Promoting the Emotional Well-Being of Children and Families

POLICY PAPER #2

Improving the Odds for the Healthy Development of Young Children in Foster Care

National Center for Children in Poverty
Mailman School of Public Health, Columbia University

PROMOTING THE EMOTIONAL WELL-BEING OF CHILDREN AND FAMILIES

This document is part of a new policy paper publication series that reflects a larger effort that the National Center for Children in Poverty (NCCP) is undertaking with generous support from the Casey Family Program to help the most vulnerable families. It continues and builds on NCCP's earlier work to document effective strategies and highlight policy opportunities and challenges to promote the emotional health of young children and families. The policy papers in this series will help policymakers, community leaders, and advocates take action to ensure the healthy development of children and their families.

This policy paper focuses on what government agencies, the courts, and other partners can do to improve the physical, developmental, and emotional health of young children in foster care—a particularly vulnerable population of children. It highlights the special risks these children face; why it is important to focus deliberate, strategic policy and practice attention on improving the well-being of children in foster care; strategies and examples of pioneering service providers, courts, and their partners; and specific action steps that child welfare professionals, judges, attorneys and other court personnel, service providers, policymakers, and advocates can take to enhance the healthy development of young children in foster care and promote their prospects for permanency.

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Improving the Odds for the Healthy Development of Young Children in Foster Care

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Executive Summary

Overview

Very young children are the fastest growing segment of the child welfare population. Over the past decade, the number of children under age five has increased by 110 percent in contrast to a 50 percent increase for all-aged children. Over 30 percent of all children in foster care are under age five. Infants comprise the largest cohort of the young child foster care population, accounting for one in five admissions, and they remain in care twice as long as older children. Ensuring healthy development and permanency for these young children, given the range of risks they face, is a many-sided challenge that requires a unique mix of resources and strategies.

Yet, there has been relatively little attention focused on linking child welfare practice with health care, early intervention, and other strategies that could effectively address the risks that these young children face and strengthen their families. This policy paper is intended to be a wake-up call—to challenge communities all over the country to attend to the needs of children in or at risk of foster care placement. It is about what child welfare agencies, courts, and other partners can do to improve the physical, developmental, and emotional health of young children in foster care. It highlights the special risks these children face and identifies strategies that service providers, courts, policymakers, and advocates can use to enhance the healthy development of young children in foster care and promote their prospects for permanency.

Key Findings from Research: Young Children in Foster Care Are Among the Most Vulnerable Children in the Country

- Nearly 80 percent of these young children are at-risk for a wide range of medical and developmental problems related to prenatal exposure to maternal substance abuse.
- More than 40 percent of them are born low birthweight and/or premature, two factors which increase their likelihood of medical problems and developmental delay.
- More than half suffer from serious physical health problems.
- Over half experience developmental delays, which is four to five times the rate found among children in the general population.
- Despite their vulnerability, a significant percentage of these young children do not receive basic health care such as immunizations, and specialized needs such as developmental delays and emotional and behavioral conditions are even less likely to be addressed.

Promising Strategies to Promote the Healthy Development of Young Children in Foster Care

- Provide developmentally appropriate health care to young children in the context of comprehensive health care for all children in foster care.
- Design and implement specialized developmental and mental health assessments and services for young children in foster care.
- Create monitoring and tracking mechanisms to ensure that needed health, developmental, and mental health services are provided.
- Ensure that young children in foster care have access to quality early care and learning experiences.
- Use the oversight authority of the court to ensure that children in foster care receive needed health, developmental, and mental health services as a part of permanency planning.

Action Steps and Key Recommendations

- Use federal laws, programs, and dollars such as the Adoption and Safe Families Act, Medicaid, Early and Periodic Screening, Diagnosis and Treatment, the Early Intervention Program (Part C of the Individuals with Disabilities Education Act), and Temporary Assistance for Needy Families to develop specialized attention to young children in foster care.
- Harness the power of the court, which reviews the placement of all children in foster care, to enhance their healthy development.

- Build collaborative partnerships between the courts and child welfare, health care, early intervention, and early childhood agencies to enhance developmental outcomes for young children in foster care.
- Ensure that court personnel, child welfare workers, biological and foster parents, and other caregivers have the training and information that they need to help young children in foster care.
- Develop explicit state and community-based strategies to ensure that young children in foster care have access to developmental health services, high-quality child care including Early Head Start, and preschool and family support programs.
- Develop formal mechanisms to track and monitor the delivery of health, mental health, and related services to children in foster care.
- Use professional and state best-practice standards and relevant federal guidelines that call for the delivery of comprehensive, coordinated, continuous, and family supportive care as a framework to develop improved approaches to promote healthy early development for young children in foster care.
- Weave together multiple approaches to enhance the well-being of young children in foster care, building on community strengths.
- Pay attention to young children at risk of placement in foster care and those being discharged from the child welfare system. These children need access to all the benefits to which they are entitled (such as continuation of Medicaid) as well as access to comprehensive and multidisciplinary services that can both enhance their healthy development and their prospects for permanency.
- Promote a federal agenda that provides incentives to states and communities to build partnerships with health care and early childhood agencies to enhance the healthy development of young children in or at risk of foster care placement.

Introduction

Very young children are the fastest growing segment of the child welfare population. Each year, about 150,000 children under age five are placed in foster care by court order, representing about 30 percent of all children in foster care. Over the past decade, the number of children under age five in foster care has increased by 110 percent, in contrast to a 50 percent increase for all-aged children.[1] Ensuring healthy development and permanency for these young children, given the range of risks they face, is a many-sided challenge that requires a unique mix of resources and strategies.

These infants, toddlers, and preschoolers enter the child welfare system already exposed to poverty, substance abuse, and parental neglect and abuse.[2] Compared to other children living in poverty, young children in foster care are far more likely to have fragile health and disabilities and far less likely to receive services that address their needs. Yet, there has been relatively little attention focused on linking child welfare practice with health care, early intervention, and other strategies that could effectively address the risks that these young children face. Ignoring their needs and failing to provide their parents with support compromises the well-being of these children and can undermine the family-building efforts of the child welfare system. Connecting young children in foster care to health and early intervention services provides an important opportunity to enhance the child's development and strengthen the child's family.

This issue brief is about what child welfare agencies, courts, and other partners can do to improve the physical, developmental, and emotional health of young children in foster care. It is organized into four sections. The first section highlights the special risks that these children face. The second section highlights the major reasons why it is important to focus deliberate, strategic policy and practice attention on improving the physical, developmental, and emotional well-being of young children in foster care. The third section identifies five strategies that pioneering service providers, courts, and their partners are using to improve the emotional and developmental status of young children, providing examples of each strategy in action. The final section identifies action steps that child welfare professionals, judges, attorneys and other court personnel, service providers, policymakers, and advocates can take to enhance the healthy development of young children in foster care and promote their prospects for permanency.

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Portrait of Young Children in Foster Care

Young children in foster care are among the most vulnerable children in the country. Nearly 40 percent of them are born low birthweight and/or premature, two factors which increase the likelihood of medical problems and developmental delay.[3] These infants and toddlers are involved in over one-third of all substantiated neglect reports and more than half of all substantiated medical neglect reports.[4] More than half suffer from serious physical health problems, including chronic health conditions, elevated lead blood-levels, and diseases such as asthma.[5] Dental problems are widespread: one-third to one-half of young children in foster care are reported to have dental decay.[6] Over half experience developmental delays, which is four to five times the rate found among children in the general population.[7] For example, one recent study found that more than half of over 200 children in foster care under the age of 31 months had language delays, compared to the general population of preschoolers in which only 2 to 3 percent experience language disorders and 10 to 12 percent have speech disorders.[8]

The risks to healthy development are especially pronounced for infants. Infants comprise the largest cohort of the young child foster care population, accounting for one in five admissions to foster care and remaining in care longer than older children. Infants placed within three months of birth are those most likely to enter care and spend the longest time in care—twice as long as older children. One-third of all infants discharged from foster care reenter the child welfare system, further undermining the likelihood of their healthy development.[9]

In the recent past, most of these young children—nearly 80 percent—have been at risk for a wide range of medical and developmental health problems related to prenatal exposure to maternal substance abuse.[10]

All young children in foster care also face heightened risk of emotional and behavioral problems. The inconsistent and unresponsive caregiving to which they are often exposed sets the stage for potentially serious emotional and behavioral difficulties, often involving difficulty in forming close relationships and managing emotions.[11] As infants and toddlers, the children may show signs of attachment disorders. As preschoolers, their behavior may be especially challenging and provocative, or they may show signs of anxiety and depression. These problems not only affect the children, but often cause great stress for those who care for them: relatives, foster parents, and child care providers, as well as their biological parents. If severe enough, these issues can disrupt the placement of the children in foster homes and prevent successful permanency outcomes.

But despite their vulnerability, too many young children in foster care do not receive services that can address and ameliorate these risks. A significant percentage do not even receive basic health care, such as immunizations, dental services, hearing and vision screening, and testing for exposure to lead and communicable diseases (see box below). Specialized needs such as developmental delays and emotional and behavioral conditions are even less likely to be addressed.[12]

FOSTER CARE IN THREE URBAN AREAS

Findings from a U.S. General Accounting Office report about how young children in foster care fared in three urban areas (serving 50 percent of all young children in foster care)

- 12 percent received no routine health care.
- 34 percent received no immunizations.
- 32 percent continued to have at least one unmet health need after placement.
- 78 percent of the children were at high risk for HIV, but only 9 percent had been tested for the virus.
- Less than 10 percent received services for developmental delays.
- Children placed with relatives received fewer health-related services of all kinds than children placed with nonrelative foster parents.

Source: U.S. General Accounting Office. (1995). *Foster care: Health needs of many young children are unknown and unmet* (GAO/HEHS 95-114). Washington, DC: U.S. General Accounting Office.

Why It Is Important to Promote the Healthy Development of Young Children in Foster Care

There are three compelling reasons to develop deliberate strategies to promote the healthy development of young children in foster care:

1. **New scientific knowledge shows the importance of the earliest years.**

   Emerging research makes it very clear that stable, nurturing early relationships are key to a child's social and emotional development. All children are born wired for feelings and ready to learn, but early experiences and/or exposure to risk factors can disrupt these processes.[13] Indeed, a compelling body of cumulative science indicates that the more risks children experience, the more likely they are to have serious negative consequences that are reflected in their behavior and development. Since research shows that children in foster care experience many risk factors, this is a very troubling picture.[14] However, research also suggests that intensive and early interventions can help reduce the harm that young children in foster care face due to their experiences with multiple risk factors.[15]

2. **Children in foster care are the state's children.**

   All children in foster care are placed by court order in the custody of the state. The court order vests the state with powers typically exercised by parents for all other children. The state determines where and with whom a child will live, the nature of any medical care, and whether the child receives early childhood services or other services to address his or her needs. Neither the biological parent nor a foster parent who may know the child best has authority to make all vital decisions on a child's behalf. Thus, unlike most other young children, many children in foster care often lack the most fundamental resource to ensure their healthy development—a stable relationship with an adult who can observe their development over time, advocate on their behalf, and provide consent to services.

Because of these enormous powers, the state has an enhanced responsibility to children in foster care above and beyond its responsibility to all other children—it has a responsibility to improve their well-being and to strengthen their families. Consistent with that enhanced responsibility, federal and state law mandates that state child welfare policy and practice ensure a child's safety and well-being and promote permanence.[16] Ignoring their needs and failing to provide parents and foster parents with support compromises the well-being of these children and can undermine the child welfare system's family-building efforts.

One way to meet these obligations is for states to ensure that young children receive appropriate and timely services, their caregivers receive respite and support, and caseworkers and court personnel understand the connections between reducing the developmental risks to young children in foster care and achieving permanency. For example, ensuring reunification, adoption, or a stable foster or kinship care placement for a young child with severe disabilities, chronic health problems, or emotionally challenging behavior is likely to be much easier if the caregivers receive respite care as well as training to manage their child's special needs.

3. **It is in society's economic and social interest to promote positive outcomes for young children in foster care.**

The third reason to promote strategic attention to interventions targeted to young children in foster care is that this nation has a vested interest in promoting the healthy development of all of its young children. In fact, more and more states are crafting policies to promote sound developmental and family support services for their young children.[17] Congress, too, has weighed in. Recognizing the links among early development, school readiness, and later school performance, this nation has set forth a national goal that "all children shall enter school ready to learn."[18] All children, of course, includes young children in foster care. But given the level of risk so many children in foster care face, promoting their healthy development and school readiness requires more than business as usual. Indeed, failing to address these young children's needs has costly consequences for society. Children who have spent part of their childhood in foster care are more likely than other children to suffer adverse outcomes such as dropping out of school, teen pregnancy, homelessness, or incarceration.[19]

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Five Strategies to Promote the Healthy Development of Young Children in Foster Care

Given the range of risks they face, ensuring the healthy development of young children in foster care is a many-sided challenge. This section highlights five core strategies that, either singly or in combination, can change the manner in which the needs of young children in the foster care system are addressed. Each strategy is illustrated with examples of the ways it is being implemented.

STRATEGIES TO PROMOTE THE HEALTHY DEVELOPMENT OF YOUNG CHILDREN IN FOSTER CARE

- Provide developmentally appropriate health care to young children in the context of comprehensive health care for all children in foster care.
- Design and implement specialized developmental and mental health assessments and services for young children in foster care.
- Create monitoring and tracking mechanisms to ensure needed health, developmental, and mental health services are provided.
- Ensure that young children in foster care have access to quality early care and learning experiences.
- Use the oversight authority of the court to ensure that children in foster care receive needed health, developmental, and mental health services as a part of permanency planning.

MAJOR FEDERAL PROGRAMS TO HELP FOSTER CHILDREN

The following federal programs are being used to promote the physical, developmental, and emotional well-being of young children in foster care:

Adoption and Safe Families Act (ASFA): This legislation and its predecessor, the Adoption Assistance and Child Welfare Act, establish the framework for child welfare policy and practice. ASFA focuses on ensuring permanence, including adoption, for all children in foster care as well as ensuring their safety and well-being. Under ASFA, the health and safety of children in foster care are to be "paramount concerns" in every child protective proceeding. It also 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: EPSDT sets forth clear regulations relating to the delivery of comprehensive health-related services to all children eligible for Medicaid, which includes all children in foster care.[20] As the title suggests, it requires ongoing and periodic screening, diagnosis, and treatment of conditions affecting the health status of children. It also permits states to use Medicaid to finance an array of EPSDT-required services that might otherwise be ineligible for Medicaid reimbursement, including early intervention services and developmental screening.

Early Intervention Program for Infants and Toddlers (Part C of the Individuals with Disabilities Education Act): The Early Intervention Program provides an entitlement to services for infants and toddlers who experience developmental disabilities and delays or physical or mental conditions with a high probability of resulting in delay. States set specific eligibility criteria. The law permits "parents," which includes biological and adoptive parents, a relative with whom a child is living, a legal guardian, and, in some instances, a foster parent and other caregivers, to receive services. These may include parent training and counseling, parental support groups, home visits, and respite care to enhance the development of their children, based on an Individualized Family Service Plan (IFSP) that is developed with family input to guide services.

Temporary Assistance for Needy Families (TANF) provision of the Personal Responsibility and Work Opportunity Reconciliation Act: TANF, the current welfare law, requires recipients of cash assistance to work and sets lifetime limits on the receipt of cash assistance (up to five years in federal law, but shorter at state option). The law, through a block grant to the states, makes funds available for a wide array of services and supports consistent with the four purposes of the law. These are to: provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage; prevent and reduce the incidence of out-of-wedlock pregnancies; and encourage the formation of two-parent families.

For sources and more information, see Appendix A.

STRATEGY 1

Provide developmentally appropriate health care to young children in the context of comprehensive health care for all children in foster care.

Every child involved in the child welfare system should have access to continuous health and developmental services. The following examples highlight how young children can receive these services in the context of comprehensive health-related strategies for all-aged children. They embody best practice principles as defined by standards developed by the American Academy of Pediatrics and the Child Welfare League of America, which require that services for children in foster care be comprehensive, coordinated, continuous, and family-supportive. (See box on page 9 for definitions).

Excellence in Health Care to Abused and Neglected Children (ENHANCE)

Syracuse, New York

ENHANCE is a comprehensive, multidisciplinary program providing pediatric health care, child development, and mental health services twenty-four hours a day, seven days a week, to over 600 children in foster care in Onondaga County. The program is a collaborative effort between the State University of New York Upstate Medical Center in Syracuse, New York, and the Onondaga County Department of Social Services (DSS).

Staff includes two pediatricians, a clinical child psychologist, a child development specialist, two pediatric nurse practitioners, two registered nurses, and access to specialists at the university hospital. The psychologist provides mental health assessments, clinical intervention and referral, and consultation to ENHANCE staff, DSS caseworkers, and foster parents. A DSS caseworker functions as a liaison between ENHANCE and DSS. A typed summary of each ENHANCE visit is given to DSS and made available to foster parents. When children are discharged from foster placement, their guardian attends a discharge visit at ENHANCE. The purpose is to ensure that the guardian is fully aware of the child's medical history, to facilitate the transfer of care to a new physician, and to be sure that the guardian has an opportunity to address all concerns. Half of these

children elect to continue their care at the Upstate Medical University after they leave foster care. Recognizing the special importance of ensuring the well-being of young children in foster care, children ages birth to 18 months are visited in their foster homes by an ENHANCE nurse practitioner, who conducts a developmental assessment.

Center for the Vulnerable Child (CVC)/ Services to Enhance Early Development (SEED)

Oakland, California

The Center for the Vulnerable Child focuses on at-risk children and their families. Located within the Children's Hospital of Oakland, the CVC program is a private, nonprofit, regional pediatric medical center serving the San Francisco Bay area and northern California that offers comprehensive health, developmental, and mental assessment; treatment; and referrals through a series of clinics. There is a special CVC program for children in foster care that now includes SEED, a pilot project in conjunction with a county child welfare office to provide services to infants and toddlers in foster care.

The CVC foster care program, targeted both to children and their biological and foster families, provides an array of family-focused services including intake assessments, foster parent support groups, home and clinic-based mental health consultation, and case management. The staff works with an interdisciplinary team of physicians, nurses, psychologists, social workers/case managers, and addiction specialists. Intensive case management is used to provide and monitor needed services and develop strong collaborative relationships with both the county caseworkers and foster parents. Primary health care is provided by the foster care medical clinic during two half-day medical clinics each week. Additionally, CVC psychologists or child development specialists screen children for early indicators of mental health and behavioral problems. Children in the program can receive intensive short-term mental health services at the clinic or be referred to appropriate community mental health resources. Health-related activities are supplemented by a rich program of supports to families, foster parents, and child welfare workers. For example, foster parents (including those whose children are not served by CVC) can participate in a support program that addresses issues of child development and parenting. The sessions are also open to professionals from local child welfare and foster family agencies. The CVC foster care program also works with a small group of children who are newly reunified with their biological parents.

The SEED pilot program provides therapeutic interventions and care coordination services for children under age three in foster care. It is being implemented in the Alameda County Department of Social Services. Four child welfare workers and a public health nurse are following 100 randomly assigned children from birth to age three. Once a child is assigned to SEED, a foster parent is contacted and a visit is scheduled for either a clinic or home visit. At the initial visit, SEED staff complete a family needs assessment. Within two months of entry into SEED, a psychologist administers a developmental assessment for each child. A public health nurse gathers the child's medical history, which may include interviews with the biological family and

STANDARDS FOR FOSTER CARE SERVICES

The American Academy of Pediatrics and the Child Welfare League of America have defined best practice standards for comprehensive health and related services to children in foster care to require that care be:

- ***Comprehensive:*** Children in foster care should receive a package of health services including preventive health care, care for acute and chronic illness, developmental and mental health screening and services if indicated, dental care, ongoing evaluation for abuse and neglect, and referrals to early intervention and early childhood programs.
- ***Coordinated:*** One person should be identified as responsible for overseeing the child's care and sharing information about the child's needs across systems— child welfare, early childhood, early intervention, education, medical, and mental health. Establishing formal mechanisms to ensure that needed services are provided and monitoring the child's health and access to care are essential components of care coordination.
- ***Continuous:*** Information about the child's health history, services, and health insurance coverage accompany the child as the child enters care, changes placement, and is discharged from care.
- ***Family-supportive:*** Information about the child's health should be shared with the child's caregivers and should provide support to families in their ongoing care of the child.

Sources: American Academy of Pediatrics, Committee on Early Childhood, Adoption, and Dependent Care. (1994). Health care of children in foster care. *Pediatrics,* 93(2), 335, and Child Welfare League of America. (1988). *Standards for health care services for children in out-of-home care.* Washington, DC: Child Welfare League of America.

Every child involved in the child welfare system should have access to continuous health and developmental services.

the child. Biological families are invited to participate where reunification is the permanency goal. This information and other health-related data are entered into a statewide computer system. Alameda County and the CVC have just begun SEED II, a refinement and expansion of SEED, for 60 children aged birth to five, within a second special unit of the child welfare agency.

Reflections

Comprehensive health care collaborations are "one-stop shopping." They provide multidisciplinary health services to children in foster care and their caregivers at a centralized site. Each involves a partnership between a local social service/child welfare agency and a health care agency—in these examples either university based or hospital based. In other examples around the country, they may be based in primary care facilities[21] or involve a managed care organization. Although the specifics of the staffing patterns and the collaborative partners vary, all use Medicaid and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) as the starting point and are guided by standards of best health care practice for children in foster care. Because these "one-stop" models often see the vast majority of children in foster care in a region, staff can develop expertise in issues related to the health of children in foster care and become a repository of information about the child's health status. Moreover, whatever their scope and structure, a special focus on young children can be accommodated easily, for example, by using public health nurses to assess and facilitate early intervention and other specialized services for them in the context of broader services to all-aged children.

STRATEGY 2

Ensure Access to Early Intervention Services for Infant and Toddlers in Foster Care.

Young children in foster care need not only access to health services, but sometimes to specialized early interventions. For this, federal law provides an important building block to ensure that young children get some of the specialized early intervention services they need—the Early Intervention Program of the federal Individuals with Disabilities Education Act (IDEA).[22] Part C, as it is known, requires services to infants and toddlers with developmental delays, a high probability of delay, or, in some states, young children who are at risk of developing delays. (See box on page 8.) Of particular relevance in the context of foster care, the law permits services to be provided to foster parents and relatives as well as to biological and adoptive parents.[23] (Some states, such as New York, also permit services to other caregivers, such as early childhood providers.)[24] Yet, despite these provisions, accessing these services on behalf of young children in foster care presents special challenges. Typically, referrals to Part C programs are made by parents or physicians. But children in foster care are less likely to receive consistent parenting and medical care. Requirements for parental consent at every juncture also complicates access—parents may be unavailable and foster parents lack legal authority. The two program examples described below reflect efforts to ensure that infants and toddlers in foster care are connected to Part C services, one through a countywide strategy, the other at a program level.

Attention to the emotional development of young children in foster care is also crucial—both through services that help the children directly, and, equally important, through services that help parents and foster parents promote healthy relationships and repair damaged relationships where necessary. The third program in this section is structured to do just this.[25]

The Starting Young Program
The Children's Hospital of Philadelphia

Philadelphia, Pennsylvania

The Starting Young Program is a pediatric, multidisciplinary developmental diagnostic and referral service that is designed exclusively for infants and tod-

dlers who receive foster care or in-home child welfare services from the Philadelphia Department of Human Services (DHS). Its aim is to link these children to early intervention services through Part C and to ensure that they receive appropriate health care and social services.

Starting Young evaluates approximately 10 percent of Philadelphia County's 1,163 foster children under 31 months of age annually, accepting referrals from over 40 agencies under contract with the DHS or directly from DHS caseworkers. The program is based at the Children's Hospital of Philadelphia. The multidisciplinary assessment team includes a pediatrician, child psychologist, speech-language pathologist, and physical therapist who provide developmental evaluations of infants and toddlers. A pediatric social worker conducts intake interviews and facilitates referrals, while a project manager schedules appointments and maintains the information database. The team includes an intake worker from the county agency that coordinates the early intervention program. This makes it easier to explain the program to the child's caregiver, complete the county intake for eligible children, and facilitate timely and smooth admission to the program. The assessment team collaborates with the child welfare social worker to develop recommendations for the child's service plan. Biological parents are encouraged to attend sessions, and training and support to help caregivers enhance their relationship with their child is a key tenet of the program.

Once authorization is obtained for the release of information, typed reports are sent to the child's social worker from the private child welfare agency, the DHS caseworker, and the caregiver (foster parent and/or biological parent). The child's attorney also receives the report in cases where the Starting Young team determines that additional advocacy is warranted. The caregiver is encouraged to share the report with the child's primary health care provider. Starting Young's social worker follows up with the caregiver 8–12 weeks after the evaluation to ensure that the child receives recommended services. Children are reevaluated every six months until 30 months of age regardless of foster care placement or discharge.

Although Starting Young does not provide primary medical care, it serves as a resource to professionals and caregivers of young children in foster care throughout the metropolitan area, including training child welfare professionals on children's health and development.

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Leake and Watts

Yonkers, New York

Leake and Watts is one of the oldest child welfare and community service agencies in the country. Its Medical and Mental Health Services Department includes pediatricians, advanced practice nurses, and psychologists operating out of two community clinics and linked to major medical centers in the region. All foster children receive ongoing medical care and are assigned a nurse case manager in addition to a caseworker. It also has a special commitment to improving the developmental status of young children, providing on-site assessment, early intervention, and early childhood programs. Thus, all children under age five receive a developmental and behavioral screening from a Nurse Developmental Specialist. These screenings occur on admission and then at regular intervals of 2–6 months and include a discussion with the foster parent to identify any concerns about the child's behavior and development. Children under three years identified as needing further evaluation are referred to their Early Intervention Unit where a service coordinator shepherds the child through the process of creating an Individualized Family Service Plan (IFSP) and works with both the foster and biological family. Children between ages three and five are referred for evaluation by agency staff through the preschool special education process.

Parents and Children Together Birth-to-Five Initiative

Detroit, Michigan

The Birth-to-Five Initiative is part of the Parents and Children Together (PACT) program. PACT is a joint effort between Wayne State University and the Michi-

gan Family Independence Agency. Its major purpose is to provide year-long training internships to post-bachelor professionals in order to enhance their skills in working with families involved in the child welfare system. All children served by the PACT program are in foster care or protective or prevention services, and range from birth to age 17. PACT interns work closely with the child's caseworker and relevant systems, providing reports to the courts and schools.

PACT created the Birth-to-Five Services Unit to meet the specialized needs of children in foster care under age five. Program staff includes three infant mental health specialists, university interns, and an early intervention service coordinator. All children receive a developmental screening, and those identified with risks for delay or disability receive a comprehensive developmental assessment. Children under age three with developmental delays are referred to the state early intervention program. PACT staff meet with biological and foster parents, make home visits, and provide individual and family counseling, parent education groups, and parent-child interaction activities. Through the visitation program, a PACT counselor coaches parents to recognize and respond to their child's needs. PACT also assists families with transportation and food vouchers. While PACT does not provide primary health care, it will ensure that a child has a medical provider and will check immunization records. Meals and snacks are served at the center to provide parents with an opportunity to spend time meeting the basic needs of their child. Wayne State University has provided funding for data collection, including the impact of the program on reunification. An evaluation of the program is in progress.

Reflections

Specialized programs for young children in foster care meet many needs. Most include careful assessment and appropriate referrals to other community-based services, including early intervention and family support services. Some focus on assessment and early detection of developmental and emotional distress; others provide a range of direct services for the children and their foster and biological parents, helping to model and promote strong relationships for both. To maximize the impact of these kinds of interventions, they also include formal mechanisms to share and interpret information about the child's need for services with caseworkers and court actors responsible for making permanency decisions. In some instances, the strategy of choice is countywide; in others, specific intervention strategies are developed by foster care agencies or early childhood programs.

A number of jurisdictions are developing specialized monitoring and tracking mechanisms that strengthen accountability to children in foster care, sometimes in response to litigation.

STRATEGY 3
Create monitoring and tracking mechanisms to ensure that needed health, developmental, and mental health services are provided.

Ensuring that children in foster care actually get the health and developmental services that they need is problematic. Caseworkers and attorneys change, children move from placement to placement, often moving to different jurisdictions, and many programs such as Early Intervention are premised on active parental involvement. To address these challenges, a number of jurisdictions are developing specialized monitoring and tracking mechanisms that strengthen accountability to children in foster care, sometimes in response to litigation. The first strategy described below is a countywide initiative.[26] The other two efforts are statewide initiatives to develop health passports to ensure that information about the child's health status is available to those who need and are entitled to it.

The Foster Care Project
Suffolk County, New York

In Suffolk County, New York, the Foster Care Project represents a collaborative effort between the Suffolk County Departments of Health Services and Social Services to provide home visits by public health nurses twice a year to children age birth to 13 years in foster care to ensure their health and well-being. During the visit, a public health nurse from the county's Bureau of Public Health Nursing, located in the local Department of Health Services, conducts a complete physical; ob-

tains the child's health history, immunization, and dental care status; and identifies the child's primary care provider. The nurse also assesses the foster parent's ability to oversee the health needs of the child and provides education to the foster family as indicated. If the assessment of the child identifies a health or medical problem, the nurse will make a referral to the child's primary care provider for follow-up. The nurse will communicate with the provider regarding the referral and any subsequent interventions.

For children under age six, the nurse conducts a developmental screening and refers eligible children under age three to the county Part C Early Intervention Program. In addition, for infants new to foster care, visits are made immediately, rather than in alphabetical order of the foster parents' names. Reports of the visit are sent to the foster care division of the county Department of Social Services. All the visits are billed to Medicaid. The Bureau of Public Health Nursing receives approximately 100 referrals each month.

The Fostering Healthy Children Project

Utah

The Fostering Healthy Children project is a collaboration among Utah's Child Welfare, Medicaid, and Mental Health agencies as well as health care providers. It was designed as a response to litigation. Thirteen public health nurses and nine support staff, funded by the Utah Health Department, are colocated at child welfare agencies throughout the state. The nurses serve as case managers to ensure that children in foster care receive screening, treatment, and follow-up services. They attend a multidisciplinary meeting that is convened within 24 hours of the child's entry to develop a medical history and health needs assessment, and they are responsible for sharing information with the child's primary health care provider and working with foster parents to ensure that the child receives services. Additionally, the nurses collaborate with and provide training for child welfare caseworkers, serve as medical case managers for children with complex needs, and ensure health care continuity during placement changes. They are also responsible for maintaining a computerized data system based on the health visit forms completed by health care providers. The database is part of the state's automated child welfare information system that contains all child welfare data. Reports are available through the Internet to users having special security clearances. Although this does not now include foster parents, the plan is that it will in the future.

The Health and Education Passport

California

Under the California Health and Education Passport program, California employs public health nurses to provide an array of supportive services to children in foster care or other out-of-home placements. The nurses are hired by county child welfare departments and by Child Health and Disability Prevention Programs.[27] Each county develops the initiative differently:

- In San Diego, the county has formed a consortium that includes Children's Hospital of San Diego and the newly created San Diego County Health and Human Services Agency (HHSA). It has also prioritized the development of passports for children under age five. The program is managed by the HHSA using funds from the EPSDT program. The passports include immunization records, information about medical and dental problems, laboratory test results, results of hearing, vision, and developmental screening, and recommendations for follow-up care. Information gathered during the child's initial medical exam (required within 30 days of care entry) is forwarded to the Health and Education Passport Unit. Located in the county HHSA, the unit consists of public health nurses and clerks. Unit staff send forms to biological and foster parents to obtain contact information for the child's health care providers and then gather information on the child's needs from these providers. The public health nurses are responsible for interpreting the health information received from the provider, summarizing the information, and entering the data into the unit's database. The nurses also train child welfare workers on medical issues and EPSDT follow-up and provide consultation on individual cases.

- In Santa Clara county, as described below, the passport system is actively used by Judge Leonard Edwards, Supervising Judge of the Dependency Division, Santa Clara Superior Court, to identify problems and gaps in services and to guide case planning.

Reflections

These tracking and monitoring efforts are potentially very significant. They combine computer-based mechanisms and efficiencies with a people-based approach, often involving the use of public health nurses. Typically, public health nurses are viewed as nonthreatening by families, have knowledge about children's health and development, are trained to educate other professionals and clients about health issues, and can work easily with other health care providers. All involved report challenges in making tracking and passport systems work efficiently for all children in foster care. But all also recognize the importance of such tracking strategies in enabling child welfare workers, foster parents, and the courts to monitor the health, emotional, and developmental status of the children, especially whether they are receiving EPSDT and other services to which they are entitled.

STRATEGY 4
Ensure that young children in foster care have access to quality early care and learning experiences.

In many ways, the first line of defense for young children in foster care ought to be ensuring that they have access to high quality early care and education programs. For young children in foster care, these programs create an opportunity for the child to experience a nurturing, stimulating environment. For families, they offer information, connection to other resources, and, sometimes, direct services to help address challenging problems.[28] Early care and education programs also can support many foster and kinship parents, who, like all other parents, must hold a job as well as be a parent.

States are increasingly investing in early childhood programs and family support programs such as Head Start, Early Head Start, Healthy Families, and Parents as Teachers. Typically, the goals of these programs are to promote healthy child development and provide family support and to help ensure that, consistent with Goal One of the Educate America Act, all children enter school ready to succeed. Yet, for the most part, young children in foster care are not deliberately enrolled in high-quality, developmentally-enriching child care and early learning experiences. Highlighted below are two approaches, one focused at the program level and the other at the state level, that ensure children in foster care and their families are included in these programs.[29]

In many ways, the first line of defense for young children in foster care ought to be ensuring that they have access to high quality early care and education programs.

West Boone Early Head Start
Spokane, Washington

The West Boone Early Head Start provides early childhood and parent-child support services to young children in foster care. It is a partnership among the Spokane County Early Head Start, the Casey Family Program, which operates a network of family foster care programs, and the Marycliff Institute, a group of mental health therapists and researchers. Early Head Start operates a full-day program serving eight infants and toddlers in out-of-home placement and their biological parents. The goal is to enhance the child's development and promote reunification of the child with the biological parent. (For that reason, foster parents do not participate in the program. However, foster families are encouraged to participate in all other Head Start/Early Head Start program options.)

A plan is individualized for each family, balancing program expectations and Child Protective Services (CPS) requirements for the family. Most families spend five days each week in the program where they learn about child development, health, nutrition, and safety while strengthening the bond with their child. Most also participate in the attachment and bonding program, Circle of Security, that was developed by therapists at the Marycliff Institute. The program includes mental health consultations for the parent and child, clinical supervision, and home visits. Referrals were initially made through the Casey Family Program, but the program now receives direct referrals from CPS. Reports are generated through regular team meetings, and the program staff have contact with Court Appointed Special Advocate (CASA) volunteers and CPS workers. The Spokane County Head Start/Early Head Start program is

currently collaborating with CASA and CPS to promote more adequate screening of families prior to referral and to educate CPS and CASA both about program requirements and early childhood development. The program views CASA as a vital link to sharing information about the children and their families with the courts.

The Birth to Three Services Program, Illinois Department of Children and Family Services

Illinois

The Birth to Three Services Program is a recent initiative undertaken by the Illinois Department of Child and Family Services (IDCFS). It is an effort by the department to take the implications of research on early childhood to scale. The program has two overarching goals: to ensure that young children in foster care enter school ready to succeed and to reduce the risks of multiple placement changes. The state now requires that every young child in foster care receive a developmental screening by a trained developmental specialist in order to identify any behavioral and developmental needs and provide appropriate services. Foster parents, and occasionally biological parents, play a role in determining services but are not permitted to decline services altogether. To date, some 7,000 children have been screened.

The program began as a public-private partnership and received half of its funding for the first two years from local foundations. It is now fully funded through departmental appropriation for staff, equipment, and screening activities. To provide enrichment services for at-risk children, the IDCFS also has appropriated $2 million of day care funds to cover the costs of private early childhood programs for children in foster care. The program is administered by a newly created unit for early childhood in the IDCFS.

The initiative has led to new partnerships between the child welfare agency and the early childhood community that involve Head Start, Early Head Start, Child Care Resource and Referral Networks, Early Intervention (Part C), and child care. For example, the IDCFS contracts for three full-time positions with the Chicago Public Schools Cradle-to-Classroom program for paraprofessionals trained as home visitors. In exchange, the Cradle program expanded its service area to include young children in foster care. The IDCFS also contracts with the Daycare Action Council of Illinois (DCACI) to provide an enhanced referral service for young children in foster care. State funding enables the DCACI to work with other agencies to develop services to meet the needs of each family.

Reflections

The deliberate inclusion of young children in foster care in high quality early childhood programs is a vitally important strategy that needs to be expanded across the country. This, coupled with parallel efforts within the early childhood community to strengthen its capacity to better meet the needs of high-risk young children and families, is a very encouraging development. It means that the early childhood community will be better able to respond to the needs of young children in foster care as well as children in their own families facing risks to their early healthy development. It also means that this is an opportune moment for making child welfare and early childhood connections, as policy and practice interest in promoting the well-being of young children takes on new momentum.

STRATEGY 5

Use the oversight authority of the court to ensure that children in foster care receive needed health, developmental/early intervention, and mental health services as a part of permanency planning.

Under federal child welfare law, each of over half a million children in foster care in the United States has a court order approving placement in foster care. The court is the central decisionmaker in every child protective proceeding, and at every hearing the court must review the child's needs and the parent's ability to meet those needs. This critical role was established by Congress in 1980 by the passage of the Adoption Assistance and Child Welfare Act[30] and reinforced by the Adoption and Safe Families Act of 1997 (ASFA).[31] ASFA makes clear that a child's health and safety are paramount considerations in child protective proceedings. Thus, every court hearing is an opportunity to raise questions about a child's developmental status. In most states, courts have broad powers to review individual case plans and to order services to ensure a child's health and well-being.[32]

Newly issued federal regulations for the AFSA reinforce this. They specifically hold states accountable for providing services to address the safety, permanency, and well-being of children and families; require families to have enhanced capacity to provide for their children's needs; and require children to receive appropriate services to meet their educational needs as well as adequate services to meet their physical and mental health needs.[33]

Those responsible for children in foster care need to pay attention to the different types of services that are necessary for children at particular ages, including infants, toddlers, and preschoolers. Yet, in practice, there is very little strategic use of the power and potential of the court to address children's developmental needs. The five examples below focus on the well-being of young children in foster care. They illustrate the importance of judicial leadership to identify the needs of children in foster care, to ensure that the court receives critical information for permanency decisionmaking, and to bring together parties and professionals to help determine services needed by children and their families.

The Healthy Development Checklist: A Project of the New York State Permanent Judicial Commission on Justice for Children's Healthy Development for Foster Children Initiative

New York State

In New York State, the Permanent Judicial Commission on Justice for Children, a multidisciplinary commission chaired by New York State Chief Judge Judith Kaye, has developed an initiative designed to help the courts augment their role in ensuring the healthy development of children in foster care. The initiative grew out of findings from research the commission conducted with support from the federally-funded State Court Improvement Project. That research found few court orders for services for young children, little indication in court records or proceedings that services were being provided to young children, and only rare inquiries about the condition of young children in foster care or their needs for services.[34] Alarmed by these findings, the commission developed the Healthy Development Checklist to raise awareness about the health, developmental, and emotional needs of children in foster care and to ensure that these needs are addressed by those involved in the court process.

HEALTHY FOSTER CARE CHECKLIST

This checklist for the healthy development of foster children was developed by the Permanent Judicial Commission on Justice for Children.

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

Source: Permanent Judicial Commission on Justice for Children. (1999). *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates, and Child Welfare Professionals.* New York, NY: Permanent Judicial Commission on Justice for Children.

The commission's booklet, *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates, and Child Welfare Professionals*, contains a checklist—10 basic questions to identify the health, developmental, and emotional needs of children in foster care and gaps in services (see box on this page). It also provides a rationale for each of these questions, as well as references to expert sources. Each question in the booklet is consistent with the national standards for health care as recommended by the American Academy of Pediatrics and the Child Welfare League of America, and by the Early and Periodic Screening, Diagnosis, and Treatment provisions of Medicaid (see box on page 8).

The commission is now conducting a major effort to educate all those involved in the court process about the health and developmental needs of children in foster care and how to use the Healthy Development Checklist to promote children's well-being. This initiative is part of the commission's goal to ensure that at least one person involved in a child welfare case will ask questions about the basic health needs of a child in foster care. The outreach has been both national and within New York State. Nationally, the commission has shared the checklist with the Court Improvement

Projects in all states and all model courts of the National Council of Juvenile and Family Court Judges.

In New York State, the training effort has involved family court judges, law guardians, social services and health administrators, selected state legislators, Early Intervention officials (Part C), public health nurse directors, advocates, parents' attorneys, child and family services providers, and CASA directors and volunteers. Court Appointed Special Advocates are specially trained community volunteers appointed by a family court judge to assist in finding safe and permanent homes for children in the child welfare system. Once appointed by the judge, the CASA becomes an official part of the judicial proceedings, working alongside the judge, attorneys, and social workers as an appointed officer of the court for a particular case to identify the child's best interests.

As a result of these training efforts, judges, lawyers, and CASAs throughout New York State are using the checklist at the earliest possible point, even in abandonment proceedings, to identify the needs of young foster children and to shape permanency planning. Some Family Court judges in New York State now routinely order that every foster child under age three be screened for developmental delays through Part C. In two New York State counties, Erie and Westchester, CASAs have been specifically assigned to cases of children in foster care under age five. With over 900 CASA programs nationwide, if the checklist were implemented on a more widespread basis, it could have significant impact.[33]

The Dependency Division, Superior Court

Santa Clara County, California

Judge Leonard Edwards, supervising judge of the Juvenile Dependency Court in San Jose, California, has been one of the principal architects of a new judicial role for juvenile and family court judges—a more activist, problem-solving role, both on and off the bench. The core of this new role is judicial leadership. Judge Edwards keeps a tight rein on individual cases, holding frequent, sometimes weekly, hearings, inquiring about children's health and developmental needs, ordering services to address those needs, and monitoring the provision of those services. He requires all court reports to contain health, education, and developmental

A child's health and safety are paramount considerations in child protective proceedings. Every court hearing is an opportunity to raise questions about a child's developmental status.

information about the child (drawing on the California Health and Education Passport program, a record that follows all children in the foster care system that is described more fully above) and for any problems to be addressed in case plans prepared by social workers. Judge Edwards is able to do all of this within an existing judicial budget. Off the bench, he exercises judicial leadership in the community by working to create the services needed by the children and their families appearing in court. He has served as a convenor, bringing together government agencies and service providers to address children's needs, as well as acting as a public spokesperson for those concerns. He meets with public agency and private service providers to ensure that they work together on behalf of children.

The Dependency Court Intervention Program for Family Violence

Dade County, Florida

In Miami, Judge Cindy Lederman, the administrative judge of the Juvenile Court, has spearheaded a pioneering effort to address the well-being of young children involved in Dade County's Dependency Court through the Dependency Court Intervention Program for Family Violence (DCIPFV). The DCIPFV is a court-initiated demonstration project awarded to the Eleventh Judicial Circuit of Florida by the U.S. Department of Justice. Led by Judge Lederman, the program represents a court-based, collaborative effort to develop and evaluate a comprehensive intervention program for women and children from homes with co-occurring domestic violence and child maltreatment. The PREVENT (Prevention and Evaluation of Early Neglect and Trauma) initiative of the DCIPFV evaluates infants, toddlers, and preschoolers who are adjudicated dependent by the court. Each child aged one to five referred from the court receives a comprehensive assessment of his or her cognitive, language, social, and emotional development. This is very important since almost 70 percent

suffer from significantly delayed language and cognitive development and many from impaired emotional development. Additionally, the quality of the relationship between the child and the parent or parents is assessed through a comprehensive videotaped play-and-teaching instruction situation. Written evaluations are provided to the court and all parties to assist in permanency and treatment planning.[36]

The 2000 Florida Legislature has designated the Dade County Juvenile Court, Eleventh Judicial Circuit of Florida, as one of three Infant and Young Children's Mental Health Pilot Project sites in the state. The evaluation and treatment practices of PREVENT have been selected to act as a model for all three of Florida's Infant and Young Children's Mental Health Pilot sites. The pilot project in Miami-Dade Juvenile Court offers comprehensive evaluation and intensive prevention and intervention services to high-risk infants and young children to enhance the quality of the parent-child attachment and bonding relationship.

In addition to the above initiatives, Judge Lederman writes court orders for all children to receive EPSDT and, if appropriate, referrals to Early Intervention (Part C) as well as to other child developmental and family support programs such as Florida Healthy Start (a home visiting program) and Head Start. She also organizes an early childhood lecture series for attorneys, guardians ad litems (i.e., children's advocates), and caseworkers.

The Family Drug Treatment Courts

Suffolk County, New York

Throughout the country, drug treatment courts have enabled substance abusers accused of crimes to receive treatment rather than be incarcerated. Family Drug Treatment Courts have emerged as a variation of this approach. These courts focus on the core reason many children are placed in foster care: parental drug addiction. There are now 10 Family Drug Treatment Courts throughout the country, each tapping into an array of funding streams, including earmarked federal funds, Medicaid, and TANF. Early indications demonstrate their success in keeping parents sober and reducing children's time in foster care.[37] In order to participate in these courts, parents must admit to both substance abuse and child neglect as well as consent to treatment.

Addressing the public health needs of participating children, including assessment, treatment, and prevention of health problems, is a critical part of the family drug court process.

The cases are tightly monitored with frequent court appearances. Attention is also beginning to be paid to the needs of the children. All of these courts make concerted efforts to develop greater coordination among the court, treatment providers, community organizations, public health agencies, and schools in responding to the needs of the child and the family.

Under the leadership of Family Court Judge Nicolette Pach, the Suffolk County Family Drug Treatment Court has incorporated elements of the Checklist for the Healthy Development of Foster Children (see box on page 16) into its court order and treatment plan forms. Addressing the public health needs of participating children, including assessment, treatment, and prevention of health problems, is a critical part of the family drug court process. Additionally, through a collaboration instituted by the court, the Suffolk County Bureau of Public Health Nursing (highlighted earlier) performs in-home assessments of all young children under age five assigned to that court. The Family Drug Treatment Court team provides the nurses with a copy of the court order and a psychosocial assessment for each referral. The public health nurses meet with the Family Drug Treatment Court team assigned to each case on a monthly basis and the nurses' involvement has resulted in more referrals to Early Intervention (Part C) for these children.

Kathryn A. McDonald Education Advocacy Project, Legal Aid Society, Juvenile Rights Division

New York, New York

In New York City, the Juvenile Rights Division (JRD) of the Legal Aid Society, which represents over 90 percent of the children in the city, employs a designated attorney to address the early intervention and special education needs of children involved with the courts because of abuse and neglect. The attorney works closely with other attorneys, caseworkers, biological and foster parents, and coordinators from the New York City

Early Intervention program to ensure that appropriate referrals to the Early Intervention program are made and that children receive evaluations and services in a timely fashion. The attorney also provides training and ongoing consultation on the Early Intervention program to the interdisciplinary staff of the Legal Aid Society as well as to New York City child welfare caseworkers and CASAs. This initiative draws on a model of expert consultation long available in legal services programs for specialized legal issues such as health, housing, or consumer law.

The JRD is seeking to expand the project over the next three to five years by creating education units in each borough in New York City that will consist of an attorney, social worker, and paralegal worker. These units will focus on addressing the early intervention and special education needs of JRD clients and on collaborating with other parties involved in the Family Court to secure services to enhance their development. Other programs providing representation to children can adopt this model in two ways: (1) by using an attorney with specialized knowledge about child development, early intervention, special education, and relevant services and programs as a consultant to other lawyers; or (2) by encouraging bar associations and other local mechanisms to provide training to lawyers.

Reflections

Courts can be a powerful gateway to health and developmental services for young children. The initiatives described here harness the power of the court to ensure that young children and families get the services they need. They educate participants about the importance of these services and convene those responsible in order to ensure that the children and their caregivers actually receive the services. They create concrete court-linked mechanisms that promote a steady focus on the health, developmental, and emotional needs of young children. The means vary—a checklist to gather information, drive queries, and identify services; an attorney with specialized knowledge about services for young children to serve as a consultant to the court and other attorneys; a seminar series for those involved with the court. The initiatives bring the expertise of critical entities that exist in most communities—CASA, public health nurses, and early intervention programs—to the courts to build the local capacity to address young children's needs. But most importantly, they are marked by pioneering judicial leadership.

Moving Forward: Summary and Action Steps

This issue brief has highlighted five core strategies to enhance the health and emotional well-being and prospects for permanency of young children in foster care:

- Provide developmentally appropriate health care to young children in the context of comprehensive health care for all children in foster care.
- Design and implement specialized developmental and mental health assessments and services for young children in foster care.
- Create monitoring and tracking mechanisms to ensure that needed health, developmental, and mental health services are provided.
- Ensure that young children in foster care have access to quality early care and learning experiences.
- Use the oversight authority of the court to ensure that children in foster care receive needed health, developmental, and mental health services as part of permanency planning.

Based on the lessons from the programs and initiatives described in this issue brief, states and communities face two interrelated challenges. The first is to make sure that issues related to early development are addressed for each and every young child in foster care. The second is to improve the array of community resources and the service delivery system to make possible these goals. In addition, this report implicitly underscores the need for more research on the most effective strategies and interventions for this vulnerable young population and a clearer accounting of the costs and benefits of each program, especially as the children enter school. Below are 10 ways to promote better attention not only to the developmental and emotional needs of young children in foster care, but also to the needs of their parents and foster parents.

WAYS TO PROMOTE THE DEVELOPMENTAL AND EMOTIONAL NEEDS OF YOUNG CHILDREN IN FOSTER CARE AND TO HELP THEIR PARENTS AND FOSTER PARENTS

- Use federal programs and dollars creatively.
- Harness the power of the court to enhance the healthy development of children in foster care.
- Build collaborative partnerships between the courts and child welfare, health care, and early childhood agencies.
- Ensure that court personnel, child welfare workers, biological and foster parents, and other caregivers have information that they need to help young children in foster care.
- Develop explicit state and community-based strategies to ensure that young children in foster care have access to developmental health services, high-quality child care, preschool, and family support programs.
- Develop formal mechanisms to track and monitor the delivery of health, mental health, and related services.
- Use professional and state best-practice-standards and relevant federal guidelines to develop improved approaches to promote healthy early development.
- Weave together multiple approaches to enhance the well-being of young children in foster care, building on community strengths.
- Pay attention not just to young children in foster care, but to those at risk of placement in foster care and those being discharged from the child welfare system.
- Promote a federal agenda that provides incentives to states and communities to build partnerships with health care and early childhood agencies to enhance the healthy development of young children in or at risk of foster care placement.

1. **Use federal programs and dollars creatively.** The Adoption and Safe Families Act, Medicaid, EPSDT, the Early Intervention program, and, potentially, TANF, provide an important framework to develop specialized attention to young children in foster care. ASFA requires states and localities to address the well-being of children in foster care. Medicaid can support a wide range of needed services, including administrative case management and the services of public health nurses. EPSDT provides reimbursement and an entitlement to early and periodic screening, diagnosis, and treatment. The Early Intervention program entitles eligible young children in foster care to developmental screenings, assessments, and services along with the possibility of supports to caregivers. TANF can fund programs to provide a wide array of child development and prevention services as long as they are consistent with the four purposes of the act. States, communities, and agencies that use these federal building blocks creatively can go a long way toward promoting better access to services for young children in the child welfare system and even for children at risk of foster care placement.[38]

States, communities, and agencies that use these federal building blocks creatively can go a long way toward promoting better access to services for young children in the child welfare system and even for children at risk of foster care placement.

2. **Harness the power of the court to enhance the healthy development of children in foster care.** Each of the over 150,000 young children who enter the child welfare system nationwide appear before specific judges, in specific communities. Thus every court appearance is an opportunity for at least one person in the court process—one judge, one lawyer, one caseworker, one CASA volunteer—to ask questions about a young child's health and developmental status, access to services, and general emotional development. Judges play a crucial role in shaping community expectations. In most cases, they can order needed services.[39] Where there are gaps in resources, they can use their role to help spur new initiatives to ensure the healthy development of every young child in foster care.

3. **Build collaborative partnerships between the courts and child welfare, health care, and early childhood agencies.** New formal partnerships among child welfare agencies; those involved in the court process (for example, Court Appointed Special Advocates); health professionals operating out of university-based health departments or other settings; state, city and county early intervention agencies; and the broader early childhood community should all be part of the effort to enhance developmental outcomes for young children in foster care. Collaborative formal partnerships (with written protocols, memoranda of understanding, and the out-stationing of professionals serving young

children in the child welfare and court systems), designed to ensure access for young children in foster care or to develop specialized approaches, can assist in meeting the safety, well-being, and permanence goals of the child welfare system in addition to national school readiness goals.

4. **Ensure that court personnel, child welfare workers, biological and foster parents, and other caregivers have information that they need to help young children in foster care.** For court and child welfare personnel, this often means making sure that the connections between services to address health, developmental, and emotional challenges and achieving permanency are clear. It also means making sure that court and child welfare workers know about child development, appropriate community resources, and how to ensure access for the children for whom they bear responsibility. In many of the initiatives highlighted here, liaison workers are on-site to provide information, although other strategies are also being used involving checklists and, most importantly, judicial leadership.[37]

5. **Develop explicit state and community-based strategies to ensure that young children in foster care have access to developmental health services, high-quality child care, preschool, and family support programs.** In most communities there are networks of early care and education providers and advocates who supply leadership to local efforts to enhance and expand early childhood and family support programs. Child welfare leaders, foster parents, and judges can connect with these efforts to make sure they include and are responsive to young children in foster care and their families. Advocates for young children and community programs also need to place young children in foster care on their radar screen. They can work with Early Intervention officials to target children in foster care and develop an automatic referral for all children in foster care under age three as part of their outreach efforts to ensure that all young children eligible for early intervention services have access to them. (Often these are referred to as Child Find activities.) They can work with Head Start programs to identify these children and their families for recruitment and designate priority slots for enrollment.

Standards of best practices, most of which call for the delivery of comprehensive, coordinated, continuous, and family-supportive care, provide a framework for action and accountability.

6. **Develop formal mechanisms to track and monitor the delivery of health, mental health, and related services.** The monitoring and tracking efforts described here define clear responsibility for assessing and coordinating a child's health, developmental, and mental health services. Some approaches use public health nurses to directly assess a child's health and developmental needs. Others designate staff to coordinate the child's care across systems and ensure that information is shared with the child's caseworker and the court through written reports. The emphasis in AFSA on monitoring states' attention to educational, developmental, and other needs of children in foster care provides an additional impetus to continue to develop and strengthen such efforts.

7. **Use professional and state best-practice standards and relevant federal guidelines to develop improved approaches to promote healthy early development.** Standards of best practices, most of which call for the delivery of comprehensive, coordinated, continuous, and family-supportive care, provide a framework for action and accountability. They mean that no community has to start from scratch. Instead, the challenge is to incorporate these standards in a meaningful way into new collaborations and partnerships.

8. **Weave together multiple approaches to enhance the well-being of young children in foster care, building on community strengths.** There are many ways to achieve the basic objective of enhancing the medical, developmental, and emotional well-being of young children in foster care. But in the most compelling examples cited here, multiple strategies are woven together to create a critical threshold for change. They involve strategies to maximize the power and authority of the court, to

develop new partnerships to ensure that young children in foster care have access to comprehensive health care and specialized services for them and their caregivers, and to engage the broader early childhood community in efforts to improve their outcomes and opportunities. None are exactly alike and all build on local strengths—the nature of judicial leadership, the constellation of services, the willingness of the child welfare system to try new ways of doing business. The challenge is for more communities to start the process.

9. **Pay attention not just to young children in foster care, but to those at risk of placement in foster care and those being discharged from the child welfare system.** This issue brief has focused primarily on young children in foster care. But the same strategies need to be in place as part of a concerted effort to prevent needless placement and to ensure family stability when children leave foster care. Young children in foster care or at risk of foster care placement need access to all the benefits to which they are entitled (such as continuation of Medicaid coverage)[40] as well as access to comprehensive and multidisciplinary services that can both enhance their health and development and their parent's ability to respond to their complex needs.

10. **Promote a federal agenda that provides incentives to states and communities to build partnerships with health care and early childhood agencies to enhance the healthy development of young children in or at risk of foster care placement.** The federal government can encourage states, through research, demonstration, training, and other innovative efforts, to link child welfare agencies and the courts with health care, early intervention, and child development and family support agencies and networks. Efforts should also be made to help states identify ways to use child welfare, TANF, and other federal funds creatively on behalf of young children in foster care. Similarly, states should be encouraged to use the broad language in Part C of IDEA to promote targeted Child Find activities and prioritize Early Head Start and Head Start slots in every county in America, in order to ensure quality child care experiences to young children in foster care. Federal initiatives should also support a research agenda to develop better knowledge about the most effective intervention strategies, their costs, and their benefits.

Conclusion

This issue brief is intended to be a wake-up call—to challenge communities all over the country to attend to the needs of young children in or at risk of foster care placement. The building blocks are judicial leadership; the creative use of federal programs; new approaches to ensuring access to health, developmental, and mental health services for young children in foster care; and linking all of these elements to the network of early childhood and family support programs within a community. The innovations and collaborations highlighted here can be used strategically in ways that fit community needs and strengths. Improving outcomes for young children in foster care is a doable task. It is also an investment in the future that can help achieve the goals this society wants for all its young children—that they be safe, that they grow up in a loving home, and that they develop to their full potential.

The innovations and collaborations highlighted here can be used strategically in ways that fit community needs and strengths.

APPENDIX A

Federal Building Blocks to Improve the Development of Young Children in Foster Care

Adoption and Safe Families Act of 1997[41]

- Emphasizes permanency and adoption
- Makes child's "health and safety" a "paramount concern" in every child protective proceeding
- Identifies situations where "reasonable efforts" toward reunification are not required, such as where the parent has subjected the child to aggravated circumstances, including abandonment, torture, chronic abuse, and sexual abuse; where the parent has committed murder, voluntary manslaughter, or a felony assault that resulted in serious injury to the child; or if parental rights have been terminated voluntarily for a sibling
- Strengthens court role in monitoring cases
- Allows concurrent planning by child welfare agency
- Tightens time frames for decisionmaking
- Requires permanency planning hearings 12 months after placement
- Requires permanency planning hearings within 30 days after placement where the court has determined reasonable efforts to reunify are not required
- Requires that Termination of Parental Rights petitions be filed when a child is in care for 15 out of the most recent 22 months unless compelling reasons exist not to do so
- Requires states to provide health insurance coverage for any child with special needs who cannot be adopted without medical assistance
- Provides fiscal incentives for states to increase adoptions
- Monitors states on their compliance in providing services to enhance the capacity of families to provide for their children's needs and to meet the educational, physical, and mental health needs of children in foster care

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Provisions of Medicaid[42]

- Applies to children in foster care
- Requires medical, vision, hearing, and dental screenings to be performed at distinct intervals as determined by "periodicity schedules" that meet standards of pediatric and adolescent medical and dental practice
- Requires that a medical screening include at least five components:
  1. A comprehensive health and developmental history assessing both physical and mental health.
  2. A comprehensive unclothed physical exam.
  3. Immunizations.
  4. Laboratory tests including lead blood testing at 12 and 24 months and otherwise according to age and risk.
  5. Health education.
- Requires hearing and vision screenings to include diagnosis and treatment for defects, including hearing aids and eyeglasses
- Requires dental screening to include assessments for relief of pain and infection, restoration of teeth, and maintenance of dental health
- Requires state Medicaid agencies to assure the provision of necessary treatment for both physical and mental health conditions to the extent required by the needs of an individual child
- Permits states to finance, through Medicaid, an array of services that might otherwise be ineligible for Medicaid reimbursement, including early intervention services and developmental screening

Early Intervention Law for Infants and Toddlers (Part C of the Individuals with Disabilities Education Act)[43]

- Provides an entitlement for eligible infants and toddlers (birth to third birthday) with developmental disabilities and delays or a high probability of developing them as a result of conditions such as Down's Syndrome, cerebral palsy, severe attachment disorders, and fetal alcohol syndrome
- Permits states to include children at risk of developmental delays due to biological conditions, such as low birthweight, environmental conditions, such as teen parents, or a history of abuse and neglect
- Requires an Individualized Family Service Plan (IFSP) to specify needed services for children and families
- Permits a broad range of services that include traditional therapies, such as occupational, speech, and physical therapies, as well as special instruction, social work, transportation, and assistive technology devices, such as wheelchairs and hearing aides. Service coordination or case management is mandatory.
- Permits parents and other caregivers to receive services to enhance the development of their children, pursuant to an IFSP. Services can include parent training, parent counseling, parent support groups, home visits, and respite care. (The definition of a "parent" includes a legal parent, whether biological or adoptive, a relative with whom the child is living, a legal guardian and, in some instances, a foster parent. For those without a "parent" broadly defined, the law requires appointment of a surrogate parent who can be a foster parent, relative, or advocate.)
- Provides money to the states for coordinating activities, but, for the most part, services must be paid for through other sources, such as Medicaid

Special Education Laws for Preschool-Aged Children (The Preschool Special Education Grants Program of the Individuals with Disabilities Education Act)[44]

- Provides an entitlement for children aged three through five to special education and related services
- Allows states to choose to continue eligibility standards of Part C—otherwise eligibility for children aged three through five must meet the standards of disability under special education law (i.e., must have a specific, diagnosed disability that affects their ability to learn)

- Permits state discretion in defining a child with a disability to include a child experiencing developmental delays in one or more areas of physical, cognitive, communicational, social, emotional, or adaptive development who is in need of special education and related services by reason of this delay
- Allows states to avoid unnecessary labeling by permitting them to find a child to have a developmental delay without further specification

Temporary Assistance for Needy Families (TANF) Provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996[45]

- Eliminates the Aid to Families with Dependent Children program and its individual entitlement to cash assistance and replaces this system of aid with block grants to states. The new law provides states with a lump sum payment for each of the years 1997–2002[46] and requires that states spend a certain amount of state money for assistance benefits and services for needy families with children.[47] Assistance is payment to meet ongoing basic needs for families that are not employed.[48] A number of services and benefits are excluded from the definition of "assistance" including: nonrecurrent, short-term (no more than four months) benefits designed to address a specific crisis; supportive services for employed families; and services (e.g., counseling, case management, peer support) that do not provide basic income support. The distinction between assistance and nonassistance is critical because many of the federal requirements associated with TANF (e.g., time limits, work requirements, child support cooperation) apply only to families receiving "assistance," not to families receiving other benefits and services funded under the block grant. Therefore, many services can be provided to families without starting the TANF time clock or creating work requirements for families that are not already receiving assistance.
- Makes funds available for a wide array of services and supports. Unless otherwise prohibited, TANF funds (federal block grant monies) and MOE monies (the state's required maintenance-of-effort funding)[49] can be spent in any way reasonably calculated to accomplish any of the four purposes of the law.[50] These purposes are to:
  1. Provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives.
  2. End the dependence of needy parents on government benefits by promoting job preparation, work, and marriage.
  3. Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies.
  4. Encourage the formation and maintenance of two-parent families.
- A state may also transfer up to 30 percent of its TANF funds to the Child Care and Development Block Grant or to the Social Services Block Grant (Title XX), subject to certain limits.[51] Many services that could benefit young children in foster care can be funded under one of the TANF purposes, through a transfer to Title XX, or under the grandfather clause, and thereby become subject to Title XX rules rather than TANF restrictions.

APPENDIX B

Program Contact Information

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Endnotes

1. For current estimates as of January 2000 see: U.S. Department of Health and Human Services, Children's Bureau. (1999). *The AFCARS report*. <http://www.acf.dhhs.gov/programs/cb> This report found 547,000 children in foster care. For other sources discussing the increasing number of young children entering foster care see Wulczyn, F. & Hislop, K. B. (2000). *The placement of infants in foster care*. Chicago, IL: Chapin Hall Center for Children, University of Chicago; Goerge, R. & Wulczyn, F. (December 1998/January 1999). Placement experiences of the youngest foster care population: Findings from the Multistate Foster Care Data Archive. *Zero to Three*, 19(3), 8–14; U.S. General Accounting Office. (1995). *Foster care: Health needs of many young children are unknown and unmet* (GAO/HEHS-95-114). Washington DC: U.S. General Accounting Office.

2. See Goerge & Wulczyn in endnote 1.

3. Halfon, N.; Mendonca, A.; & Berkowitz, G. (1995) *Health status of children in foster care: The experience of the Center for the Vulnerable Child*. Archives of Pediatric and Adolescent Medicine, 149(4), 386–392. For a discussion of the impact of prematurity and low birthweight on a child's development as well as a comprehensive analysis of the medical, developmental, and emotional concerns related to young children in foster care see Silver, J. A.; Amster, B. J.; & Haecker, T. (Eds.). (1999). *Young children and foster care*. Baltimore, MD: Paul H. Brookes Publishing Co.

4. The most recent child abuse and neglect data reveal that among victims of substantiated child maltreatment, infants represent the largest subpopulation, accounting for about 7 percent of all substantiated reports in 1997. Children between birth and age three were involved in 34 percent of all substantiated neglect reports, the largest category of substantiated maltreatment reports. Additionally, children under age three accounted for more than half of children entering care due to medical neglect. See Wulczyn & Hislop in endnote 1.

5. Studies demonstrating the serious health and developmental problems of children in foster care are consistent nationwide. For Baltimore see Chernoff, M. D.; Combs-Orme, T.; Risley-Curtiss, C.; & Heisler, A. (1994). Assessing the health status of children entering foster care. *Pediatrics,* 93(4), 594–601; for California see Halfon, Mendonca, & Berkowitz in endnote 3; for Illinois see Hochstadt, N.; Jaudes, P.; Zimo, D.; & Schachter, J. (1987). The medical and psychosocial needs of children entering foster care. *Child Abuse & Neglect,* 11(1), 53–62; for New York see Blatt, S. D.; Saletsky, R. D.; & Meguid, V. (1997). A comprehensive, multidisciplinary approach to providing health care for children in out-of-home care. *Child Welfare,* 76(2), 331–349; for Philadelphia, Pennsylvania, see Silver, J.; DiLorenzo, P.; Zukoski, M.; Ross, P. E.; Amster, B. J.; & Schlegel, D. (1999). Starting young: Improving the health and developmental outcomes of infants and toddlers in the child welfare system. In K. Barbell & L. Wright, (Eds.). Special edition: Family foster care in the next century. *Child Welfare,* 78(1), 148–165; for Washington see Takayama, J. I.; Bergman, A. B.; & Connell, F. A. (1994). Children in foster care in the state of Washington: Health care utilization and expenditures. *JAMA,* 271(23), 1850–1855. Approximately 80 percent of all foster children have at least one chronic medical condition, with nearly one-quarter of these children having three or more chronic problems. For example, numerous studies document the prevalence of serious respiratory illness among foster children. One study of foster children from Oakland, California, revealed that 16 percent had asthma—about three times the national average for asthma. See Halfon, Mendonca, & Berkowitz in endnote 3.

6. See Swire, M. R. & Kavaler, F. (1997). The health status of foster children. *Child Welfare,* 56(10), 635–653 (one-third of the preschool children studied had dental decay) and Chernoff, Combs-Orme, Risley-Curtiss, & Heisler in endnote 5 (almost half of the children studied needed to see a dentist). The U.S. General Accounting Office reports that dental disease is one of the most prevalent chronic illnesses impacting children's overall health. See U.S. General Accounting Office. (2000). *Oral health: Dental disease is a chronic problem among low-income populations* (GAO/HEHS-00-72). Washington, DC: U.S. General Accounting Office.

7. See Silver, DiLorenzo, Zukoski, & Ross in endnote 5, and Silver, Amster, & Haecker in endnote 3. See also Silver, J. (2000). Integrating advances in infant research with child welfare policy and practice. *Protecting Children,* 16(5), 12–21 and Klee, L.; Kronstadt, D.; & Zlotnick, C. (1997). Foster care's youngest: A preliminary report. *American Journal of Orthopsychiatry,* 67(2), 290–299.

8. Amster, B.; Greis, S. M.; & Silver, J. (1997). Feeding and language disorders in young children in foster care. Paper presented at the American Speech Language Hearing Association Annual Convention, November 22, Boston, Massachusetts. (On file at the Permanent Judicial Commission on Justice for Children)

9. See Wulczyn & Hislop in endnote 1.

10. Research reveals that more than half, and some studies report as many as 80 percent, of children in foster care have been exposed to maternal substance abuse. See U.S. General Accounting Office. (1994). *Foster care: Parental drug abuse has an alarming impact on young children* (GAO/HEHS-94-89). Washington DC: U.S. General Accounting Office. The Multistate Foster Care Data Archive, a database that contains foster care histories for all children who have been placed in foster care between 1983–1994 in six states: California, Illinois, Michigan, New York, Texas, and Missouri reports the increasing number of substance-exposed infants entering foster care. See Goerge & Wulczyn in endnote 1.

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11. For an overview of the impact of foster care on the emotional development of young children see: Morrison, J. A.; Frank, S. J.; Holland, C. C.; & Kates, W. R. (1999). Emotional development and disorders in young children in the child welfare system. In Silver, Amster, & Haecker in endnote 3; and Katz, L. L. (1987). An overview of current clinical issues in separation and placement. *Child and Adolescent Social Work,* 4(3–4), 61–77.

12. Despite their level of need, less than one-third of children in foster care nationwide receive mental health services. See Rosenfeld, A. A. (1997). Foster care: An update. *Journal of the American Academy of Child and Adolescent Psychology,* 36(4), 448–457. Most of these services focus on older children; mental health services for young children are underdeveloped. See Knitzer, J. (2000). Early childhood mental health services: A policy and systems development perspective. In J. P. Shonkoff & S. J. Meisels. *Handbook of early childhood intervention*. New York, NY: Cambridge University Press.

13. See Shonkoff, J. & Phillips, D. (Eds.). (2000). National Academy of Science and Institute of Medicine. *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press and Shore, R. (1997). *Rethinking the brain: New insights into early development*. New York, NY: Families and Work Institute.

14. Research on risk factors shows that the more risk factors children experience, the more likely they are to develop learning disabilities, behavioral problems and/or mental illness. On average, studies reveal that children in foster care have more than 14 risk factors. See Werner, E. & Smith, R. (1992). *Overcoming the odds: High-risk children from birth to adulthood*. Ithaca, NY: Cornell University Press; Thorpe, M. & Swart, G. T. (1992). Risk and protective factors affecting children in foster care: A pilot study on the role of siblings. *Canadian Journal of Psychiatry,* 37(9), 616.

15. See Gross, R. T.; Spiker, D.; & Haynes, C. W. (Eds.). (1997). *Helping low birth weight, premature babies: The Infant and Health Development Program*. Stanford, CA: Stanford University Press and Zeanah, C. H. & Larrieu, J. A. (1998). Intensive intervention for maltreated infants and toddlers in foster care. *Child and Adolescent Psychiatric Clinics of North America,* 7(2), 357–371.

16. *The Omnibus Budget Reconciliation Act of 1989* (P.L. 101-239) requires states to maintain up-to-date health records, such as immunization records and a child's health conditions, for children in foster care.

17. Cauthen, N. K.; Knitzer, J.; & Ripple, C. (2000). *Map and track: State initiatives for young children and families*. New York, NY: National Center for Children in Poverty, Mailman School of Public Health, Columbia University.

18. *Goals 2000: Educate America Act,* P.L. 103-227, enacted March, 1994. The concept of school readiness addressed in this goal is broad, including attention to the emotional, cognitive, physical, and social aspects of child development.

19. Courtney, M. E. & Piliavan, I. (1999). *Foster care transitions to adulthood: Outcomes 12 to 18 months after leaving care.* Madison, WI: University of Wisconsin-Madison School of Social Work and Institute for Research on Poverty.

20. Medicaid eligibility is based on provisions that vary across the states. Children in foster care automatically are eligible for Medicaid coverage if they receive Title IV-E foster care assistance. Foster children who do not receive IV-E assistance can qualify for Medicaid through one of the other mandatory eligibility categories or through one of the optional categories. Rosenbach, M.; Lewis, K.; & Quinn, B. (2000). *Health conditions, utilization, and expenditures of children on foster care: Final report.* Cambridge: MA: Mathematica Policy Research Inc. <http://aspe.hhs.gov/hsp/fostercare-health00/index.htm>. See also English, A. & Freundlich M. (1997). Medicaid: A key to health care for foster children and adopted children with special needs. *Clearinghouse Review,* 31(3-4), 109–131.

21. For example, in Monroe County, New York, New York Foster Care Pediatrics (FCP) is a full-service primary care pediatric office with limited on-site developmental and mental health services. FCP averages 3,600 visits annually and operates under the auspices of the Monroe County Health Department in collaboration with Monroe County Department of Social Services. For more information contact Moira Szilapyi, M.D.; phone: 716-274-6149; fax: 716-292-3942; e-mail: mszilapyi@mcls.rochester.lib.ny.us.

22. 20 U.S.C. § 1432 (5)(A)(I)(ii)(2000).

23. See 34 C.F.R. 303.19 for definition of parent under Part C.

24. *New York State Law, Public Health Law,* article 25, title II-A.

25. See also Burns, S.; Stagg, V.; & Bennermon, B. (1999). *Putting it together: Providing mental health services in early intervention.* Harrisburg, PA: Pennsylvania CASSP Training and Technical Assistance Institute.

26. Class action lawsuits in numerous states have lead to consent decrees that have created catalysts for system change including increasing quality and documentation of health care provided to children in foster care. See Dicker, S. & Gordon, E. (2000). Safeguarding foster children's rights to health services: The right to health care. *Children's Legal Rights Journal,* 20(2), 45–53. Lutz. L. L. & Horvath, J. (1997). *Health care of children in foster care: Who's keeping track?* Portland, OR: National Academy for State Health Policy.

27. The California Department of Health Services has produced statewide guidelines for public health nursing in child welfare services. See California statewide guidelines for public health nursing in child welfare services. (1999). In J. Rawlings-Sekunda. *Opening the toolbox: Resources for states seeking to improve health care for children in foster care.* Portland, OR: National Academy for State Health Policy.

28. See Yoshikawa, H. & Knitzer, J. (1997). *Lessons from the field: Head Start mental health strategies to meet changing needs.* New York, NY: National Center for Children in Poverty, Mailman School of Public Health, Columbia University and American Orthopsychiatric Association; Knitzer, J. (2000). *Using mental health strategies to move the early childhood agenda and promote school readiness.* New York, NY: The Carnegie Corporation of New York and the National Center for Children in Poverty, Mailman School of Health, Columbia University; Donahue, P. J.; Falk, B.; & Provet, A. G. (2000). *Mental health consultation in early childhood.* Baltimore, MD: Paul H. Brookes Publishing Co.; and Cohen, E. & Kaufmann, R. (2000). *Early childhood mental health consultation.* Washington, DC: U.S. Department of Health and Human Services, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA).

29. Another strategy provides early intervention and early childhood services in the context of a foster care agency. In Brooklyn, New York, the Early Childhood and Family Center, a division of foster care agency Brookwood Child Care, is a therapeutic nursery that provides services to children birth to age three who have emotional and developmental difficulties. Approximately 60 percent of the children are in foster care. Most children are referred by the agency's on-site medical clinic or by caseworkers. Working with both biological and foster parents, center staff serve as coaches and models in a classroom setting to assist parents in learning strategies for engaging their children, addressing their child's developmental and emotional needs, and managing the child's behavior. Every child referred to the center receives a comprehensive evaluation by a psychologist, and a treatment plan is developed collaboratively with the caregivers. The center offers a special education classroom, early intervention services, parent support groups for biological and foster parents, parent-child therapy, and individual therapy for child and parent. The classroom sessions are two and one-half hours daily and provide a range of supervised early childhood activities for the child. When children leave the program, a service coordinator helps transition them to other programs such as special education or Head Start. For more information contact Faith Sheiber; phone: 718-596-5555, ext. 454; fax: 718-596-0985.

30. *The Adoption Assistance and Child Welfare Act of 1980,* Pubic Law No. 96-272, Social Security Act Titles IV-B, IV-E, 42 U.S.C. §§620 et seq., 670 et seq.

31. *The Adoption and Safe Families Act of 1997,* Pubic Law No. 105-89, 111 Statute 2115–2135.

32. 45 C.F.R. § 1355.34 (b) (1) (iii).

33. *Ibid.*

34. See Armstrong, M. L.; Conger, D.; & Finck, K. (1997). New York State Family Court improvement study. Washington, DC: Vera Institute for Justice, unpublished paper (on file at the Permanent Judicial Commission on Justice for Children) and Heidt, J. (1996). Survey of key child welfare actors in the court. Unpublished paper (on file at the Permanent Judicial Commission on Justice for Children).

35. For more information about the CASA program see: <http://www.casanet.org>.

36. Lederman, C. S.; Malik, N. M.; & Aaron, S. M. (2000). The nexus between child maltreatment and domestic violence: A view from the court. *Journal of the Center for Families, Children, and the Courts,* 2, 129–135.

37. These courts are using TANF funds to provide supportive services to parents. For more information about Dependency Drug Treatment Courts see the U.S. Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project (DCCTAP) at <http://www.ojp.usdoj.gov/dcpo>.

38. Some states and counties are using TANF funding to promote the well-being of children and their families. The New York State Office of Children and Family Services (OCFS) developed a Request for Proposals (RFP) for prevention programs to use TANF funding to create new community-based services for vulnerable children and families to reduce the need for out-of-home placement. The RFP is a collaborative effort between OCFS and the New York State Office of Alcoholism and Substance Abuse Services. See New York State Office of Children and Family Services. (2000). *Prevention programs request for proposals*. (On file at the Permanent Judicial Commission on Justice for Children). The RFP awarded $33 million in grants in 2001. A substantial grant was awarded to the New York State CASA Association to fund the CASA Statewide Safe Family Expansion (SSaFE) initiative (see <http://www.casanys.org/0102TANF.htm>). This initiative will serve 350 children in 22 New York State counties meeting TANF eligibility requirements who are at-risk of being placed in foster care or who are currently in foster care with the goal of returning home. The TANF funding will enable the expansion of local CASA programs throughout New York State and supports recruiting, training, and supervising additional volunteers necessary to serve these children as well as enhance their training and technical and training.

An example of a local TANF initiative can be found in El Paso County, Colorado. Through the TANF program, the El Paso Department of Human Services provides kinship services to grandparents raising their grandchildren, including preventative financial assistance and support services aimed at keeping the extended kinship family intact. Child welfare staff were transferred to the TANF program and matched with TANF technicians to create a unit specifically designed to serve grandparents and other relative caretakers. Using TANF funds, the county has implemented a Child Care Coordination program that includes the development of a child care resource and referral database available to all relevant families, including families receiving child welfare services. The Teen TANF program offers pregnant and parenting teens on TANF case management services, assessment, home visits, nurse visitation, continuing education, job training, and parenting instruction. This program is staffed in part by former child welfare workers who are now housed and funded with TANF monies. The agency also is combining family preservation and foster care placement prevention services with preventive TANF services to create a service continuum that bridges the funding and service philosophy gaps between child welfare and welfare.

39. Standardized forms that provide consent to release health-related information and court orders can facilitate sharing of information among attorneys, caseworkers, health care providers, and other professionals working with children in foster care and their families. (Sample court orders on file at New York State's Permanent Judicial Commission on Justice for Children.)

40. A recent report documented that one-third to one-half of children in foster care were not enrolled in Medicaid in the month after their foster care eligibility ceased. See Rosenbach, Lewis, & Quinn in endnote 20.

41. Public Law. 105-89, 111 Statute 2115–2135 (1997) (codified as amended in scattered sections of 42 U.S.C.)

42. 42 U.S.C. § 1396 (a) (10) & (43) (2000); 42 U.S.C. § 1396d (a) (4) (B) (2000) & 1396d (r). See also 42 C.F.R. § 441.50–441.62 (2000).

43. 20 U.S.C. § 1431 (2000); 34 C.F.R. Part 303 (2000).

44. 20 U.S.C. §1419(a) (2000); 34 C.F.R. Part 301 (2000).

45. Public Law No. 104-193, 110 Statute 2105. Assistance is made through the TANF block grant. 42 U.S.C. § 607(a).

46. 42 U.S.C. § 603, 609. The basic federal awards, plus the state required maintenance of effort funds, mean there is approximately $27 billion per year available to serve these families. See Lazere, E. (2000). *Unspent TANF funds in the middle of federal fiscal year 2000*. Washington, DC: Center on Budget and Policy Priorities <http://www.cbpp.org> for a breakdown of the various federal and state funding streams that contribute to the total figure.

47. States have broad discretion to define "needy" and can define the term differently for different services and supports. 64 Fed. Reg. 17825

48. 45 C.F.R. § 260.31. For a discussion of the significance of the assistance/nonassistance distinction in designing state policies and programs, see Greenberg, M. & Savner, S. (1999). *The final TANF regulations: A preliminary analysis*. Washington, DC: Center for Law and Social Policy <http://www.clasp.org/pubs/TANF/finalregs.PDF> and Greenberg, M.. (1999). *Beyond welfare: New opportunities to use TANF to help low income working families*. Washington, DC: Center for Law and Social Policy <http://www.clasp.org/pubs/TANF/markKELLOGG.htm>.

49. For a fuller description of these appropriation principles and the rules surrounding the use of TANF and Maintenance of Effort (MOE) funds for child welfare services, see Hutson, R. Q. (Forthcoming). *Tapping TANF for child welfare: A guide to expanding services and to filling gaps in the child welfare system*. Washington DC: Center for Law and Social Policy <http://www.clasp.org>.

50. For an overview of allowable spending under TANF, see U.S. Department of Health and Human Services. (1999). *Helping families achieve self-sufficiency: A guide to funding services for children and families through the TANF Program*. Washington, DC: U.S. Department of Health and Human Services <http://www.acf.dhhs.gov/programs/ofa/funds2.htm>.

51. While a total of 30 percent can be transferred, no more than 10 percent can be transferred to Title XX, and Title XX transfers must be for services to children and their families below 200 percent of poverty. Beginning in FY 2002, no more than 4.25 percent of TANF funds may be transferred to Title XX. Funds transferred to another block grant become subject to the rules of that other block grant rather than to TANF rules. See 42 U.S.C. § 604. The 4.25 percent limit on the amount transferred to Title XX was supposed to begin in FY 2001, but as part of the final appropriations package adopted by the 106th Congress on December 15, 2000 (H.R. 4577), the 10 percent limit on transfer to Title XX was maintained for FY 2001.

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