Building Bridges for Babies in Foster Care: The Babies Can't Wait Initiative

BY SHERYL DICKER AND ELYSA GORDON

ABSTRACT

In 2001, the New York State Permanent Judicial Commission on Justice for Children, chaired by New York State's Chief Judge Judith Kaye, developed the Babies Can't Wait Initiative to maximize the well-being and permanency prospects of infants in foster care. This court-based innovation became a path to healthy development for babies in foster care, a bridge to unprecedented collaboration among the New York City Family Court, child welfare system, and service providers and merged knowledge about child development with court and child welfare practice. This article tells the story of the Babies Can't Wait Initiative—its creation, implementation, successes, and lessons.

In February 2001, the New York State Permanent Judicial Commission on Justice for Children (the Commission), chaired by New York State's Chief Judge Judith Kaye and the nation's only children's commission based in the judiciary, embarked on a court-based innovation to maximize the well-being and permanency of infants in foster care. The Commission was well aware of research finding that infants are the largest group of children to enter, remain in, and re-enter the child welfare system.[1] Indeed, one in five admissions is a baby under 12 months of age.[2] This trend was even more alarming because the Commission's previous work had revealed that infants in foster care are at great risk for serious medical problems, developmental delays, and disabilities. The Babies Can't Wait Initiative, funded by the Robert Wood Johnson Foundation, partnered the court, child welfare system, and service providers and merged knowledge about child development with court and child welfare practice. The result was an unprecedented focus on the often invisible babies in New York State's Family Courts and collaboration among permanency decision makers, advocates, and service providers.

Building a Case for an Infant Initiative

Since its inception, the Commission has focused its attention on the well-being of children involved in cases before New York State Courts. The Commission's implementation of the federal State Court Improvement Project (CIP) found ample evidence that scant attention was paid to the needs of children, particularly young children, in court proceedings.[3] The Commission's work in securing passage of and its monitoring of the New York Early Intervention law also revealed that young children in foster care were at heightened risk for developmental delay and were not being connected to vital Early Intervention services.[4] Early Intervention and CIP efforts began to flow together as the Commission learned of research nationwide that documented the fragile health and disabilities among children in foster care and their inadequate access to entitlements and programs that can address their needs.

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THE PERMANENT JUDICIAL COMMISSION ON JUSTICE FOR CHILDREN'S CHECKLIST FOR THE HEALTHY DEVELOPMENT OF FOSTER CHILDREN

1. Has the child received a comprehensive health assessment since entering foster care?
2. Are the child's immunizations up-to-date and complete for his or her age?
3. Has the child received hearing and vision screening?
4. Has the child received screening for lead exposure?
5. Has the child received regular dental services?
6. Has the child received screening for communicable diseases?
7. Has the child received a developmental screening by a provider with experience in child development?
8. Has the child received mental health screening?
9. Is the child enrolled in an early childhood program?
10. Has the adolescent child received information about healthy development?

In November 1999, the Commission published the *Healthy Development Checklist for Foster Children* and the booklet, *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates and Child Welfare Professionals.*[5] The checklist contains 10 questions to identify a foster child's health needs and gaps in services. The booklet serves as a companion tool, providing the rationale for each question and references to expert sources. To date, more than 25,000 booklets have been disseminated throughout New York State and nationwide. As a result of the widespread use of this advocacy tool, many children have received the basic health care to which they are entitled under Federal and State law.

As part of its work on the Healthy Development Initiative and the Model Courts of the New York State CIP, the Commission found that the needs of infants, often regarded as the easiest population to work with, are often invisible to the court and child welfare system. A review of the literature confirmed that the risks to healthy development are especially pronounced for infants in foster care. The vast majority are prenatally exposed to maternal substance abuse and 40% are born low birthweight or prematurely, increasing the likelihood of chronic medical conditions, developmental delay, and disability.[6] Infants are the largest subgroup among confirmed cases of physical abuse and neglect.[7] While monthly well-child visits and even the slightest sniffle bring many 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 receive early intervention and early childhood services.[8]

The abundant scientific evidence of the influence of early child development further fueled the Commission's decision to focus on infants. The publication in 2000 of *From Neurons to Neighborhoods: The Science of Early Childhood Development* by the National Research Council and the Institute of Medicine confirmed that more brain growth and learning occurs during infancy than any other time of life, building a foundation essential to all future development.[9] The research also confirms that planned intervention can increase the odds of favorable developmental and emotional outcomes for infants and toddlers. The Commission believed this research could provide those involved in the court process with a basis to better understand the link between healthy development and permanency.

To assist in understanding the experience of infants in foster care, the Commission invited researcher Fred Wulczyn to an October 2001 meeting to present key findings from his demographic studies on infants in foster care. The Commission also invited Professor Michael Wald, a noted expert on child welfare, to respond to his presentation. Dr. Wulczyn cast a spotlight on an alarming trend—infants are the largest group of children to enter, remain in, and re-enter the child welfare system.[10] His research found that of the almost 600,000 children in foster care nationwide, one in five admissions is an infant. It also revealed that infants move through the child welfare system differently than older children—they remain in care longer and re-enter care after discharge in alarming numbers. Most alarming, his research found that 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. More than one-third enter foster care directly from the hospital after birth. The likelihood of reunification with a biological family is lower for infants, but adoptions are more frequent. And nearly 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.[11] At the conclusion of this presentation, Professor Wald suggested the need for a specialized focus on infants in Family Court. Armed with this knowledge, and relying on the Commission's experience of the New York State Court Improvement Project and its activities to promote the healthy development of all children in foster care, Chief Judge Judith Kaye urged the Commission to develop a court-based innovation—a hallmark of the Commission's prior successes—to address the unique needs of infants in foster care.[12]

At that time, Dr. Wulczyn also shared his research findings with the Commissioner of the New York City Administration for Children's Services (ACS). His data further fueled ACS's commitment to understanding the placement patterns of infants in New York City as part of its Adoption and Safe Families Act (ASFA) enforcement work.[13] The burgeoning interest in infants at the Commission and ACS soon merged to become a pathway to healthy development for babies in foster care and a bridge to unprecedented collaboration between the New York City court and child welfare system.

Creating the Babies Can't Wait Initiative

In February 2001, the Babies Can't Wait Initiative was born. The Commission's initial efforts focused on a review of the law related to infants in foster care and a research project to understand the needs of infants in foster care and the system of services to infants in one New York City borough. The statutory review affirmed that infants in foster care were entitled to comprehensive health services under the Early Periodic Screening Diagnosis and Treatment (EPSDT) provisions of the Medicaid law and that many were eligible to receive developmental and support services under the federal Early Intervention Program, Part C of the Individuals with Disabilities Education Act (IDEA). ASFA made clear that a child's health and safety is a paramount consideration in every child protective proceeding and that courts have broad authority to address health needs.[14]

The Commission chose to locate the Babies Can't Wait Initiative in the Bronx Family Court because the jurisdiction possessed an extensive network of early childhood and health care resources for infants. It also included two prominent Commission members who were faculty members of the Albert Einstein College of Medicine.[15] Additionally, the Robert Wood Johnson Foundation had a significant, existing interest in projects serving children and families in the Bronx. Research efforts found that petitions were filed for 491 infants in the Bronx between April 2000 and March 2001.[16] The Commission staff developed a preliminary profile of infants in the Bronx by reviewing 10% of these cases, or 48 court case files. Findings mirrored the national trends and highlighted current practice and gaps in services:

- A vast majority of these infants were placed in foster care from the hospital at birth and were removed due to positive toxicology.
- The average age of the mothers was 34 and most mothers had an average of five children.
- The majority of the infants had parents whose parental rights for older children had been terminated.
- Most of the infants resided in non-kinship foster care.
- One-third of the files contained court orders for services to parents, primarily orders for generic parenting skills classes and substance abuse treatment.

- Less than one-fifth of the files contained court orders for services to the infant or information on the infant's health and development.
- Nearly one-third of the files contained a court order for visitation and these orders were often vague regarding frequency and specifications for supervision.

Implementing the Initiative

These initial activities highlighted three challenges facing the courts and child welfare systems—identifying and addressing the health and developmental needs of infants; understanding and supporting caregivers' capacity to meet the needs of their infants and enhance prospects for permanency; and linking infants in foster care to medical care and early intervention and early childhood services. To meet these challenges, the Commission identified five essential components of the Babies Can't Wait Initiative:

- Identifying and convening local stakeholders;
- Judicial leadership;
- Building a knowledge base and toolbox;
- Creating opportunities for collaboration and relationship-building; and
- Data support.

Identifying and Convening Local Stakeholders

Important goals of the Babies Can't Wait Initiative were to generate significant interest in infants in foster care among permanency decision makers and professionals serving young children in the Bronx and to encourage cooperation and collaboration among the courts, child welfare system, and service providers. To meet these goals, the Commission identified and convened stakeholders in the Bronx Family Court and child welfare system as well as in the Bronx early intervention and early childhood community. The Commission staff provided briefings on the research and the goals of the project to New York City Family Court Administrative Judge Joseph Lauria, Bronx Family Court Supervising Judge Clark Richardson, and Bronx Family Court Judge Gayle Roberts and her court attorney who were implementing an abandoned infant project.[17] A second goal was to ensure that the efforts and learning from the project would remain part of the culture in the Bronx long after the grant ended. To this end, the Commission identified local experts in the fields of child development, health and infant mental health and provided numerous opportunities to establish and develop professional and personal relationships among these local leaders, the court, and child welfare staff.

Previous experiences with the development of the Healthy Development publications made clear that additional, new resources were required to assist the court in asking questions, gathering information and translating results of screenings and evaluations relevant to permanency decision making. Expanding on the success of its statewide CASA Project that called upon the resources and expertise of CASA volunteers to use the Healthy Development Checklist on cases assigned to them by a judge, the Commission worked closely with the New York City CASA Director and the Bronx CASA Supervisor to provide additional resources to the Babies Can't Wait Initiative. Identifying Bronx CASA as a local resource to assist the court in gathering information needed for decision making, each participant in the court process became more aware of the infant's needs and the resources available to meet those needs. Indeed, CASA involvement often provided a tangible link among the court, ACS caseworkers, and community service providers.

From the outset, the Commission staff was committed to close collaboration with ACS to focus attention on infants in foster care. The Commission's Healthy Development Initiative activities had facilitated good professional and personal relationships among Commission staff and ACS management staff. The Commission trained ACS staff on the Healthy Development Initiative, and the checklist was incorporated into ACS's permanency hearing forms. The ACS management staff was instrumental in identifying ACS staff in the Bronx Field Office to help the Commission understand the profile of infants in foster care in the Bronx and identify the local child welfare agencies and service providers serving these babies as well as those in the Babies Can't Wait Advisory Group. The Commission shared the initiative's findings with ACS management staff and learned about ACS practices involving infants in foster care. In February 2002, ACS management staff and the Commission co-sponsored a

meeting of Bronx foster care agencies at the Bronx Family Court to introduce the project. Supervising Judge Clark Richardson and Judge Gayle Roberts also were present for this unique meeting. It was the first time Bronx foster care agency representatives met with the Bronx judges and court staff at Bronx Family Court.

In April 2002, Commission Director Sheryl Dicker briefed the newly-appointed ACS Commissioner, William Bell, on the Commission's activities including the Babies Can't Wait Initiative. Commissioner Bell's high interest in the initiative resulted in his appointment of a work-group composed of high-level ACS staff, expert community-based providers from our Bronx Advisory Group, and Commission staff to address emerging policy and practice issues involving infants. The result of this work-group has been an ACS Babies Can't Wait Initiative to develop infant-sensitive protocols and practice and to bring the lessons of the Commission's Babies Can't Wait Initiative to other boroughs.

To guide the initial work and create a forum where stakeholders could share ideas and expertise, the Commission convened an Advisory Committee composed of Commission members and staff, Judge Richardson, Judge Roberts, the Administration for Children's Services staff, Legal Aid, Court Appointed Special Advocates, the Bronx Early Intervention program, and Bronx medical, developmental and infant mental health, early intervention, and early childhood providers. The Committee identified three tasks for the project:

- Conduct a multidisciplinary training series about infant health and development for those involved in the court and the child welfare systems;
- Develop an infant checklist and booklet focusing on the unique needs of infants for those involved in the court process; and
- Partner with the child welfare system in changing policy and practice concerning infants.

Judicial Leadership

Judges play a crucial role, not only as the central decision maker in every child welfare case, but in shaping courtroom climate and community expectations. Judges can encourage advocates and child welfare professionals to spotlight a child's healthy development as an essential component of case review and permanency planning. Chief Judge Kaye's leadership focused the Commission's efforts on developing court-based strategies to spotlight the basic needs of children involved in child protection cases. At every speaking engagement, she encouraged judges to be "champions for change" to ensure that children and families benefit when their lives are touched by the courts.[18] She sent the Healthy Development booklet to all the chief justices in the United States and the judges of New York's Court of Appeals, and cited the booklet in her State of the Judiciary messages. She encouraged judges to consider an alternative to the remote adjudicator model of judging—the problem-solving model of judging. In this model, judges write court orders for services and orders that permit the parties to obtain and share information about a child's needs. They might rearrange court resources or procedures to improve outcomes. They may need to reach beyond the courtroom to partner with agencies and community groups to improve functioning of the system as a whole. And, where questions expose the inadequacy of resources or protocol to meet the needs, judicial leadership can help spur new initiatives to ensure the healthy development of children in foster care.

The imprimatur of Judge Kaye's leadership was critical for the Babies Can't Wait Initiative—her attendance at the first Bronx training demonstrated that the initiative was a top priority of the New York State court system. The leadership of the other judges on the Commission contributed to the enthusiasm for the project among child welfare professionals and advocates. Supervising Judge Richardson chaired the Advisory Committee, participated in the entire Babies Can't Wait training series, encouraged all judges and court staff to attend the trainings, and issued directives on prioritizing the use of CASAs for infant cases. Judges were active participants at every advisory meeting and training, setting the tone of leadership and collaboration. Judge Roberts agreed to use her courtroom as a laboratory for the Babies Can't Wait Initiative. She assigned a CASA to every infant case, attended advisory group meetings, participated in trainings and became a champion for infants in foster care.

The judges in the Bronx also exhibited judicial leadership by encouraging sensitivity to the court process

and culture. As a result, the Babies Can't Wait training curriculum was grounded in the law, held on site at the courthouse, and limited to a one-hour format during the court's lunchtime to encourage attendance. Every participant received copies of the presentation and other companion materials tailored to accommodate participants' busy schedules. Time constraints also underscored the importance of follow-up training and ongoing support and were instrumental in developing the court-based follow-up consultation clinics.

Building a Knowledge Base and Toolbox

The Commission's review of the literature and Bronx court files highlighted the need to build a knowledge base and toolbox to help the courts, child welfare professionals, and advocates identify and address the most critical guideposts for infant's health. To meet this challenge, the Commission created a collaborative, interdisciplinary effort that reflected cutting-edge research as well as local needs and resources. With the assistance of the Advisory Committee, the Commission conducted a lunchtime training series, *Infant Health and Development: What Courts and Child Welfare Personnel Need to Know*, to educate those involved in the court process about this issue. The training highlighted the medical, developmental, and emotional needs of infants and provided information on resources to address those needs. The five-part series informed participants about the developmental vulnerability of infants and toddlers in foster care due to biological and environmental risk factors that often are not tracked because of caregiver changes. The training sessions included:

- **Understanding the Health Care Needs of Infants**—This session, presented by a pediatrician, outlined the specific health risks and problems facing infants in foster care, components of the pediatric health visit, and strategies to enhance the health of infants in foster care. The trainer reviewed the environmental and biological risks faced by infants in foster care, identified common diagnoses found among infants in foster care, and suggested basic questions to determine an infant's health status. Particular attention was given to the complications of prematurity. The trainer also discussed issues related to consent and confidentiality. The session concluded with case studies to help participants gain skills in assessing health risks and developing a problem list and plan.
- **Understanding Infant Development**—This session, presented by a developmental psychologist, provided a basic understanding of brain and child development in the first year of life and developmental disorders in infancy and early childhood. The trainer reviewed the developmental tasks and milestones of infancy and defined the distinction between a screening and assessment. The session concluded with an introduction to the Early Intervention Program and the scientific evidence of the effectiveness of well-designed early intervention.
- **Understanding the Emotional Needs of Infants**—This session, presented by a clinical psychologist and a social worker, underscored the emotional needs of infants and offered insight on how their needs impact permanency decision making including permanency goals, visitation, and services. The trainer highlighted the importance of early relationships for an infant's development and emotional well-being. Participants gained an in-depth understanding of attachment.
- **Accessing the Early Intervention Program and Early Childhood Education Programs for Infants**—This session, presented by an Early Intervention official, reviewed the developmental disorders in infancy and early childhood and provided an overview of the Early Intervention Program and early education programs for infants. Participants gained specific knowledge of the federal and New York State Early Intervention law, the design of the Early Intervention Program, the program's eligibility requirements, and protocol for referral, evaluation, and service planning. The trainer outlined how the program can be used as part of permanency planning and decision making. Participants also received practical information on the Head Start program and other home visiting services.
- **Case Study**—This session enabled participants to review an infant case and use the checklist to determine a permanency plan. It also reinforced the learning of the four earlier sessions.

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 im pact his or her capacity to parent this infant?
5. What resources are available to enhance this infant's healthy development and prospects for permanency?

In addition to introducing the Bronx court and child welfare professionals to local resources, the training sessions provided participants with contact information for the Early Intervention Program and a list of ACS Head Start programs for the Bronx, broken down by zip code. A by-product of the training was the development of a strong link among the Family Court, Legal Aid, CASA, and treatment resources in the Bronx. More than 80 professionals including Bronx Family Court judges, court attorneys, CASAs, Legal Aid attorneys and social workers, parents' attorneys, ACS legal and program staff, and advocates attended the training.

The evaluations of the training were uniformly excellent. Most interesting was the response to the question: "What one piece of information that was provided to you will you incorporate into your practice immediately?" Participant answers included asking whether an infant has received a medical evaluation by a pediatrician and other specialists at the earliest possible point in the court proceedings, and whether the infant received developmental testing and a referral to the Early Intervention program, particularly when the infant was born premature. Others identified the importance of minimizing removals and changes in placements, advocating for preventive services prior to removal and prior to final discharge, and stressing the importance of attachment issues.

The positive feedback from the Bronx training series encouraged the Commission to develop a similar series in other boroughs. The Commission identified key stakeholders and community experts in Brooklyn, Manhattan, and Queens and worked with the Family Courts in these boroughs to host the series as well as follow-up consultation clinics based on the Bronx Model. Additionally, the Commission, in concert with ACS, trained approximately 400 ACS staff throughout New York City on infant issues.

The Commission and the Advisory Group also decided to build on the success of the Healthy Development Checklist and its companion booklet by developing a checklist and training booklet for infants in foster care. Like the first checklist, the infant checklist is based on the national research on infants in foster care and recommendations by the American Academy of Pediatrics Committee and the American Academy of Child and Adolescent Psychiatry. It is a tool to gather, document, and track risk factors that impact the healthy development and permanency prospects of infants in foster care.

Since April 2002, Bronx Family Court Judge Gayle Roberts has used the Infant Checklist on all new cases involving infants. CASA agreed to assign a volunteer to each of the judge's infant cases to assist the court in completing the checklist questions and keeping specific data. The Bronx Legal Aid Society law guardians also use the checklist on all infant cases. Using the checklist, the Bronx CASA has compiled data on the 29 infant cases in one courtroom for six months in 2002. The data reveal both the vulnerability of these infants as well as the clear impact the initiative has had on enhancing their healthy development. The CASA findings also mirror the national data:[19]

- The vast majority of infants entered care within one month of birth and were placed directly from the hospital;

A DETAILED INQUIRY FOR INFANTS IN FOSTER CARE

The Medical Checklist

- What health problems and risks are identified in the infant's birth and medical records (i.e., 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?

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?

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?

The Caregiver Capacity Checklist

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

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 Head Start or other early childhood program?

- Most infants were born with positive toxicology;
- One-third of the infants were born low birthweight;
- Ten percent of the infants had a biological mother who was identified as having a mental health diagnosis; and
- Twenty-one percent of their mothers indicated that they had prenatal care.

By asking the questions and following up, CASAs not only gleaned important information about the infants, they also raised awareness about important services. This multiple use of the checklist assured receipt of important services resulting in every infant having up-to-date immunizations and nearly 80% having an assigned pediatrician, a next pediatrician visit scheduled, and a referral to the Early Intervention program.

To further assist judges, attorneys, and child welfare professionals, the Commission wrote an infant booklet designed to spotlight the unique needs of infants and the resources available to address those needs. As a complement to the first booklet, the Commission envisions the infant booklet as a tool not only to enhance an infant's healthy development, but also to shape permanency planning and decision making. The booklet, co-published by the National Zero to Three National

Center for Clinical Infant Studies, is a product of the collaboration between the Commission and the Babies Can't Wait Advisory Group whose members extensively reviewed and provided substantive content.

Creating Opportunities for Collaboration and Relationship-building

To shape the project and provide ongoing opportunities for discourse and relationship-building, the Commission convened a highly inclusive Advisory Group comprised of representatives from the court, child welfare, and local child development experts. The Advisory Group ensured that the project reflected the voice of all those involved in serving infants in foster care and their families and fostered an unprecedented, ongoing relationship between the court and community resources. Recruiting local child development experts as trainers gave the court and child welfare professionals a better understanding of and access to community resources. It also provided an opportunity for the court to receive ongoing consultation and support on specific cases beyond the trainings. The trainers reported that their knowledge of the local court process and culture, and their access to community judges, advocates, and child welfare professionals improved their ability to shape clinical recommendations and resolve difficult cases.

Additionally, the Commission developed monthly consultation clinics returning the trainers to the Bronx Family Court to answer questions about infant health and development. The clinics reinforced the highly successful training series and provided additional opportunities for building relationships between the court and local service providers. Six consultation clinics were held between May and December 2002. Each clinic drew nearly 30 participants including judges, court attorneys, legal aid and parents' attorneys, and ACS staff. The clinics provided detailed information and answered questions from participants about the Early Intervention program, Head Start, and health and attachment issues. They also shaped practice, clarified the learning of the trainings, and cemented relationships between the experts and the courts. This is exemplified by one session at which a judge asked Lisa Shulman, a pediatrician and trainer, a key question: "What should I be asking to determine if it is safe for an infant with a positive toxicology to return home?" Dr. Shulman's response gave the judges several practical questions to ask, helping to elucidate the issues and shape court practice:

- Does the mother have a substance abuse addiction, does she accept that diagnosis, and is she compliant with treatment?
- What supports does the mother have, particularly at three a.m. when the infant is awake and crying?
- What is the mother's track record with her other children regarding her ability to be compliant with school attendance, medical appointments, and treatment regimens?

At its December 2002 meeting, the Advisory Group decided to plan additional clinics on parenting education and overcoming barriers to enrolling foster children in the Early Intervention program.

The trainings and consultation clinics created informal opportunities, outside the adversarial setting of the courtroom proceeding, to share concerns, questions, and experiences related to meeting the needs of infants in foster care. Judges have attended more community meetings and have continued to ask questions of their new professional allies. The experts have consulted their court contacts to better understand the court process and untangle particularly complex cases. The building of these relationships was facilitated by the openness of the process. It was not uncommon for training participants to share their experiences and concerns about the children in their own lives. Judges attended the trainings without their robes and the experts presented without their white coats. The final training session introduced a group problem-solving activity that helped everyone to not only cement the learning of the training, but understand each other's roles.

The Commission believed that information sharing and collaboration were essential to the success of the Babies Can't Wait Initiative. From previous experience with the CIP and Healthy Development Initiative, we understood that child development experts have a critical role to play in helping courts and child welfare staff to translate the information about children in foster care in ways to aid in decision making concerning placement stability, visitation, and permanency. At the same time, these experts informed us that knowledge about a

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CASA stated that the initiative strengthened the Bronx CASA program by giving it a clear focus, role, and expertise. The judges reported that it shone a spotlight on the critical need for information about the health and development of all children involved in the courts. At the close of this meeting, members decided to continue project activities under the chairmanship of the Bronx Supervising Judge.

In addition to the impact on New York City Family Court, the initiative is also shaping ACS practice. The ACS Working Group not only designed and presented training to more than 400 child welfare supervisors in the Bronx, it has devoted months to two initiatives: developing placement guidelines for only-child cases and developing referral mechanisms for all foster children to enter Head Start. The Commission worked with ACS to draft factors to consider in selecting a foster home to place infants with no siblings. The factors were reviewed and reworked by a joint committee and now serve as the basis for future infant home-finding practice.

Statewide Impact

Since the Commission is a statewide body, many of its members brought word of the Babies Can't Wait Initiative back to their communities. In Westchester County, under the leadership of Supervising Judge Joan Cooney, CASAs are using the infant checklist on every infant case. The Commission launched the project in Erie County (Buffalo) in July 2003 when Commission member Administrative Judge Sharon Townsend brought learning to Erie County. She initiated the development of a Babies Can't Wait project as part of Erie County's larger Model Court Stakeholders Group. Erie County has added members of local Early Intervention programs and Child Care Resource and Referral agencies to its planning group. It will replicate the Babies Can't Wait training curriculum in May 2004 using local experts as trainers. The Commission obtained a grant from the New York Community Trust Foundation to expand the project to all the boroughs of New York City.

Word of the Commission's Babies Can't Wait Initiative also has spread to the New York State Office of Children and Family Services (OCFS). Due to a finding of noncompliance by the federal Child and Family Services Review (CFSR), OCFS organized a committee to write the required Program Improvement Plan (PIP) that included Commission staff. The PIP refers to the Commission's work, and one provision specifically calls for an automatic referral system to the Early Intervention Program for all young children in foster care.[20] The Commission-OCFS collaboration has led to the convening of a statewide conference, "Sharing Success," of judges, lawyers, and Department of Social Services staff to highlight successful court and child welfare reform initiatives. Presentations about the project were made at the first morning of the conference by both Commission and ACS staff to emphasize its statewide importance and ensure that all attendees are exposed to its learning. As a result, several additional counties will be initiating Babies Can't Wait projects.

Systemic Impact

The Babies Can't Wait Initiative also has influenced child welfare practice. To an even greater extent than the Healthy Development of Foster Children Initiative, Babies Can't Wait has strengthened the ability of courts and child welfare professionals to make the connection between healthy development and permanency. The connection was clear for babies because individuals could understand how an infant who cries constantly could impact a caregiver's ability to parent that infant, thereby creating stress on the family and the infant's prospect for permanency. The trainings also demonstrated that infants appear more responsive to intervention. Some cite the influence of the early childhood research and the availability of entitlements and programs such as Early Intervention and Early Head Start. Others see the infant cases through the lens of their own experiences as parents. Regardless of the motivation, the babies became the "hook" to help the court and child welfare systems focus attention on the needs of children in foster care regarding not only services but on placement, visitation, and permanency decision making.

Preliminary data suggest that even a small amount of knowledge about a child's needs, gaps in services, and resources for family support can have a tremendous impact on the decision-making process. For example, health information gathered by using the infant checklist resulted in court orders for referrals to the Early

Intervention program. Judges and lawyers report that knowledge about the complex health needs of infants made them more aware of the need to consider caregiving capacity issues in making decisions about placement, visitation, and permanency. They are now asking specific questions about a caregiver's ability to meet his or her child's particular medical, developmental, and emotional needs. Influenced by the project's trainings and consultation clinics, decision makers and advocates also have increased their sensitivity to the impact of visitation schedules and changes in placement on an infant's attachment needs. ACS management staff developed an infant placement checklist based on child development principles. It has begun to revise its concurrent planning procedures and to standardize developmental screenings and case management for infant cases. Priorities include finding appropriate first placements for infants, identifying families simultaneously willing to work with birth families and to adopt if reunification efforts are unsuccessful, minimizing movements in care, and reviewing its current core training for child development content.

National Impact

The Babies Can't Wait Initiative is beginning to reach beyond New York State. As a National Zero to Three Mid-Career Fellow, Commission Director Sheryl Dicker has developed *Babies Can't Wait II,* a project to reform court and child welfare practice to reflect infant research. She has had several opportunities to share the learning from the Babies Can't Wait Initiative and to receive assistance from national experts on infants to expand the project in New York State. In July 2003, Chief Judge Judith Kaye received the Child Health Advocate of the Year award from the American Academy of Pediatrics, highlighting the Commission's work to promote the healthy development of children and infants in foster care. The Commission staff has made numerous presentations on Babies Can't Wait at national conferences.

Conclusion

The Commission's Babies Can't Wait Initiative built a bridge to link child welfare practice to child development knowledge as well as to connect courts, child welfare professionals, and early childhood experts to enhance healthy development and permanency. It also has begun to close the gap in services to the vulnerable infants living in foster care. The crux of these successes has been the development of judicial leadership and cross-system collaboration. It is our hope that these bridges continue to expand beyond the Bronx and New York State for every infant and child in foster care.

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END NOTES

1 Wulczyn, F. H., Hislop, K. B., & Harden, B. J. (2002). The placement of infants in foster care. *Infant Mental Health Journal, 23,* 454-475; R. B. Clyman & B. J. Harden (Eds.). (2002). Special issue: Infants in foster and kinship care. *Infant Mental Health Journal, 23*(5).

2 Wulczyn, F. H., & Hislop, K. B. (2002). Babies in foster care: The numbers call for attention. *Zero to Three,* April/May, 15.

3 Armstrong, M. et al. (1997). *New York State Family Court Improvement Study: Targeted Assessment.* New York: Vera Institute. Unpublished report on file with the authors.

4 20 USC §1341-1445. See also New York State Public Health Law, Article 25A, Title II.

5 The booklet can be ordered from the New York State Permanent Judicial Commission on Justice for Children, 140 Grand Street, Suite 404, White Plains, NY 10601, (914) 948-7568.

6 For an extensive overview of the physical and developmental needs of infants in foster care, see J. Silver, B. Amster, & T. Haecker (Eds). (1999). *Young children and foster care.* Baltimore: Paul H. Brookes Publishing Co.

7 Wulcyzn, F. H., Harden, A. W., & George, R. W. (1997). *Foster care dynamics 1983-1994: An update from the multistate foster care data archive.* Chicago: The Chapin Hall Center for Children at the University of Chicago.

8 U.S. General Accounting Office. (1995). *Foster care: Health needs of many young children are unknown and unmet* (GAHS-95-114). Washington, DC: Author; American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care. (2000). Policy statement: Developmental issues for young children in foster care. *Pediatrics, 106,* 1145-1150.

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10 *Supra* note 1, Wulczyn et al.

11 *Ibid.*

12 New York State Permanent Judicial Commission on Children. (2003). *Accomplishments Twelve Year Report 1991-2003,* New York, NY.

13 Adoption and Safe Families Act of 1997, P.L. 105-89, 42 U.S.C. §§670 *et seq.*

14 45 C.F.R. §1355.34 (b) (1) (iii). For a detailed discussion see Dicker, S., & Gordon, E. (2000). Safeguarding foster children's rights to health services. *Children's Legal Rights Journal, 20,* 45-53.

15 Michael Cohen, M.D., Retired Chair, Department of Pediatrics, Montefiore Medical Center and Nancy Dubler, Esq., Director, Division of Legal and Ethical Issues in Health Care, Montefiore Medical Center.

16 ACS data indicate that in 2001, 1,300 children out of approximately 8,500 were admitted into foster care in New York City under age one. Forty percent entered care alone and had no other siblings in care. Thirty-five percent entered care alone but had older siblings in care and 21% entered care with siblings. In New York, between 1990-97, infants entering care under age one stayed an average of 37.2 months in care, compared to a statewide average for all ages of 18.5 months. For infants admitted in the first three months of life, the median length of stay was 40.8 months; 28.5% of infants admitted to care in New York State between 1990 and 1994 and subsequently discharged were readmitted to foster care.

17 This project is an outgrowth of an earlier New York State Court Improvement Project that expedited permanency for abandoned infants under six months of age.

18 Kaye, J.S. (Nov. 15, 1999). *Strategies and need for systems change—Improving court practice for the millennium.* Washington, DC: NCJFCJ Millennium Conference.

19 See Clyman & Harden at note 1 for a review of the national data on the profile of infants in foster care.

20 New York State Office of Children and Family Services (2003). *New York State Program Improvement Plan for the Child and Family Services Review.*