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INTERDISCIPLINARY EXCHANGE

Mental Health Assessments for Infants and Toddlers

by Sheri L. Hill and JoAnne Solchany

Infant Mental Health… a contradiction in terms?

It is often difficult to think about infants and young children dealing with mental health issues, so difficult in fact, that it is easily dismissed by some—seen as irrelevant or implausible. Can a four-month-old infant be depressed? How can an eight month old have an adjustment disorder? What could possibly suggest that a two year old might be dealing with post-traumatic stress?

We like to believe that infants and toddlers are immune from these issues, that parents can protect them, or that when their age is measured in months rather than years they will be inherently insulated and more resilient. Accepting that an infant might have mental health issues might be tolerated for the isolated case, but accepting the concept of *infant mental health* takes us into uncomfortable territory, which tends to challenge our understanding of infants and children in the world.

Infants and toddlers do experience mental health issues. They do experience stress and emotional pain in response to separations, witnessing violence, experiencing neglect, or being denied the stability of a primary caregiver. If we look at what infants see and try to see through their eyes, then the impact of those experiences becomes clearer. For example, infants cannot ask for help when feeling threatened or unsafe. They instead protect themselves by doing the only thing they can do, shut down or withdraw. If this becomes a pattern, it can quickly (within just a few days) develop into depression—often characterized by refusing food, crying incessantly, experiencing sleep disruptions, refusing to make eye contact, and "just giving up." In fact, although infant depression was first identified over 60 years ago, it is still difficult for many of us to bear the thought that an infant can experience the helplessness, sadness, and emptiness seen in depression.

What Is "Infant Mental Health"?

ZERO TO THREE: National Center for Infants, Toddlers and Families defines "infant mental health" as the *capacity of the child from birth to three to experience, regulate and express emotions; form close and secure interpersonal relationships; and explore the environment and learn. Infant mental health is synonymous with healthy social and emotional development*. It is how the child fits into the world around them—attachment with their primary caregiver, relationships with important others, smooth developmental progress, the increasing ability to control behavior and express emotions, and the ability to explore and play.

Understanding infant mental health means understanding the world as experienced by the baby. For example, in a divorce situation the parents may be extremely stressed as they go through negotiations and court procedures. The young child may be especially vulnerable to the same stressors—the separations, moving, fewer resources—as well as the added stress of not being able to depend on parents in the usual way as one or both are so focused on the divorce. What is it like for a baby whose world has been mom and dad—having shared meals with them, and felt confident knowing they were both available in the safe haven called home—when suddenly it all falls apart? There are also those young children who fall into circumstances that put them at risk very early in life. What of the child of the addicted parent who is trying hard to do the right

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What's Inside:

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thing—staying clean and sober, maintaining adequate housing, and working—but is derailed by their addictions? This child does not see addictions or sobriety. This child sees mom or dad becoming unavailable to them.

Infant mental health assessments provide opportunities to see the world through the eyes of the child. They assess how the child is responding to their environment, how they are developing, what kinds of problems they may be experiencing, and how supportive their caregiving relationships are. They allow us to explore what is going on with that baby and answer questions such as:

- How is this child being impacted?
- What might this mean for the future?
- Will this child be at risk?
- What is the baby's experience of the situation?
- Can that baby seek and find comfort with the available caregivers?
- Are current experiences impacting development and growth?
- What protective factors are in place for this child?

In what kinds of cases are infant mental health assessments useful?

Separation from Primary Caregiver(s). Any case which involves a young child possibly separating from a primary caregiver should, at minimum, involve a consult and may require both an infant mental health assessment as well as ongoing monitoring. Separations, even if temporary and done with the best of intentions, can bring about grief and mourning that without adequate support can lead to extreme sadness and withdrawal. These could include:

- divorce cases that are initiated in pregnancy or in a child's first three years of life,
- cases involving termination of parental rights,
- cases involving incarceration of a primary caregiver,
- cases wherein a caregiver enters residential rehabilitation.

Traumatic Events. An infant mental health consultation or assessment is recommended with any case involving exposure to domestic or community violence or other traumatic events. Babies can and do develop traumatic stress responses including re-experiencing of traumatic events. Contrary to popular belief, babies do remember—though not in the same ways that we think of remembering as adults. A variety of events, including hospitalization, may be experienced by the very young child as traumatic. However, no two children experience or respond to the same event, even a traumatic one, in the same way. Assessment allows us to explore how an event has impacted an infant or toddler.

Outside Placements. Any dependency case involving the placement of an infant or toddler (0-3) outside the care of their primary attachment figure warrants an assessment. Removing a child from her home is a traumatic experience for that child, even if it is for excellent reasons. Infants and young children can and do attach to multiple caregivers, but they rely—physically and psychologically—on a primary attachment figure. Removing a child from his primary attachment figure equals plunging him into the unknown; it is scary and overwhelming even if the child already has, or can develop, a trusting and loving relationship with the alternate caregiver. Primary attachment figures are not interchangeable. Losing one during the early years means the young child will experience abandonment, even when it is in the best interests of the child. Assessment helps us consider how the experience of removal, and subsequent placement, impacts the child and what can be done to provide support through these changes.

Red Flag Behaviors. Assessments are also useful in cases where caregivers report seeing "red flags" around the child's development or behavior. For example, babies often show us they are distressed through their eating, sleeping, elimination, and with aggression in their relationships. It is common to see development become delayed or even go backwards with children who are experiencing mental health issues and no intervention. An assessment helps to identify how a child's experiences are impacting his overall developmental progress and well-being (see sidebar, p. 138).

Who typically conducts the assessment? What qualifications should the evaluator have?

Infant Mental Health Training. The evaluator should have had specific training in *infant mental health, not just child development*. Training in infant mental health should be substantial, including focus on infant development, parent-child relationships, emotional functioning, pathology, diagnostics, assessment, and intervention. An increasing number of states have training programs and infant mental health centers such as our Center on Infant Mental Health and Development at the University of Washington's School of Nursing. The mission of these programs is to provide education and clinical training on the unique needs and circumstances of the youngest of children (see the Resources sidebar for details). Because they cannot tell us their story, infants and young children can be one of the most challenging and difficult popula-

tions to understand and work with.

At a minimum, the person conducting or coordinating the assessment should be able to ensure there is a thorough assessment of the whole child. The assessment should not be limited to an assessment of the parents' skills or to whom the child seems "most attached." It is optimal to look *simultaneously* at what the caregiver(s) bring(s) to the setting AND what the baby brings to the setting, as well as how the child and caregiver work together in both calm and stressful times.

Experience with Infants/Toddlers. Infant mental health evaluators should have a background with substantial experience with infants and toddlers. Experience conducting evaluations on young children or families does not automatically equate to expertise with infants or toddlers. Assessing preverbal children requires training and experience in observing babies and an understanding of what capabilities an infant does and does not have to interpret the world. An infant mental health specialist cultivates his or her ability to see the world through the eyes of the infant. Babies' behaviors do not always mean what an untrained eye might initially guess. For example, babies are often more likely to show their distress and act out when they are in the presence of the caregiver with whom they feel the most secure. This can seem counterintuitive to those who have not worked with this young age group.

Skill in Evaluating and Diagnosing Young Children. Evaluators should also be familiar with the DC 0-3, the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (1994, 2005)*. This is a diagnostic system specifically designed to evaluate and diagnose children from birth through age three. It frames mental health issues in the

Case Study: Shelby

This case shows how an infant mental health assessment was used in a dependency case.

Shelby, age six months, and Karin, age three, were both born positive for cocaine. Their mother continued on a rocky road of addiction—trying to remain drug-free but falling back on her old habits periodically. The children's father was in jail on drug charges and the 21-year-old mother was frequently homeless. Finding the children living with their dazed mother in a tent, near an overpass on a rainy winter day, prompted removal and placement of the children into foster care with the mother's aunt and uncle, who were happy to take in the children.

An initial mental health assessment on both girls revealed two children who were behind developmentally, were hypervigilant and fearful of people around them, and hesitant to make eye contact. Karin sat silently, refusing to talk to anyone, keeping her head down and looking confused. Shelby was irritable, waking several times throughout the night, and crying inconsolably.

In the care of their relatives the girls began to improve. Karin began to seek out her new caregivers when she was hurt or needed something. She began to demonstrate a range of emotions, including anger, sadness, and joy. She slept soundly and did not have any nightmares for over three weeks. Shelby gained two pounds in a month, moving her up to the 30th growth percentile. She still woke up during the night but was easily settled when her aunt rocked and reassured her. She would squeal and reach out for her uncle when he came home from work, snuggling with him into the evening.

In the meantime, mom stayed sober for over a month. She secured housing and found a job working at a fast food establishment. She wanted her children to be returned to her. Visitation was ordered and she began to see both girls four times a week at the caseworker's office for two hours each visit. These visits seemed to go well, and the caseworker observed mom interacting positively with the girls. She was able to engage them in play and they seemed to have a good time with her. However, when they returned back to the aunt and uncle, Shelby became hysterical—crying inconsolably and arching her back, refusing to be comforted. Karin became quiet and withdrawn and began to have nightmares again.

An infant mental health assessment update was warranted and the assessor observed the children with the aunt, uncle, and her mom. She also worked with the three-year-old in a play session and spent time interacting with Shelby, as well. The assessment revealed that the children did do well with mom when they saw her; however, they fell apart when they returned to the stability of their aunt and uncle.

Arrangements were made to have mom visit in the aunt and uncle's home for fewer visits (2X/week), with one visit involving mom in a family mealtime. Arrangements were also made for mom to have a weekly meeting with the aunt and uncle to help them connect and review how the girls were doing, what was working well, the established routines, and what the girls needed to thrive. The next step involved mom having an additional weekly visit with each daughter separately, supporting her in getting to know each girl on a one-to-one basis. The aunt and uncle also needed support and coaching as well as guidance on how to include mom in their family interactions. This is a case in progress; it continues to move in a positive direction with all adults focusing on the needs of the young children. It shows how some issues are only resolved through a slower, more thoughtful, and collaborative approach.

Case Study: Jordan

This case shows how an infant mental health assessment was used in a family law matter.

Jordan is 14 months old. His parents separated when he was eight months old. Since then his mother became increasingly depressed, spending little time with him. She provided only basic care, and hardly ever talked to or engaged him. She reported keeping him in his crib sometimes so he would be "safe" as she often found herself falling asleep. Jordan's dad had to increase his work hours to keep up with the additional bills since the separation. When he was able to visit Jordan it often ended in an argument between him and his wife. He criticized her for the untidy home and about Jordan still being in pajamas; she, in turn, yelled at him for being critical, not coming around enough, and not understanding how difficult it was for her.

When the separation began, Jordan would cry and reach out for his parents, who were too busy arguing to acknowledge him. Six months later, he sat quietly, showing no emotion but watching every move and taking in all the hostility around him. Court-ordered parenting evaluations found both parents expressing a great deal of affection and desire for their son, although they also demonstrated a great deal of anger, blame, and belittlement of one another. *Both* parents demonstrated sound knowledge of how to care for a baby and provide adequate financial resources.

Despite this, Jordan had begun to go "downhill." At 14 months, he was still not walking, he would cry when any stranger entered the room, and he did not demonstrate joy or happiness at all—in fact, during an hour home visit Jordan never smiled or tried to engage anyone, even his mother. Jordan had begun losing weight and had not grown in length for the past three months. His movements were slow and floppy, and even when mom or dad reached out to pick him up he just lay quietly, not moving or reciprocating. Mom would often find him laying in his crib, awake, but just staring at his hands or the ceiling.

An infant mental health assessment, which included several observations of Jordan in the context of his home and primary caregivers, found that Jordan was depressed and had fallen significantly behind physically, emotionally, and developmentally. At 14 months, Jordan should have been fairly active, wanting to play and try to walk. Instead, he held his body stiff, lay motionless for much of the time, and seemed to have little or no energy. He should have been demonstrating joy, sadness, frustration, and contentment—but he was not showing any emotion, he was shut down. He should have been reaching out for his parents when he saw them, instead he lay there disinterested. The assessment process provided an opportunity for each of Jordan's parents to see the world through Jordan's eyes. His mom and dad who he loved and admired had unwittingly abandoned him in many ways. Once they could see past their own feelings and begin to understand how Jordan was being impacted, they began to change.

A mutually agreed upon neutral place to transfer Jordan between parents was found and was helpful in reducing some of the hostility between the parents. Both parents were able to develop some understanding of how important they each were to Jordan. This led to them supporting Jordan's relationships with one another through positive discussion. Mom was able to see how her mood and behavior were impacting Jordan and was able to get some help for her depression. Dad was able to see how much his son missed him and created more balance in his work schedule. The challenges did not disappear, but their impact on Jordan lessened and he was able to get back on track with his parents, his growth, and his development. Jordan now smiles and reaches for his mom and dad when he sees them.

context of the development and relationships of the young child. A growing number of localities have accepted this diagnostic criterion to be used with infants and young children in addition to, or in place of, the DSM-IV-TR.

Varied Professional Backgrounds. The evaluator(s) themselves may come from a variety of disciplines—social workers, psychologists, nurses, nurse practitioners, psychiatrists, occupational therapists, pediatricians, speech-language pathologists, or early intervention specialists. Infant mental health assessments are often conducted by teams. For example, the speech therapist may conduct a speech evaluation, an occupational therapist may evaluate the child's skills and abilities, and the psychiatric nurse practitioner or psychologist may evaluate the child's emotional, social, and family functioning. Collaborative skills are critical for an effective infant mental health assessment, and can be particularly helpful for the courts.

What does an infant mental health assessment typically include?

An infant mental health assessment should include evaluation of the child's:

- **primary attachment relationship—**How is this relationship constructed? How does the child experience this relationship? Can the child depend on this individual to provide for their needs?
- **significant relationships—** specifically those who provide any kind of care or regular interaction. Parent(s), grandparent(s), other relatives, foster parent(s), and child care providers may all fall into this group; as would any partners of caregivers who may regularly have a great deal of influence on that baby's environment and care.

For foster children, if reunification remains an option or if the biological parent(s) have visitation, assessments of these relationships are also vital.

- **sensory capacity—**Can they tolerate touch? Do they become overwhelmed by too much noise? etc.
- **self-regulation—**the ability to self-sooth or calm themselves down when upset.
- **attainment of developmental milestones.**
- **ability to engage or connect with caregivers—**this includes eye contact, checking that a caregiver is near, and seeking out caregivers when hurt or frightened.
- **communication—**verbal and nonverbal.
- **demonstration of curiosity, ability to play, and cognitive development.**
- **social-emotional functioning**—Do they smile and show a range of emotion?
- **physical growth and development.**

While these areas should all be screened, some areas may require more in-depth assessment or evaluation.

It is important to recognize that *developmental assessments,* commonly done with young children, are *not the same as* a thorough infant mental health assessment. Routine developmental assessments for children entering foster care may review developmental milestones and general growth, yet, not assess social-emotional development or relationships. An infant's fine and gross motor skills might be progressing well, but if they are not relating or connecting with the adults in their lives then their ability to learn is compromised, possibly leading to delays in cognitive or social-emotional development.

What tools are typically used when conducting an infant mental health assessment?

Multiple observations in different contexts. Infants and toddlers cannot be effectively assessed in one meeting. In fact, most infant mental health assessments will involve several sessions (four to six sessions are recommended by ZERO TO THREE, The National Center for Infants, Toddlers, and Families). These sessions need to include multiple contexts over time. Assessments should include at least one home visit, and should include visits to child care if applicable. Children need to be seen in their own environments, as this is where they should be the most comfortable. However, clinic or office visits may also be included to look at differences in behaviors and interactions in an unfamiliar setting.

Adult Questionnaires. Measures or questionnaires completed by adults may be included in assessments; however, caution must be used when applying these to the assessment of an infant or young child. They should never be the sole source of information. Parents and other adults see children through their own interactions and experiences which can lead to biased or inaccurate information.

Ongoing Monitoring and Updates. Infants and toddlers develop and change rapidly—a day can be the difference between crawling and walking. Assessments may need to be updated within as few as four to six months. Weekly or monthly monitoring may also be required, depending on the situation. For example, significant changes in the caregiving environment (divorce finalized, changes to visitation, parent being released from treatment or custody, change in foster home, etc.) often necessitate a more in-depth reassessment. An outline of

National Resources

www.zerotothree.org
Zero to Three

http://www.zerotothree.org/imh/
Includes resources and information about infant mental health programs around the country.

http://www.zerotothree.org/policy/
Outstanding briefs on a variety of topics including child care, child welfare, early intervention and more. Be sure to read: **A Statement before Congress on Infant Mental Health.**

http://www.zerotothree.org/policy/childwelfare.html

- **Ensuring the Healthy Development of Infants in Foster Care: A Guide for Judges, Advocates & Child Welfare Professionals**
- **Court Teams for Maltreated Infants and Toddlers**—a fact sheet describing a new effort by Judge Cindy Lederman and Dr. Joy Osofsky, in conjunction with ZERO TO THREE and the National Council of Juvenile and Family Court Judges.
- **Questions Every Judge and Lawyer Should Ask about Infants and Toddlers in the Child Welfare System**—a technical assistance brief from the National Council of Juvenile and Family Court Judges.

www.nycourts.gov/ip/justiceforchildren
New York Permanent Judicial Commission on Justice for Children

www.futureunlimited.org
Louisiana State University Violence Intervention Program

www.childtrauma.org
The Child Trauma Academy

www.infant-parent.com
The Infant-Parent Institute

Red Flags

Note: The following are frequent warning signs that something is going on with the young child. These behaviors or changes do not always mean there is pathology present.

- Drops in growth rate, parameters or percentile (height, weight, head circumference). These changes seen in children under two signify major life disruptions may be occurring.
- Major sleep disruptions, particularly when it is an abrupt change in their behavior—these may include frequent wakings, inconsolable crying spells, nightmares, night terrors, sleep walking, or crying out during sleep.
- Sudden changes in digestion not associated with a change in diet, such as chronic diarrhea or constipation, vomiting, excessive reflux.
- Significant regression that persists for more than a week. For example, a potty trained child who begins to wet or soil their pants on a regular basis.
- The development of, or an increase in, aggressive behaviors such as biting, hitting, hair pulling, pinching, or throwing tantrums.
- Self-abusive behaviors such as biting self, banging head on floor, walls, or bed, ramming head into walls, or pulling hair.
- Disruptions or declines in developmental progress—all areas need to be considered such as motor skills, self-calming, cognitive progress, communication, and social interactions.
- Parents or caregivers reporting changes in the baby's ability to connect and relate. For example, a parent might report that the baby used to nurse readily and look them in the eye, but now avoids the parent's face. Or, the child who used to easily transition to child care now screams and clings to the parent.

planned updates and recommendations for future age-specific assessments should be provided.

Screening tools. Infant mental health assessments may also include certain instruments or screening tools such as a sensory checklist or a developmental assessment. For example, children who have not been touched or held much often develop difficulties tolerating touch. While most babies will grasp your finger when you place it in their palm, babies with such difficulties withdraw from your touch. Sensory checklists also help identify other issues such as lack of eye contact, inability to tolerate water or clothing on skin, or difficulties tolerating being cuddled. A developmental assessment would identify developmental delays in cognitive areas. These may be helpful but, again, should never be the only source of information. Infant mental health assessments rely much more heavily on observations and interactions.

It is important to note that these assessments and subsequent treatments may be covered by health insurance.

What information should assessments provide child advocates and the court?

Behaviors, Competencies, Problems. Ideally an assessment will tell you how the infant is functioning in the settings in which she is being cared for, how she is growing and developing, and what challenges she faces. The child's behaviors, competencies, and problems are identified as well as how that child can regulate their behavior and emotions with and without their caregiver's support. An infant mental health assessment will help to identify the primary attachment figure and how this child is able to access and use this person to be successful and thrive. Secondary attachment figures and other significant relationships are also evaluated. A diagnostic profile, which provides specific diagnoses on several axes, may or may not be generated by an assessment.

For example, using the DC 0-3 Diagnostics, a child may have an Axis I diagnosis of Traumatic Stress Disorder if the child has witnessed ongoing domestic violence in their family and an Axis II diagnosis of an Underinvolved Parent-Child Relationship if the father is unavailable and the mother is too overwhelmed or depressed to care for her baby as needed. An Axis III diagnosis would reflect any medical conditions, Axis IV would identify current and chronic stressors, and Axis V looks at a child's social-emotional capacities in interactions with both primary caregivers and with a skilled play partner such as a clinician.

Needed Supports. The purpose of the infant mental health assessment is not to ascribe blame, but to assess what challenges exist for the infant in his current environment. It is also to assess what changes and supports could be provided in that environment to get her back on track. Questions that should be addressed include:

- What have we learned about this infant that will help create an environment that will protect and support his growth through all the changes that he is facing?
- What are the key sources of stability and security for this baby during this time of stress?
- Who is this child's primary attachment figure? Is this person able to provide the structure,

nurturance, and care that he needs?

- What have we have learned about this baby's life that we need to address so she can continue to grow and develop in the most optimal way possible?

What are some pitfalls or challenges of infant mental health assessments?

Misinterpretation. The main pitfalls with infant mental health assessments lie in the hands of those who review them. Parties who are unfamiliar with, or resistant to, the concept that infants and toddlers "have mental health" may discount the need for these assessments or dismiss the results. This can be damaging to all parties involved and can be devastating for the young child.

Reports can be misinterpreted by individuals who don't understand how infants experience their worlds or how infants develop. For example, a common misinterpretation often occurs around breastfeeding. If an assessment reports that an 18-month-old child has become more dependent on breastfeeding since her parent's separation, it is often interpreted as a mother trying to manipulate visitation. In truth, children who are experiencing stress and separation often want more regular comfort through breastfeeding.

Another common misinterpretation occurs around tantrum behaviors. When a young child tantrums when returning to the foster dad after visiting birth relatives, it does not necessarily mean he is upset to be with foster dad. Rather, it might be that he feels safe and secure with foster dad and can therefore let his emotions out much more readily when with him.

It is important to remember that babies develop their attachments and relationships based on their daily experiences with their caregivers. Babies don't see who has more resources; they see only who connects them with the world, who soothes their anxiety, and who is physically, emotionally, and psychologically available. Babies don't see legal or blood relationships — they only see interpersonal relationships.

Outdated Assessments. Another danger is accepting an outdated infant mental health assessment. Young children develop and change quickly; a child can demonstrate profound physical, emotional, and cognitive changes in a matter of days. Often, court proceedings involve delays. An assessment done even one month previously without any follow-up may provide an inaccurate picture. This is particularly true with very young infants.

Misused Assessments. An infant mental health assessment should not be considered a parenting evaluation; and likewise, a parenting evaluation cannot replace an infant mental health assessment. They look at things through similar, but different lenses. Furthermore, an infant mental health assessment should never be used to deny or reward one caregiver or another. It should not be about the needs of the adults involved — it must be about the needs of the child. The goal should be discovering or uncovering what is going to be in the best interest of this child and get them on the best trajectory.

In Closing

It is common to think about babies and young children as resilient and immune from the hard things that impact their lives. Any of us working on behalf of children and families wish for every child to have a safe and nurturing life. We would like for all children to be given the opportunity to grow up to be successful and happy adults who will be able to parent their own children in optimal ways. Sadly, even the youngest children experience loss, separation, trauma, and fear. They get sad, frustrated, and angry. They can feel hopeless and yearn for the safety and security of someone who will love them unconditionally and provide for them emotionally as well as physically. In infant mental health we strive to explore, assess, and intervene in the lives of the youngest children. Seeing the world 'through the eyes of the infant' means seeing things from a whole new perspective. Opening our eyes

Recommended Articles

Dicker, S. & E. Gordon. "Building Bridges for Babies in Foster Care: The Babies Can't Wait Initiative." *Juvenile and Family Court Journal,* Spring, 2004, 29-41.

Lederman, C. & J. Osofsky. "Infant Mental Health Interventions in Juvenile Court: Ameliorating the Effects of Maltreatment and Deprivation." *Psychology, Public Policy, and Law* 10(1), 2004, 162-177.

Lederman, C., J. Osofsky & L. Katz. "When the Bough Breaks the Cradle Will Fall: Promoting the Health and Well Being of Infants and Toddlers in Juvenile Court." *Juvenile and Family Court Journal,* Fall 2001, 33-38.

Lillas, C., L. Langer & M. Drinane. "Addressing Infant and Toddler Issues in the Juvenile Court: Challenges for the 21st Century." *Juvenile and Family Court Journal*, Spring 2004, 81-96. (This article uses a case study to consider the role of infant mental health in the courts from the perspectives of an infant mental health specialist, a judge, and a lawyer.)

to infant mental health and the insight such assessments can provide will help us truly serve the best interests of all children.

Sheri L. Hill, PhD, is Faculty Lead on Policy for the University of Washington's Center on Infant Mental Health and Development. Her specialties include infant mental health, developmental psychology, and speech-language pathology. She also serves as auxiliary faculty for the University of Washington School of Social Work in the area of child development and mental health.

JoAnne Solchany, PhD, ARNP, BC is an assistant professor at the University of Washington and a Board Certified Psychiatric Nurse Practitioner and Therapist with infants, children, and families. Her research and clinical interests lie in the relationships between children and their primary caregivers. Her specialties include adoption, attachment, children who have experienced trauma in their caregiving relationships, pregnancy, and maternal mental health. She is a frequent presenter on these topics nationally and internationally, and is the author of the book, *Promoting Maternal Mental Health During Pregnancy* (2001), as well as numerous articles and book chapters.

Sign up online with the ABA's Hurricane Katrina Volunteer Legal Assistance Database. It should only take you a few minutes.

There is a box to check that your specialty area is "Child Welfare" (it's the first box on the list). We are hoping to provide further information to those who check that box.

The web address is: **http://www.abanet.org/katrina/** and then click "I Would Like to Volunteer My Professional Legal Services."

IN PRACTICE

Protecting the Rights of Service Members in Litigation Involving Children

by Althea Izawa-Hayden

The Servicemembers Civil Relief Act (SCRA) protects the legal and other rights of men and women on active duty or absent from duty in America's armed forces due to injury, sickness, or leave. This Act was formerly known as the Soldiers' and Sailors' Civil Relief Act (SSCRA) of 1940, and was recently revised and signed into law on December 19, 2003.[1] The Act applies whether the servicemember is the plaintiff or more frequently the defendant in a case, and places limits on when active servicemembers can be brought into court.

The government (e.g., Secretary of Health and Human Services, the Secretary of Commerce) must provide written notice of this Act's protections, and a servicemember can waive any of the Act's protections and rights.

Cases that have involved this issue have come up in the context of divorce, dependency, and other proceedings. For example, in *Olsen v. Davidson*, 350 P.2d. 338 (Colo. 1960), the court determined that the SSCRA of 1940 did not apply since there was a showing of service of process and waiver of rights. The facts of the case showed the defendant did not contact his wife although he was given emergency leave from duty, received telegrams, notice of the adoption proceedings were provided and sent to his address, and the judge personally wrote him.

In another case, *Christine M. v. Superior Court*, 69 Cal. App. 4th 1233 (1999), the defendant father servicemember appealed the denial of his stay request of placement proceedings under the SSCRA of 1940. The court held that under the facts and circumstances of the case, since the father showed no interest in maintaining contact with the child and never personally appeared at any hearing, his request was properly denied. The analysis of each case is very fact specific, and often, the ultimate question is whether military service has adversely affected the opportunity to be heard in court. (For a summary of court decisions involving the SCRA in dependency cases, see the chart, pp. 142-43.)

The common thread between both of these cases was that the defendant servicemember had adequate notice of the proceedings, but chose not to act. Often, though, diligent searches for defendants in military service are not always conducted, and termination of parental rights (TPR) petitions are granted by default. What happens next is almost predictable—the child will be adopted, the defendant servicemember will file a petition to set aside the TPR due to violations of SCRA, and the court will have to grant these petitions. This causes adoption disruption, is not in the best interests of the child, and adoptive parents are left defenseless. Strict compliance with SCRA requirements from the beginning of a case is best for all parties involved, most importantly the children.[2]

The pertinent sections of the Act include:

Section 201

- Protects against default judgments when the defendant servicemember does not appear for any civil action or proceeding.
- Court must appoint an attorney to represent defendant servicemember before a judgment is entered.