and their families. You also have a unique ability to encourage action among public and private child-serving agencies. For example, convening a meeting to address the availability of parent and child mental health services in your community could bring together not only advocates for each of the parties in child welfare cases but also mental health service providers throughout the community.

Your strong judicial leadership draws on the assets of all the collaborative partners to support the mutual goals and efforts of the program. In addition to the court, it is essential to work with the child welfare agency, early childhood specialists, and attorneys who know how the special needs of very young children should guide their requests for services on behalf of their clients.

Seek research-based reforms.

Any coordinated effort or intervention to improve outcomes for very young children in the child welfare system should be based on sound research. Enlisting early childhood experts and other knowledgeable parties is therefore essential. Equally important is developing tools to help identify gaps in local services and monitor how any intervention is affecting children's well-being and progress. For instance, child-parent psychotherapy shows promising early outcomes for safe reunification of young children with their parents. The collaborating entities should assess whether the community has the capacity to provide sufficient mental health interventions for the parent and child together, and if not, pursue ways in which such therapy could be offered. Judges can inform the community about gaps in services and mobilize community leaders and resources to address those gaps.

Seek procedural enhancements.

Core components that fall under procedural enhancements include many that you influence directly. For instance, the frequency of case review hearings can be set from the bench. Time between review hearings should be shortened and used productively. Frequent case reviews ensure that very young children receive services that are effective and age-appropriate. Regular meetings of the collaborative team members can also help ensure case progress.

Ensure services are child-focused.

As a judge, you can also ensure the services you order are child-focused. Implement concurrent planning requirements; ensure the case plan provides frequent, regular visits; ensure all necessary services are ordered for every young child; and order evidenced-based services to meet the family's needs. You can also use your position within the court to support ongoing training and assistance for legal and child-serving professionals working in your courtrooms to learn about the impact of abuse and neglect on early development.

Evaluate, evaluate, evaluate.

Finally, you can request ongoing evaluation of efforts to improve outcomes for infants, toddlers, and preschoolers. Routine evaluation is essential to identify whether court deadlines are being met, appropriate services are being offered and provided, or if gaps in services exist. Evaluation can also help support additional funding requests.

Now is the Time to Act

By implementing the recommended practice tips provided in this guide, you can ensure they become common practice among the nation's juvenile dependency courts. Always demand complete and current information about the health status of the infants, toddlers, and preschoolers who come before you and ensure that their needs are met. Continue to identify innovative approaches to address the health and developmental needs of very young children involved in the child welfare and court systems.

Please share this guide with other judges and advocates in your community. Judges, judicial officers, court administrators, attorneys, guardians ad litem, social workers, medical and health professionals, and others working with very young children can work together to create court systems that serve the specific needs of infants, toddlers, and preschoolers. Working together, you can improve both their immediate well-being and their long-term health and permanency outcomes.

Endnotes

1. National Council of Juvenile and Family Court Judges. *Children and Families First: A Mandate for America's Courts*, 1993, 4.

2. *A Judge's Guide to Improving the Legal Representation of Children.* Edited by K. Grasso. Washington, DC: ABA Center on Children and the Law, 1998, 13.

3. Hudson, L. et al. *Healing the Youngest Children: Model Court-Community Partnerships.* Washington, DC: ABA Center on Children and the Law and Zero to Three, 2007.

4. Ibid.

Author Biographies

American Bar Association
Center on Children and the Law

The ABA Center on Children and the Law, a program of the Young Lawyers Division, aims to improve children's lives through advances in law, justice, knowledge, practice and public policy. The Center's HRSA-funded Improving Understanding of Maternal and Child Health Project seeks to enable legal professionals to improve health outcomes for vulnerable young children who are involved in the legal and judicial systems. It develops new materials and provides training and technical assistance to improve child health-related knowledge and skills of attorneys and judges who handle cases involving young children.

Eva J. Klain, JD, is the director of Child and Adolescent Health at the ABA Center on Children and the Law. She examines legal responses to the health and developmental needs of infants and toddlers, adolescent health issues including teen pregnancy, statutory rape, domestic trafficking of children for sexual exploitation, and other issues. She has published several monographs, manuals and a bench book on criminal prosecution issues, including monographs on the prostitution of children and child sex tourism and the criminal justice system response to child pornography. Ms. Klain received her bachelor of arts degree from Cornell University and her law degree from Georgetown University.

Lisa Pilnik, JD, MS, is a staff attorney with the ABA Center on Children and the Law where she works on health issues related to court-involved infants, toddlers and preschoolers and adolescents. She also focuses on issues relating to juvenile status offenders and father involvement in the child welfare system. She has written several articles on legal and health issues related to children. Ms. Pilnik received her law degree from the University of Pennsylvania Law School and a master of science degree from the University of Pennsylvania School of Social Policy & Practice.

Erin Talati, JD, MD, earned a bachelor of arts degree at Northwestern University with majors in biology and science in human culture with honors. She subsequently graduated from the University of Pennsylvania School of Medicine with doctor of medicine and master in bioethics degrees and from the University of Pennsylvania Law School with a juris doctor degree. At Penn, she worked as a child advocate for dependent children through the Penn Legal Assistance Office. She is currently a resident physician in pediatrics at the University of Chicago Hospitals.

National Council of Juvenile and Family Court Judges

The NCJFCJ Permanency Planning for Children Department (PPCD), directed by Nancy B. Miller, plays an essential role in working with judges to ensure that each child's case is handled swiftly and that safety, permanency, and well-being are paramount. Through national projects and initiatives, training, technical assistance, and research, the PPCD works with judges, jurisdictions and communities nationwide to implement best practices and improve outcomes for the nation's abused and neglected children and their families.

Candice L. Maze, JD, has worked for more than a decade in the child welfare arena. Ms. Maze is the president of Maze Consulting, Inc. and has directed a variety of advocacy programs and projects that interface with the juvenile court and its community partners. She has authored and coauthored a number of publications and has presented locally and nationally on topics related to children and families in the child welfare system. Ms. Maze is serving as a consultant to NCJFCJ for this project. She earned her law degree from the University of Arizona in Tucson.

Zero to Three National Policy Center

The Zero to Three Policy Center is a research-based, nonpartisan program that brings the voice of babies and toddlers to public policy at the federal, state, and community levels by translating scientific research into language that is accessible to policy makers, cultivating leadership in states and communities, and studying and sharing promising state and community strategies.

Kimberly Diamond-Berry, PhD, is a licensed clinical psychologist and a writer/training specialist for the Early Head Start National Resource Center at Zero to Three. She has developed and implemented programs for children living with chemically dependent parents in both Chicago, IL, and Washington, DC. Dr. Diamond-Berry received her doctorate in psychology from Loyola University.

Lucy Hudson, MS, is the director of the Court Teams for Maltreated Infants and Toddlers Project at Zero to Three. She has more than 30 years of experience in project management, program implementation, and policy development in public and private sector child care, child welfare, health care, and youth-serving organizations. She received her master of science degree from Wheelock College.

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Inquiry Note:

Attachment 4, an Interim Report to the Children's Court, titled
"A Comparison of Clinician's Recommendations and Court Orders for Protection Matters Referred to the Court Clinic by the Children's Court of Victoria",
is not published within this submission at the request of the author.