



Ensuring the Healthy Development of Infants in Foster Care:

**A Guide for Judges,
Advocates and Child
Welfare Professionals**

January 2004

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Permanent Judicial Commission on Justice for Children



ZERO TO THREE[®]

POLICY CENTER

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New York State Permanent Judicial Commission on Justice for Children

About ZERO TO THREE: ZERO TO THREE's mission is to promote the healthy development of our nation's infants and toddlers by supporting and strengthening families, communities, and those who work on their behalf. The organization is dedicated to advancing current knowledge; promoting beneficial policies and practices; communicating research and best practices to a wide variety of audiences; and providing training, technical assistance and leadership development.

About the ZERO TO THREE Policy Center: The ZERO TO THREE Policy Center is a research-based non-partisan effort at ZERO TO THREE that is committed to promoting the healthy growth and development of our nation's babies, toddlers and families. The Policy Center brings the voice of babies and toddlers to public policy at the federal, state and community levels by: translating scientific research into language that is more accessible to policymakers; cultivating leadership in states and communities; and studying and sharing promising state and community strategies.

About the New York State Permanent Judicial Commission on Justice for Children: The Permanent Judicial Commission on Justice for Children was established to improve outcomes for children whose lives and life chances are shaped by New York State's courts. As the nation's only children's commission based in the judiciary, the Commission is chaired by New York's Chief Judge Judith Kaye and its membership includes not only judges and advocates but also physicians, social workers, legislators and state and local officials. During the past decade, the Commission pioneered major reforms that have enhanced the lives of children throughout New York and nationwide, including improving access to early intervention services for infants and toddlers with disabilities, establishing the nation's first statewide system of children's centers in the courts, implementing the federal Court Improvement Project in New York State and developing a multipronged strategy to enhance the healthy development of children in foster care.

Cover photos by Marilyn Nolt

ZERO TO THREE would like to thank members of the ZERO TO THREE Policy Task Force for their time and advice: Sheila Kamerman, Ronald Lally, Harriet Meyer, Carol Berman, Linda Gilkerson, Mickey Segal, and Jack Shonkoff. The organization would also like to thank members of the Child Welfare Work Group for their thoughtful review: Martha Grace, Megan Gunnar, Sheila Kamerman, Diana Kronstadt, Cindy Lederman, Alicia Lieberman, and Joy Osofsky. Finally, ZERO TO THREE would like to thank Julie Cohen, Erica Lurie-Hurvitz, Cindy Oser, Sheri Lacy, and Victoria Youcha.

The New York State Permanent Judicial Commission on Justice for Children would like to acknowledge the Robert Wood Johnson Foundation for its support of the Babies Can't Wait project. The authors would also like to thank the following individuals for their time and advice: Judith Kaye, Steven Blatt, Susan Chinitz, Michael Cohen, Rob Conlon, Joan Cooney, Monica Drinane, Nancy Dubler, Azra Farrell, Dorothy Henderson, Susan Knipps, Katherine Locker, Molly Nozyce, Clark Richardson, Gayle Roberts, Lisa Shulman, Judy Silver, Moira Szylagyi, Sharon Townsend, and Darlene Ward.

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Introduction

Infants — babies less than 12 months of age — are the largest group of children to enter, remain and re-enter the child welfare system. Of the almost 600,000 children in foster care nationwide, one in five admissions is an infant. Since an alarming number of these babies are born prenatally exposed to drugs, premature or low birthweight, they are far more likely than other children to have serious medical problems, disabilities and developmental delays.

If left undetected and unaddressed, the needs of infants in foster care can jeopardize their healthy development and prospects for a permanent home. For their families, many of whom struggle with addiction, serious mental illness and extreme poverty, the strain of meeting these complex health needs can make it more difficult to manage the daily challenges of parenting. For advocates and permanency decisionmakers, an infant's complex health needs can undermine efforts to reunify families and recruit and retain foster and adoptive parents.

Fortunately, the new scientific research on the first months and years of life tells us that infancy presents an unparalleled window of opportunity to promote a child's healthy development and family stability. Our nation's courts and child welfare systems are at the front line for linking the new knowledge about infants with child welfare practice. We would move closer to achieving the goal of healthy development and permanency for every infant in foster care if at least one person involved in the court process — one judge, one lawyer, one Court Appointed Special Advocate (CASA), one caseworker — would ask basic questions to spotlight that infant's needs and integrate those needs with permanency planning efforts.

Written as an accompaniment to the booklet, *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates and Child Welfare Professionals*, this handbook is a working tool to help you understand the questions to ask and the resources that can address the special needs of infants in foster care and strengthen their families.

A Checklist for the Healthy Development of Infants in Foster Care

1. What are the medical needs of this infant?
2. What are the developmental needs of this infant?
3. What are the attachment and emotional health needs of this infant?
4. What challenges does this caregiver face that could impact his or her capacity to parent this infant?
5. What resources are available to enhance this infant's healthy development and prospects for permanency?

THE FIRST STEP: Building Your Knowledge of Infants in Foster Care

Infants are the largest subgroup among confirmed cases of physical abuse and medical neglect. These risks often are compounded by their parent's limited cognitive abilities, serious mental illness or drug and alcohol addiction. Compared to older children in foster care and even those babies living in poverty, infants in foster care face far greater risks to their healthy development and future adult well-being. The vast majority are prenatally exposed to maternal substance abuse and forty percent are born prematurely or with low birthweight — increasing the likelihood of chronic medical conditions, developmental delay and disability. And many infants in foster care experience multiple placements within their first year of life that can inhibit their capacity to form emotional attachments.

Infants also move through the child welfare system in ways that are different from older children — they remain in care longer and re-enter care after discharge in alarming numbers. The youngest babies, those under three months of age, are the most likely to enter foster care and spend twice as long in care as older children. And about one-third of all infants discharged from foster care return to the child welfare system, a strong indication that the problems leading to initial placement have remained unresolved.

Despite their vulnerability, too many infants in foster care remain off the public radar screen. Their portability and the perception that they are easy to parent make courts and child welfare professionals less likely to view infants as difficult cases. While monthly well-child visits and even the slightest sniffle bring most other newborns to the pediatrician's office, substantial research reveals that a significant number of babies in foster care do not receive even basic health care such as immunizations. Developmental and emotional delays are even less likely to be identified and addressed. And despite compelling evidence of the importance of early experiences on child development, few infants are linked to early intervention and early childhood services for which they may be eligible.

Facts At Your Fingertips: A National Look

- Infants are the largest cohort of children in foster care.
- Babies under three months of age are the most likely to enter care.
- More than one-third of infants enter foster care from the hospital.
- One-third of infants discharged from foster care re-enter the child welfare system.
- The likelihood of reunification with a biological family is lower for infants, but adoptions are more frequent.
- Nearly 80% are prenatally exposed to substance abuse.
- Nearly 40% are born low birthweight and/or premature.
- More than half have developmental delays or disabilities.

THE SECOND STEP: Building Your Knowledge of Early Child Development

Infants in foster care experience changes in placement and even visitation in ways that are very different from older children. While it would not occur to most parents to treat an eight-month-old the same as an eight-year-old, all too often our overburdened child welfare and court systems do not address the unique needs of babies in foster care.

Abundant scientific knowledge about early child development is available and should be used to make meaningful decisions about placement, visitation, services and permanency. Recent research has produced substantial evidence that infancy is a time of extraordinary opportunity and vulnerability. We now know that more brain growth and learning occurs during infancy than any other time of life, building a foundation essential to all future development. Yet, at the same time, in no other period do children rely so completely on the adults in their lives. The care received and attachments made in the first months of life are critical building blocks for future development and adult well-being.

The Science of Early Child Development

- All children are born wired for feelings and ready to learn.
- Early environments matter and nurturing relationships are essential.
- Children's early development depends on the health and well-being of their parents.
- Planned intervention can increase the odds of favorable developmental outcomes.

Shonkoff, J., & Phillips, D. (Eds.) (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.



TOOLS YOU CAN USE: LAWS AND GUIDELINES TO ENSURE HEALTHY INFANT DEVELOPMENT

This guide is consistent with the national standards for health care for infants as outlined in the federal Medicaid law through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions. The guide also suggests inquiries based on more stringent standards of health and developmental care for children in foster care as mandated under New York State law and as recommended by the American Academy of Pediatrics and the Child Welfare League of America. Additionally, the guide provides questions based on established principles of child development and infant mental health as advocated by the National Academy of Sciences, ZERO TO THREE, and the American Academy of Child and Adolescent Psychiatry. Question Five in this guide provides an in-depth explanation of the entitlements and resources available to promote the health and permanency of infants in foster care.

Federal Programs to Enhance the Healthy Development of Infants in Foster Care

- Adoption and Safe Families Act (ASFA): Establishes the framework for child welfare policy and practice. ASFA requires that the health and safety of children in foster care be “paramount concerns” in every child protective proceeding, strengthens the court’s role in monitoring cases and tightens timeframes for making decisions about permanency.
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Provisions of Medicaid: Sets forth regulations relating to the delivery of comprehensive health services to all children eligible for Medicaid, which includes all children in foster care.
- Early Head Start (EHS): Serves low-income pregnant women and families with children from birth to age three by providing education, health, mental health, social, nutritional and family support services.
- Early Intervention Program for Infants and Toddlers (Part C of the Individuals with Disabilities Education Act): Entitles infants and toddlers who experience developmental disabilities and delays or who have a physical or mental condition with a high probability of resulting in delay to an array of services including family support.
- Supplemental Nutrition Program for Women, Infants and Children (WIC): Provides food, nutrition counseling and access to health services to low-income pregnant and postpartum women, infants and children.

American Academy of Pediatrics Guidelines for Health Care to Young Children in Foster Care

- All children entering foster care should have an initial physical exam before or soon after placement.
- All children in foster care should receive a comprehensive physical as well as a mental health and developmental evaluation within one month of placement.
- Individual court-approved social service case plans should include the results of all health assessments and incorporate the recommendations of health providers.
- The physical, developmental and mental health status of a child in foster care should be monitored more frequently than that of children living in stable homes.

American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care, (2002)

QUESTION 1: WHAT ARE THE MEDICAL NEEDS OF THIS INFANT?

Eight-month-old Robert entered foster care due to neglect by his biological parents. At the time of removal from his home, an emergency room physician examined Robert for abuse and neglect and found that he was dehydrated and small for his age. The foster care agency had no other information about Robert's pediatric care or health status. Within one month of placement, Robert's foster parents took him to visit a pediatrician in their neighborhood.

When he was undressed for the physical examination, the physician found a large abdominal scar. The foster mother reported that he had arrived at her home with the scar well-healed and that she had no information about prior health conditions or surgeries. She informed the physician that Robert had difficulties with feeding and often slept all day and was awake all night. With no medical records, the physician could only hypothesize about the scar. The scar might be consistent with a major abdominal procedure related to a condition often seen in extremely premature infants. If Robert had been born prematurely, his feeding and sleeping problems might be related to his premature birth or the surgery. But there might be other causes as well.

Knowledge about Robert's birth and medical history at the time of placement might have enabled him to receive a developmental assessment and services early on and assisted his physician in monitoring him for serious conditions affecting his health and development.

The Medical Checklist

- What health problems and risks are identified in the infant's birth and medical records (e.g. low birthweight, prematurity, prenatal exposure to toxic substances)?
- Does the infant have a medical home?
- Are the infant's immunizations complete and up-to-date?

What health problems and risks are identified in the infant's birth and other medical records?

Babies in foster care have disproportionately high rates of health problems. Nearly 80 percent experience prenatal drug exposure. Forty percent are born prematurely at less than 37 weeks of gestation or low birthweight, weighing less than 5.5 pounds, increasing the likelihood of chronic medical conditions particularly neurological and respiratory problems, as well as developmental delays and disabilities. Identifying and addressing the health needs of infants in foster care require that permanency decisionmakers have information about their health history and risks, and that the infant have access to ongoing, comprehensive preventive and specialty medical care.

The majority of infants enter the child welfare system within the first three months of life and a significant number are placed in foster care directly from the hospital nursery. For these babies, information about risks to healthy development such as prematurity, low birthweight, lack of prenatal care and treatment recommendations should be obtained from the hospital. Permanency decisionmakers and the infant's primary health care provider should have access to an infant's birth and immunization records, and where available, the State newborn screening results for metabolic, endocrine, hearing and genetic disorders. This information is vital for informed decisionmaking concerning placement and services for the infant. The social worker at the hospital nursery may be helpful in obtaining and translating these records.

When infants are removed from their biological home or change placement, their medical records should move with them. Child welfare professionals should obtain consent from parents to share health information about the infant at the earliest possible point. If consent is unattainable, court orders can be secured to share health information about the child. Decisionmakers can ask whether the infant has a centralized, and updated medical file at the foster care agency which includes birth records. Initial and ongoing health information is critical to identifying health and developmental conditions that require medical attention and risks that necessitate further assessment.

Common Medical Diagnoses Seen in Infants in Foster Care

- Fetal alcohol syndrome
- Congenital infections such as HIV, hepatitis and syphilis
- Growth failure including failure to thrive
- Shaken baby syndrome
- Lead poisoning
- Respiratory illness
- Hearing and vision problems

Key Information to Obtain from Medical Records

- Prenatal risks and circumstances of birth (e.g. exposure to drugs, low birthweight, prematurity)
- Immunizations
- State newborn screening results (metabolic and genetic disorders, hearing screen)
- Identified health needs and conditions
- Treatment recommendations
- Primary care provider

Does the infant have a medical home?

Because all infants entering foster care are at particular risk for a number of acute and chronic medical problems, they require access to comprehensive, continuous health care by a pediatrician or physician knowledgeable about the health problems of foster children. The American Academy of Pediatrics (AAP) recommends that all children in foster care have a “medical home” — a place where all of their health care services are provided by a single practitioner who knows them and their caregivers.

The American Academy of Pediatrics recommends that all infants visit their primary physician according to a specific schedule for preventive pediatric health care at the following ages: at one week, one month, two months, four months, six months, nine months and one year. These well-baby visits enable the child’s health care provider to compile an infant and maternal history, track an infant’s growth, conduct developmental and behavioral screenings and administer immunizations. The Academy recommends that preventive care visits include an initial comprehensive physical examination to identify medical and developmental concerns, observe parent-child interaction, screen for hearing and vision, and lead exposure, provide immunizations and evaluate for child abuse and neglect and anticipatory guidance.

For children in foster care, the American Academy of Pediatrics recommends additional monitoring that reflects their increased risk for physical, developmental and emotional problems. The schedule includes an initial health screening before or shortly after placement, a comprehensive health assessment within one month of placement and, at a minimum, monthly health assessments for the first six months of age and every two months for ages six to twelve months. Monitoring should include close inspection for child abuse and neglect, close tracking of growth (poor weight gain is often the first sign of a sub-optimal placement) and monthly preventive visits up to six months of age. The Academy suggests that health supervision coincide with critical child welfare junctures — entry into foster care, placement change, visitation and discharge from foster care or at the time of termination of parental rights and adoption.

In most states, infants in foster care are eligible to receive preventive and ongoing pediatric health care under the Medicaid law’s Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Those involved in the child welfare and court systems can ask whether the child has a medical home where the child receives preventive and, where needed, specialty care. They can inquire about identified health needs, recommendations for ongoing care and whether caregivers attend health visits. For families with infants in foster care, the preventive care schedule reinforces consistent health supervision and measures a caregiver’s capacity to meet their infant’s basic needs.

Key Ingredients for Healthy Development of Infants in Foster Care

- Medical home
- Appropriate growth patterns (height, weight, head circumference)
- Up-to-date and complete immunizations
- Good feeding and nutritional status
- Caregiver capacity to meet infant’s basic health needs

Are the infant's immunizations complete and up-to-date?

Complete, up-to-date immunizations provide the best defense against many childhood diseases that can cause devastating illness. Immunization status is an important measure of vulnerability to childhood illness and access to basic health care. Incomplete or delayed immunization suggests that the child is not receiving adequate medical care and is not regularly followed by a provider familiar with the child's health needs.

The American Academy of Pediatrics publishes an immunization schedule for all children and recommends that immunizations for Hepatitis B, Polio, Measles, Mumps, Rubella, Pertussis, Diphtheria, Tetanus, Haemophilus Influenza Type B, Chicken pox and Rotavirus begin at two months of age, with follow-up at specific intervals thereafter. The Advisory Committee on Immunization Practices and the American Academy of Pediatrics recommend that infants receive immunizations at two, four, six and twelve months of age. Federal law requires that state Medicaid programs use the most current approved immunization schedule.

QUESTION TWO: WHAT ARE THE DEVELOPMENTAL NEEDS OF THIS INFANT?

Ten-month-old Alexis entered foster care after her mother left her unattended overnight. The foster mother brought her to a local pediatrician for an initial visit. The foster mother had no medical history or immunization record for Alexis. She reported that Alexis arrived at her home with a severe diaper rash, appeared very thin with a poor appetite and irritability. She informed the physician that Alexis was neither rolling over nor sitting on her own. She made very few verbal sounds and slept many hours of the day. The foster mother also reported that Alexis often did not turn her head when she spoke to her or when other children entered the room.

The pediatrician referred Alexis to the Early Intervention program where she was found to have delays that made her eligible for an array of services, including hearing aids. After just a few weeks of therapeutic intervention and hearing aids, Alexis is now described as a happy baby who eats well and has gained quite a bit of weight. She recently began to crawl and sit on her own. The foster mother reports that Alexis now enjoys listening and swaying to music with the other children in her home.

The Developmental Checklist

- What are the infant's risks for developmental delay or disability?
- Has the infant had a developmental screening/assessment?
- Has the infant been referred to the Early Intervention Program?

What are the infant's risks for developmental delays or disability?

Given that a vast majority of infants in foster care are prenatally exposed to drugs and alcohol, born premature and/or low birthweight and have experienced adverse environmental factors that can thwart healthy brain development, it should not be surprising that more than half exhibit developmental delays and disability. Inattention to the impact of these risk factors can cause problems in motor development, hearing and vision as well as growth retardation and language delays. These problems have a significant impact on a child's overall development and functioning. For example, untreated hearing loss during infancy interferes with the development of speech and language skills that are essential for early learning and social adaptation.

Developmental Red Flags

- Premature birth
- Low birth weight
- Abuse or neglect
- Prenatal exposure to substance abuse

Has the infant had a developmental screening/assessment?

While it is important to address all concerns voiced by caregivers about a child's development, research has found that reliance alone on foster parent and caseworker assessments of a child's developmental needs are often inadequate — only one-third of the problems identified in a study by professionals were reported by caregivers and caseworkers. The American Academy of Pediatrics recommends that all children receive preventive pediatric health care that includes developmental and mental health screenings, screening for exposure to lead at six months and one year of age, hearing screens at birth and one year, vision screens on exam at each visit and testing for infectious diseases. The EPSDT requires screening of both physical and mental health development as well as vision and hearing.

A developmental screening is a set of quickly administered techniques that identify a child whose development will need more thorough evaluation. These screens often use developmental milestones as a guide to monitor a child's development. For example, a developmental screen finding that a six-month-old infant shows minimal interest in social interaction, avoids eye contact or smiles and vocalizes infrequently or that an eight-month-old does not yet sit may indicate developmental problems or inadequate caregiver attention.

Because of the high likelihood of developmental delay, the American Academy of Pediatrics and the Child Welfare League of America recommend that every child in foster care have a formal, comprehensive developmental evaluation within one month of placement. An assessment or evaluation is a more in-depth evaluation of a child's development, usually using standardized instruments and a multidisciplinary team of evaluators with expertise in child development. For example, recognizing that a child's developmental well-being depends on the quality of their caregiving environment, the New York State District II American Academy of Pediatrics recommends that developmental assessments for children in foster care also include an evaluation of the quality of the foster care environment and the planned permanent family as well as re-evaluation of the child's developmental progress and caregiving needs periodically and at every change in placement.

A Quick Look At Developmental Milestones

- Month 1 - Responds to sounds, can fixate on a human face and follow with eyes, lift heads momentarily and move all extremities.
- Month 2 - Responds with smiles and coos to a caregiver's voice and has some head control in an upright position.
- Month 4 - Masters early motor, language and social skills such as smiling, laughing and full head control.
- Month 6 - Can sit with support and babble.
- Month 9 - Some mobility such as crawling.
- Month 12 - Using first sounds and words.

Has the infant been referred to the Early Intervention Program?

Children from birth to age three who have a developmental delay or a condition with a high probability of resulting in developmental delay (e.g. Down Syndrome, cerebral palsy, severe attachment disorders, failure to thrive) are eligible for the Early Intervention Program, known as Part C, under Federal and State law. The Early Intervention Program entitles eligible infants to a multidisciplinary evaluation and an Individualized Family Service Plan that can include hearing and vision screening and treatment, occupational, speech and physical therapy and special instruction as well as family support services such as parent training, counseling and respite care to enable parents and caregivers to enhance the infant's development.

The Keeping Children and Families Safe Act of 2003 that amended the Child Abuse Prevention and Treatment Act (CAPTA) (P.L. 108-36) requires that each state develop “provisions and procedures for referral of a child under age 3 who is involved in a substantiated case of child abuse or neglect to early intervention services funded under Part C of the Individuals with Disabilities Education Act (IDEA).”

QUESTION THREE: WHAT ARE THE ATTACHMENT AND EMOTIONAL NEEDS OF THIS INFANT?

Ruth was born three weeks premature, weighed less than four pounds and tested positive for prenatal exposure to cocaine. She was placed from the hospital with her grandmother who was unable to manage her persistent crying, sleeping and feeding difficulties. During the first six months of life, Ruth was moved to four different foster homes. Her crying, feeding and sleeping problems persisted. By six months of age, she made no eye contact, did not reach for objects and began to bang her head and pull her hair. At seven months, she was placed in her fifth foster home with experienced foster parents with two preschoolers of their own. They sought support with Ruth's emotional difficulties and enrolled Ruth in the Early Intervention program that included infant mental health therapy. Ruth began to heal and respond positively to her foster family.

When she was one-year-old, Ruth's biological mother gave birth to her third child. Like Ruth, Richard was born premature and with a positive toxicology for cocaine. He also had feeding intolerance and excessive irritability. When the foster care agency asked Ruth's foster family to take Richard, they declined because they felt that caring for Ruth and their own children was challenging enough. Despite the developmental and emotional gains Ruth made in the care of her foster family, the agency made the decision to remove her because they believed the siblings should be together.

The Emotional Health Checklist

- Has the infant had a mental health assessment?
- Does the infant exhibit any red flags for emotional health problems?
- Has the infant demonstrated attachment to a caregiver?
- Has concurrent planning been initiated?

Has the infant had a mental health assessment?

The newest research on infant mental health tells us that babies require permanence in their relationships and consistency in their daily routines. Consistent early relationships and experiences are the foundation upon which all subsequent emotional development rests. Multiple changes can be traumatic for very young children — babies grieve when their relationships are disrupted. For infants, every event in their foster care experience — removal, visitation, placement change and reunification — has implications for their healthy emotional development.

Infant mental health principles are based on research and clinical experience that support infants' emotional development within the context of their caregiving relationships. Helping caregivers to understand and manage their infant's emotional behavior can assist them in responding more effectively to the infants and can enhance interactions between infants and caregivers. For infants in foster care, this guidance and support can mean the difference between a stable placement and placement disruption and also can strengthen families for reunification or adoption. The American Academy of Pediatrics and the Child Welfare League of America recommend that all children in foster care have a comprehensive mental health evaluation within one month of placement. The American Academy of Child and Adolescent Psychiatry recommends mental health assessments for infants who exhibit excessive fussiness, feeding and sleeping problems and failure to thrive.

Does the infant exhibit any red flags for emotional health problems?

Self-regulatory skills are the building blocks for other early childhood development tasks. Self-regulation is achieved through consistency in caregiving and daily routines such as sleeping and feeding. This consistency allows infants to gain a sense of security that reduces their stress when faced with new or challenging situations, helping them to self-regulate their emotions and behavior. Babies born with low birthweight, those with mothers who abuse substances or have serious mental illness or those who are exposed to neglect and violence — in other words, babies for whom stress has reached unmanageable levels — are particularly vulnerable to problems with regulation. These infants often exhibit challenging behaviors including colic, excessive fussiness and sleep or feeding disturbances. Poor growth or failure to thrive and multiple placements can also signal a risk for emotional health problems.

Has the infant demonstrated an attachment to a caregiver?

Consistency in relationships for infants is achieved through attachment — the formation of an enduring emotional bond with a primary or small number of stable, responsive and sensitive caregivers. Disrupted attachment not only contributes to emotional and social problems, but can have biochemical consequences in a developing brain. Research indicates from birth to two months, an infant's preferences are limited to familiar smells and sounds. Between two and four months of age, they begin to know differences among caregivers, but a preference is not strongly expressed. By six months, however, most infants show preferred attachment and begin to develop anxiety when a stranger approaches or when separated from a primary caregiver.

Infants in foster care are at particular risk for attachment disruption. Decisions to remove infants from their home or move them once in a placement must reflect these needs. An infant's particular comfort and needs also should shape the frequency and location of visitation. In the context of permanency decisionmaking, changes in placement and visitation can produce great stress for infants of all ages and should raise a red flag for decisionmakers.

Emotional Health Red Flags

- Chronic sleeping or feeding disturbances
- Excessive fussiness
- Incessant crying with little ability to be consoled
- Multiple foster care placements
- Failure to thrive

Has concurrent planning been initiated?

For babies in foster care, the importance of attachment and regulation signals a need for concurrent planning. A component of the Adoption and Safe Families Act (ASFA), concurrent planning encourages simultaneous efforts to reunify children with their biological parents and efforts to secure an alternative permanent home. Concurrent planning can limit attachment disruptions by placing the infant in a caregiving environment that has the potential to become the adoptive family if reunification efforts are unsuccessful. Research demonstrates that babies can attach to more than one person and that responsive care by a primary adult can help a child attach to future caregivers.

Successful concurrent planning requires that foster parents be screened carefully for their ability to nurture and structure the caregiving environment appropriate to the child's special needs and that they are included in treatment decisionmaking for the child. It also requires that both biological and foster parents receive services to enhance their understanding of the child's needs and their capacity to parent the child. Concurrent planning also provides an opportunity to facilitate attachment between an infant and a parent who is participating successfully in a substance abuse treatment program or in mental health therapy.

QUESTION FOUR: WHAT CHALLENGES DOES THIS CAREGIVER FACE THAT COULD IMPACT HIS OR HER CAPACITY TO PARENT THIS INFANT?

Darren entered foster care at birth with a positive toxicology for cocaine. His biological mother abandoned him at the hospital and his father's whereabouts were unknown. In his first eight months of life, he was hospitalized several times for respiratory infections and other medical problems. He was described by nurses as withdrawn and unable to tolerate any changes in his environment. He was placed with a foster family who was also open to adoption. They were willing and able to meet his extraordinary medical and emotional needs, including constant nighttime monitoring for sleep apnea. The Judge was so concerned about the strain on the foster family that she ordered an aide be provided to give the family respite.

When Darren reached nine months of age, his biological mother reappeared and requested his return. The Judge ordered substance abuse treatment and frequent visitation for the mother who was compliant and became sober. Due to Darren's fragile condition the Judge ordered the visits in the home of the foster parents who were willing to share their experiences and knowledge about Darren's needs to assist in reunification. Despite their collaboration and the biological mother's consistent efforts, Darren would not allow anyone other than the foster parents to hold him. At the next hearing, the biological mother told the Judge that she understood the child's extraordinary needs and believed he was better off with the foster parents. Darren was adopted by his foster parents but has occasional contact with his biological mother according to an open adoption agreement.

The Caregiver Capacity Checklist

- What are the specific challenges faced by the caregiver in caring for this infant (e.g. addiction to drugs and /or alcohol, mental illness, cognitive limitations)?
- What are the learning requirements for caregivers to meet the infant's needs?
- What are specific illustrations of this caregiver's ability to meet the infant's needs?

What are the specific challenges faced by the caregiver in caring for this infant?

Building a relationship between a child and primary caregiver is a basic task of the first months of life. It requires that a caregiver read and understand the baby's signals and know how to respond in consistent and nurturing ways. For an overwhelming majority of biological parents of infants in foster care, addiction to drugs and/or alcohol, serious mental illness or cognitive limitations can compromise their capacity to protect and nurture their children. The challenges of parenting an infant with complex and chronic medical, emotional and developmental needs also can threaten the sobriety and functioning of those parents.

In every case involving infants, decisionmakers need to understand how the health and developmental needs of a particular infant impact caregiving. They need to ask whether the challenges faced by a particular caregiver — be it a biological, foster or adoptive parent — impact the ability to meet that infant's needs. They must ask whether a caregiver can meet the infant's basic health and safety needs. The age of the caregiver and the number of other children in the home and their needs can provide clues about a caregiver's capacity and resources. In choosing a foster home for an infant, decisionmakers should assess whether the foster parent has physical or cognitive limitations that can interfere with the ability to carry, lift, or feed the infant, hear the infant cry or stay awake at night with the infant. They should also assess the foster parent's willingness to participate in a partnership with the birth parents during time-limited reunification efforts, and to adopt the infant if reunification efforts are unsuccessful.

Caregiver Capacity Red Flags

- Noncompliance with the infant's scheduled health appointments and medication or therapeutic regimens
- Caregiver substance abuse and noncompliance with psychiatric treatment and medications
- Confirmed instances of child abuse or neglect
- Incomplete immunizations and a child's poor growth or arrested development



What are the learning requirements for caregivers to meet this infant's needs?

Health care and child development professionals play a critical role in helping courts and other decisionmakers obtain and translate information about the needs of infants in foster care, its impact on caregiving and a caregiver's capacity to parent a particular infant. For example, they can explain the specific daily routines required by the infant's extensive health and developmental needs and the learning requirements to meet these needs. They can provide information about how a caregiver's limited literacy or cognitive skills can impact his or her ability to administer medications to the child or participate in therapeutic regimens, and can make recommendations for needed supports. They also can provide information about a child's transportation and equipment requirements. Where reunification is a goal, it is critical that biological parents have regular and frequent occasions to learn about and perform their infant's daily routines — this not only increases caregiving capacity, but also enhances emotional attachment.

Health care and development experts also can assist child welfare decisionmakers in linking caregivers to services that educate them about the specific needs of their infants and provide opportunities for supervised involvement in their infant's routines. It's important to ensure that programs be modified to address parent's limitations as well as their strengths in order to adequately train parents about their infant's needs. Health care supervision visits, early intervention services, and early childhood and home visiting programs modified to reach caregivers allow them to learn best how to parent their child.

What are specific illustrations of this caregiver's ability to meet their infant's needs?

Even with services and supports, some parents may continue to have difficulty meeting the needs of their infants. Health care and service providers can offer specific examples of a caregiver's capacity to manage their child's daily routines. This information can be used to shape placement, visitation and permanency decisions. Service providers need to simultaneously assess and build on the strengths of the home and family. Regardless of the assessment or whether the caregivers are likely ultimately to succeed or fail, concurrent planning is particularly essential for these infants and their families.

QUESTION FIVE: WHAT RESOURCES ARE AVAILABLE TO ENHANCE THIS INFANT'S HEALTHY DEVELOPMENT AND PROSPECTS FOR PERMANENCY?

Nathan was born one month premature weighing four pounds with a positive toxicology for cocaine. He was difficult to feed and console. His teenage mother, desperate to keep her baby, readily agreed to enter a residential treatment program. At the first hearing, the Judge ordered a referral to Early Intervention for Nathan as well as substance abuse treatment for the mother and visitation to increase with sobriety. Nathan began to receive Early Intervention including a nurse who helped with feeding and crying and later, speech and occupational therapies were initiated. The foster parent received training by the therapist so she could do therapy exercises with Nathan. After participation in Early Intervention, Nathan's skills improved.

The mother did well in the substance abuse treatment program and began to visit Nathan several times a week. Prior to the next court appearance, a Court Appointed Special Advocate (CASA) revealed that the success of Early Intervention services provided at the foster parent's home was cited as a reason to delay reunification. Further inquiries by the Court facilitated a change in the child's Individualized Family Services Plan to allow services to take place at the home of the biological mother. Nathan was soon reunified with his mother with all needed services. The Judge estimated that Nathan returned home months earlier due to the CASA asking questions about the child's needs and access to the Early Intervention Program.

The Resource Checklist

- Does the infant have Medicaid or other health insurance?
- Is the infant receiving services under the Early Intervention Program?
- Have the infant and caregiver been referred to Early Head Start or another quality early childhood program?

Does the infant have Medicaid or other health insurance?

Virtually all infants in foster care are eligible for Medicaid. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions of the Medicaid law sets forth clear guidelines for the delivery of comprehensive health assessments, screens and services to all children eligible for Medicaid. But as infants move in and out of the child welfare system, they may lose their Medicaid eligibility. Asking questions about an infant's eligibility for Medicaid or a federally-funded State Children's Health Insurance Program at these junctures can ensure continuous health coverage and care. While having health insurance entitles an infant in foster care to health care, it does not guarantee that medical, developmental and mental health services are actually obtained. Every inquiry about the needs of infants in foster care must also address whether the services entitled under EPSDT are being accessed by the infant.

Is the infant receiving services under the Early Intervention Program?

In addition to the EPSDT, the Early Intervention Program (also known as Part C of the IDEA) is the strongest entitlement to services for infants in foster care. Infants who have a developmental delay or a condition with a high probability of resulting in developmental delay such as cerebral palsy, fetal alcohol syndrome, failure to thrive and severe attachment disorders, are entitled to early intervention services under Federal and State law. More than half of all infants in foster care can meet these eligibility requirements. Early Intervention provides a rich array of services that can address or ameliorate developmental delays including occupational, physical, speech and language therapies, psychological services, assessment and counseling, social work, special instruction, assistive devices such as hearing aids and wheelchairs, assessment and treatment of hearing and vision problems, nutrition counseling and transportation to early intervention services. Service coordination, which is mandatory, provides a case manager to help families navigate the eligibility process and insure that needed services are provided. Early Intervention services can be provided in the home and in out-of-home settings such as a clinic, child care program and during supervised parental visitation. The American Academy of Pediatrics and the Child Welfare League of America recommend that children in foster care receive a developmental evaluation at the earliest possible juncture, and if eligible, a referral to Early Intervention.

Perhaps most importantly, the Early Intervention Program is an entitlement for both the infant and their parent. It allows caregivers — biological and foster parents — to receive services that can help them enhance their child’s development. These services can include parent counseling and training, respite care and home visitation. Services for the child and family are enumerated in an Individualized Family Services Plan (IFSP) that is developed collaboratively by the family, evaluators and the early intervention official.

Parental consent and participation is the premise of the entire Early Intervention law. Yet, this emphasis on parent involvement can create a barrier to Early Intervention for many infants in foster care. Parents may be unavailable due to incarceration or homelessness or lack the capacity to participate due to serious mental illness, addiction or their own cognitive limitations. Parents also may fear intrusion by another state agency. Fortunately, the Early Intervention law defines “parent” broadly to include biological and adoptive parents, a relative with whom the child is living, a legal guardian and in some instances, a foster parent. The law specifically excludes state officials from acting as a parent. It also provides for the appointment of a surrogate parent if the child has no parent as defined under the Early Intervention law. The role of the surrogate parent is limited to representing the child in all matters related to the Early Intervention program. Nothing in the law prohibits a foster parent from serving as the surrogate parent.

Have the infant and caregiver been referred to Early Head Start or other early childhood program?

All infants in foster care and their caregivers can benefit from early childhood programs. High-quality early childhood programs provide more than respite and child care for caregivers. They can enhance the well-being of infants in foster care by linking them to health and entitlement programs, create an additional opportunity for the infant to establish a stable relationship with a caring adult, and promote early learning. They can strengthen families by teaching caregivers skills to manage their child’s needs. Like Early Intervention, these programs also support permanency efforts by providing a neutral, supervised setting for parent visitation, training and observation. Early Head Start is a federally-funded, comprehensive program of education, health, mental health, social, nutrition and family support services for pregnant women and families with children from birth to age three.

Some other quality early childhood programs embrace the two-generation approach of Early Intervention and Early Head Start, providing services for the child and supports for parents. Throughout the country, the Child Care Resource and Referral Programs maintain information about child care services, parent education and family-centered programs that exist in local communities. An initiative known as Starting Early, Starting Smart works with health care and early childhood providers in twelve sites nationally to address the emotional health needs of very high-risk children and families. Many communities have public health nursing and home visiting programs that can benefit infants in foster care and their families. Some drug and alcohol recovery programs provide services to help parents meet the needs of their children while receiving treatment for their addiction. For many infants in foster care, formal and informal supports from extended family members can bolster a caregiver’s capacity to parent.

The Supplemental Nutrition Program for Women, Infants and Children (WIC) provides low income, nutritionally at-risk pregnant and postpartum women, infants and children with nutrition education and counseling, screening and referral to other health, welfare and social services. The WIC program has been found to improve immunization rates and the developmental and nutritional status of infants and children as well as to increase the likelihood that they receive regular medical care.

An important resource for enhancing access to services for infants in foster care and their families can be found in our nation's courts. As the central decision-maker in every child protection proceeding with broad power to order services to ensure a child's health and well-being, the court can promote a steady focus on the medical, developmental and emotional needs of infants and link those needs to permanency efforts. Court orders can obtain the information that service providers have about infants and facilitate consent to services. Judges can convene the parties to monitor compliance with case plans and ensure that infants and their caregivers actually receive entitlements and necessary services, and that the child's well-being and safety are not compromised.



The importance of positive early environments and stable relationships for a child's healthy development is incontrovertible. At the same time, a lack of attention to infants in or at risk of foster care placement has long-term implications for those children and our society. Children who spend their early years in foster care are more likely than other children to leave school, become parents as teenagers, enter the juvenile justice system and become adults who are homeless, incarcerated and addicted to drugs. Answering the cry of infants in foster care is an investment in their lives and the future of all children.

Additional Resources

- New York State Permanent Judicial Commission on Justice for Children – <http://www.courts.state.ny.us/ip/justiceforchildren/>
- ZERO TO THREE – <http://www.zerotothree.org>
- Child Welfare League of America – <http://www.cwla.org>
- American Academy of Pediatrics – <http://www.aap.org>
- The Pew Commission on Children in Foster Care – <http://www.pewfostercare.org>
- Future Unlimited – <http://www.futureunlimited.org>
- Miami Safe Start Initiative – <http://www.miamisafestart.org>
- Babyjudge listserv – To subscribe “join-ldi_babyjudge@lists.zerotothree.org”
- Early Head Start National Resource Center – <http://www.ehsnrc.org>
- National Association for the Education of Young Children – <http://www.naeyc.org>
- California Institute for Mental Health – <http://www.cimh.org>
- The Annual Recommended Childhood and Adolescent Immunization Schedule of the American Academy of Pediatrics – <http://www.aap.org/policy/2003Imm.pdf>

Additional Reading

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