

***CHILD-CENTERED, VERTICALLY STRUCTURED,  
AND INTERDISCIPLINARY:  
AN INTEGRATIVE APPROACH TO  
CHILDREN'S POLICY, PRACTICE AND RESEARCH***

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## I. INTRODUCTION

As we begin to recognize children as persons with rights and voices of their own, a modern discipline of the study of childhood is emerging. In response to the needs of children, childhood studies and formation of policy for children have become more integrative of the range of disciplines and professions concerned with children's welfare. Children's issues do not exist in a vacuum, nor are they the province of any single profession or discipline. Legal issues are intricately intertwined with issues of child development, history, economics and social science. Medical practice must be informed by statutory and constitutional law and knowledge about family sociology. Social work professionals in the field and the laboratory must apply judgments drawn from law and medicine as well as the social sciences. Moreover, advocates for children working at all vertical levels—from theory and policy formation to clinical and court practice—must remain in constant conversation, so that our theory and policy may never lose touch with the real lives of children and our practice may be reinvigorated by new theoretical perspectives.

This paper will describe the genesis and philosophy of the Center for Children's Policy Practice and Research at the University of Pennsylvania ("CCPPR").<sup>1</sup> The plan to create such a center at

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University of Pennsylvania was first conceived in 1998 by faculty from the Schools of Law, Arts and Sciences, Medicine, Nursing and Social Work. In December of that year, a diverse group of colleagues from across the University began to meet to discuss how we might form a vehicle to integrate our common professional interests in children and their welfare. By Fall of 1999, the idea had crystallized into CCPPR, had found a physical home through at 4200 Pine Street, and had been formalized as “a joint project of the Schools of Law, Medicine and Social Work.”

The founders were convinced that the study of childhood, and the creation of child-centered social policies can only be accomplished in an interdisciplinary setting. The mission of CCPPR was to mobilize the resources of all disciplines engaged in childhood issues across the campus to seek innovative solutions for the crises facing America’s children. We chose the name because its acronym, CCPPR, matched our goals– to provide “a double dose of CPR (cardio-pulmonary resuscitation) for a child welfare system in need of resuscitation.” Rather than confining our involvement only to practice, or policy, or research, we sought to combine all three levels of activity in a vertical structure that would maintain linkages at all stages of scholarship, practice, and reform. This paper will describe our methods and the projects we have undertaken, and will also discuss the pitfalls and challenges of this highly demanding integrative approach.

## II. THE CRISIS IN CHILD WELFARE PRACTICE AND POLICY

Children must have a stable and nurturing environment in order to become self-sustaining adults capable of caring for their own families. However, the lives of far too many children in the United States are compromised by violence, poverty, inadequate health care, and the failures of the systems designed to protect and treat dependent and delinquent children. In many respects, American children at the beginning of the millennium are facing a “crisis of neglect.” Our accelerated age has resulted in community instability, fragmented families, and a generation of pseudo-mature children forced to function in domains far beyond their developmental capabilities.

Children are increasingly both victims and perpetrators of sexual offenses, hate crimes, homicide, even mass murder. The well-being of children and adolescents is often overlooked or ignored until the need for intervention reaches crisis proportion. Attempts to remedy the problems facing children and families by social service agencies, health care professionals, the justice system, and government agencies are too often stop gap, poorly implemented, fragmented, and ultimately ill fated.

By any measure, as the twentieth century closed, the United States continued to fail miserably in assuring the rights of all its children to be healthy, safe and secure in their own homes and

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communities. Consider the following data:

- As many as half of the children who are killed by parents or caretakers are killed after the children and their families have come to the attention of the child welfare system. Children are also killed in foster care, again while supposedly under the protection and supervision of the child welfare system. (Gelles 1998)
- As many as 600,000 children, one percent of the population of children under the age of 18 years old, are in foster care on any given day. The average age of children entering the foster care system is younger than a decade ago, and younger children remain in the system longer than do older children. (Gelles 1998)
- The average length of stay for children in foster care is two years and nine months. More than half of the children in foster care on September 30, 1999 stayed in care longer than 18 months. Approximately 118,000 children in foster care are waiting to be adopted. (Children's Bureau, 2000).
- Teenagers represent an estimated 30 percent of the foster care population. An estimated 20,000 young people leave foster care at age 18 or 19 each year with no formal connections to family. They have not been returned to their birth families and they have not been adopted (Children's Defense Fund, 2000).
- Youths aging out of foster care face many significant difficulties. A national study reported that within two to four years of leaving foster care only 54 percent had completed high school, fewer than half were employed, 25 percent had been homeless, 30 percent had no access to needed health care, and 60 percent of the young women had given birth (Children's Defense Fund, 2000).
- Children are often removed inappropriately, and children in foster care are also disproportionately African-American or minority children. Many critics of the child welfare system view the system as oppressive and destructive of minority families. In Philadelphia, a city with a large percentage of minority families, a stunning seven percent of all children are officially deemed abused and neglected. (Guggenheim 2000, Roberts 1999)
- In 1998, 4 million children lived in households headed by their grandparents and 1.4 million of these children had neither parent present. The number of children living with grandparents with neither parent present in the home grew almost 52 percent between 1990 and 1998, making it the fastest growing portion of children living with relatives (Census Bureau, 1998).
- Eight years ago, the National Commission on Children reported, "If the nation had deliberately designed a system that would frustrate the professionals who staff it, anger

the public who finance it, and abandon the children who depend on it, it could not have done a better job than the present child welfare system. Marginal changes will not turn this system around.” At least 25 state child welfare agencies are presently operating under a court order as a result of lawsuits arising out of the various failings of the agencies. (Schwartz 1998)

- The booming economy and apparent effective strategies to control crime and domestic violence have had no impact on child maltreatment. Child abuse and neglect reports have increased dramatically to about 3,000,000 per year. (Kalichman 1999) Child fatality numbers have remained at around 1,200 per year, with a rise of 8% between 1997 and 1998 in deaths from child abuse. Out of home placements remain at about 500-600,000 children on any given day. (Kalichman 1999; Schwartz 1999).
- Children who witness violence at home are at risk of suffering from numerous emotional and behavioral disturbances, physical symptoms, and difficulties in school. Emotional and behavioral disturbances include withdrawal, hypervigilance, nightmares, self-blame, developmental regression, post traumatic stress disorder, anxiety, aggression, depression, and low self-esteem. Physical symptoms include sleep disorders, headaches, stomach aches, diarrhea, and asthma. Difficulties in school include high rates of poor school performance, truancy, absenteeism, and difficulty concentrating (Peled, Jaffe, and Edleson 1995).
- Health care, child welfare and legal systems designed to protect our children too often fail to respect children’s rights to participation and voice. (Cervone 1999, Ross 1999, Peters 1999) Children who are subjects of child protective proceedings are unrepresented in a large percentage of cases. Case loads for children’s attorneys are crushing. The average child protective hearing lasts ten minutes. (ABA, America’s Children at Risk 1996). Children are not entitled to be consulted about medical decisions, even when they involve chronic illnesses or experimental therapies.

Children are the least powerful of persons and as such are most in need of high quality advocacy, research and policy initiatives. Recent “reforms” have exacerbated barriers to accessible health services and deprived families of economic support, potentially placing children at increased risk. In child welfare, the tried and true “reforms”—pouring more staff, more funding, more training, more services into a flawed system—have failed to have even a small impact. Our knowledge of the underlying issues remains insufficient. Few individuals have the breadth of training and access to interdisciplinary perspectives necessary to make recommendations for substantive change.

### III. BUILDING THE CENTER FOR CHILDREN’S POLICY PRACTICE AND RESEARCH

In this section we will describe the components of the Child-Centered, Vertically Structured, Interdisciplinary Project we hope to use as a vehicle for attacking these problems. We will also

describe some features of the academic, political and social community in which it is situated.

#### A. THE COMMUNITY CONTEXT

Often, the disjunction between policy and practice is exacerbated by physical and social barriers that separate field level and theoretical workers. University of Pennsylvania has the advantage of being located in a large urban area which concentrates many of the most difficult problems of child welfare. Philadelphia, with a population of 1.5 million, currently has 24,557 children under supervision of the Department of Human Services (DHS), the county agency responsible for child protection. The leadership of DHS, while struggling against difficult conditions, is committed to serving the many desperately poor and needy children in its population.

The University is also well situated as a site for interdisciplinary work on behalf of children. The University community includes Schools of Medicine, Law, Social Work, Education, Nursing, Business, and Communications. These professional schools are in addition to the School of Arts and Sciences, which is organized into numerous departments including Sociology, History, and many other fields of study, and trains students both at the undergraduate and graduate levels. The University is also home to many specialized research centers such as the Center for Bio-Ethics, the Institute for Law and Economics, and the Center for the Study of Youth Policy.

Finally, the City has a vibrant public interest community, of nongovernmental organizations (NGOs) concerned with children and youth. Involvement in juvenile and children's issues of the Juvenile Law Center, the Support Center for Child Advocates, the Education Law Center, Public Interest Law Center of Philadelphia, the Women's Law Project, the Public Defender Association, Community Legal Services and Philadelphia Legal Assistance, to name a few, contributes to a lively debate about policies and practices affecting children. The City of Philadelphia's subdivisions that deal with children, including the District Attorney, Department of Human Services, and Family Courts, are engaged in dialogue with these NGOs as well as with the University community. In short, the community context of public, private and academic resources in close proximity to a population of children at risk presents rich resources for work on behalf of children.

#### B. THE STRUCTURAL FRAMEWORK

As CCPPR's founders realized, our goals and principles needed to be translated into a structured framework. Five structural factors emerged as integral to achieving our vision. We agreed that our project must be: (1) a vertically integrated; (2) interdisciplinary; (3) team-based; (4) child-centered and (4) developmentally informed.

*Vertical Integration* refers to a commitment to operate simultaneously at all levels of action. Traditionally, a project is focused on one among a variety of levels at which action and the production of knowledge about children take place. At the "ground level" is the clinic, providing medical, legal and/or social services to individual children. At the mid level is the

research center with a mission of identifying and carrying out research on issues of importance to children and youth. Operating at a third level is the center for policy and advocacy engaged in providing consultation and inputs to policy-makers with the objective of achieving broad systemic reform. While some of the founders were firmly rooted in clinical practice, and others were primarily engaged in theoretical modeling, policy formation, or research, all of us agreed on the importance of integrating these fields of activity. Too often, policy makers become disengaged from the realities of practice. Theoreticians and researchers can waste time and energy on problems that are irrelevant to those in the field. We hoped to improve our own individual capacities for analysis and action by participating in the full range of activities. We believed our collective capacities would be enhanced by adopting and maintaining a vertically integrated structure. Our structure must be one that ensures our continuing engagement at all levels.

*Interdisciplinarity* refers to a commitment to viewing the problems and study of childhood through a variety of critical and professional perspectives. Working in isolation, scholars and professionals from social work, medicine, law, political science, education and sociology are disabled from addressing problems that cut across a wide range of disciplines. Since children are our subject, we must pay attention to the child's whole experience and environment. One cannot isolate the child's mental development and physical health from his access to justice and education, or his social well-being from the material and social conditions of his family and community. A sense of historical perspective and a sensitivity to race, class and gender must inform our work at every vertical level. No one profession or discipline has "the answer" and all must work together in order to identify and address the problems facing children and effectively meet children's needs. Our structure must ensure the maintenance of interdisciplinary perspectives.

*Team-Based* structures assume that any endeavor, whether clinical or theoretical, is enhanced by collaboration. The very process of assembling a team forces us to identify and engage diverse perspectives and approaches. Team-based activities enrich the discussion and educate the participants. Team-based operations provide a learning environment for novices as well as for experienced professionals, and are an important tool for accomplishing the teaching mission of a university. Team work, however, is not necessarily "efficient." In fact, it is often more labor intensive and time consuming than individual effort. Our structure, we concluded, must ensure a continuing commitment to collaborative, team-based activity.

*Child-centered* refers to a shared commitment to moving children and their experiences from the periphery, where they have traditionally been marginalized (barely seen and not heard at all), to the conceptual and practical center. A child-centered perspective plays out differently in different contexts. In the realm of law, for example, a child-centered perspective asks that we reframe legal doctrines that have so often focused on "parents' rights" so that they are re-focused on "children's needs and experiences." (Woodhouse 1994) It requires that we constantly ask: "What does this policy or practice mean to children? Is children's welfare served or disadvantaged by this policy choice?" One of us, in her writings, has labeled this "child-centered

perspective as “generism” and its practitioners as “generists.” (Woodhouse 1994) A generist approach identifies the next generation as the primary focus of study and of action. Just as feminists focus on women, in studying or working with victims of domestic violence, economic dislocation, family dysfunction and access to medical services, a generist or child-centered perspective commits us to exploring the child’s experiences. Domestic violence, family dissolution, economic, medical and mental health policies have specific implications for children, sometimes quite different than their implications for adults. Children’s voices and experiences can be overshadowed or ignored unless a conscious effort is made to place children at the center of analysis. Our structure must explicitly and implicitly commit us to adopting and maintaining a child-centered perspective and resisting the pull of the adult-centric perspective.

*Developmentally informed* policy, practice and research must be cognizant of and consistent with what we know and are continuing to discover about child development. Child development is distinct from the idea of childhood. Childhood is, in many ways, a social construct. In some cultures, children “work” side by side with adults almost as soon as they can walk, and in others they are segregated in “play” and “educational” settings well into young adulthood. (Comer 1992). Child development, however, is a very real physical and neurological process. While children and youths are entitled to equal dignity and equal justice with adults, they are also entitled to be treated differently from adults when doing so is necessary to meeting their needs, understanding their reality, and protecting their developmental potential.

### 3. THE TEAM-BASED APPROACH

The work of the CCPPR is carried out by interdisciplinary teams. The composition of a given team depends on the task at hand and draws upon the people most skilled in the particular fields relevant to the team’s specific mission. Following is a listing of our teams and some of the matters they have handled.

#### *Clinical Team*

A clinical team will usually include a social worker, a legal professional and a medical or mental health professional, as well as students in each of these disciplines. Clinical teams carry out clinical evaluations and provide expert testimony in legal proceedings. Following is a brief sample of cases handled by CCPPR’s clinical teams.

- 5 siblings facing termination of parental rights (TPR) under the Adoption and Safe Families Act (ASFA), with newly identified extended family resources.
- 10 and 14 year old siblings facing complex decisions regarding adoption and TPR, loss of contact with foster mother and biological mother.
- 14 and 15 year old brothers charged with first degree murder in shooting of their abusive father.

- 17 year old girl charged as an adult, raising questions of appropriate standards for decertification.
- 20 month old in need of developmentally appropriate interstate custody and visitation plan.
- 9 year old boy denied counsel and sign language interpreter in child protective proceedings.

#### *Research Team*

A research team is composed of scholars engaged in preventive interventions related to child welfare and juvenile justice. CCPR has been involved in research and design of a computerized risk assessment system. Grant proposals are currently under way for research into many child welfare issues.

#### *A Technical Assistance/Training Team*

Agencies seeking to improve or evaluate their operations contract with CCPR for consultation and training on a one-time or continuing basis.

- Evaluation of state's pilot program using police officers to investigate abuse cases.
- Assessment of compliance by states and counties with consent decrees ensuring access by children to child protection, mental health and special education services.
- Consortium to address youth hate crimes.
- Development of model for permanency planning in urban child protection system.
- Provision of a social worker, a lawyer and a psychiatrist to lead a discussion among district attorneys at the field level on the challenges of dealing with child sexual abuse cases.

#### *Law and Policy Team*

Team members are prepared to address law and policy issues at all levels but especially the upper levels of the vertical structure. For example, law and policy teams have submitted "friend of the court" or amicus briefs in important cases at the federal Appellate and Supreme Courts and have testified to Congress and state legislatures.

- Amicus Brief in *Brian B. v. Commonwealth*, filed on behalf of a coalition of corrections and education groups, with U.S. Court of Appeals for the Third Circuit on rights to education of juveniles incarcerated as adults.
- Amicus Brief in *Troxel v. Granville* submitted to U.S. Supreme Court regarding the

importance to children at risk of placement of ties to kin and extended family.

- Testimony to Congress on dangers of Religious Liberty Protection Act to abused children.
- Testimony to California Legislature on adverse effects on child abuse investigations of parental rights amendment.
- Testimony opposing state bill allowing DNA to be used to rebut presumption of paternity at divorce.
- Expert testimony to assure access to mental health and health care for children with disabilities.
- Development of web-based network of advocates for children.

#### IV INTERDISCIPLINARITY IN ACTION

The concept of interdisciplinarity is best understood with specific case examples. In Part A, we will provide a detailed report on a case, as viewed through the eyes of M.S.W. Alyssa Burrell Cowan. The description disguises the identity and alters the facts to protect the confidentiality of the family involved. In Part B, Dr. Steinberg will illustrate how interdisciplinary practice improves services for children, using case studies of her work with CCPPR.

##### 1. A CLINICAL TEAM CASE STUDY: *Michael Carter (A 7 Year Old Boy)*

*The Clinical Team Concept:* One of the central components of CCPPR's approach is the interdisciplinary clinical evaluation team. The main role of CCPPR's interdisciplinary evaluation team is to provide evaluations to departments of child welfare, children's attorneys and family courts to assist them in determining the appropriate disposition for children and families involved in the child welfare system for reasons of child maltreatment.

The clinical team assembled for this case was headed by Dr. Annie Steinberg, a child psychiatrist/pediatrician. It also included myself, Alyssa Burrell Cowan, M.S.W. (then a senior social work student), and a psychologist, Sacha Coupet, J.D., Ph.D. (who was then a third year law student). Law Professor Barbara Bennett Woodhouse and Social Work Professors Carol Williams and Richard Gelles were available to supervise student inputs and to participate in review of the team's cases and evaluations. In describing the team's activities, I will refer to the student members of the team by their disciplines (ie., lawyer, social worker, etc.).

Principles underlying the evaluations include, assuring the child's safety, well-being, and permanence as well as assisting judges and child welfare agencies to affirm children's rights to continuity and stability in their attachments and familial relationships and to bodily and developmental integrity. The law trained members of a CCPPR evaluation team do not form an

attorney client relationship with the child or any of the parties, but instead are utilized by the team as resources to educate the team on the relevant legal issues and assure that CCPPR's evaluation is responsive to these issues.

*Procedural Context:* Families are referred to CCPPR for these evaluations from a variety of agencies within Philadelphia, including children and youth services, family court, pro bono legal services, child advocacy organizations and individual attorneys and families. Regardless of who makes the initial referral, it is the policy of CCPPR to seek court appointment and/or agreement of all the parties so that CCPPR's recommendation can retain its child-centered focus rather than be allied with the parent or the state.

All children are entitled to lawyers in Philadelphia Dependency Court cases, and are usually represented by attorneys from the Child Abuse Unit of the Public Defenders Association (PD). Michael, however, was referred to CCPPR by the Support Center for Child Advocates (SCCA), a private, non-profit center that represents, and trains pro bono lawyers to represent, children in especially difficult child abuse cases. SCCA attorneys often handle cases in which the PD's office is "conflicted out" because a public defender is already representing a parent accused of criminal abuse or neglect. The court appointed an SCCA attorney to advocate on Michael's behalf because of concerns that his mother, due to her cocaine and alcohol addiction, was unable to care for him and his siblings.

*Presenting Problem:* Michael was a prime cause for concern because his mother had reported that he sits and rocks excessively moving the furniture about the house with the fierceness of his rocking. In addition, Michael's school counselor reported that Michael was having extreme problems at school, rocking back and forth in his seat and crying every afternoon, almost continuously. His behaviors also included sucking his thumb constantly, standing up, rolling on the floor, turning in circles until he fell over, and pulling his shirt over his head and talking under his shirt, saying: "I can't stand him, I don't like him." His teacher reported that with one-to-one support, Michael was able to complete his school work and is not significantly delayed. However, without immediate supervision and support, he has difficulty maintaining attention and focus. In spite of his problems, the teachers reported that Michael is a likeable child who is kind and never aggressive toward others. In fact, he runs around the classroom and "tries to hug everyone."

*Prior DHS Involvement:* Sadly, Michael's family was not unknown to the child welfare system. DHS had been involved with Michael and his family many times in the past. Ten years before, a case was first opened on this family as a result of a call to the child abuse hotline regarding Ms. Sheila Carter's (Michael's mother) crack use and lack of bonding to an older sibling, Trevor. The next involvement was after another sibling, Becky, was born with syphilis, and Sheila failed to follow-up with medical treatment for the infant's congenital syphilis. Five years ago, DHS initiated Services to Children in their Own Homes (SCOH), sending workers to the home to provide assistance to the child and caretaker. Because of concerns with the mother's stability and capacity, the maternal grandmother agreed to take temporary legal custody. As the children were

now living with a capable adult caretaker, the case was closed the following month. The family again came to DHS's attention in two years ago when Michael's sister, Becky, was molested by an adolescent relative who resided in the home. The molester was tried and incarcerated, and Becky went to live with her adult sister. It was unclear why DHS had not reopened the case following that incident given the abundance of information regarding the ongoing use of cocaine and alcohol by Michael's mother.

A new crisis occurred when the maternal grandmother who had temporary legal custody died about a year and a half ago, and her two daughters (Ms. Sheila Carter and her sister, Ms. Pam Carter) moved in to the home. However, no reassessment was done of the children and their safety in the home, which was now headed by Sheila Carter and her sister, Pam, also a cocaine and alcohol abuser. No new court order was issued respecting custody despite the death of Michael's legal custodian. While Michael remained in legal limbo, he was also suffering emotional distress. Because Michael's symptoms were emotional, and there had been no reports of physical abuse, DHS expressed doubts that sufficient evidence existed to support legal intervention. Because of the legal, social and medical complexity of the case and the ongoing risk to the child, CCPPR accepted Michael and his family for an interdisciplinary clinical evaluation.

*Evaluation Method:* The philosophy behind a CCPPR evaluation is inclusive and integrative. It starts with inviting as many family members as possible to attend the session. This makes it possible for the evaluators to obtain a more holistic and balanced view of the family as well as to construct a better assessment of the family's resources, strengths and weaknesses. The clinic's child-centered perspective conceptualizes the child at the center of a system of family and community resources. Every effort is made to avoid seeing the child as an isolated unit, out of context from the adults who know and care for him/her. An assessment of the quality of the child's attachment with siblings and with adults who have occupied a caretaker role in the past or present is an important part of the initial group evaluation. Prior to the evaluation session, the law-trained members of the team researched the pivotal legal issues and briefed the other team members on the standards that will be pivotal to the case evaluation. In Michael's case, for example, the key legal issue initially appeared to be establishing a causal connection between a child's emotional distress and environmental or parenting deficits sufficient to deem the child "dependent" or lacking "proper parental care and control," the statutory standard for intervention.

Having many family members present for an evaluation would not be feasible if there were only one professional managing the session. With three or more team members participating, it is possible to uncover much more information about the family and the child's life in order to make a better assessment and recommendation to family court. Moreover, having an interdisciplinary team provides a richer, more meaningful evaluation of the child and family. While the pediatrician/child psychiatrist is able to observe and evaluate the child's mental status/health in order to make a medical diagnosis, the psychologist can assess the attachment relationships between child and family members, and the social worker is able to interview the family members about their support system and family and social history. Meanwhile, the lawyer is able

to listen critically to all information, assessing its relevance to the legal principles and exploring ways in which the law, as applied to the emerging facts, might affect the options available to the other professionals. As noted below (see Research, Policy and Practice Issues), this description does not fully capture the interactions among the professionals before, during and after an evaluation.

*The Initial Evaluation Session with the Carter Family:*

Michael attended the evaluation session at CCPPR with his mother Ms. Sheila Carter, four of his siblings, and his 4 year old niece and 1 year old nephew. During this session with the Carter family, the psychologist was able to learn that Ms. Sheila Carter believed Michael has been rocking since he was a very young child. Mother ascribed his rocking to his withdrawal from cocaine that she used during her pregnancy and compared his response to the prenatal cocaine exposure with the responses of her other two children. She described the rocking as intense and intolerable and beyond the imagination. He has rocked while awake and rocked while asleep. His rocking awakes other family members in the middle of the night.

I, in my role as social worker, talked with Michael's mother about her cocaine addiction. Ms. Sheila Carter has been using (crack) cocaine for eighteen years. Sheila briefly attended a treatment program in which she enrolled independently. Sheila reported at this session that she has been clean for the previous two and ½ months. She also said that she had relapsed three times since going clean three months ago. She was incarcerated for drug possession three years ago. Ms. Pam Carter, Sheila's sister, also has a substance abuse problem (cocaine and alcohol); their respective drug habits and unpredictable mood and behavior exacerbate the underlying familial conflicts. Pam Carter lives in the same home as Sheila Carter, Michael, and his twelve-year-old brother, Trevor.

I was also able to explore with Michael's mother the family system and Michael's past and present parenting resources. Sheila explained that Michael lived with his father (and his family) from age 1 to age 3 until his father was incarcerated for selling drugs. Michael then moved into the home of his maternal grandmother from age 3 to age 5. During this time, Sheila was incarcerated and Michael's grandmother had legal guardianship of him. His grandmother passed away about 1 ½ years previous to this interview. Now, Sheila Carter and Pam Carter reside in their deceased mother's house and are Michael's primary caretakers. According to Sheila, Michael's father is now out on parole, but is likely to return to jail soon because of being rearrested. She reported that Michael's father had expressed no desire to have contact with Michael, and had provided neither emotional nor financial support.

As the social worker and psychologist/lawyer uncovered details about Michael's family network and life history, the child psychiatrist/pediatrician was able to focus on assessing Michael's mental and physical health. She observed that Michael's mood was depressed and his affect was flat. He became visibly anxious and moved to closer physical proximity with his mother whenever she verbally scolded him or teased him. There was considerable thought, preoccupation and awareness of his mother's whereabouts and her general demeanor toward him.

Michael expressed feeling, "bad" when he is hit and believes that he is to blame for his misdeeds. The psychiatrist also observed that there was no evidence of psychomotor hyperactivity, and the rocking behaviors were not observed.

The child psychiatrist/pediatrician, psychologist/lawyer, and social worker all questioned the children about how their mother's addiction affects them. Both Michael and his siblings expressed great distress at watching their mom leave the house to get high and then return home upset and irritable. His twelve-year-old brother, Trevor, reported that Michael rocks "cuz he's upset." For Trevor, the most challenging part of his mother's drug use is her return home irritable and moody; Michael nodded to concur with this. Michael's nine-year-old sister, Becky said that when her mom returned home high and irritable, she had always felt like "I did something to her [mom]." Trevor thinks Michael is the most worried of the children (about their mom). Both Trevor and Michael nodded vigorously when asked if Sheila screamed, yelled, and hit them when she is coming off her high. Sheila also added that Michael clings to her legs, to her side, and will not leave her alone upon her return. This is distinct from her other children, who avoid her when she is coming off her high. Sometimes this clinging behavior makes her mad, and she has stuck Michael in the past because of it. Mother acknowledges that she will "pop" Michael on whatever part of him she can catch with anything that she can grab, including coat hangers. Sheila also reported that Michael searched for her in the neighborhood crack houses when she did not return home, although he is turned away typically and not allowed to enter, regardless of her presence within the building.

*Drafting and Finalizing CCPPR's Report:* At the conclusion of the evaluation, the pediatrician/child psychiatrist, lawyer/psychologist, and social worker combined all of their notes into an assessment and made recommendations to submit to family court to assist the court in making a decision about Michael's disposition. Upon completion of the draft final report, the child psychiatrist, psychologist/law student, and social work student reconvened with the supervising law and social work professors. They again reviewed the relevant legal rules and precedents that provided the backdrop for the family court's review of the report and its decision-making process. The lawyers made organizational suggestions for how to structure the written report in a manner that would be most accessible and most useful to the judge. It is CCPPR's policy to finalize its reports before sharing them with attorneys or agencies, to avoid pressure to alter the tone or conclusions.

The report addressed six main conclusions of the evaluation session. These points were as follows:

1. Michael is chronically and severely anxious, agitated, depressed, socially withdrawn, and may have mini-psychotic or dissociative episodes- all in response to his (reasonable) fear that he will be abandoned, unfed, physically struck, or emotionally taunted. He has not been allowed to achieve to his potential and his clear ability to accomplish age-appropriate developmental and social tasks has been intercepted by overwhelming intra-familial violence and an unpredictable world without a caretaker to protect him and

assure his safety. While Michael seems very connected to his mother, this is an anxiety-laden, insecure attachment. Michael has also developed age inappropriate (regressive) coping responses which may represent his attempts to compensate for her physical and emotional unavailability.

2. There is clear and convincing evidence that Michael's symptoms are the result of active physical abuse and chronic emotional abuse and neglect, sustained both by the actions and inaction of his mother and aunt. He has had inconsistent caretakers and most likely lost his earliest attachment relationship, either in his move from his paternal family's home or when his grandmother died (and he became reliant on his unavailable mother and aunt). This is the time in which his symptoms worsened.
3. Michael's legal custody needs to be clarified. While he currently resides with his mother, she did not have legal custody prior to her mother's death. It is unlikely that the custody order issued in dependency court that removed the children from her custody was intended to permit her to become default custodian in the event that the placement with grandmother was disrupted. It appears that Michael "slipped through the cracks" when his grandmother died and his mother resumed de fact custody, as a result of systemic neglect. There is a need for the reevaluation of Michael's custodial needs as well as his mother's capacity to parent. While she is aggressively using cocaine and alcohol, there is imminent risk of abuse to Michael, his sibling Trevor, his cousins who reside in the home with his mother and aunt, and the eight children for whom she is caretaker daily.
4. Michael has many strengths despite the significant emotional abuse and neglect, as well as physical abuse, he has sustained. He is kind, gentle, compassionate, and easy-going. It is critical to intervene immediately in order to protect his safety and to preserve these strengths. While a prognosis is difficult, it is quite conceivable that, in a safe and consistently caring and nurturing environment, many of the symptoms of anxiety, agitated depression, disassociation, and hypervigilance may subside spontaneously.
5. There are many, many strengths in this family. The family members are all extremely likeable individuals, with a highly developed sense of humor, an openness and willingness to receive assistance, a love for one another, and a yearning to escape the cycle of poverty and addiction. While we initially discussed SCOH services as the primary intervention, given Sheila's history of consistent substance use and recent relapses, substitute care may be necessary to assure Michael's safety and recovery. Since the Carter family is very close-knit and has taken care of each other during stressful times, it would be worth considering a kinship care placement with his adult sisters, maternal great-aunts, and the extended paternal family.

*Short Term Outcome:* Because of CCPPR's clinical evaluation and final report, the Support Center for Child Advocates was able to persuade Michael's mother to enroll him in an inpatient

psychiatric treatment program at Children's Hospital of Philadelphia. Despite scarce mental health resources, aggressive advocacy by the child psychiatrist who lead Michael's CCPPR clinical team was successful in securing Michael a bed in a children's psychiatric ward. Within the first few days of inpatient care, Michael's rocking stopped completely and he stabilized quite well. In my role as social worker for CCPPR's team, I continued to work with the Support Center for Child Advocates and the Department of Human Services to find a stable home for Michael. First the possibility of placing him with kin was investigated. Because of various circumstances, a kin placement was not possible for Michael. We worked together with DHS to facilitate a timely placement of Michael into a therapeutic foster home.

*Policy, Practice And Research Implications:* Since CCPPR's interdisciplinary evaluation team is fairly new and still in the process of defining the roles and responsibilities of the different team members, clearer practice guidelines are still being developed. However, at this point in its evolution, the roles that are forming among CCPPR's multi-disciplinary cadres of faculty and students include: the child psychiatrist focusing on the child's and family's mental health status and making proper psychiatric diagnoses, the psychologist examining family relationships and bonding between family members and the child, the social worker assessing the family's social history as well as family and community resources that could provide the child with a safe and permanent living situation, and the lawyer advising team members on legal standards so that the relevance of facts and evidence are not overlooked.

This description of our roles, focusing on the separate identity and practice agenda of each professional, does not fully capture the richness of the interdisciplinary team method. Both before, during and after an evaluation session, the team members are continually challenged to integrate the visions and approaches of their colleagues into his or her own professional perspective and analysis of the problem and its solutions. This interaction of "who I am and how I practice" with "who you are and how you practice" adds to our professional training and development and has the potential to result in a uniquely interdisciplinary brand of psychiatry, lawyering, social work, etc.

In addition to the goal of CCPPR's interdisciplinary clinical evaluation teams to provide comprehensive evaluations to departments of child welfare and family courts to assist them in determining the appropriate disposition for children and families involved in the child welfare system, a long term goal is to develop parameters or guidelines for permanency planning evaluations. These parameters will be based on the team's collective experience, the current research and knowledge base, and input from the child and family, as well as community professionals.

## 2. THE BENEFITS OF CHILD-CENTERED INTERDISCIPLINARY PRACTICE

The benefits of child-centered interdisciplinary practice are best illustrated through case examples. As Michael's case shows, a purposefully interdisciplinary approach has many

strengths. These benefits are present even outside the formal team structure, in more informal collaborations and consultations among scholars and practitioners from a variety of disciplines. In the following section, Dr. Steinberg will describe the unique potential of child-centered interdisciplinary practice, as illustrated in a series of cases in which Dr. Steinberg reflects on her interaction with CCPPR colleagues, and how it enhanced her practice and her theorizing, and improved case outcomes.

6. Child centered interdisciplinary practice yields potent advocacy for the child.

*Joanne (a 13 year old immigrant runaway girl)*

Joanne is a 13 year old immigrant female. She has run away from home several times in the past month and has said she will cut or kill herself if she is not removed from her parent's home. Joanne explicitly alleged that her parents were abusing her both physically and sexually and she refused to go home. The assigned child protection worker pursued an investigation which revealed no physical evidence of abuse. The case worker was inclined to close the case as "unfounded" and return Joanne to her parent's home. Joanne continued to be quite adamant that she would not remain in the care of her parents. Her parents admitted to physical discipline of Joanne, but denied that they had touched her in a sexual manner. They complained of her efforts to behave as an American girl, rather than following their cultural customs.

Although I had not formally evaluated her, I was asked to attend a session with her school counselor and participate in a telephone contact with the case worker's supervisor. I insisted that Joanne was not safe to return home, because she had run away several times already, had been assaulted on the street during one of those times, and would almost certainly run away again. Her parents did not have the capacity to keep her safe at this time and it was the county's duty to step in and help to protect her.

While CCPPR was not extensively involved in this case, I did have the opportunity to review my response and rationale with the team during a staff meeting. The feedback from the group was consonant with my initial reaction (which differed greatly from the plan of the case worker and supervisor). Re-framed in the precise legal framework of dependency law, the purpose of intervention is to address *risks to the child* not the guilt or innocence of the parent. Joanne's running away placed her at severe risk. Having the opportunity to review and listen to the corroborating feedback of my colleagues, I was able to move ahead forcefully in support of her placement in an appropriate therapeutic residential facility.

7. A child-centered interdisciplinary approach integrates medical, legal and social domains with better results for children and their advocates.

*Maurice and Marissa (siblings in need of permanency)*

Mother was referred for assessment of her ability to parent her children Marissa, age 9 and Maurice, age 14. We were asked to address issues related to pending termination of parental rights, specifically, mother's mental health, family communication, and the quality of the relationship between mother and children, as well as the overall maternal capacity to provide for her children's needs. Mother is a thirty-four year old Deaf woman of color who has had an active case with the child protective services agency for eight and half years following a substantiated referral for medical neglect of her son.

At the initial evaluation, Maurice was a bright and articulate 14 year old who managed his own diabetes. Marissa was a shy 9 yr old who enjoys "reading, playing with baby dolls, and playing outside" with her many friends. She was born with a physical disability requiring three related hospitalizations since 6 months of age. When asked about adoption, Marissa expressed a preference to be with her "mom", although she could not recall an instance in which her mother had initiated a hug or played with her. "I'd like to live with my real mom. I don't get to spend a lot of time with her." She persisted in expressing this desire despite her mother's constant criticism and rejection. Maurice admitted that he knew his mother was not capable of caring for his diabetes, but still did not wish to be adopted. "How would you feel if you were adopted from your sister and your brother and your mom didn't have anyone to take care of her and her mother and her father was dead.... I'll be 18 in 4 years and I don't see why we gotta be adopted. I want to get me an apartment, go to college and pick my sister up and live with my sister."

The sessions were of note for the mother's lack of emotional responsiveness and delusional thinking. When her daughter slouched toward her and attempted to lean over onto her shoulder, mother sneered and pushed the child's head away, expressing concern that she/they were not her own biological children because of their physical differences and disabilities. Both children attempted to reason with and convince their mother that they were, indeed, her children. She also expressed concern regarding the finances of assuming care of her children, and the impact on her lifestyle. When the evaluation was completed, she departed without saying goodbye to her children.

While mother exhibited little to support the preservation of her parental rights, her children appear to recognize her as well intentioned but limited, and responded with positive affect to and an expressed wish to be with her. Termination of parental rights was not the expressed preference of either child, the biological parent, or the foster parent. No one wanted to end interpreter supported visitation and a change in status had many implications for both children, who did not want to be "adopted". As the forensic examiner, I felt cornered by needing to report that mother was unable to assume care, knowing this would lead to the termination of mother's parental rights. I was given no opportunity to report my assessment that termination was not in the best interests of her children.

Having team members who serve as legal advocates for children allowed me to feel assured that their rights, preferences and developmental needs were entitled to consideration. We recommended that they remain in foster care, to acknowledge mother's limitations and the

children's need for accessible communication and support in visitation.

Unfortunately, this recommendation was not well received. Despite the 8 and ½ years with their foster mother, her house was suddenly deemed “out of compliance”, and the children were told they could not remain with her. Facing a new disruption, Maurice generated a list of possible adoptive homes and they were placed with the third option on his list, a friend of their original foster mother. While Maurice was opposed to being adopted by a "stranger", he had come to accept adoption as a path to stability and to getting DHS out of his life. In the final session, attended by the children and their new foster/pre-adoptive mother, Maurice openly discussed his anger and grief at the failure of DHS to help him contact or meet his father before his death or to facilitate contact with his paternal grandfather. His sister's preferences and views about adoption had not changed. She was constant in her expressed desire to be reunified with her biological mother. However, when asked to draw “your family”, she drew a portrait depicting her new family, including her new foster/pre-adoptive mother, her brother, and the new family dog.

This complex case raised multiple issues regarding the inclusion of the child's stated preference, enacted preference, and assessed best interests. In addition to this large domain, I struggled with the apparent statutory requirement of adoption, which would cause the children to lose the benefit of interpreter-supported family visitation. The lawyer and social work team members explained the alternatives that had been ignored by DHS (e.g., permanent guardianship) and offered the possibility of subsidized adoption to offset the loss of foster care benefits.

Understanding what had transpired as the rigid misapplication of the Adoption and Safe Families Act offered little consolation for two children whose lives had been repeatedly disrupted. In addition, the lack of open adoption as an option under state law forced a choice between permanency and continuing contact with the biological mother. Fortunately their new foster/pre-adoptive mother was a kind and loving woman who understood their needs for continued contact with biological relatives. The lawyer member of the team was also able to respond to Maurice’s questions with regard to his Social Security survivor's benefits and encourage him to seek assistance from his assigned attorney or a public interest office such as the Juvenile Law Center. Collectively, we empowered this articulate child to advocate for his own rights and the rights of other children; Maurice now plans to study family law.

8. Child centered interdisciplinary approach reduces burnout and sustains clinicians in challenging cases.

*Pamela (a young adult seeking to protect her sibling from abuse)*

Pamela is an almost 20 year old girl who is deaf. She was severely abused both physically and sexually in early childhood by her mother’s paramours, but has been able to engage in a meaningful working-through process in which she has gained tremendous insight, has developed the capacity to tolerate many of her memories and strong feelings and begin to integrate the

different states of being into which she had retreated when threatened. Pamela is graduating high school, but does not wish to go to college and has no job. She is aging out of the protection and supervision of the Department of Human Services. She consulted me for help in assisting her two younger siblings, Jason and Johnny. Recently, six-year-old Johnny, was found wandering the streets and was placed in an emergency shelter. Johnny was subjected to sexual abuse at the hands of their mother's paramours and may have been prostituted in exchange for drugs, much as Pamela had been years before. Jason (approximately 7 years of age) remains in the care of their mother because DHS investigation revealed "insufficient evidence to substantiate abuse or neglect."

This case is one in which only brief consultation was necessary to assist me. I described what had transpired for my colleagues, and their disbelief and visible contempt for the inadequate risk assessment and deeply flawed legal reasoning was enough to propel me to take further action, reducing the sense of dissociation, numbing, helplessness, and paralysis that can overtake the clinician in such a case. Locating and naming a "system failure" (faulty risk assessment, misapplication of legal principles) can help overcome a sense of powerlessness in the face of inexplicable failures to act.

9. A child centered interdisciplinary approach offers the opportunity to shift paradigms.

*Maria (a 10 year old on the threshold of neglect)*

Maria is a 10 year old with multiple handicapping conditions. She had a congenital infection which resulted in deafness, multiple learning disabilities, impulse control problems, etc. She is in a special education setting in which her behaviors have been stabilized, however, she is noted to talk to herself when left alone and to require consistent one-to-one supervision, structure and support. For years, Maria's mother acknowledged that she uses alcohol to treat her depression, and spends much time in a local bar. Mother has tried very hard to make improvements in her own life but struggles with her depression and resultant addiction. School staff all recognize that mother works hard to care for her child, feeds, clothes, shelters, and loves her consistently, but is not able to provide for all of her needs and as a result, her developmental progress has been thwarted. Once, in response to the raised possibility that child protection services may become involved to access services in her own home, mother responded with a plea, "no, don't call them, please, I love my daughter; please, please, don't let them take her away from me."

This case raises the issue of clinical thresholds for reporting neglect warranting the involvement of child protective services. The clinician's decision making, while incorporating legal thresholds for state intervention in a vague way, moves from inference to evidence base, consideration of differential diagnosis and rule outs. There are reasoned actions, planned behaviors, treatment approaches and algorithms, and intervention paradigms. This typically does not utilize state laws, definitions and criteria which could certainly alter the decision making process to what would appear to be a 'clean' differentiation of presence or absence of the "refusal of appropriate

treatment that seriously interferes with a child's ability to accomplish age appropriate developmental and social tasks". As a clinician member of the interdisciplinary team, I appreciate the opportunity to utilize different paradigms of decision making when at an impasse.

10. A child centered interdisciplinary practice assures the integrity of vision and mission.

*Lilly (a 10 year old yearning for the stability of adoption)*

Lilly is a 10 year old Caucasian female. Sexualized, self-stimulatory, and bizarre behaviors characterized her early years and she refused to use the toilet; retaining her stool until her abdomen became tense and distended (encopresis). It was evident in play that Lilly had been exposed to sexual activities and violence. In therapy, mother admitted that she had been with several boyfriends who had been quite abusive to her and that Lilly had been left in their care at times. Despite adherence to therapy, she was unable to leave these abusive relationships and ultimately—with great anguish and courage—voluntarily relinquished the custody of Lilly to DHS.

Lilly was fortunate to be placed in a very stable foster family which has adopted a number of the other children. While mother could not communicate with Lilly, who is deaf, her foster mother pursued sign language studies aggressively. Lilly in the following three years thrived and her cognitive capacities increased dramatically, so much so that even her testing results appear to demonstrate a different psychological profile than at initial testing. Lilly, who previously "zoned out," staring into space, appearing highly distractible, unable to follow a conversation, suddenly began to converse quite normally. During one meeting in which her foster mother described the upcoming adoption of one of her siblings, Lilly asked if she would be adopted and when foster mother stumbled to find the words to respond (she had not considered adoption at that point for Lilly), I asked Lilly what adoption meant. She responded, "adoption means you get to stay."

When the issues of adoption was raised, Lilly's biological mother became quite upset, reporting that she had never imagined when she placed her voluntarily that her daughter would be adopted and did not wish that to happen. Foster mother now recognized a need for Lilly to have permanence and was considering the possibility of adopting Lilly. However, the DHS attorney rapidly accommodated the biological mother's bid to preserve her rights. ASFA requires the state to show "compelling reasons" for not seeking a TPR. The reasons cited were "deafness" and "encopresis" (resolved since placement). These medical "reasons" were clearly spurious, as neither were relevant to the TPR, yet I sympathized with mother's plight.

The legal rules have changed since this child entered foster care, and this clinician must adjust to the new criteria assuring permanence for children. A quick anecdotal account of this child's situation with my colleagues—who were less enmeshed in the case and without memory of the mother's grief and courage in the moment of relinquishing Lilly's custody, and who doggedly maintained a child-centered approach—afforded me the recognition that there will always be trade-offs and that we strive to support the least detrimental alternative for the child, even if it is not least detrimental for the parent.

11. A child-centered interdisciplinary practice can mobilize resources effectively to promote more developmentally informed legal standards.

*Betty (a child victimized by developmentally inappropriate visitation policies)*

Betty is a 20 month old child who resides with her biological mother and maternal grandparents. The judge responded to the biological father's custody petition by ordering visitation across state lines (350 miles distance), to occur every two months for two weeks periods of time; transfer to occur midway between the parents' residences, in designated locations.

Betty was seen prior to and following transfers between mother and father. At first evaluation, she was a bright and competent 20 month old child who engaged quickly and comfortably. She was easy going in nature and enjoyed interacting with all people. She had a very positive connection to both of her parents and both sets of grandparents. Both of her parents behaved immaturely and impulsively in their interactions with one another, and viewed their own needs (to some extent) prior to Betty's needs. Of the two parents, mother had assumed the role of primary caretaker, being responsible for the bulk of her daughter's child care, medical care, educational needs, as well as clothing, purchase of developmentally appropriate toys, etc. Father was noted to be highly distractible and less attuned to his daughter's whereabouts and her growing needs.

Betty was quietly distressed at departure of her mother and transfer to father's care. She stood and stared at the door and asked for her mother repeatedly. She was able to be distracted to play with her father. Upon return, after a two week visit with her father, she initially did not react to seeing her mother at all. After about five minutes, she peered at her mother tentatively, saying "mama, mama." Her expression grew in intensity, turning into a chant of "mama love, mama love." Finally, she was able to embrace, kiss, and be kissed by her mother. After that, Betty refused to be physically separated from her mother, remaining in immediate proximity, and would not return to her father's care. While being held by her mother, she sang to herself, "mama love, mama love, mama love".

The judge's ruling in this case, separating a 20 month old child every 6 weeks for two weeks at a time from her primary attachment figure, was clearly developmentally inappropriate. Yet no developmentally competent guidelines existed in Betty's local courts to educate the judge about children's age appropriate, developmental needs. The capacities of the interdisciplinary team allowed me to gather data from around the country (thanks to the AALS family law section listserv). As a result, key publications were identified in less time than otherwise possible, and relevant and developmentally attuned visitation schedules from other jurisdictions were shared with the judge and the parties. Without the insights of my colleagues, and their networks, these materials would have been relatively inaccessible to me, preventing me from appreciating the options for child-centered recommendations in this challenging situation.

12. Child centered interdisciplinary practice optimally address legal problems in a medical context:

*Barry and Ellen's children (a family with untapped kinship resources)*

An evaluation was requested by Barry when the state sought to obtain guardianship of his four children, to terminate his parental rights and place the children for adoption. Barry sought to retain his parental rights and be reunified with his children, thus, the focus was on his capacity to parent and provide care for his children, and to assess his bonding with his children in the context of a past history of substance abuse, physical abuse of one child 6 years earlier, and a failure to comply with treatment and the restricted visitation mandated by the child protection agency when in their mother's care. Mother reported that she and her spouse were inseparable and live and function as a single unit. For each of the next three years, another child was born and placed because of injuries sustained by the first child five years earlier, the failure to disclose an earlier pregnancy to child protection, and noncompliance with restricted visitation.

Despite this history, the family retained a strong sense of identity. The children's foster homes were close in proximity and they attended the same daycare. The case worker reported that the children were all doing well and "There is bonding everywhere, there is bonding all around with this family." The case worker felt strongly that they should be preserved as family unit, at least as a sibling unit, regardless of whether grounds existed for a TPR. However, it was unlikely that the Barry and Ellen would have the capacity to parent independently in the near future, except with extensive assistance from their family. Under ASFA, a TPR seemed inevitable and, after the caseworker left the agency, the goal was changed to adoption of the children by their foster parents or through outreach to unrelated families. At the last minute, the extended family was mobilized and a paternal aunt and uncle relocated from another state to assume permanent guardianship of the children. Evaluation revealed a deeply committed childless couple who had assumed the care of other kin in recent years. They described raising children as a "lifelong dream" yet, as relatives, they were comfortable with legal guardianship status, and with Barry and Ellen's retaining their status as parents.

This case involved parents who showed serious limitations in independent parenting capacity but persistent and unwavering love for their children and concern regarding their best interests. Guardianship/custody by family members offered the children stability, structure, and kinship bonds. But the option surfaced so late in the legal proceedings that it was potentially disruptive to already existing bonds with foster parents. The value of the sibling bond and relationship vs. the primary attachment figure would need to be assessed not only for each child, but for the family unit as a whole. It seemed that once the caseworker who knew this family left the agency, the progression toward adoption by the foster parents appeared inexorably on autopilot. Careful review of the state's version of the Adoption and Safe Families Act by the lawyer on the team, identified a crucial legal standard that the referring attorney had not explained: even where a basis existed for termination, a termination order should not be entered if the harm to the children from termination outweighed the benefits. My awareness of this standard allowed me to present the

findings of the evaluation consonant with the requirements and the language of the law, enabling the rights of the children to be recognized by the court, and allowing the family unit to be preserved.

#### IV. VERTICALITY IN ACTION

In this section, we will explore the benefits of operating in a vertically integrated structure. In Part A we will describe in some detail a case in which CCPPR's goal was to influence law-making and public policy at the level of constitutional doctrine. In Part B, Professor Woodhouse will describe some of the benefits of a vertical structure, as she has encountered them in her CCPPR practice.

##### I. A LAW AND POLICY TEAM CASE STUDY: *Amicus Brief to the U.S. Supreme Court in Troxel v. Granville*<sup>2</sup>

*The Law and Policy Team Concept:* The goal of a CCPPR law and policy team is to make timely interventions in appellate court cases and legislative reform, in hopes of channeling the development of laws and policies that may have significant downstream effects—positive or negative—on the welfare of children. When a legislature is drafting or seeking public comment on a piece of proposed legislation, members of CCPPR may be asked to participate in an advisory committee or to provide testimony and briefings to legislators. Another context in which law is formed is the appellate case in which higher level courts make pronouncements about the meaning of a specific law (e.g., *Suter v. Artist M.*) or about constitutional doctrine (e.g., *Smith v. OFFER*; *Moore v. City of East Cleveland*; *Stanley v. Illinois*). In cases raising constitutional or statutory issues of importance to children, CCPPR will seek to submit an amicus brief on its own or may join with others in authoring or signing a brief submitted on behalf of a coalition of child advocacy groups.

CCPPR has consciously chosen not to engage in direct representation of parties bringing impact litigation or class action law suits. While such suits are an important element in law reform and often serve to mobilize public institutions to better serve children and vindicate children's rights, direct participation comes at a price. Advocacy organizations engaging in such work must assume an adversarial role towards the agencies and government entities whom they are suing. The advocacy organization is then limited in its ability to participate collaboratively in systems reform.

When developing reforms in response to a successful lawsuit, the defendant cities and states will turn to resources that have been less directly involved in the prosecution of the case. CCPPR seeks to avoid such direct conflict, in order to remain available as a collaborator and consultant (i.e., through its Technical Assistance/Training Team).

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<sup>2</sup>The text of the *Troxel* brief as well as of *Brian B.*, is on CCPPR's web page at [www.law.upenn.edu/ccppr](http://www.law.upenn.edu/ccppr).

Like the clinical teams, a law and policy team must be interdisciplinary and child-centered. Good laws and policies depend upon accurate social science and an understanding of developmental and medical issues, as well as on a clear understanding of constitutional principles and family law jurisprudence. The composition of a law and policy team depends upon the primary issues in a case. For example, our amicus brief in *Brian B.* addressed the question whether adolescents tried and convicted as adults, have a constitutional right to education while incarcerated. The team included specialists in juvenile justice, corrections, economics, child development, neurology and education theory. The goal of our brief was to brief the judges on the unique developmental and neurological needs of the adolescent, on the economic consequences to these children and society of depriving them of education, and to provide social science data establishing that the policy of withholding education was irrational and arbitrary—and thus unconstitutional. The *Troxel* case described below posed the question whether the parents’ constitutional rights were violated when states intervened to protect children’s relationships with family and kin outside the nuclear family circle.

*Procedural Setting for Troxel Amicus Brief:*

The State of Washington had passed a law that gave standing to anyone at any time to seek court-ordered visitation, which was to be granted if the court found that visitation would serve the best interest of the child. Mr. And Mrs. Troxel had sought and won expanded contact with the two young daughters of their deceased son. The girls’ mother, Tommie Granville, protested that the court order violated her Fourteenth Amendment liberty to direct the upbringing of her children, as established in a line of cases from the United States Supreme Court beginning with *Meyer v. Nebraska* (1923) and *Pierce v. Society of Sisters* (1925). The Washington Supreme Court agreed with Granville, and struck down its own state’s law as violative of the federal Constitution. The United States Supreme Court granted certiorari to consider the case.

Supreme Court practice provides a vehicle for participation of interested entities other than the plaintiff and defendant in the specific litigation. The purpose of a “friend of the court” or “amicus” brief is to provide additional perspectives on the potential impact of the case. Many groups filed amicus briefs in the *Troxel* case, including parents’ rights groups, grandparents rights groups, bar and professional groups, women’s advocates, and civil liberties groups. CCPPR’s goal was to insure that the justices considered the impact of their decision on children at risk of placement. While we at CCPPR agreed with the notion that parents are entitled to deference in raising their children, we were also highly sensitive to the important role played by extended family, partners and kin in creating a safety net for children at risk of placement in the foster care system. CCPPR sought permission to file an amicus brief drawing the Court’s attention to these other contexts in which children’s relationships with nonparents must be protected from disruption.

*Stanley v. Illinois* illustrates what can happen when the Court decides a family law case without sufficient perspectives on the broader issues. (Woodhouse 1994) *Stanley* involved an unmarried biological father who had lived with and raised his children but was accorded no parental rights when their mother died. The Court, in vindicating Mr. Stanley’s claim, made unnecessarily sweeping statements about the rights of biological fathers. This dicta was interpreted by lower

courts and legislatures, as conferring rights on absent and unknown fathers, a principle that threw the law of adoption and child protection into chaos. The Court was forced to backtrack, step by step, as it clarified in subsequent cases that, while a father has a unique opportunity to develop a protected relationship, he must seize this opportunity by acknowledging and supporting his child in order to claim constitutional protection of the relationship. Our goal was to prevent a similar unintended disruption of child welfare and family policy.

*Assembling the Troxel Team:* This team was lead by Professor Barbara Bennett Woodhouse, who clerked at the U.S. Supreme Court, is admitted to practice in the Supreme Court, and has authored or co-authored a number of briefs to the Court in cases involving children’s rights. The team included Sacha Coupet, a third year law student and psychologist whose Ph.D. thesis studied the role of African American grandmothers in providing care giving for grandchildren. Another third year law student, Keren Rabin, researched the nonparent visitation statutes in the fifty states. In addition, the team included senior M.S.W. student Alyssa Burrell Cowan and sociologist Richard Gelles, a specialist in family violence and an author of the recently enacted federal Adoption and Safe Families Act, which stresses the need to involve children’s extended family resources and kin in child protection and foster care. Social Work Professor Carol Williams, who had served in the Children’s Bureau in Washington, which is charged with child protection at the federal level, provided perspectives on systemic barriers and on issues of race and class, and pediatrician/psychiatrist Dr. Annie Steinberg provided the psychiatric and developmental perspectives on the child’s need for permanency and stability in attachment relationships and the effects of disruption of such relationships. Finally, Professor Elisabeth Slusser Kelly, law librarian at University of Pennsylvania, provided research resources and consultation to the team.

*Conceptualizing the Brief:* The first step was to provide team members with relevant legal materials, and answer questions about the legal principles. After discussion of the developmental and social issues, the team developed a strategy and a central policy theme. The strategy was to urge the Court not to make sweeping statements about parents’ rights in the course of deciding the *Troxel* case, but to decide it on the narrow facts presented. The grandparents in this case had never been the primary caretakers or co-resident with the children, and the mother was not seeking to terminate all contact. The mother was a fit and competent parent and no indications existed of risk to the children. The children were not parties to the case and had expressed no position with respect to visitation. Yet the danger existed that the Court, which does not handle many family law cases, might approach the case as an opportunity to enunciate an abstract hierarchy of constitutional rights between adults, placing the autonomy of the biological parent first, regardless of specific facts, attachment relationships, and the needs of children. The “child-centered” theme we adopted was that sound policies in the custody and visitation would approach these cases on a case by case basis, and would “avoid sharpening the battle of rights” among adult family members, focusing instead on maximizing children’s family resources.

*Drafting and Finalizing the Brief:* Based on this discussion, the team leader drafted an outline, and each team member was assigned responsibility for writing or providing research for a specific section of the brief, according to his or her area of expertise. The team leader assembled all the

texts, edited them and harmonized them into a first draft. This draft was then circulated to all members for comment and correction and was discussed at various meetings of the team. The argument was further refined, and additional scientific, sociological or legal sources were provided. In the past, the difficulty and expense of producing a printed brief conforming with the precise rules of the Court on size, color of cover, type and font has been a substantial financial and logistical barrier. Electronic publishing has greatly reduced these barriers. Thanks to a donation to support printing and filing costs, CCPPR is in a position to print and file such briefs despite its limited resources. An electronic text of the brief was sent to a professional printing service and it was printed and served on the various parties to the case and filed with the Clerk of the Supreme Court.

*Outcomes:* It is impossible to know what effect, if any, an amicus brief has on the Court's deliberations. However, the Courts' decision in the *Troxel* case definitely avoids the dangers of oversimplification. Six members of the Court agreed that Granville's rights to parental autonomy had been violated, but they were unable to reach consensus on the theory behind their ruling. The justices among them produced six separate opinions—a plurality opinion (written by O'Connor and joined by Rehnquist, Breyer and Ginsburg), two concurrences (by Thomas and Souter) and three dissents (by Scalia, Kennedy and Stevens). The plurality took a cautious approach, holding that the Washington statute was not necessarily void on its face, but *as applied to this mother and her family*, it infringed her protected rights. The judge had failed to give any deference to the mother's choices and, in ordering that the children visit twice a month, the judge had simply second-guessed her decision that the children's welfare would be adequately served by once a month visits. Justice O'Connor also stressed the need for deference to family court judges and the need for case by case adjudication in this area. Other justices, including Kennedy, in their opinions discussed the diversity of family forms and the importance of extended family and grandparents. Justice Stevens specifically addressed the difference between a family court case, balancing the rights and interests of many parties, and a case involving individual rights. He also stressed the child's interests in protection of attachment relationships as meriting independent weight. Whether coincidentally or not, many of the concepts stressed in the CCPPR brief were reflected in the writings of the justices. By starting cautiously, with a set of opinions that provides a full and nuanced discussion of the issues but avoids broad pronouncements, the Court has escaped the trap of oversimplification it fell into in *Stanley*. (Woodhouse 2000)

*Practice, Policy and Research Implications:* The Court's difficulty reaching a consensus in the *Troxel* case indicates that the next decades will see much debate over the constitutional analysis of state laws and court practices that attempt to protect children's extended family and other care giving relationships. CCPPR must remain vigilant to insure that this debate remains child-centered and pluralistic. The voices of all children-- not only children of divorce but children in foster care, not only children from affluent nuclear families but poor children from disabled, immigrant and minority populations--must be included in these debates. More research is needed--research that is sensitive to culture, class and race--before we can fully understand the roles of extended family in preserving children's developmental potential or weigh the effects of disrupting attachment relationships in the name of parental autonomy. By the same token, more research is needed into

the effects on family stability of coercive court interventions and more exploration is needed of alternatives that are less traumatic and disruptive to family functioning.

## 2. THE BENEFITS OF A VERTICALLY INTEGRATED STRUCTURE

The benefits of a vertically integrated structure are, perhaps, best understood when illustrated by concrete examples. Case evaluations that are part of a larger enterprise having a vertically integrated structure provide important linkages between clinical activities and policy, practice and research at other levels, and vice versa. And as the *Troxel* case illustrates, constitutional law develops incrementally, in a case by case analysis that starts at the family court level. Issues presented at the trial court level develop, often years later, into the raw materials of constitutional doctrine at the Appellate Court and Supreme Court level. Below, Professor Woodhouse will describe her assessments of the benefits of verticality.

13. A vertically integrated structure helps us to translate lessons learned in the trenches into systemic safeguards and policy reforms.

Michael's case, in which a child was reverted by default to the care of an unfit mother at his grandmother's death, brought home to me the importance of systemic safeguards that will avoid a child's slipping through the cracks when death of a custodian results in a change in the child's care taking resources. Pamela's case, in which faulty risk assessment and faulty interpretation of the law paralyzed a system that ought to have moved quickly to protect a new generation of vulnerable children, taught me how poor training at the field level can translate into tragic consequences. Through CCPPR, I and my colleagues are able to apply this learning not only horizontally (in other case evaluations) but also vertically (towards policy reform and systemic change), when we provide consultation through its Technical Assistance/Training Team, as well as when our Law and Policy Team engages in legislative drafting efforts.

14. A vertically integrated structure makes plain the importance of interdisciplinarity at all levels, not just the clinical level.

Michael's case illustrated the importance of proper training of line workers not only in social work practice but also in the legal standards that define and control actions in a wider range of problem solving and decision-making. The DHS workers in this case mistakenly believed that physical symptoms caused by emotional abuse and neglect were insufficient as a matter of law to justify DHS intervention. CCPPR, because of its vertical structure, can translate lessons learned in the field into programmatic content for its Technical Assistance/Training Team. This is why I insist that the training and technical assistance teams working with agencies include a lawyer or law student, as well as other professionals whose roles are more obviously implicated.

The *Troxel* brief likewise illustrates the importance of interdisciplinary collaboration at the upper levels of law reform. Legal issues and drafting of good laws are inextricably intertwined with knowledge of sociology, systems administration and child development and decision-makers must

have access to experts, not only at trial but at all levels where the law meets the facts. I am a better advocate because I understand how the issues play out in medical and social as well as legal contexts.

15. A vertically integrated structure provides team members engaged in law reform and appellate advocacy with persuasive narratives that can change the hearts as well as the minds of those with the power.

Michael's case shows the importance of continuity of contact with primary attachment figures, and the importance of extended family resources to children at risk of placement. For want of a grandmother, this child was nearly lost. Maurice's story is a powerful tale of the psychological importance to an adolescent, struggling to acquire his own identity, of contact with his deceased father's family. As Maurice said, "You need to know your roots." This issue of the value of extended family, from the child's perspective, was addressed by CCPPR's Law and Policy Team in the *Troxel* Amicus Brief. A central section of our brief in *Troxel* was composed of narratives drawn from CCPPR's clinical evaluations. These stories were worth a thousand words of legal argumentation, bringing home the diversity of cases affected by the *Troxel* case and the importance to "at risk" children of extended family relationships. The ability to use narratives in legal research and writing enhances my scholarship as well as my practice. (Woodhouse 1996)

16. A vertical approach educates law makers on the real world consequences of their decisions.

Law makers are often isolated from the real world consequences of their actions. They operate in a climate dominated by political strategists and powerful interest groups. Children are among the least powerful of citizens. Since they do not attend \$1,000 a plate fund-raising dinners or donate large sums of money, and do not have the vote, their perspectives are most likely to be ignored in the political arena. In a Hill Briefing, I have believably asserted that "children will die if this Bill becomes law," (and your Senator will be blamed). Such statements mesmerize an audience where arguments about cost-benefit would fall on deaf ears. Speaking for CCPPR, I have participated in Hill Briefings and submitted testimony opposing proposed legislation that, while popular with the religious right, would pose serious risks to children. I have submitted testimony to state committees about the real world costs of their actions, that shift the momentum away from an adult-centric and towards a child-centered perspective. (Byrne 1999) The ability to draw on personal experience with real world cases lends credibility to my predictions about real world consequences.

17. A vertical structure allows scholars to educate law makers on the extent and limitations of the existing knowledge base.

In general, the sociology and science in an amicus brief is acquired second hand, through research in secondary sources. Because CCPPR is engaged in research as well as case work and policy work, we are more directly linked to the world of research. This makes us more cognizant of the limitations of the existing knowledge base. Our location in a research university gives us access to state of the art research in a wide range of fields. It also gives us access to "associated faculty"

who donate their time to explain and critique the methods behind published studies and experiments. In the *Brian B.* case, CCPPR's amicus brief included current research on the education of at risk juveniles. In the *Troxel* Brief, we described the neurological effects on the brain of separation from attachment figures. In each case, the scientific or sociological data was presented directly, in the words of the researchers and scholars themselves. How different from my former practice of pouring over books and articles, trying to extract a legal argument from materials I could not hope fully to comprehend.

18. A vertical structure encourages thinking about legal abstractions in concrete medical, educational and social context.

The *Troxel* case involves a seemingly abstract principle: the constitutional liberty interest of a parent in controlling the upbringing of his child. Neither the child nor the parent, however, exists in isolation. Experience at the individual case level with children such as Maurice (who longed to visit his paternal grandfather despite his mother's opposition), Betty (whose suffering at separation from her primary care giver was palpable); and Lilly (whose relationship with her biological mother had been supplanted by a life-sustaining tie to her foster mother), allows legal advocates to see abstract issues in a developmentally grounded, child-centered larger context.

## V. THE RISKS OF AN INTERDISCIPLINARY, VERTICALLY STRUCTURED APPROACH

If this approach is so wonderful, you may ask, why isn't everyone doing it? Certainly, many other groups around the globe are realizing the benefits of interdisciplinary collaboration. But these benefits do not come free of costs. In this section we will reflect on some of the risks and down-sides of our project.

### 1. COMMUNICATING ACROSS CULTURAL DIVIDES

In our work, we have found it very easy to be awed, inspired and impressed by each other's professional competence. Each of us is boringly familiar with our own discipline, but the other collaborator's professional acumen never ceases to amaze. The stresses emerge when we try to deal with daily administrative chores. Medical, social work and legal cultures differ radically, from major issues such as client confidentiality and autonomy to minor issues such as the order in which authors are listed on a publication. Lawyers need crisp clear answers and are trained to meet non-negotiable deadlines. Medical professionals evaluate and reevaluate, always ready to change their diagnosis or run another test. Social workers are attuned to the social context, where other might focus on the individual. Interdisciplinarity requires a constant commitment to communication. Tacit assumptions must be made explicit. Misunderstandings must be aired immediately. And protocols must be developed that respect the various professional cultures without making one or another dominant.

It is also more, not less, time consuming to work with partners from other disciplines. Time that

would otherwise be used to write or work is given to consultation with others, to translating their perspectives into a work product in progress, to teaching and to listening and learning.

## 2. TRYING TO BE IN TOO MANY PLACES AT ONCE

The common expression for being over committed is “working 24/7.” We find ourselves working what feels like 28/10, largely because we are trying to work in so many spaces. From the family court trenches to the Supreme Court covers a lot of territory. A major motivating force in specialization is the difficulty of doing everything well or even of doing it at all. We recognize, as well, that a group can acquire a momentum that drives it, in spite of itself, into specialization in one or another arena of action. Balance may be difficult or even impossible to maintain. It remains to be seen whether we can sustain the commitment to verticality.

In addition, we are literally “in too many places” because we occupy different physical and institutional spaces. While e-mail and electronic printing have reduced the physical distances between the Law School, the School of Medicine and the School of Social Work, we must still find time for the weekly face to face meetings that cement our partnership. Less tangible than the physical distances, are the institutional distances. In many Universities, turf wars would make a collaboration such as ours impossible. Even where the administrators encourage collaboration, it is difficult for each School fully to appreciate work taking place off site and involving faculty from other schools. When the time comes to recognize faculty members’ work, in promotions and tenure decisions, how well will this work translate into the idiom by which research and scholarship are judged within a particular school and discipline?

## 3. MONEY vs. TIME vs. INDEPENDENCE

Finally, the enterprise needs money to survive. Consulting work can produce income to pay for the time of consulting doctors, and buy release time for faculty who need more time for research and practice, but it can also create dual loyalties, when our avowedly child-centered perspective conflicts with the needs of an agency living in the real world of politics. Grant money provides a way around this dilemma. But grant-writing is time consuming and increasingly difficult as more “private” entities are drafted into providing public services, and must compete for shrinking charitable dollars. Alumni who give money to worthy causes are attracted to children’s welfare, but we must compete with bricks and mortar and with endowment, also pressing institutional needs. In an era when much of the public sector is being urged to privatize, children find they have little purchasing power in the market. It is no surprise that children’s hospitals are being converted into centers for executive fitness, and programs for poor children have difficulty competing for tax dollars with programs for affluent elders.

## CONCLUSION

CCPPR is confident that these barriers are surmountable. The benefits of the structure and mission

we have chosen seem well worth the costs. As we continue to develop our model of child-centered, team based, vertically integrated action, we look forward to sharing experiences with others, both in the U.S. and elsewhere, who are seeking to improve the current systems serving children and youth.

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