Infant mental health and family law: questions every lawyer should ask about infants in child protection hearings

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The family court hearing is a *pivotal* opportunity to identify infants in distress and ensure that their physical, developmental and emotional needs are considered. According to the American Bar Association, the lawyer representing a child in an abuse or neglect case "should not be merely a fact-finder, but rather, should zealously advocate a position on behalf of the child."[1] But what position should counsel advocate to the court and how will he or she come to this decision? Lawyers representing infants face particular challenges if they are to appropriately represent their clients' best interests.

First, infants cannot describe their experiences or express their wishes the way older children can. It is easy to misunderstand or discount their feelings when their only means of expression is through behaviors such as inconsolable crying, listlessness, altered sleep patterns, and feeding or digestion problems. Some babies stop giving distress cues because they have abandoned hope of getting a response. Only a trained observer can spot the difference between a contented baby and one that is actually in despair.

The conflict between the need for a prompt decision about custody arrangements and the need to give parents ample time to mount a vigorous defense against allegations of abuse is also challenging for the lawyer representing infant clients. In early childhood, rapid physical and emotional growth, especially in the brain, is the foundation for all future development.[2] Infants need predictable, repetitive, and nurturing interactions with a consistent caregiver *in the first years of life* for brain development to occur properly.[3]

Third, while it is now widely understood that infants can suffer serious but treatable emotional problems, infant mental health expertise is not uniformly available to offer guidance and testimony in family court hearings. Infants are capable of intense emotional experiences, including anxiety, depression, love, and joy. However, mental health services across Canada are only beginning to offer services to children under the age of six years. Expertise is not always available to describe the needs of very young children and plan treatment for emerging disorders.

While in the early stages, research into the effects of maltreatment on very young children has led to some surprising findings:[4]

- infants are the largest group of children involved in substantiated abuse cases and are the largest group of children entering foster care. These infants are increasingly likely to need representation in court hearings;
- the majority of children who die of abuse and neglect are under the age of four;[5]
- more than 40 per cent of young children in foster care are of low birth weight, premature, or developmentally delayed; [6]

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1 AMERICAN BAR ASSOCIATION STANDARDS OF PRACTICE FOR LAWYERS WHO REPRESENT CHILDREN IN ABUSE AND NEGLECT CASES Approved by the American Bar Association House of Delegates, February 5, 1996.

2 Children's Emotional Development is Built into the Architecture of their Brain (2004). National Scientific Council on the Developing Child Working Paper No. 2. Retrieved March 26, 2007 from http://www.developingchild.net/pubs/wp-abstracts/wp2.html

3 Glaser, D. (2000). Child abuse and neglect and the brain-a review. Journal of Child Psychology and Psychiatry, 41(1), 97-116.

4 Dicker S., and Gordon, E.(2004). Ensuring the Healthy Development of Infants in Foster Care: A Guide for Judges, Advocates and Child Welfare Professionals, Zero To Three Policy Brief. Retrieved November 23, 2007 from: http://www.zerotothree.org/site/PageServer?pagename=ter_pub_courtteams

5 Watson, J (2005). Literature Review: Child Neglect. Centre for Parenting and Research, New South Wales, Australia. Retrieved March 26, 2007 from www.community.nsw.gov.au

6 Perry, B., Runyan, D., and Sturges, C. (1998). Bonding and attachment in maltreated children: How abuse and neglect in childhood impact social and emotional development. Child Trauma Academy, 1(5) January 1998. Retrieved May 28, 2007 from

- one-third of infants discharged from foster care will return to foster homes; and
- chronic neglect accounts for the majority of infant maltreatment cases and is particularly devastating in infancy.[7]

Zero To Three, a national (U.S.) center for infants, toddlers and families defines "infant mental health" as the capacity of the child, from birth to age three, to experience, regulate, and express emotions, form close and secure interpersonal relationships, explore their environments and learn. Infant mental health and development are intertwined.[8] Infants who are not doing well emotionally tend to lag behind their peers in achieving developmental milestones. A healthy attachment relationship is central to the infant's physical and emotional well-being and is vitally important for brain development.[9]

Children who enter care with developmental disabilities are more likely to remain in care long-term.[10] Delays in speech-language development are especially worrisome because of the strong link between speech delays and behavior problems.[11] As the burden of risk accumulates, the chances of a positive outcome for maltreated children quickly deteriorate.[12]

Although it is well established that maltreated children are at higher risk of delays associated with deprivation, there are several barriers to assessment and intervention. The rapid pace of development, changes in caregivers, lack of consistent medical care, and inadequate child development training among child welfare personnel can derail developmental assessments and interventions for these children.[13]

What does this mean for abused or neglected infants, and for the lawyers representing their interests? These questions capture the most salient risk factors that influence the health and development of young children.

Has the child been screened for medical, dental, developmental, or social emotional problems?
The consistent use of validated screening tools, starting as early as four months after birth, by pediatricians, public health nurses, and other specially trained professionals can provide data on the child's progress in comparison to its peers. These screenings are important for early identification of problems and can help establish eligibility for specialized programs.

Are developmental, mental health, or other specialized pre-school programs available for the infant or pre-school client? Since many eligible children are not enrolled in these services, it should not be assumed that infants and toddlers are not entitled to these services. Most communities have access to community health nurses, early intervention programs, and/or pediatricians who will be familiar with local resources for infants and toddlers. Family physicians and pediatricians are the gateway to these services, so it is especially important that infants at risk get consistent medical care and developmental tracking.

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http://www.childtrauma.org/ctamaterials/bonding.asp

7 Garland, A. F., J. L. Landsverk, et al. (1996). "Type of maltreatment as a predictor of mental health service use for children in foster care." Child Abuse Neglect, 20(8): 675-88.

8 (www.zerotothree.org).

9 National Scientific Council on the Developing Child (2004). Children's emotional development is build into the architecture of their brain. Working paper No.2. Retrieved March 26th, 2007 from www.developingchild.net/pubs/wp/emotional_development_is_built.pdf

10 Horwitz, S.M., Simms, M.D., Farrington, R. (1994). Impact of developmental problems on young children's exits from foster care. Developmental and Behavioral Pediatrics. 15:105-110.

11 Alberta Association of Clinical Speech-Language Pathologists and Audiologists Fact Sheet.

12 Sameroff, A., & Mackenzie, M. (2003). A quarter –century of the transactional model: how have things changed? Zero to Three Policy Center, Washington, D.C.

13 Simms, M., Dubowitz, H., and Szilagyi, M., (2000). Health care needs of children in the foster care system. Pediatrics, 106 (4) 909 - 918.

Does the child have a consistent and long term relationship with a caregiver who is capable of meeting basic needs for physical care, comfort, and stimulation?
A sense of urgency should be communicated when children under three are in temporary caregiving situations, such as foster care. Family reunification efforts should be intensive and time-limited; not half-hearted and prolonged as is sometimes the case. Family reunification is more likely to be successful with infants and toddlers when frequent visits occur, when caregiver mental health is supported through appropriate treatment, and when caregiver stress is reduced through access to a stable income, affordable housing, and high-quality child care. A realistic evaluation of parental motivation and capacity for self-reflection are crucial for successful outcomes, regardless of the intervention planned.

Are child protection authorities making a serious effort to pursue a concurrent plan in the event that family reunification fails? Time is the enemy of young children in temporary care. Opportunities for adoptive placements diminish rapidly as children age, and children with a history of placement disruptions develop behavior problems that alienate potential caregivers, teachers, and peers. Lawyers representing young children in foster care should press for a concurrent permanent plan that is attached to strict timelines.[14]

Lawyers who represent abused and neglected infants must see themselves as a voice for our most vulnerable citizens and as an agent for system change. Greater collaboration across disciplines such as family law, infant mental health, early childhood development, and health care will be needed to put high-risk infants and toddlers on the national agenda.

For more information on cross-disciplinary advocacy efforts contact Dr. Brenda Miles, director of infant mental health promotion at the Toronto Hospital for Sick Children.

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14 National Clearinghouse on Child Abuse and Neglect Information. (2005). Concurrent planning: What the evidence shows. Washington, DC: U.S. Department of Health and Human Services. Retrieved 11/25/2007 from http://nccanch.acf.hhs.gov/pubs/issue_briefs/concurrent_

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