ABA Child Law Practice
clp
Vol. 34 No. 1 January 2015 CLP Online: www.childlawpractice.org

TRAUMA IN PRACTICE

Supporting the Mental Health of Trauma-Exposed Children in the Child Welfare System

by Lisa Conradi

You are an attorney working in the dependency court system representing an adolescent with severe behavior problems. You are doing your best to help this adolescent, but she continues to be oppositional, blowing out of placements repeatedly. You are concerned she will cross into the juvenile delinquency system. The adolescent has experienced significant abuse and neglect and you wonder if those experiences could be related to her current behavior? What mental health interventions could help stabilize and put her on a healthy developmental path?

The prevalence of potentially traumatic events in court-involved children and adolescents is high (see the first article in this series, "Understanding Trauma and Its Impact on Child Clients," in the September 2014 *CLP* for definitions of types of trauma and information on its prevalence in court-involved children and adolescents). As a result, they may display challenging behaviors and reactions that may be related to the trauma they have experienced. Therefore, it is critical that court professionals understand the impact of trauma on the child's reactions, behaviors, and relationships. This article highlights these behaviors and how they impact relationships and functioning.

Understanding Emotional and Behavioral Responses to Trauma

Know how a child's trauma history influences behavior.
Trauma-exposed children may exhibit a range of complex emotional and behavioral responses to events they have experienced. When working with a child or adolescent who has experienced trauma, it is important to be sensitive to the ways in which a child's trauma history affects the child's current behavior. The behavior of a child exposed to trauma can reflect his efforts to adapt to overwhelming stress and may be difficult to identify and manage. For example, a child may reenact aspects of his trauma (e.g., aggression, self-injurious behaviors, or sexualized behaviors) in response to a reminder of a previous traumatic event, or as an attempt to gain mastery or control over her experiences.

Be aware of the child's trauma triggers.
A trauma reminder is any person, place, situation, sensation, feeling, or thing that reminds a child of a previously experienced traumatic event. When faced with these reminders, a child may re-experience the intense and disturbing feelings tied to the original trauma. These trauma reminders can lead to behaviors that seem out of place in the current situation but were appropriate—and perhaps even helpful—at the time of the original traumatic event. For example, a child may be triggered by events as conscious as seeing a person or place connected to the trauma, or as subconscious as certain smells, lights, or sounds that are reminiscent of the trauma. (Sidebar 1 highlights traumatic responses by age.)

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CLP is published monthly by the **ABA Center on Children and the Law,** a program of the ABA's Young Lawyers Division, 1050 Connecticut Ave., NW, Suite 400, Washington, DC 20036.

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CASE LAW UPDATE

Officer Not Required to Determine if Child Had a Disability Before Arrest

J.H. v. Bernalillo County, 2014 WL 6612060 (D. N.M.).

Although child was ultimately found incompetent to stand trial for battery on a teacher and peer, school resource officer was not required to determine if she had a disability before arresting and transporting her to detention. Although her disability was relevant at later points, including competency and if there had been a disposition, an officer must only reasonably investigate evidence readily available to them up until they have probable cause to arrest.

An 11-year-old child began hitting a marble loudly in class and would not stop when her teacher said it was disturbing other students. She cursed at her teacher and a peer. A short time later, she got up and threw the marble across the room. She got up and hit the peer on the back of the head. The teacher got between the two and asked the peer to leave the room, which he began to do. The teacher held the child above her wrists and the child attempted to head butt and bite her. The child scratched the teacher's hand, drawing blood, and got free. She pursued the peer, hitting him on the back of the head and following from class.

Meanwhile, someone had called the school resource officer. As he arrived he saw the teacher holding the child's arms outside the room. He also saw the child kick the teacher. The officer approached and took out his handcuffs. The child went back into the classroom and sat down hiding her hands. She sat crying for 15 minutes before he handcuffed her, in part because he was waiting for another officer to arrive. Also, he intended to walk the child to his car while classes were in session to minimize embarrassment. At that point, she stood up calmly and allowed him to handcuff her.

The officer transported the child to the county juvenile detention center for assault on her teacher. She was released to her mother after review by the Division of Youth and Families based on their risk assessment criteria.

The Children's Court Attorney filed a four count delinquency petition including battery, battery on school staff, disorderly conduct, and interference with school processes.

The child underwent a competency evaluation. Because she did not cooperate with the evaluation, the psychologist's report was deemed preliminary. She was identified with anxiety disorder and oppositional defiant disorder. The psychologist explored her understanding of the court process and felt she may not be competent to assist in her defense.

The state trial court dismissed the delinquency petitions, finding the child incompetent to stand trial.

The mother and child filed a suit in state court alleging unlawful seizure under the Fourth Amendment and violations of the ADA. The case was removed to the Federal District Court for New Mexico.

The federal district court noted probable cause for arrest occurs when the "facts and circumstances within the arresting officer's knowledge and of which they have reasonably trustworthy information are sufficient in themselves to warrant a person of reasonable caution to have the belief that the offense has been or is being committed by the person to be arrested."

Here, the battery on the teacher was not questionable. The officer witnessed part of the battery first hand. The plaintiff contended that, under the Americans with Disabilities Act (ADA) and the Individuals with Disabilities in Education Act (IDEA), the officer should have known or investigated to learn the child lacked the proper *mens rea* to commit the offense given her age and disability.

The officer countered that the child stopped kicking the teacher when she saw him. He claimed this showed she knew what she was doing was wrong. She also told him that she should use words when angry.

Plaintiffs pointed to a Tenth Circuit case where the court found officers should have reviewed a surveillance tape before arresting an individual for shoplifting to support their argument that the officer had a duty to investigate whether the child had the ability to form a criminal intent. The officer countered that, in this case, to further investigate would have required he examine mental health records—an impractical request in this context. He argued the state had a duty to prove *mens rea* at trial, but this was not required before an arrest. The court agreed with the officer. It held an officer has a duty to reasonably examine evidence that is easily accessible before making a warrantless arrest. A contrary rule would not be practical in fast-moving situations requiring action to protect the public.

The court found the IDEA did not prevent the officer from arresting the child. The IDEA gives students with disabilities rights, including that their disability be examined. If a student's disability is responsible for the student's behavior, the IDEA requires the student continue in their special education program. The IDEA does not prohibit school staff from contacting, or law enforcement from arresting or charging, students with crimes.

The court determined that while a student's disability should be considered in crafting a disposition, it does not erode probable cause.

Next, the officer argued that even if it was unlawful to arrest the child, he was entitled to qualified immunity. The court held that there was no clear precedent. In contrast even to the cases that found arrests lawful, here the officer saw the child commit a battery. Further, the other cases did not deal with disabilities.

The court therefore granted the officer's motion to dismiss.

Untimely Reunification Suit Barred by Immunity and Statute of Limitations

Anthony K. v. Dep't of Health & Human Servs., 855 N.W.2d 788 (Neb.).

Where parents sued agency, employees, and guardian ad litem (GAL) because their children were allegedly in care too long, immunity protected the defendants against monetary damages. The declaratory judgment requested was barred because the case was already closed, and other claims failed because the parents had not timely alleged specific instances of unconstitutional conduct.

Three of the family's children were removed in 2000 and were returned in 2008. The parents sued the agency and guardian ad litem for violating their federal rights under 42. U.S.C. § 1983 alleging that they failed to make reasonable efforts and should have returned the children sooner.

The district court denied their claims, holding they were barred by sovereign immunity for agency employees for actions performed in their professional capacity. The district court also held the defendants were entitled to absolute immunity for testimony delivered in court, and qualified immunity regarding the claimed violation of family integrity as that was not a clearly established right. Further the district court found that the claims would be barred by the statute of limitations. Although the parents contended there were ongoing violations of the law, they made no specific allegations for actions after 2005, so the court concluded the claims would have had to have been filed by in 2009.

The Nebraska Court of Appeals, dismissed the parent's appeal.

The parents then appealed to the Nebraska Supreme Court, which affirmed the trial court. The court began by noting that suits against the state were generally barred by sovereign immunity. In claims against individual employees, monetary damages are generally barred because, when acting in the professional capacity, the state would be liable. However, prospective relief, such as injunctions to stop or begin complying with the law, may be individual in nature.

Here, the parents' claims for monetary damages against the individual agency workers were barred by sovereign immunity. The claim for declaratory judgment was barred because it could not be considered prospective; there are no ongoing allegations since the case is closed.

As to claims against the GAL, the court cited previous Nebraska and other state opinions holding the GAL's functions were performed as an agent of the court, thus the GAL was entitled to absolute immunity. This position, the court held, would not change if the parents' allegation was that the GAL was negligent in his duties by failing to consult with the children during the case. A failure of the quality of the GAL in his duties is not enough to overcome immunity. Rather, to state a claim, the GAL would have to be acting outside his duties. No allegation fit this standard.

Regarding the dismissal against individual employees, the court agreed with the district court that the applicable statutory timeframe was the four years provided for personal injury under state law. However, the timing for the statute of limitation began to toll, as a § 1983 claim, when the parents should have known about the violations, according to federal precedent. Here the parents' claims did not allege specific violations, but instead that the individuals were assigned as caseworkers or supervisors during the time periods. The latest specified action was in 2005 when the agency called a meeting to help the parents understand the need for prompt reunification since the county attorney was asking about termination of parental rights.

By the time the parents filed their claims, they were time barred under state and federal law.

STATE CASES

Arkansas

Fox v. Arkansas Dep't Human Servs., 2014 WL 6488884 (Ark. Ct. App.). TERMINATION OF PARENTAL RIGHTS, FAILURE TO PROTECT
Evidence supported termination of mother's parental rights because child would be subject to potential harm if returned to mother's custody. Mother was unstable and failed to take responsibility for child's removal or deaths of child's two siblings from husband's physical abuse. Mother failed to take reasonable action to adequately supervise or protect child from physical abuse by husband.

Connecticut

In re Mindy F., 2014 WL 6491643 (Conn. App. Ct.). TERMINATION OF PARENTAL RIGHTS, INCARCERATION
Termination of father's parental rights was upheld because he failed to achieve sufficient rehabilitation to support reunification within a reasonable time and termination was in child's best interest. Father initially declined visits while incarcerated, child identified with foster family, and father's ability to remain sober and abstain from substance use was uncertain.

Indiana

In re E.P., 2014 WL 6461747 (Ind. Ct. App.). TERMINATION OF PARENTAL RIGHTS, INCARCERATION
Based on evidence, there was no reasonable probability the conditions resulting in child's removal would be remedied. Thus, order terminating father's parental rights to child was supported. Father had been convicted of child molestation, the victim was child's half-sibling, and father was incarcerated and would be unavailable to parent child for at least 15 years.

Iowa

In re A.M., 2014 WL 6497172 (Iowa). DEPENDENCY, PRIVILEGE
Statute governing adjudicatory hearings in child protection cases permitted juvenile court to compel therapist to testify about mother's compliance with treatment goals and her mental health. Therapist was well positioned to provide the court with vital information to determine children's best interests. HIPAA does not require a contrary result.

In re D.S., 2014 WL 6495704 (Iowa). DELINQUINCY, HARASSMENT
Juvenile accused of harassing peer during after-school confrontation appealed delinquency adjudication under harassment statute. Juvenile yelled a profanity at friend, which instigated the altercation with complainant, who was not the target of the profanity. Evidence did not support finding that juvenile purposefully or intentionally made personal contact with the specific intent to threaten, intimidate, or alarm.

Louisiana

State in re K.V., 2014 WL 6498342 (La. Ct. App.). TERMINATION OF PARETNAL RIGHTS, FAILURE TO IMPROVE
Evidence supported termination of parental rights of father and mother due to lack of substantial compliance with case plan. For two years, children had been removed from parents' custody and there was no reasonable expectation of significant improvement in the future. Parents failed to comply with counseling and anger management requirements, children received minimal engagement or nurturing from parents, and both parents recently tested positive for illegal drugs.

Maine

Walton v. Ireland, 2014 WL 6657081 (Maine). ORDER OF PROTECTION, HEARSAY
Child's statements to clinical therapist were admissible in proceeding for order of protection from abuse under exception to hearsay rule because statements were made for the purpose of medical diagnosis or treatment. Child's statements identifying her father as her abuser were used by the therapist to develop a treatment plan to treat child's anxiety.

Maryland

Reece v. State, 2014 WL 6769893 (Md. Ct. Spec. App.). ABUSE, CHILD WITNESSES
Trial court did not deny defendant due process in prosecution for child sex offenses by denying his request for pretrial taint hearing on reliability of victim's testimony. Defendant was permitted to present evidence at trial that victim's memory had been tainted by interviewers. Trial court was not required to question child victim about forensic evaluation at a hospital before determining that victim's statements during later forensic evaluation had particularized guarantees of trustworthiness.

Montana

In re K.J.B., 2014 WL 6966247 (Mont.). TERMINATION OF PARENTAL RIGHTS, LEGAL REPRESENTATION
Father who was unrepresented, indigent, and incarcerated in federal prison in another state was denied fundamentally fair process before termination of his parental rights through entry of default judgment. Trial court entered default judgment due to father's failure to file a timely answer while simultaneously refusing to accept that answer due to a filing technicality. Father was entitled to hearing and appointment of counsel before entry of judgment.

New York

In re Dayyana M., 2014 WL 6462087 (N.Y. App. Div.). TERMINATION OF PARENTAL RIGHTS, FAILURE TO IMPROVE
Despite diligent efforts of social services to encourage and strengthen parental relationship, mother permanently neglected child. Social services scheduled and facilitated visitation, monitored participation in mental health treatment program mother selected, and explained importance of compliance. Mother failed to keep appointments, maintained treatment was unnecessary, and failed to complete parenting classes or maintain regular visitation with child.

In re Jalil U., 2014 WL 6461963 (N.Y. App. Div.). TERMINATION OF PARENTAL RIGHTS, BEST INTEREST
Family court properly determined that best interests of children would be served by terminating mother's parental rights and freeing children for adoption by their foster parents. Suspended judgment was not appropriate given mother's lack of insight into her problems and her failure to address primary issues that led to children's removal.

In re Joseph E.K., 2014 WL 6496015 (N.Y. App. Div.). TERMINATION OF PARENTAL RIGHTS, INCAPACITY
In proceeding to terminate mother's parental rights, court properly found mother was then and for foreseeable future unable, by reason of mental illness, to provide proper and adequate care for her child. Mother suffered from paranoid schizophrenia, and psychologist testified she was unable to

care for special-needs child who would be in greater danger if placed with mother.

In re Sean P.H., 2014 WL 6462153 (N.Y. App. Div.). TERMINATION OF PARENTAL RIGHTS, PRESENCE OF PARTIES
Mother in termination of parental rights proceeding was not deprived of right to be present when court denied her attorney's request to delay start of fact-finding hearing until she arrived. Mother did not call attorney, guardian ad litem, court, or agency to state she would be delayed. Both her attorney and guardian ad litem were present during direct testimony of witness, and after mother appeared late, court allowed mother's attorney to conduct cross-examination.

North Carolina

In re A.W., 2014 WL 6436161 (N.C. Ct. App.). TERMINATION OF PARENTAL RIGHTS, REASONABLE PROGRESS
Evidence supported termination of father's parental rights because father willfully left child in foster care for more than 12 months without showing reasonable progress had been made to correct the conditions that led to removal of child. In two years between when father learned he was child's biological father to when his parental rights were terminated, he made no meaningful effort to remove child from state custody.

In re J.R.W., 2014 WL 6436187 (N.C. Ct. App.). TERMINATION OF PARENTAL RIGHTS, REPRESENTATION
Trial court was not required to conduct inquiry to determine if guardian ad litem should be appointed for mother in termination of parental rights proceeding due to mother's past mental health issues. Statute granted trial court discretion to hold hearing, and record established that mother's mental health issues were well known to the court and did not render her incompetent.

In re T.L.H., 2014 WL 6435869 (N.C. Ct. App.). TERMINATION OF PARENTAL RIGHTS, REPRESENTATION
Trial court was required, in termination of parental rights proceeding, to inquire whether it was necessary to appoint mother a guardian ad litem in substitutive capacity, given serious nature of mother's multiple ongoing mental health conditions. Trial court relied on those conditions to support grounds for termination, and mother's parental rights to other children were terminated, in part, due to unresolved mental health issues.

Rhode Island

State v. Verry, 2014 WL 6491746 (R.I.). ABUSE, GENETIC EVIDENCE
In prosecution for assault and child abuse, trial court acted within its discretion in denying defendant's request for a continuance to investigate genetic-testing results based on family history of broken bones. Trial court noted that defendant had an opportunity to investigate the scientific reliability of the testing but had not done so, and trial court determined that defendant was attempting to obtain evidence that was speculative.

Utah

State in re N.D., 2014 WL 6477634 (Utah Ct. App.). TERMINATION OF PARENTAL RIGHTS, FAILURE TO IMPROVE
Evidence supported termination of mother's parental rights for failure to correct reasons for children's out-of-home placement within reasonable time despite reasonable efforts provided by child welfare agency. Mother completed required assessments but not services, and peer parent testified that mother learned some parenting skills but remained distracted, did not provide appropriate supervision, and frequently missed or was late for visits.

State in re R.A., 2014 WL 6478041 (Utah Ct. App.). TERMINATION OF PARENTAL RIGHTS, FAILURE TO IMPROVE
In termination of parental rights proceeding, evidence supported finding that mother was unfit. Mother abused prescription medications and refused to obtain help to remedy her addiction. She failed to complete domestic violence counseling and failed to apply information provided in parenting skills class. She had no ability to support herself and no stable housing.

Washington

In re G.G., 2014 WL 6765164 (Wash. Ct. App.). TERMINATION OF PARENTAL RIGHTS, REPRESENTATION
Mother appealed order terminating parental rights to her three children, claiming she was deprived of right to counsel of choice when the trial court denied her motion for a continuance to hire private counsel. Trial court did not violate her right to counsel because she had not selected substitute counsel and failed to show she had the ability to obtain substitute counsel.

In re N.M., 2014 WL 6806889 (Wash. Ct. App.). TERMINATION OF PARENTAL RIGHTS, RELATIVES
In proceeding to terminate mother's parental rights, trial court did not abuse its discretion in denying a continuance so mother could explore a possible guardianship by paternal grandmother. Grandmother had never agreed to or expressed interest in a guardianship rather than adoption. Mother was not denied due process right to present evidence of possible guardianship because there was no identified guardian.

In re S.I., 2014 WL 6464351 (Wash. Ct. App.). TERMINATION OF PARENTAL RIGHTS, HEARINGS
Termination of mother's parental rights by default after mother failed to appear at termination proceeding did not violate her procedural due process rights. Process required sworn testimony of person familiar with case and opportunity for trial court to independently question the person, which minimized risk that parental rights would be terminated in error, and mother was allowed opportunity to have default order vacated.

West Virginia

In re J.P., 2014 WL 6635055 (W. Va.) ABUSE, CHILD WITNESS
Children's guardian ad litem appealed trial court's failure to adjudicate children abused or neglected. On appeal, court found parents did not feed their children or keep food in their home, father snorted pills in front of children, the home was very dirty, and the two-year old child was observed drinking a beer that parents left unattended.

FEDERAL CASES

8th Circuit

United States v. Stong, 2014 WL 6910688 (8th Cir.). ABUSE, HEARSAY
Defendant's statements suggesting content of videotapes that he made of minors engaged in sexual intercourse were statements by opposing party and not hearsay. A statement by an opposing party is not hearsay if the statement is offered against an opposing party and was made by the party in an individual or representative capacity.

Sidebar 1: **Effects of Trauma by Developmental Stage**	
Developmental Stage	**Effects of Trauma**
Young Children (0-5)	■ Express their distress through strong physiological and sensory reactions (e.g., changes in eating, sleeping, activity level, responding to touch and transitions) ■ Become passive, quiet, and easily alarmed ■ Become fearful, especially regarding separations and new situations ■ Experience confusion about assessing threats and finding protection, especially in cases where a parent or caretaker is the aggressor ■ Engage in regressive behaviors (e.g., baby talk, bedwetting, crying) ■ Experience strong startle reactions, night terrors, or aggressive outbursts ■ Blame themselves due to poor understanding of cause and effect and/or magical thinking ■ Have difficulty forming and maintaining attachment relationships or, conversely, attaching quickly and indiscriminately to others leaving them vulnerable for further abuse.
School-Age Children (6-12)	■ Experience unwanted and intrusive thoughts and images ■ Become preoccupied with frightening moments from the traumatic experience ■ Replay the traumatic event in their minds in order to figure out what could have been prevented or how it could have been different ■ Develop intense, specific new fears linking back to the original danger ■ Alternate between shy/withdrawn behavior and unusually aggressive behavior ■ Become so fearful of recurrence that they avoid previously enjoyable activities ■ Have thoughts of revenge ■ Experience sleep disturbances that may interfere with daytime concentration and attention, which may mimic the behaviors associated with ADHD
Adolescents (13-21)	■ Aggressive or disruptive behavior ■ Sleep disturbances masked by late-night studying, television watching, or partying ■ Drug and alcohol use as a coping mechanism to deal with stress ■ Self-harm (e.g., cutting) ■ Over- or underestimation of danger ■ Expectations of maltreatment or abandonment ■ Difficulties with trust ■ Increased risk of revictimization, especially if the adolescent has lived with chronic or complex trauma

(Cont'd from first page.)

Understand how a child's behavior is often a coping mechanism. In some cases, a child may be aware of his reaction and its connection to the traumatic situation. However, often the child is unaware of the root cause of his feelings and behaviors and may exhibit increased behavioral problems as a way of coping with trauma and traumatic stress. These behaviors can be difficult to understand and cope with for the court professional. For instance, in the absence of more adaptive coping strategies, a trauma-exposed child or adolescent may use drugs and/or alcohol to avoid experiencing overwhelming emotions. Similarly, in the absence of appropriate boundaries and interpersonal skills, a sexually abused child may revert to sexual behaviors with others because that is the only way he has ever experienced any degree of acceptance or intimacy.

Understand how trauma relates to controlling behaviors. Trauma-exposed children may also exhibit over-controlled behavior in an unconscious attempt to counteract feelings of helplessness, and impotence may manifest as difficulty transitioning and changing routines, rigid behavior patterns, repetitive behaviors, etc. At the other extreme, due to cognitive delays or deficits, some children who have experienced trauma display under-controlled behavior in terms of planning, organizing, delaying gratification, and exerting control over their behavior. This may manifest as impulsivity, disorganization, aggression, or other acting-out behaviors. Trauma-exposed children's maladaptive coping strategies can lead to behaviors that undermine healthy relationships and establishing positive connections, including:

- Sleeping, eating, or elimination problems
- High activity levels, irritability, or acting out
- Emotional detachment, unresponsiveness, distance, or numbness

- Hypervigilance, or feeling that danger is present when it is not
- Increased mental health issues (e.g., depression, anxiety)
- An unexpected and exaggerated response when told "no"

Know the child's mental health diagnoses and clinical/educational services.

Court-involved children and adolescents have often been diagnosed with many different mental health diagnoses through their interactions with various child-serving systems. The most common of these include attention deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, bipolar disorder, and reactive attachment disorder.

Many of these children also receive special education services (see Sidebar 2 for more information on the interface between trauma, special education, and disabilities). Neither the diagnoses nor the clinical and/or educational interventions provided capture or address the full extent of the developmental impact of trauma. The symptoms leading to these diagnoses may in fact be a child's reaction to a trauma reminder, which can result in withdrawn, aggressive, reckless, or self-injurious behaviors. Court professionals should understand how a child or adolescent's diagnosis may result from behaviors associated with coping with trauma rather than a statement about his personality structure overall.

Screening, Assessment, and Evaluation

Know the difference between screening, assessment, and evaluation.

When thinking about mental health evaluations and reports, it is important to distinguish between screening, assessment, and evaluation (see Sidebar 3). Information from the screening and assessment process can help courts understand a child's history and behaviors and make decisions about placement. Integrating information from the trauma screening process into court reports is one strategy some jurisdictions are using to create more trauma-informed courts that understand the impact of trauma on a child's behavior and use that information to make case-planning decisions. Regardless of whether this information is strategically integrated into a court report process, a comprehensive trauma-informed mental health assessment should be conducted by an experienced mental health professional and that information should be shared with the court and used to inform case-planning efforts.

In general, the purpose of a comprehensive assessment is NOT to provide recommendations regarding placement and visitation within the child welfare context. An assessment conducted as part of an intervention is usually very different from one conducted as part of a placement resource. For example, an evaluator generally interviews all relevant caregivers, lets the caregivers know they are being evaluated, and informs them that the assessment will be shared openly with the court. On the other hand, therapists may work with only some family members and may not be in a position to make unbiased placement recommendations as they have not observed the child with the other caregivers.

Improving Resiliency and Well-Being

Enhance the child's resilience.

Many children are naturally resilient, and can get through the difficult experiences they have had and even flourish. Resilience is the ability to overcome adversity and thrive in the face of risk. Neuroplasticity (i.e., the ability of the brain to rewire neural connections) allows for resilience to be developed through corrective relationships and experiences. Factors that can enhance resilience include:

- Supportive relationships
- Family support
- Having a strong relationship with at least one competent and caring adult
- Feeling connected to a positive role model/mentor
- Peer support
- Competence
- Having talents/abilities nurtured and appreciated
- Self-efficacy
- Self-esteem
- School and community connectedness
- Spiritual belief

. . . court professionals can verbally identify areas of competence and strength that the child exhibits throughout the process, and identify areas of talent or ability that they may witness, no matter how small. . .

Court professionals can play an important role supporting these factors by serving as a corrective relationship for the child. For example, court professionals can verbally identify areas of competence and strength that the child exhibits throughout the process, and identify areas of talent or ability that they may witness, no matter how small or seemingly insignificant.

Acknowledging challenging situations, while mirroring healthy coping responses can provide a child or adolescent with language to manage a difficult situation. Court professionals can also encourage court-involved children and adolescents to maintain connections to their friends and school and support any spiritual beliefs or connections they may hold.

Build the child's relational capacity.

There are several ways in which child-serving professionals can promote a child's well-being and

(*Cont'd on p. 10*)

Sidebar 2

Strategies for Managing the Needs of Special Education Students with Early Trauma Histories

by Susan Craig

Many court-involved children with early trauma histories receive special education services. These services are provided when children's poor self-regulatory skills and limited executive functioning restrict their ability to learn and develop social skills. Children identified for special education are often coded as learning disabled, behavior disordered, or language delayed. Some are diagnosed as having Attention Deficit Disorder (ADD), Attention Deficit Disorder with Hyperactivity (ADHD), or Asperger's Syndrome.

Regardless of the label, an early trauma history usually affects how children think and reason, how they view themselves and the world around them, and how they process information. Weaknesses in these areas make their involvement with the courts challenging. When an attorney knows what to expect, positive outcomes are more likely.

Recognize Faulty Logic

Children develop their understanding of core concepts like cause and effect, prediction and estimation, sequence, and self-awareness by interacting with predictable, loving caregivers. When deprived of these formative experiences they make faulty assumptions about themselves and others. They have little insight into the effect their behavior has on others, and they are incapable of learning from their mistakes. They see themselves as victims and feel powerless in their own lives.

Interpret Sullenness as Despair

A learning disability or limited expressive language deepens an already complicated set of cognitive distortions. Children with these issues can appear sullen, and lack remorse for what they have done. The sullenness often reflects their frustration and despair over their inability to stay out of trouble. They are unable to use language to explain their behavior or how they feel. They are out of touch with their bodies and memories. These details are inaccessible to them and those trying to help them. Neither consequences nor rewards help motivate the desired behavior because they see no relationship between what they do and what happens to them.

Strategies for building relationships with these clients include:

- **Establish a timeline of events that led to the client's court involvement.** Let the client tell you his version first. Listen neutrally. Write each step on a separate index card. Then review the sequence with him. Correct or clarify any areas of faulty logic or misrepresented facts. Using this type of visual timeline addresses the inability to think sequentially observed in many children with early trauma histories.
- **Give the client "court appropriate" language.** Include how to address the judge, what words or phrases are not allowed, etc. Do not assume the client knows any of this, or is capable of generating them spontaneously. Stress hormones shut down the area of the brain responsible for expressive language. When children with early trauma histories are anxious, they are quite literally "at a loss for words."
- **Use role playing and rehearsal strategies to practice appropriate courtroom interactions.** These strategies help children with early trauma histories compensate for deficits in their ability to meet behavioral expectations of a new environment.
- **Familiarize the client with the courtroom.** If possible, visit the courtroom with the client before his appearance, so he is familiar with the physical plant. At the very least, show the client pictures of the courtroom, explain who sits where, and what role each person plays.
- **Walk the client through what happens in court or when they meet with you.** This strategy helps the client anticipate a sequence of events and prepare to participate in it. The client is less likely to be caught "off guard," a common trigger for traumatized children.

Expect to Be Rejected or Ignored

Children's early experiences define how they see themselves, their caregivers, and the world around them. When parents are deeply attached to their children and have good coping skills themselves, children tend to think of adults as available and competent. They expect to be taken care of, and feel comfortable exploring the world around them. They are well prepared to meet the challenges of a dynamic and ever-changing world view.

Children with early trauma histories or poor attachment relationships seldom have this kind of relationship with their caregivers. Their parents often have poor coping skills, and have trouble managing stress. Parents often neglect their children's need for protection and reassurance. These children experience adults to be unavailable or incompetent. They don't expect to be cared for, and view the world as dangerous and insecure. They have a limited vocabulary to explain what they think. They have a rigid mindset that makes it hard to meet new challenges, accept help, or allow others to change their mind about themselves.

Strategies for establishing trust

with distrustful clients include:

- **Emphasize safety when a client's distrust of authority stems from an early trauma history.** This is most easily achieved by using the same, predictable framework for all conversations and interactions with them.
- **Practice "empathic objectivity."** Take nothing that your clients say personally, and frequently remind yourself to avoid confrontation. Children with early trauma histories are masters at drawing professionals into a "re-enactment" of their destructive relationships with early attachment figures. If necessary, walk away until you can deal with the situation in a neutral manner.
- **Manage the "double struggle"** of keeping your own emotions in check as you de-escalate the client's arousal and/or threatening behavior.
- **Praise the client for positive behaviors.** When possible, give specific praise for behaviors that show an ability to take responsibility for positive behaviors or a willingness to accept help from others.

Reduce Stress to Improve Problem-solving

The brain uses one of two networks to process incoming information. The first monitors incoming information for evidence of any potential for threat. It operates somewhat unconsciously regulating the body's stress response. Protective in nature, it triggers the "fight, flight, or freeze" reaction when it perceives danger.

The second network is less reactive, and can override the impulses of the lower brain with logic and reassuring self-talk. Referred to as "executive function," this area of the brain is responsible for planning, goal setting, pattern recognition, and other executive functions.

Both information-processing systems develop within the context of children's early attachment relationships. Children learn self-control when caregivers are available to help them regulate their emotions and internal states. Their capacity for executive functioning grows with repeated experiences of predictable routines, interactive play opportunities, and ongoing conversations about what they are doing and why.

Children with early trauma histories seldom develop age-appropriate executive functioning skills. As a result, they have poor problem-solving skills, are easily aroused, and overreact to perceived threats or dangers. They resist change in routine and are vulnerable to "meltdown" for no apparent reason. They have difficulty generating other ways of looking at a situation, or solving a problem. When threatened, they are prone to depression and self-mutilation, sometimes cutting themselves as a way of managing their anxiety.

Strategies for interacting with clients who display these behaviors include:

- **Give clients choices about how to complete tasks.** For example, if paperwork needs to be done, give the client a choice to complete it alone or with help. This prevents power struggles and noncompliant behaviors.
- **State your case simply.** Avoid long explanations, and unnecessary words.
- **Use space and silence to de-escalate behavior.** If the client appears agitated, say "It looks like you need some time to re-group. I'll wait until you're ready. Take your time." Maintain a neutral body position and facial expression until the client is ready to talk to you. If necessary, set a kitchen timer, so they know how long they have.
- **Give alternate solutions to client problems.** Put each solution on a separate index card. Say, "Here are some alternative solutions to the problem we're trying to solve. Do you want to try one of these or do you have another idea? We need to pick one."
- **Do not demand eye contact from clients with autism or Asperger's Syndrome.** It is difficult for people with these disorders to process what is being said while looking at the speaker. An averted glance usually means the person is listening, and if given enough time will respond.
- **Avoid surprises and sudden changes in routine.** Children with an early trauma history have trouble "shifting gears" or dealing with novelty.
- **Use rituals to engage clients.** Use the same greeting each time you meet, follow the same sequence of events during meetings, and whenever possible meet in the same room. Give clients a topic list to be covered so they can cross items off as they are addressed.

Court experiences will almost always be difficult for children with trauma histories, especially if these children also suffer from cognitive disabilities. Patience and client-focused strategies can help manage the stress and lead to better outcomes.

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Sidebar 3:

Screening, Assessment and Evaluation

- **Screening** refers to a brief measure, test, instrument or tool that is universally administered to children by individuals working directly with children (i.e., child welfare workers, attorneys, educators, etc.). Screening tools focused on trauma typically detect exposure to potentially traumatic events/experiences and/or endorsement of possible traumatic stress symptoms/reactions, although they are not diagnostic. Information from a trauma screening tool is used to determine if a child needs to be referred for a trauma-informed mental health assessment.
- A trauma-informed **mental health assessment** is a comprehensive process conducted by a trained mental health provider/clinician. It examines multiple domains, including trauma and developmental history, traumatic stress symptoms, broader mental health symptoms, caregiver/family needs or difficulties, environmental/systems issues, and resources and strengths (for child, caregiver, family, and community). It typically includes several forms of data collection, including clinical interviews with the child/caregivers/and others, administration of tests, and behavioral observations.
- **Psychological evaluation** refers to a comprehensive diagnostic evaluation of all domains of functioning, including an assessment of the child's cognitive (both intellectual and achievement), developmental, social/emotional and personality. It is completed by a licensed psychologist and is typically conducted in response to a specific referral question.

The type and number of tools administered in an evaluation often varies depending on the reason for referral. However, use of a standard battery of tests is not uncommon. A psychological evaluation may contain components of a trauma assessment but depending on the referral question this may not be indicated. A psychological evaluation may be warranted under several circumstances, including if there is confusion between the child's self-report and the parent report, if a question related to the onset and duration of symptoms is unclear, or if there is question regarding defensive/coping processes or personality structure.

(*Cont'd from p. 7*)
resilience. A key to promoting well-being and resilience is by developing a child's relational capacity. This may occur through informal supports, such as participating in mentorship programs, sports, and other activities. It can also occur through the referral to a trauma-informed evidence-based practice. The Institute of Medicine (IOM) defines "evidence-based practice" as a combination of the following three factors: (1) best research evidence, (2) best clinical experience, and (3) consistent with patient values. Current research on treatment models for child traumatic stress suggests several common elements found in effective evidence-based trauma treatment (see Sidebar 4). Court professionals working with court-involved children and adolescents should be able to identify these elements in any proposed treatment plan for children presenting with primary trauma issues.

Advocate for evidence-based treatments.

A number of evidence-based trauma treatments are available that include these components and research supports their efficacy with children and families who have experienced trauma. When working with court-involved children and adolescents, be aware of treatment practices in your region that serve children who have experienced trauma and provide referrals as needed. (Sidebar 5 lists evidence-based trauma treatment programs for children and/or adolescents rated by the California Evidence-Based Clearinghouse for Child Welfare. See www.cebc4cw.org for more information).

Seek trauma-informed therapists.

Many therapists who treat trauma-exposed children lack specialized knowledge or training in trauma and its treatment. When you have a choice of providers, select a therapist who is most familiar with the available evidence and has the best training to evaluate and treat the child's symptoms. (Sidebar 6 provides 10 questions court professionals can use to advocate for trauma-informed mental health services for court-involved children and adolescents.)

Parent Trauma

Many parents involved in the child welfare system have histories of trauma and substance abuse. A recent study found 61% of infants and 41% of older children in out-of-home care had a caregiver who reported active alcohol or drug abuse. Whether parents experienced the traumatic events during childhood or adulthood, these events can affect their ability to engage in healthy and positive parent-child interactions, protect their children from harm, and help their children recover from traumatic events.

Assess the parent's trauma history.

A parent's trauma and substance abuse history may not only increase the child's risk for maltreatment, but can also impact the parent's ability to mitigate the impact of a trauma on the child. How a child responds and fares after a traumatic experience depends partly on the caregiver's ability to manage his own emotions related to the trauma, the caregiver's own trauma history, and the caregiver's ability to respond to the child and re-establish safety. A parent with an unresolved

trauma history is less likely to be able to manage her own emotional reaction and, therefore, less likely to be able to support the child. In fact, it is common for a child's traumas to trigger a parent's own traumatic memories, which can interfere with the parent's ability to protect and support the child and could lead the parents to engage in maladaptive coping mechanisms, such as substance abuse.

Understand how caregiver functioning affects child functioning. Child welfare system interventions, such as removing children from their parents, can be highly distressing for parents and can serve as reminders of parents' past traumatic memories and further impede parent functioning. Across multiple studies, caregiver functioning has been found to be a major predictor of child functioning following the child's exposure to traumatic experiences. Thus, a trauma-informed child welfare system needs to support the caregivers and provide intervention for the caregivers' symptoms if it hopes to improve child outcomes. Failure to understand and address parent trauma can lead to the following:

- Failure to engage in treatment services
- An increase in symptoms
- An increase in management problems
- Re-traumatization
- An increase in relapse
- Withdrawal from service relationship
- Poor treatment outcomes

Identify and address parents' trauma-related needs. As court professionals, you can empower parents by ensuring efforts to identify and address their trauma-related needs and involving them in decisions:

- Ask what services they think might be helpful, recognizing that they may not know.
- Identify mental health services, especially trauma-informed services the parent has already received and the response to those services.
- Ensure there is a trauma-informed assessment conducted on each parent that includes their relationship with each child.
- Let parents know you understand the significance of their past trauma, while still holding them accountable for the abuse and/or neglect that led to system involvement.

Conclusion

Court-involved children and adolescents have often experienced many traumatic events that may impact their behaviors, ability to regulate their emotions, and capacity to develop positive and stable relationships. Court professionals play a critical role understanding how a child's trauma history may be impacting their behaviors and ability to cope with the situation, but also in providing necessary supports to assist them in the court process. These supports include encouraging a child's strengths and resilience, empathizing with a child's challenges while providing them with corrective language and healthy coping strategies, and encouraging the child to sustain important relationships in their lives.

Further, court professionals can work with other professionals by supporting the mental health needs of children and their families involved in the dependency system and understanding the core components of effective trauma treatment. Recognizing trauma symptoms through screening and assessment is the first step, followed by efforts to secure mental health supports and evidence-based treatments. Finally, court professionals can support the entire family by understanding that many parents have their own history of trauma and would benefit from their own trauma screening and referral for mental health services as needed.

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Sidebar 4:

Core Components of Evidence-Based Trauma Treatments

- Building a strong therapeutic relationship between the child and therapist.
- Providing psychoeducation to children and their caregivers about the traumatic event experienced and common responses to trauma.
- Parent support, joint parent-child therapy (when the parent and child meet together with a therapist), or parent training.
- Emotional expression and regulation skills that increase children's abilities to identify various feelings and develop coping skills to manage feelings such as anger, sadness, or anxiety.
- Anxiety management and relaxation skills to help the child develop relaxation skills to cope with trauma-related distress.
- Trauma processing and integration in which the therapist will help the child find a way to gradually express her traumatic experience and process related feelings about how the trauma has impacted the child's life.
- Personal safety training and other empowerment activities.
- Resilience and closure: At termination of treatment, the therapist focuses on helping the child identify strengths and areas of resilience to cope with future adversity.

Sidebar 5:

Evidence-Based Trauma Treatment Programs for Children and Adolescents

The California Evidence-Based Clearinghouse for Child Welfare (CEBC, www.cebc4cw.org) reviews published, peer-reviewed research for programs related to child welfare. The following trauma treatment programs for children and adolescents have been rated by the CEBC into the following scientific rating categories. Their target populations from the website are included below:

Well-Supported Research Evidence

Eye Movement Desensitization and Reprocessing (EMDR)—Target Population: Children and adults who have experienced trauma. Research has been conducted on posttraumatic stress disorder (PTSD), posttraumatic stress, phobias, and other mental health disorders.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)—Target Population: Children with a known trauma history who are experiencing significant PTSD symptoms, whether or not they meet full diagnostic criteria. In addition, children with depression, anxiety, and/or shame related to their traumatic exposure. Children experiencing childhood traumatic grief can also benefit from the treatment.

Supported Research Evidence

Child-Parent Psychotherapy (CPP)—Target Population: Children age 0-5 who have experienced a trauma, and their caregivers.

Prolonged Exposure Therapy for Adolescents (PE-A)—Target Population: Adolescents who have experienced a trauma (e.g., sexual assault, car accident, violent crimes, etc.). The program has also been used with children 6 to 12 years of age and adults who have experienced a trauma.

Promising Research Evidence

Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)—Target Population: Caregivers who are aggressive and physically, emotionally, or verbally abuse their children. Children who experience behavioral dysfunction, especially aggression, as a result of the abuse, as well as high-conflict families who are at-risk for physical abuse/aggression.

Child and Family Traumatic Stress Intervention (CFTSI)—Target Population: Children ages 7-18 recently exposed to a potentially traumatic event, or having recently disclosed physical or sexual abuse, and endorsing at least one symptom of posttraumatic stress.

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)—Target Population: 3rd through 8th grade students who screened positive for exposure to a traumatic event and symptoms of post-traumatic stress disorder related to that event, largely focusing on community violence exposure. It has been used in high school settings as well.

Combined Parent-Child Cognitive-Behavioral Therapy (CPC-CBT)—Target Population: Children ages 3-17 and their parents (or caregivers) in families where parents engage in a continuum of coercive parenting strategies.

Fairy Tale Model (Treating Problem Behaviors: A Trauma-Informed Approach)—Target Population: Teens (13 to 18 years of age) with emotional and behavior problems. It is so named because it is taught with the telling of a fairy tale, in which each element of the story corresponds to one of the phases in treatment.

Preschool PTSD Treatment (PPT)—Target Population: 3-6 year-old children with posttraumatic stress disorder (PTSD) symptoms. PPT is a manualized, 12-session cognitive behavioral therapy protocol to treat very young children with posttraumatic stress disorder (PTSD) and trauma-related symptoms.

Sanctuary Model—Target Population: This program is not a client-specific intervention, but a full-system approach that targets the entire organization. The focus is to create a trauma-informed and trauma-sensitive environment in which specific trauma-focused interventions can be effectively implemented.

Seeking Safety for Adolescents—Target Population: Adolescents with a history of trauma and/or substance abuse. Seeking Safety for Adolescents is a present-focused, coping skills therapy to help people attain safety from trauma and/or substance abuse. The treatment may be conducted in group or individual format for adolescents (both females, and males) in various settings.

SITCAP-ART—Target Population: At-risk and adjudicated youth, ages 12-17, with a history of trauma and/or loss. SITCAP-ART is designed for at-risk and adjudicated youth. SITCAP-ART integrates cognitive strategies with sensory/implicit strategies.

Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET)—Target Population: Youth ages 10-18 with posttraumatic stress disorder (PTSD). TARGET provides practical skills that can be used by trauma survivors and family members to de-escalate and regulate extreme emotional states, manage intrusive trauma memories in daily life, and restore the capacity for information processing and autobiographical memory.

Trauma-Focused Coping (TFC)—Target Population: Children and adolescents in schools who have suffered a traumatic exposure (e.g., disaster, violence, murder, suicide, fire, accidents). TFC targets the internalizing effects of exposure to trauma in children and adolescents, with an emphasis on treating posttraumatic stress disorder (PTSD) and the collateral symptoms of depression, anxiety, anger, and an external locus of control (i.e., tendency to attribute one's experiences to fate, chance, or luck).

II Center within the National Child Traumatic Stress Network (NCTSN), and the ACYF-funded "California Screening, Assessment, and Treatment Initiative" (CASAT). Her areas of focus include trauma screening and assessment practices, creating trauma-informed systems and innovative practices designed to improve the service delivery system for children who have experienced trauma.

This article is one in a series produced under a grant from the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this article those of the contributors and do not necessarily represent the official position or policies of the U.S Department of Justice or ABA.

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Sidebar 6:

Questions to ask Agencies/Therapists who Provide Services

1. Do you conduct a comprehensive trauma-focused mental health assessment? What specific standardized measures are given? Do you provide trauma-specific or trauma-informed therapy? If so, how do you determine if the child needs a trauma-specific therapy?
2. How familiar are you with evidence-based treatment models designed and tested for treatment of child trauma-related symptoms?
3. Do you have specific training in an evidence-based trauma treatment model? If so, what model(s), when were you trained, where were you trained, by whom were you trained, how much training did you receive?
4. Do you receive ongoing clinical supervision and consultation on any of the models that you have been trained in?
5. How do you approach therapy with children and families who have been impacted by trauma (regardless of whether they indicate or request trauma-informed treatment)?
6. What does therapy typically entail? Can you describe the core components of your treatment approach?
7. How are parent support, joint parent-child therapy, parent training, and/or psycho-education offered?
8. How are cultural competency and special needs issues addressed?
9. Are you willing to participate in the multidisciplinary team (MDT) meetings and in the court process, as appropriate?

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SUPREME COURT NEWS

Can Mandatory Life Without Parole Sentences for Juveniles be Applied Retroactively?

The U.S. Supreme Court will consider whether its 2012 ruling in *Miller v. Alabama* banning mandatory life without parole sentences for juvenile offenders may be applied retroactively. Courts around the country have split on the issue. Many courts have ruled *Miller* creates a substantive rule that must be applied to juveniles sentenced before June 2012. Other courts have ruled the decision is procedural and does not apply to those juveniles already sentenced; further, these courts have found *Miller* did not ban life without parole, but rather that such sentences could not be mandatory.

In the underlying case, *Toca v. Louisiana,* a juvenile was charged with accidentally shooting his partner in an unsuccessful armed robbery attempt in 1984. He was sentenced to mandatory life without parole. After *Miller*, a judge ruled the decision applied retroactively to Toca. However, the Louisiana Supreme Court later overturned that decision, concluding *Miller* was not retroactive.

Toca's attorney has sought a resentencing hearing and urged the court to apply *Miller* retroactively, citing the majority of courts that have done so. Oral arguments will likely occur in spring 2015.

The ABA Center on Children and the Law's Child and Immigration Project and the Immigrant Legal Resource Center have prepared a fact sheet series explaining the features of the Reuniting Immigrant Families Act. An overview appears here. Stay tuned for fact sheets exploring the overview topics in more detail.

The Reuniting Immigrant Families Act

by the ABA Center on Children and the Law and the Immigrant Legal Resource Center

Overview

The Reuniting Immigrant Families Act ("SB 1064" or "The Act"), enacted September 30, 2012, is the nation's first law addressing the reunification barriers faced by many immigrant families involved with the child welfare system. The law clarifies that maintaining children's ties to their families remains the priority despite barriers imposed by immigration status, including immigration detention and deportation.

Reasonable Efforts

The Act clarifies that reasonable efforts must be provided to reunify a family after the court and child welfare agency consider the particular barriers a detained or deported parent faces in accessing services and maintaining contact with the child.

- The Act lists examples of ways the agency can help deported parents including helping them contact local child welfare authorities and obtaining services in their country.
- Parents detained by immigration authorities can be ordered to engage in counseling, parenting classes, or vocational training programs under the Act, but only where those services are actually accessible. The Act also provides examples of how the agency can assist detained parents, including with phone and in person visitation, transportation, and services for relatives and foster parents caring for the child.

Extended Reunification Periods

The Act added immigration-related issues to the list of compelling reasons for which the court can extend the period of family reunification services. As with other listed special circumstances, extension of the service period is not automatic. In determining whether to extend a reunification deadline, the court will examine:

- Parental contact & visitation (taking into account any barriers posed by the parent's immigration situation);

> The law clarifies that maintaining children's ties to their families remains the priority despite barriers imposed by immigration status, including immigration detention and deportation.

- The parent's progress in resolving the issues that led to the child's placement in foster care; and
- Whether the parent has demonstrated the capacity or ability to complete his or her case plan.
- Under SB 1064, courts also have the authority to extend the time period in which the agency may pursue a diligent search for a parent who may have been detained or deported, or to find a potential relative placement.

Relative Placements

SB 1064 includes a number of provisions confirming equal treatment of relatives, regardless of immigration status. Recent changes to the law:[1]

- Prohibit the disqualification of relatives (including parents) based on immigration status alone;
- Clarify that relatives receive preferential placement consideration regardless of immigration status;
- Allow certain alternative types of documentation for non-citizen relative records checks; and
- Describe how a child removed from the custody of his or her parents may be placed with a relative outside the United States if the court finds that placement to be in the best interest of the child.

Immigration Relief Options

SB 1064 requires the California Department of Social Services to provide guidance to child welfare agencies on assisting children eligible to apply for Special Immigrant Juvenile Status (SIJS), T and U-visas, and Violence Against Women Act self-petitions.

Encouraging Agency/Consulate MOUs

SB 1064 requires the California Department of Social Services to provide guidance on establishing Memoranda of Understanding (MOUs) with appropriate foreign consulates in juvenile court cases in which a parent has been arrested and issued an immigration hold, detained by DHS, or deported. Sample MOUs & relevant policies are available at http://research.jacsw.uic.edu/icwnn/state-specific-resources/#California

This overview was prepared by the ABA Center on Children and the Law's Child Welfare and Immigration Project, and the Immigrant Legal Resource Center.

Endnotes

[1] Most of these recent changes were made by SB 1064. The last, which addresses a child's placement outside the United States, was added by AB 2209, enacted July 17, 2012.

New Guidelines for Vision Screening in Preschoolers

All children should undergo vision health screening between age 36 and 72 months—preferably every year—using evidence-based test methods and with effective referral and follow-up, according to recommendations published in the January 2015 issue of *Optometry and Vision Science*.

The National Expert Panel to The National Center for Children's Vision Health makes recommendations for vision health screening in preschool-aged children, including specific guidance for screening tests and the screening process. The recommendations are available as open access articles on the journal website: http://optvissci.com/.

Vision Health Screening in Preschoolers: Recommendations and Best Practices

Preschool-aged children need screening for early detection of vision problems, particularly refractive error (vision problems requiring glasses), amblyopia ("lazy eye"), and strabismus (a disorder of eye alignment). Prompt diagnosis and referral to an eye care professional (optometrist or ophthalmologist) has major implications for school readiness and child development.

The recommendations are intended to guide the development of vision health screening programs in school and community settings, performed by appropriately trained lay screeners or nurses. The National Expert Panel was made up of leading professionals in optometry, ophthalmology, pediatrics, public health, and related fields.

The Panel recommends vision health screening or comprehensive eye exams for all children, between age 36 months and before age 72 months. Annual screening is defined as "best practice"; screening at least once after age three years is an "accepted minimum standard."

Certain children—including those with recognized eye or vision abnormalities, developmental disorders, and other high-risk groups—need immediate referral to an eye care professional, rather than screening. The Panel also outlines recommendations for re-screening or referral in young children who are unable or refuse to complete screening.

Prompt diagnosis and referral to an eye care professional (optometrist or ophthalmologist) has major implications for school readiness and child development.

Recommendations for Tests, Training, and Procedures

The guidelines specify acceptable screening methods, along with definitions of pass/fail screening results. The Panel identifies two "best practice" screening tests: visual acuity testing with eye charts and instrument-based testing using equipment called an autorefractor. The acuity test recommendations call for testing of one eye at a time, using specific types of vision charts and test distances. Specific models of autorefractors with adequate supporting evidence are identified.

The guidelines also address the training and certification of screeners, requirements for space, equipment and supplies, and recording and reporting of the results to the family, health care providers, school, and state agencies.

The January issue also presents an additional National Expert Panel report with recommended measures and definitions for determining vision health screening rates and appropriate follow-up for preschool-aged children. Another report proposes the establishment of integrated health information systems to help ensure quality eye care for children at the local, state, and national levels.

After publication, the recommendations will be periodically updated and posted on the on the website of The National Center for Children's Vision Health: http://nationalcenter.preventblindness.org/. The website also offers supporting materials and demonstrations of the vision health screening process for communities and organizations seeking to establish screening programs.

"Unfortunately, many children receive neither appropriate screening to help identify those who need immediate eye attention, nor a comprehensive examination by an eye care professional prior to beginning school," comments Anthony Adams, OD, PhD, Editor-in-Chief of Optometry and Vision Science.

"These National Expert Panel reports are an important starting point for identifying vision health screening procedures and tests and definitions of expected performance measures to be tracked across the country," said Adams. "They also advocate the establishment of integrated health information systems, with the goal of ensuring that children with problems identified on screening tests receive appropriate, comprehensive eye examinations and follow-up care."

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ABA Resources

For more information on **child health and child development,** visit the ABA Center on Children and the Law's Child and Adolescent Health Project online:

www.americanbar.org/groups/child_law/what_we_do/projects/child-and-adolescent-health.html

Do Fatherhood Programs Work? Four Programs to Watch

The Fatherhood Research and Practice Network, a collaboration between Temple University and Denver's Center for Policy Research, has awarded $350,000 to four projects that will evaluate fatherhood programs in order to determine how to best serve low-income fathers. Selected from an initial group of 71 proposals, the projects are in Goldsboro, North Carolina; Baltimore; Chicago and Ohio.

Fatherhood programs provide services to help dads become more involved in their children's lives and assist them in removing barriers that may prevent them from doing so. They often serve low-income, nonresident or minority fathers. The four FRPN funded projects will examine the effectiveness of specific fatherhood programs and services and include:

Circle of Parents – Goldsboro, N.C.
A research-practice partnership between Paul Lanier at the University of North Carolina School of Social Work, and the Wayne Action Group for Economic Solvency (WAGES) in Goldsboro. The primary purpose is to test the impact of Circle of Parents, a peer support network, on the involvement of 200 fathers of young children receiving Head Start/Early Head Start services.

Developing All Dads for Manhood and Parenting – Baltimore
The Center for Urban Families and lead researcher Bright Sarfo of Columbia University will test the effectiveness of "Developing All Dads for Manhood and Parenting" among 140 low-income, African-American fathers. The study will explore how participation is associated with changes in paternal involvement and economic security; if changes in fathers' parental behaviors can be correlated to childhood wellbeing; and how individual characteristics impact the curriculum's effects on fatherhood behavior and childhood wellbeing.

The Home Visiting for Fathers Study – Chicago
Conducted by University of Denver's Jennifer Bellamy in collaboration with Metropolitan Family Services and four other Chicago-based programs, the study includes a group of 200 fathers and 200 mothers participating in Dads Matter (a home visiting service enhancement). The study will examine how certain factors may boost or dampen efforts to better serve fathers in home visiting programs such as employees' attitudes about working with fathers, and the attitudes of mothers and fathers about fathers' participation in home visiting.

The Ridge Project – Ohio
Led by Baylor University researchers, in collaboration with Ohio's Ridge Project Inc., a family strengthening services program, this study includes 400 low-income fathers drawn from nine cities—Canton, Cincinnati, Cleveland, Columbus, Findlay, Lima, McClure, Toledo and Wooster—who will attend a 20-hour program over five weeks. Researchers will analyze improvement over time in father-child relationship quality.

"Research shows that nonresident fathers can positively influence their children's lives," said Jay Fagan, co-director of the FRPN and social work professor at Temple. "But in order to better serve fathers who face significant barriers to being involved with their children, the fatherhood field must have a better understanding what services are most effective. These four projects are well designed, scientifically valid evaluation studies that have the potential to positively impact program delivery and outcomes."

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