



Second  
Interim Report to  
the Court of Appeals on the  
State Court Improvement Project

March 2001



New York State Permanent Judicial Commission on Justice for Children

## **Introduction**

The Permanent Judicial Commission on Justice for Children (“the Commission”) was established in 1988 to address the problems of children whose lives and life chances are shaped by New York State’s courts. The Commission is chaired by Chief Judge Judith Kaye and its members include judges, lawyers, advocates, physicians, legislators and state and local officials. The Commission has spearheaded several reform initiatives that have enhanced the lives of New York’s children, including the 1992 and 1993 Early Intervention laws and the nation’s first statewide system of children’s centers in the courts. Our 28 centers in New York State’s courts last year served over 43,000 children.

In 1994, the Court of Appeals designated the Commission to implement the State Court Improvement Project (“the CIP”), a federally funded project to assess and improve foster care, termination of parental rights and adoption proceedings. Funding was for the first time specifically directed by Congress to the highest court in each State to ensure statewide improvement of child welfare proceedings. A formula determines the amount each state receives; New York has received approximately \$400,000 annually for a period ending in August 2002. The CIP goes beyond these federal funds and includes several initiatives funded with other resources aimed at improving child welfare proceedings and outcomes for children. This report provides a mid-point overview of Phase II, the implementation phase of the CIP.

## **Background**

During Phase I, the Commission conducted the federally required assessment of how New York State Family Courts were handling child welfare cases. To ground its work within a larger conceptual context, the Commission undertook two additional research efforts. First, it reviewed benchmarks of court and social service delivery innovations in other states to assess their possible applicability in New York. Second, the Commission reviewed the history of the Family Court in New York State and court reform within the context of child welfare and other social reform efforts in New York State and nationally (Appendix A provides a summary of Phase I research).

At the conclusion of Phase I, the Commission developed a reform agenda, with Effective Judicial Leadership as its core. This leadership role is comprised of three parts:

- creating a clear philosophy regarding the court’s role in protecting the rights of children and families by preventing unnecessary placements and promoting permanency;
- overseeing the implementation of effective case planning by keeping a tight rein on cases; and
- working to create services needed by children and families involved in the court process.

Phase I demonstrated that these goals are implemented by the following broad activities:

- communication and cooperation with the Department of Social Services – to build a strong social service system that provides effective preventive and

family preservation services, and good information to the court about children in care and their families;

- development of internal court mechanisms to expedite and improve outcomes for children—including creation of dependency units, accelerated time frames for adjudication and disposition, a front-loaded system with adequate hearing time for each case, and the assignment of one Judge to a family throughout the life of a case; and
- use of non-adversarial alternative dispute resolution mechanisms—including pre-trial conferencing, mediation and family group conferencing to resolve cases earlier, provide better information to the courts, and develop service plans that reflect the needs of the individual child and family.

The Commission shared the reform agenda with Family Court Judges from around the State at the 1998 Mohonk Conference, “Foster Care Improvement Forum: Judicial Leadership in Child Welfare.” At the Conference, the Phase I research findings came alive as Judges from the benchmark courts discussed the feasibility of change, the need for judicial leadership and the importance of the reform elements.

After the Mohonk Conference, the Commission began implementation of Phase II by initiating pilot projects in two counties -- New York and Erie -- and by developing statewide reform activities to assist all Family Courts. Statewide activities include developing tools to focus on the individual needs of children in foster care, identifying new resources to assist the court in decisionmaking and increasing resource capacity to improve outcomes for children.

## **CIP Pilot Projects**

The pilot projects in New York and Erie County Family Courts were designated national Model Courts in October 1998 by the National Council of Juvenile and Family Court Judges, making them eligible for additional training and technical assistance resources. These Model Courts have reduced the time children spend in foster care by implementing all of the reform elements developed during Phase I including:

- using judicial leadership to develop a problem-solving approach to protecting the rights of children and families and promoting accountability of all those involved in the court process;
- overseeing implementation of effective case planning by keeping a tight rein on cases, using frequent progress reports, mandatory conferences and hearings and continuity of Judges, attorneys and participants in all stages of the case;
- developing services needed by children and families through formal collaborations between the court and child welfare systems including convening attorneys, caseworkers from the Department of Social Services and foster care contract agencies; and
- creating internal court mechanisms to expedite, improve and track outcomes for children including the creation of specialized dependency units and the implementation of a child-specific data system.

## **New York County**

### **The Model Court Project**

The New York County Model Court was initiated on January 1, 1999 as one of six child protective parts in the New York County Child Protective Division, New York Family Court. Under the leadership of New York City Family Court Judge Sara P. Schechter, and drawing upon the Phase I reform elements and the Resource Guidelines established by the National Council of Juvenile and Family Court Judges, the Model Court utilizes a problem-solving approach to expedite and monitor child protective cases. The Model Court Team includes a Court Attorney Referee, a Court Attorney and a Case Manager/Senior Clerk funded by the Court and a Masters-Level Social Worker assessment coordinator funded by the CIP grant. The Team provides oversight and coordination of all aspects of a case from the filing of the original petition to the final permanency decision. A CIP Project Director and a Senior Management Analyst coordinate operations and have developed the JCATS/NY data system for tracking and analyzing the project.

The cornerstone of the Model Court Team approach is the use of court leadership to consolidate and coordinate existing procedures. At the outset, the Court addresses service of process problems, appoints counsel, schedules hearings and convenes the parties to identify early the pressing service needs of the child and family and explore permanency alternatives. The Judge, Court Attorney Referee and Court Attorney keep a tight rein on cases through frequent conferences, hearings and progress reports. The Case Manager tracks cases and monitors compliance with court orders. The Social Worker works closely with the Judge, Court Attorney Referee and Court Attorney to identify issues that can affect permanency decisionmaking, uses the Healthy Development Checklist (discussed later in this Report) to address the health and developmental needs of the child, and works with attorneys and caseworkers to establish accountability and responsibility for assessments and reports.

The outcome of the Model Court approach has been shortened timeframes and more meaningful dispositions. From January 1999 through September 2000, 65 percent of the Model Court cases went to disposition within three months of the filing of the petition, compared to only 14 percent of the New York City Family Court neglect and abuse cases. Also, 93 percent of the Model Court cases reached disposition within six months, compared with a 33 percent in New York City Family Court. Only one percent of the Model Court cases took over seven months to reach disposition compared to almost half of the Family Court cases. The average time to fact-finding in abuse and neglect cases also are in marked contrast to other courts in New York City. The average time to fact-finding in neglect cases is 61 days and 81 days to disposition in the Model Court compared to 163 days and 180 days in New York City Family Court. Abuse cases in the Model Court took an average of 84 days to fact-finding and 101 days to disposition compared to 251 days and 233 days in New York City Family Court. Since its inception in January 1999, the Model Court Project in New York County has heard 1,482 cases representing the cases of 753 children and 346 families.

Over 400 pre- and post-dispositional conferences were held. As a result of these efforts, permanency has been achieved for 146 children.

### The Abandonment/Permanency Part

The Abandonment/Permanency Part began operations in 1999 and in 2000 was extended to each borough in New York City. Under the leadership of New York City Family Court Judge Rhoda Cohen, the Part was initiated to develop a new way to handle the small number of cases of abandoned infants. In the past, these cases were processed identically to other cases, resulting in infants -- even those abandoned at birth -- languishing for years in foster care. The Part developed expedited procedures to identify and fast-track cases of children under six months old at the time of filing the petition, where the mother's whereabouts were unknown to the Administration for Children's Services (ACS) and the child was presumably abandoned.

At the outset, the Court works closely with ACS to identify and serve parties, obtain all necessary paperwork such as the child's birth certificate and identify and investigate a safe pre-adoptive home for the child. A Court Attorney reviews each new Article 10 filing to determine if the case is appropriate for the project and if so, Judge Cohen receives the case for Intake. The Court keeps a tight rein on cases by adjourning at one-month intervals to complete the diligent search and ACS investigation, holding dispositional hearings approximately six months after the filing of the petition and closely tracking court-ordered termination filings. The case is calendared shortly after the sixth month to determine the Termination of Parental Rights (TPR) status and remains on the calendar until TPR is filed. To expedite permanency, the Court orders concurrent filing of a TPR and an adoption petition. The cases in the Abandonment/Permanency Project are entered and tracked in the new information system providing data for future analysis.

In the Fall of 2000, Commission Member Administrative Judge Joseph Lauria designated specialized parts in the Bronx, Brooklyn and Queens Counties to hear all abandonment cases in each borough using New York County's abandonment protocol.

### Training Activities

The New York County Model Court has shared its reform initiatives with all New York City Judges and their staff. Judge Joseph Lauria invited the Commission to conduct several trainings for the Judges and Court Attorney/Referees in New York City including sessions on the Adoption and Safe Families Act (ASFA) and the health and development of children in foster care. In June 2000, the Commission invited Dr. Judith Silver to share her research and experience working with infants and toddlers in foster care in Philadelphia with new Judges and Judges assigned to the Abandonment Parts. The Commission's Executive Director, Sheryl Dicker, met with eight newly appointed Judges to discuss court improvement and the Commission's statewide initiatives. In October 2000, the

Commission and the Model Court staff worked with the National Council of Juvenile and Family Court Judges to provide a week-long training for all Judges and court staff at the borough and citywide levels. To prepare for this training, Judge Joseph Lauria, Model Court staff, the National Council of Juvenile and Family Court Judges and the Commission conducted a “listening tour” throughout New York City to identify topics for ongoing training and outstanding systemic issues and strategies.

#### Collaboration with the Administration for Children’s Services

Consistent with the reform agenda developed in Phase I of the CIP, the New York City Model Court Project endeavored to establish an ongoing relationship with the ACS to identify problem areas and craft solutions. The ACS Commissioner is a member of both the Commission and the CIP Working Group. A troubleshooter from ACS works full-time at the Court to identify any problems in service provision to children and their families that may slow the permanency process. In July 1999, Manhattan Family Court provided space to ACS personnel to begin a Court Document Scanning Project. The project has improved internal communication between the numerous ACS offices and its contract agencies and the court by disseminating court orders electronically through the ACS e-mail system. In January 2000, the Commission used its federal Adoptions Opportunities grant to fund an Adoptions Specialist in ACS. The project focuses on cases of children with a goal of adoption who are not freed and children with a goal of returning home who have been in care for more than two years. The ACS Specialist uses list-sharing and targeted casework to explore bottlenecks in the process.

## Erie County

The Erie County Court Improvement Project has implemented the Phase I reform agenda through judicial leadership and the development of a close collaboration between the Court and the Department of Social Services (DSS). This initiative forged by Commission Members Erie County Family Court Supervising Judge Sharon Townsend and Erie County DSS Commissioner Deborah Merrifield has resulted in a significant increase in adoptions, quicker and more meaningful dispositions and a reduction in the number of children in foster care. The project is staffed by a CIP Project Manager and a Special Assistant to the DSS Commissioner, funded by the Commission's federal Adoptions Opportunities Grant. In order to enhance replicability throughout the State, the Model Court is implementing the National Council of Juvenile and Family Court Judges Resource Guidelines with a regular caseload. The Erie County Family Court has established specialized dependency units effective January 2001 to implement courtwide the learning from the CIP.

## Expedited Adoption Project

The Expedited Adoption Project, "Spring Into Permanency," began in 1998 as a joint endeavor between the Court and DSS to develop new procedures for filing, managing and finalizing adoption petitions. The Court exchanges and reviews data regularly with DSS to provide greater accuracy and prevent delays. A case management system has been developed for all adoption cases that provides each judge with monthly reports on all pending adoptions. The development of an "Adoption Manual" standardized the handling of adoption cases. To expedite adoptions, the Court schedules proceedings at the earliest possible date. The result has been a reduction in the time between filing the petition and finalizing the adoption case from 72.7 days to 47.5 days. A key initiative of the Project has been the quarterly Adoption Days. Since May 1999, nine Adoption Days have resulted in the adoption of 207 children.

The Project also has fine-tuned its own procedures each year, demonstrated by completing 177 adoptions in 1998, 225 adoptions in 1999 and 316 adoptions in 2000. This represents a 21% increase in finalized adoptions from 1998 to 1999 and a 29% increase from 1999 to 2000 for a total of 718 adoptions. The length of stay of children adopted from foster care was reduced from 5.7 years in 1998 to 5.21 years in 1999 and to 5.1 years in 2000. The number of children in foster care has been significantly reduced from 2,336 in 1997 to 1,541 in 2001. These improvements are a result of joint efforts by DSS and Family Court to expedite long-pending cases and the targeting of CIP funds to caseworker overtime which has doubled the completions of home studies. The introduction of systemic improvements by both systems has also contributed to expedited permanent homes for children in the project.

## The Model Court

Under the direction of Erie County Family Court Judge Janice Rosa, the Model Court began operations in January 2000. The Model Court draws on the Phase I

research, the experience of New York County Model Court and the Resource Guidelines of the National Council of Juvenile and Family Court Judges. The Court hired a Court Attorney/Referee in March 2000 to handle conferences for uncontested dependency matters, service plan reviews, permanency hearings, case management appearances, and to review all court-ordered reports. CIP funds were used to hire a Court Officer/Data Entry Clerk to assist the Referee in maintaining the calendar and managing the cases using the JCATS system.

Since the Court Attorney/Referee officially began hearing cases in April 2000, the Model Court completed 80 percent of its abuse and neglect cases by admission, compared to 46.5 percent for the rest of the Family Court in 1999. Of the initial neglect cases, 77 were resolved by admission in an average of 19.8 days from their initial hearing in the Model Court. Only 50 percent of neglect cases in the rest of the Family Court were resolved by admission.

### Collaboration

Collaboration between the Court and DSS is the hallmark of the Erie County Project. A CIP Working Group meets monthly to troubleshoot and design system improvements. Members include the Supervising Judge, the CIP Director, the DSS Commissioner, the DSS Project Coordinator and DSS supervisory staff. A steering committee includes representatives from the court, service providers, DSS staff and the legal community. A stakeholder group of 160 community-based representatives comprise sub-committees that focus on expediting adoption, understanding legal issues and barriers to permanency, identifying training needs and exploring issues related to substance abuse, kinship care, mediation and children's well-being. The Court and DSS have collaborated to expedite adoption cases and to prioritize clearances as required under New York State ASFA law.

### Training

In March 1999, The Family Court received assistance from the National Council of Juvenile and Family Court Judges to present a multidisciplinary training on ASFA and concurrent planning for nearly 400 Judges, lawyers, caseworkers and policymakers from Erie County and the surrounding counties.

In June 2000, the Court collaborated with the Department of Social Services and the local Catholic Charities agency to provide a one-day Child Permanency Mediation Symposium. Attendees included law guardians, parents' attorneys, child welfare caseworkers and service providers from the public and voluntary sectors. Speakers for the Symposium included National Council of Juvenile and Family Court Judges from Model Courts in San Jose, CA, Newark, NJ and Charlotte, NC. Commission staff also provided training to Erie County Court Appointed Special Advocates (CASA), caseworkers and attorneys on the healthy development of children in foster care.

## **Statewide Initiatives**

During Phase I of the Court Improvement Project, the Commission conducted an assessment of how child protective cases are handled in New York State Family Courts. This research found that courts often have little information about the children and families, limiting effective decisionmaking. Commission research further found that scant attention was paid to the health and developmental needs of children and that court orders seldom contained specifications for services to children.

During Phase II, the Commission conducted an extensive research and literature review of the health, developmental and educational needs of children in foster care and identified national models of health care to children in foster care. We found that foster children nationwide are at grave risk of poor health and disability. Nearly 80 percent have one chronic medical condition and nearly a quarter have three or more. Over half have significant developmental delays and/or emotional and behavioral problems that require intervention. At the same time, our review of the research nationwide found that a significant number of these children received no routine health care and had unmet health needs. We discovered that the profile of New York's foster children mirrors the national picture.

The Commission has launched several statewide initiatives to support the overarching goals of the CIP to protect the rights of children and families and to promote better outcomes for children. These initiatives also are consistent with the goal of child protective proceedings under New York law and ASFA to protect the safety and well-being of children in foster care. They include strategies to:

- highlight and address the individual needs of children in foster care;
- identify new resources to facilitate the court's new problem-solving role; and
- increase the capacity of communities to provide services needed by children and families involved in the court process.

## **Individual Needs of Children**

### **Healthy Development of Foster Children Initiative**

The Healthy Development of Foster Children Initiative is the cornerstone of the Commission's strategy to address the individual needs of children in foster care. The Commission's Health Care Working Group created a multi-pronged strategy that included developing a booklet and training curriculum to assist all those involved in the court and child welfare system in identifying a foster child's health needs and highlighting policy issues to insure that foster children actually receive needed services.

A major product of the Commission's strategy is its booklet, *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates and Child Welfare Professionals* (Appendix B). The booklet was published in October 1999 and provides a ten-question checklist to identify a foster child's health needs and

gaps in services. The booklet is a vehicle to ensure that at least one person involved in the court process asks questions about a foster child's health and highlight the connection between a foster child's healthy development and his or her prospects for a stable, permanent home. The Commission worked closely with the New York State American Academy of Pediatrics to develop the checklist and to share the booklet with health care providers statewide.

Chief Judge Kaye formally unveiled the booklet during her keynote address at the November 1999 Millennium Conference in Washington D.C. sponsored by the U.S. Department of Health and Human Services Children's Bureau, the National Council of Juvenile and Family Court Judges and the Department of Justice Office of Juvenile Justice and Delinquency Prevention. The booklet was disseminated to all participants at the conference including all of the 49 State Court Improvement Projects, 22 Model Courts of the National Council on Juvenile and Family Court Judges and officials of the U.S. Department of Health and Human Services and the U.S. Department of Justice Office of Juvenile Justice Delinquency Programs. In addition, copies have been provided to conference participants at the Arkansas Court Improvement Conference (September 2000), at the California Judicial Conference (December 2000) and to Court Improvement Projects in Arizona, Colorado, Nebraska and Tennessee. CASA programs throughout New York State and in Arkansas, California, Delaware, Hawaii, Illinois and Pennsylvania have requested booklets. In all, the Commission has disseminated 15,000 booklets nationwide. In New York State, the Commission has shared the booklet with all Family Court Judges, local Social Services and Health Commissioners, State Legislators, Early Intervention Officials, Public Health Nurse Directors, advocates, law guardians, parents' attorneys and service providers. Judges, attorneys and CASAs throughout the state and nation are using the checklist to identify health needs of children in foster care and gaps in services. Additionally, the Commission has published several companion writings to highlight the court's role in the healthy development of children in foster care, the connection between healthy development and permanency and existing resources that can be tapped to improve outcomes for children in foster care and their families (Appendix C).

### **Data System/JCATS**

In implementing the elements of court reform, the Commission recognized that the collection of child-specific data in the courts was critical. Good data enables the court system to understand the individual needs of children and their families, identify gaps in services and establish a framework for system change. The Commission selected the Juvenile Case Tracking System (JCATS) first developed for Hamilton County, Ohio, one of the benchmark courts studied in Phase I. JCATS has been used successfully by the nation's first model court to reform its own processes and to improve communication between the Court and Department of Social Services. The Commission chose to modify the existing JCATS system to reflect New York law and terminology.

The JCATS/NY data system became operational in New York County Family Court in May 1999, providing an innovative tool to track dependency cases in the court.

The system includes information about specific children, length of time in foster care, type of placements, case-processing times and parental compliance with services. The Healthy Development Checklist questions have been incorporated into the JCATS database. It generates weekly and monthly reports to help determine trends. The system also has the capacity to serve as a reminder for any upcoming reports or filing ordered by the court. By using a common identifier with the local child protective agency, the system facilitates communication to insure compliance with court orders. The JCATS system is being used by the Model Court in Erie County Family Court and the Suffolk Family Treatment Court. Plans are underway to utilize JCATS throughout the Family Court in New York City.

### **New Resources for the Court**

#### **Court Appointed Special Advocates (CASA)**

The CASA project harnesses the resources and expertise of CASA volunteers to assist the Court in identifying and addressing the well-being of foster children. CASA volunteers provide information to help courts shape court orders and monitor compliance and the progress of permanency plans. CASA involvement also helps courts prevent delays in cases caused by adjournments based on inadequate information. The Commission is working with New York State CASA to use the Healthy Development Checklist on every case assigned to them by a Judge.

The Commission has trained all the New York State CASA Directors to use the checklist and the directors have trained their local volunteers. CASA volunteers are collecting data on the use of the checklist and creating a health profile of the children in their caseload. As a result of CASA involvement, more Judges are aware of children's health and developmental needs and their connection to permanency planning. In several instances, CASA involvement has encouraged Judges to write court orders specifying health services to be provided to a child. In Erie and Westchester Counties, CASAs are specifically assigned to cases of foster children under age five. The courts have incorporated the information gathered by the CASAs in court orders for specific health and developmental screenings to be obtained for individual children.

This initiative strengthened the New York State CASA program and increased its availability as a resource for Judges statewide. Several Judges at the July 2000 Judicial Training School requested the Commission's help in starting CASAs in their counties and continuing start-up is imperative. Insuring that a child-focused CASA program is available as a resource to Judges is critical to the long-term success of the CIP. The newly invigorated New York State CASA program was able to garner a major grant from the Office of Children and Family Services which will provide base funding for all CASA programs and the development of additional programs this year.

### **MSW Judicial Internship**

The Commission has developed a Masters in Social Work (MSW) Judicial Internship Program that places MSW students in Family Court to assist Judges and court staff in reviewing case plans, shaping dispositions and identifying unmet needs of foster children. As part of this project, the Commission has established strong working relationships with the Columbia University and Hunter College Schools of Social Work. The students are supervised by Commission staff and also receive on-site supervision by the New York City Model Court Project's MSW Assessment Coordinator.

During the 1999-2000 school term, the Commission placed two MSW students -- one was assigned to Commission Member Judge Joan Cooney's Permanency Part in Westchester Family Court and one was assigned to the Model Part in Manhattan. Judge Cooney's student became an integral part of her Permanency Part team, identifying service needs of individual children and completing a Resource Guide of parenting programs in Westchester County for the Family Court. The Model Court student focused on cases involving pregnant and parenting teens in foster care and spent time working with Commission Member Judge Lee Elkins in Kings County Family Court. The student profiled these cases and used the healthy development checklist to assist court staff in identifying the needs of the teens and their children. During the 2000-2001 school term, the Commission placed one student at the Brooklyn Family Court to work full-time with Judge Elkins and one student with Judge Cooney in Westchester County. Judge Elkins' student continues to focus on cases involving pregnant and/or parenting adolescents and is developing a resource manual of programs for adolescents for Kings County. Additionally, the student has assisted the court with compliance work on cases involving adolescents to identify barriers to service provision. Judge Cooney's student is completing a resource manual on Independent Living Programs in Westchester County and creating a brochure about the Westchester Family Court process for youth in foster care.

### **Westchester County Neglect and Abuse Permanency Part**

To implement the goals of ASFA and the Commission's reform elements, the Westchester County Family Court has established a Neglect and Abuse Permanency Part, located in the White Plains Family Court, to hear all neglect and abuse cases involving children from Westchester County (except Yonkers). The Part, presided over by Commission Member Westchester County Family Court Supervising Judge Joan Cooney, focuses on achieving within time frames set by ASFA, prompt resolutions of abuse and neglect cases and making permanent plans for foster children. In developing the Part, Judge Cooney and her staff have tapped the Phase I research, the expertise of the Commission staff and the experience of the Manhattan Model Court.

To effectively resolve these cases, the Court utilizes the help of a variety of resources. The Court's full-time Court Attorney/Referee holds permanency

hearings for each child who has been in foster care for one year. The hearing establishes a permanency plan for the child and sets a specific time within which the plan must be accomplished. In cases where close monitoring is necessary, the Court Attorney/Referee holds post-dispositional conferences to monitor compliance with court orders.

The Commission has brought several critical resources to this initiative. Judge Cooney assigns a CASA to each foster child under age five to monitor the child's health and developmental needs. The CASAs are using the Commission's Healthy Development Checklist to identify health needs of young foster children and gaps in services. Commission staff have provided ongoing training and consultation for the Westchester CASAs involved in this project. Through its MSW Judicial Internship project, the Commission has assigned students to Judge Cooney's court to oversee aspects of individual cases and to identify community resources. A new resource funded by the Commission is a part-time educational consultant to assist Judge Cooney in reviewing, evaluating and providing recommendations as to the appropriateness of school placements.

Through collaboration and cooperation with DSS and others involved in the court process, this initiative has been able to identify and remove individual and systematic barriers to permanency. To achieve this goal, Judge Cooney convenes bimonthly meetings of a multi-disciplinary Advisory Council on Permanency for Children. The Council is chaired by Judge Cooney and includes representatives from the Court, the Department of Social Services, the County Attorney's office and service providers. Commission staff attend these meetings and have presented on topics related to the Commission's statewide activities.

## **Training**

During the past three years, the Commission has been involved in an intensive training effort for Judges, attorneys and child welfare agencies. (See Appendix D for list of training events.)

In addition to providing participants with written materials and access to experts in the fields of child health and development, our training sessions highlight practical strategies to meet successfully the requirements of ASFA while focusing on the well-being of individual children in foster care. The training curriculum spotlights the critical connection between healthy developmental and permanency and reviews the legal entitlements of foster children to health, developmental and educational services. The Commission staff has developed an impressive roster of trainers that includes Judges, attorneys, pediatricians and child development specialists nationwide to serve as training resources to the New York State courts. We also work closely with national organizations including the National Zero to Three, National Council of Juvenile and Family Court Judges and the American Academy of Pediatrics to present strategies that link those involved in the court and child welfare systems with other professionals working with vulnerable children.

## **Capacity Building**

### **Policy Work**

Focusing attention of all those involved in the court process on the healthy development of foster children and its connection to permanency decisionmaking is meaningless if services to address their needs do not exist. Implementing the Commission's Checklist statewide has uncovered gaps in services statewide. As part of its statewide CIP activities, the Commission is working at both the state and county levels to ensure that services needed by children in foster care actually exist.

The Commission's Health Care Working Group met with the Medical Oversight Workgroup of the New York State Department of Health and the Office of Children and Family Services to ensure that quality health care is available to foster children in New York State. The Commission has commented on draft standards and encouraged the Workgroup to consider strategies to address the disparity of health care services to children in direct care and children in the care of voluntary agencies. In addition, the Commission has pointed to the need for specific oversight and monitoring guidelines to ensure that foster children actually receive health services and to establish formal mechanisms to ensure collaboration with state Early Intervention, Special Education and Head Start programs.

Additionally, Commission staff have made presentations, shared materials about the health and developmental needs of children in foster care, and provided consultation to the New York State Early Intervention Coordinating Council and local Early Intervention Officials statewide. Our correspondence with the U.S. Department of Education has resulted in clarification of regulations defining "parent" under the federal Early Intervention law, an issue of particular concern to children in foster care. We also have commented on proposed federal regulations, urging the inclusion of foster children in mandated Child Find activities.

Most recently, the Commission has collaborated with the National Center for Children in Poverty to write an Issue Brief, "Improving the Odds: Promoting Health, Developmental and Emotional Well-Being of Young Children in Foster Care." The Issue Brief describes what courts, child welfare agencies and other partners can do to improve the well-being of young children in foster care and identifies effective models throughout the country. The publication will be distributed nationally to policy leaders and advocates.

### **County Projects**

The Commission additionally is working in several counties to bring about changes in practice involving services to children in foster care. The Commission worked closely with Region II of the U. S. Department of Health and Human Services to plan and conduct a one-day conference for the seven counties in the mid-Hudson region (Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester) on the health needs of children. The health of foster children, early intervention services and enrollment in Medicaid and Child Health Plus were the themes of the conference. Following the conference, the Commission has been

contacted by several counties to help develop county initiatives to meet the health and developmental needs of foster children.

### **Dutchess County**

The Commission was contacted by a member of the Dutchess County Legislature who co-chairs the Citizens Advisory Committee on Foster Care and Adoption. This multi-disciplinary Committee, which includes Family Court Judge Damian Amodeo, invited the Commission to make a presentation on the health needs of children in foster care. As a result of that presentation, the Committee has chosen to develop a system to refer all foster children under age three to the Early Intervention Program and to explore the creation of a comprehensive system of health services for all foster children. The Commission will provide consultation and technical assistance for this effort.

### **Suffolk County Family Treatment Court**

The Commission has worked to provide resources and technical assistance to the Suffolk County Family Treatment Court developed by Commission Member Suffolk County Family Court Judge Nicolette Pach. These efforts have included bringing JCATS to the Court and training the Drug Court Team to use the Commission's Checklist for the Healthy Development of Foster Children. As a result, the Suffolk County Drug Treatment Court has incorporated elements of the Checklist into their court order and treatment plan forms. Additionally, the court staff is working closely with the Suffolk County Bureau of Public Health Nursing to do assessments of all young children under age five assigned to that court. The Drug Court Team staff provides the nurses with a copy of the court order and a psychosocial assessment for each referral. The public health nurses' meet with the Treatment Court team to discuss specific cases.

The Suffolk County Public Health Nursing Bureau and the County Department of Social Services also have developed a formal collaboration where public health nurses conduct home visits twice a year to all foster children under age thirteen. An interesting result of this effort has been the development of a working relationship and protocol to refer young foster children to Early Intervention that can serve as a statewide model. The Commission has highlighted this model in several statewide and national trainings.

### **Bronx County**

The Robert Wood Johnson Foundation has awarded the Commission a sixteen-month grant to develop a specialized, court-based strategy for infants in foster care in Bronx County. The project will gather accurate data on the number of infants in foster care, identify key service providers, facilitate collaboration between the Court and community service providers, and provide training and consultation for the Court on issues related to infants and develop protocols for cases involving infants in foster care that can be replicated statewide. It will marry a focus on infant development with the research and experiences of Phase I and II of the CIP to expedite and improve the handling of cases involving infants in foster care.

## **Next Steps**

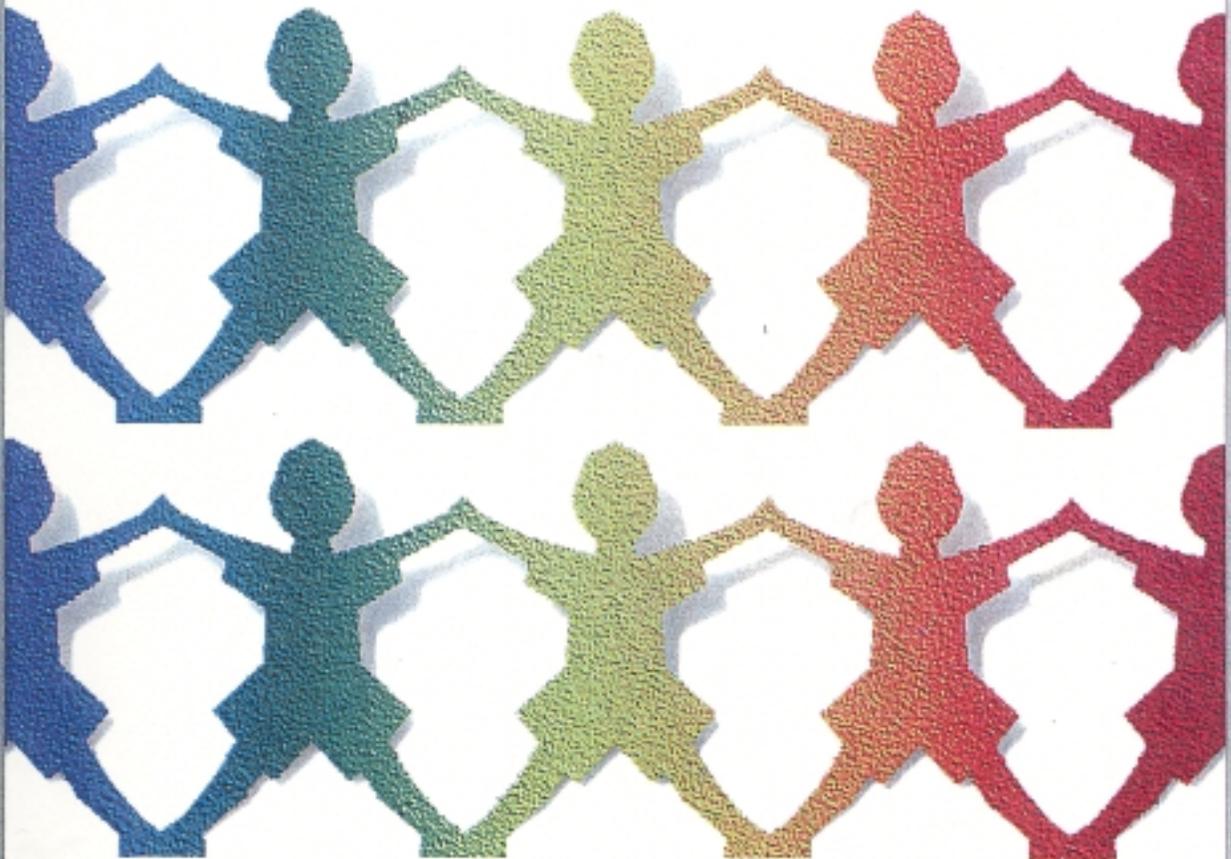
Over the next year and a half of the Court Improvement Project, the Commission plans to share the learning from Phase I and II by assisting courts in the replication of the reform elements and Model Court procedures, completing an extensive evaluation of the Court Improvement Project and developing protocols for expediting permanency and meeting ASFA standards. The centerpiece of our efforts will be the continuation of statewide training on court innovations and issues related to the well-being of children in foster care and their families. Additionally, the Commission will undertake new initiatives to improve outcomes for children in foster care. This will include developing a project in Bronx Family Court to ensure the healthy development and permanency of infants in foster care and their access to Early Intervention and early childhood education services, promoting the expansion of CASA as a critical resource to Family Courts and increasing the capacity of communities to provide health services to all children in foster care.

# APPENDIX A



Interim Report to  
the Court of Appeals on the  
State Court Improvement Project

February 1998



New York State Permanent Judicial Commission on Justice for Children

**PHASE ONE**  
**THE RESEARCH**

## STATE COURT IMPROVEMENT PROJECT

### **Introduction**

In 1994 the Court of Appeals designated the Permanent Judicial Commission on Justice for Children (Commission) to implement the State Court Improvement Project, a four year federally funded project to assess and improve foster care, termination of parental rights and adoption proceedings. Funding was specifically directed to the highest court in each state to ensure statewide improvement of child welfare proceedings. This report provides an overview of the Commission's work during Phase One, the research phase, of the Court Improvement Project. The accompanying materials constitute all of the documents produced for Phase One. It also sets forth the reform agenda for Phase Two, the implementation phase of the project.

In authorizing funds, as part of the larger Family Support and Preservation initiative, Congress recognized that significant improvements in the child welfare system also depended on improvements in court process. Over the last two decades, reforms in federal and state law have increased the number of issues, hearings and parties before the court. Additionally, problems of crack, HIV-AIDS and homelessness have further complicated child welfare cases. Yet the resources allocated to the courts hearing these cases have not kept pace with the changing needs.

The Commission began Phase One by conducting an assessment of how New York State Family Courts were handling child welfare cases. To ground its work within a larger conceptual context, the Commission, in addition to conducting the federally required assessment, undertook two additional research efforts. First, it reviewed benchmarks of court and social service delivery innovations in other states to assess their possible applicability in New York. Second, to provide a context for the reform, the Commission reviewed the history of the Family Court in New York State, successful and unsuccessful court interventions, and court reform within the context of child welfare and other social reform efforts in New York State and nationally.

### **(A) The Assessment**

The assessment itself had four components: an analysis of federal and state child welfare laws; a profile of the state's foster care population; the results of a survey of key actors in the child welfare system statewide; and a more detailed look at the handling of cases involving infants and adolescents in five selected counties. In addition to these components, Commission staff conducted interviews, meetings, and focus groups with judges, court administrators, attorneys, advocates, adoptive and foster parents,

commissioners of social services, historians, and social scientists to gain a deeper understanding of the issues and problems identified.

In the review of applicable statutes and case law it is noted that “the New York State and federal statutory and regulatory frameworks reflect a heavy emphasis on the preservation of families, as well as due process protections as requisites for governmental intrusions upon family life.” Thus, child welfare system problems are not primarily a result of legislative or statutory limitations; nor does the body of applicable legislation and statute restrict reforming that system to address those problems.

In the Profile of the Foster Care Population in New York State available data from the Office of Court Administration and the Department of Social Services was analyzed to provide a picture of the foster care population statewide. Key findings from this report include:

- New York State’s foster care population is young. Thirty-four percent of children in care from New York City (New York City represents three-quarters of the in-care population of approximately 60,000 children) are younger than two years of age. This age group comprises at least 30 percent of foster care admissions in many of the state’s other large counties such as Erie, Monroe, Onondaga, Suffolk, and Westchester.
- Children in foster care reside in a range of placements. Forty-six percent of New York City children are in kinship care compared to seven percent in the rest of the state as a whole, although a number of upstate counties also have high rates of children in kinship placement. Forty-four percent of New York City children are placed in non-kinship homes compared to 66 percent in the rest of the state. The rest of the state has a much higher proportion of children in congregate care than New York City -- 24 percent compared to nine percent -- reflecting the higher percentage of adolescents elsewhere in the state.
- The length of stay in care is long: more than two-thirds of New York City children remain in care for more than three years as do half of the children elsewhere in the state.

In addition, the report demonstrates wide county-to-county variation in the rates of abuse and neglect petitions, distribution of placement types, ages of the children in foster care, and court workload.

The Commission surveyed key actors in the child welfare system in each of New York State’s 62 counties (including the five boroughs of New York City): law guardians, respondents’ counsel, Court Appointed Special Advocates (CASAs), attorneys

employed by county Departments of Social Services, and county social service commissioners. Key findings of the survey include:

- Courts have little information available to them on which to base decisions. There is very little continuity among caseworkers and attorneys in the processing of cases; many attorneys report that they do not have time to review case records; and investigation of children's well-being prior to hearings is sporadic. This is a particular problem with regard to reasonable efforts and service delivery.
- There are significant delays in the processing of cases. A high percentage of petitions are not filed on time, particularly in New York City. In addition, there are a high number of adjournments averaging three adjournments per case per stage of the process. The average length of an adjournment is seven weeks in New York City and four weeks in the rest of the state.
- Social service departments and/or respondents do not comply with court orders in a large percentage of cases.

These reports shaped the charge given to the Vera Institute of Justice as it began its detailed study of infants and adolescents. The overview of key actors highlighted problems of inadequate information, significant delays, and lack of coordination between Family Courts and social service departments.

Based on these findings, the Commission's Working Group selected two age groups on which Vera would focus: infants, whose number is growing and who disproportionately swell the child welfare rolls because they have the longest potential lengths of stay; and adolescents close to the end of their careers in the system whose discharge planning Working Group members suspected was often inadequate. The Working Group also decided that Vera should study five counties: two in New York City (the Bronx and Manhattan); Erie, which accounts for the largest number of cases outside of New York City; Suffolk, a large suburban county; and Oswego, a small rural county.

The study reviewed court records and observed court proceedings in these counties. It confirmed and provided more detail on many of the conclusions of the statewide research. Major findings include:

- Social service caseworkers and/or attorneys attended 87 percent of the proceedings observed, ranging from 81 percent in Erie to 100 percent in Oswego. Parents were present in 42 percent of the proceedings, although there was a wide variation among counties with parents present in 86 percent of the proceedings in Oswego and 34 percent in New York and Suffolk.

- Caseworkers provided written information for the court records in only 29 percent of the records reviewed, dramatically limiting the information available.
- Reasonable efforts inquiry was made in only 47 percent of the proceedings observed.
- The judges ordered one or more services in 58 percent of the proceedings; orders for services ranged from 34 percent of the cases in the Bronx to 83 percent in Erie. Substance abuse treatment for parents was the most frequently ordered service, and services were rarely ordered for children. Services were ordered in only 25 percent of the cases involving infants.
- The courts studied responded quickly to abuse and neglect petitions; delays are common, however, in subsequent hearings, largely due to the high number of adjournments per case. More than half of the extension of placement hearings documented in the records reviewed for the study, for example, were adjourned.

Thus, Vera's study provides detailed evidence of the problems identified in the profile of children in foster care and overview of key actors in the child welfare system. The next section describes other jurisdictions' successful attempts to address them.

## **(B) Benchmarks**

A review of court innovations in other states focused primarily on three localities identified as having implemented successful court reforms: Hamilton County, Ohio (Cincinnati); Santa Clara County, California; and Kent County, Michigan (Grand Rapids).<sup>1</sup> Other court and social service innovations studied are being implemented in several jurisdictions include: mediation, family conferencing, and subsidized guardianship.

The three courts studied rely on adversarial court proceedings in the handling of child welfare cases only as a last resort. Instead, they provide strong family preservation and preventive services that divert cases from the court process. In addition, they use non-adversarial dispute resolution techniques to foster settlements in the cases that are not diverted. These filters help to reduce the court calendar and allow judges sufficient time

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<sup>1</sup> Hamilton County with a population of approximately nine hundred thousand is comparable in size to Erie County. Santa Clara County has a population of 1.6 million and is larger than Manhattan and the Bronx and slightly smaller than Queens. Kent County, the smallest of the benchmark courts has a population slightly larger than Onondaga County. The foster care population in each of these counties is smaller than its New York counterpart because of the successful reform efforts. For example, Hamilton County at the beginning of its reform effort had a foster care population of 4,000 and today has approximately 1,000 children in foster care. In Erie County today there are approximately 2,500 children in foster care at the beginning of our reform initiative.

to hear the cases before them. Additional court staff in Kent and Hamilton Counties also help to facilitate the timely handling of cases and the gathering of the information required for sound decision-making and for a high rate of compliance with court orders. These court structures, along with strong and consistent court leadership, have created court cultures and practices that improve outcomes for children. More children can remain at home successfully, and those who are placed in foster care have shorter lengths of stay.

Among the characteristics of successful jurisdictions are:

- *Effective court leadership.* Each jurisdiction has a judge who has provided sustained, consistent, and strong leadership. These judges are activists who have established mechanisms and structures that facilitate permanence and have taken a broader community role in advocating for services.
- *A clear philosophy within the court regarding permanence.* Hamilton County's principles are illustrative: permanency decisions must be made based on a child's sense of time; families are meant to raise children; foster care placements must be stable; and the local social service department must have a plan to maximize the realization of these principles and to monitor the extent to which the plan is followed.
- *A strong statutory framework.* All three jurisdictions operate under state statutes that have expedited time frames for adjudication and disposition and tight controls on adjournments. A number of other states are also using expedited time frames. Colorado is particularly interesting in that it requires expedited proceedings including frequent court reviews for children under the age of six. It should be noted, however, that while accelerated time frames are necessary, they must be supported by a strong court and sufficient judicial resources if they are to be met.
- *Creation of dependency units.* To ensure sufficient resources for the handling of child welfare cases, each of the sites has a separate dependency unit that handles child welfare matters and that has established effective linkages to its social service agency.
- *Non-adversarial dispute resolution.* Each of the courts has mechanisms for the non-adversarial resolution of cases. By improving communication between the parties and focusing on issues, the solutions are richer and more individualized than those that would result from adversarial proceedings. Since parents are active participants in the process and in developing a final agreement, they are more likely to comply with its terms. Formal mediation is used in Santa Clara County, in four other counties in California, and in several other states and

localities, but the stages of the court process that actually employ it vary among jurisdictions. It seems to be quite effective, with 60 percent of the cases reaching full agreement before trial and almost 90 percent reaching partial agreement or settlement. Even if the issues are not resolved, there are still benefits from mediation including improved communication among the parties, better information, and greater appreciation of the issues.

- *Establishment of a front-loaded system with adequate hearing time for each case.* In Hamilton and Kent Counties, hearings are set for a specific and sufficient time. In Santa Clara County, hearings are scheduled for the morning, while afternoons are reserved for trials. Hearings are frequent to ensure compliance with the case plan and court orders. The focus of each hearing is clearly defined, and a new court date is set at the end of each hearing. In Hamilton County, the expectations for the next court hearing are discussed and the entry copied and distributed to all parties.
- *One judge handles a case throughout its life.* Each court operates under the rule of one judicial officer/one family. The guardian *ad litem* is also assigned for the life of a case in all three sites.
- *Cooperation and collaboration between the court and the social service agency.* Each of the jurisdictions has established a collaborative and cooperative relationship with its social service agency. Judges are active participants in identifying and developing community-based services. There are also formal linkages to address systemic issues.
- *A strong social service system that provides effective preventive and family preservation services.* Because of the extensive work up-front, particularly in Hamilton and Kent Counties, petitions are filed only for those children whose safety or welfare is seriously jeopardized or whose families refuse to accept services. Santa Clara and Kent Counties, through their social service agencies, are piloting the use of Family Group Conferencing. This practice originated in New Zealand. It looks first to the extended family for solutions to issues of child abuse or neglect and excludes state intervention until the family has had an opportunity to come to its own agreement and form a plan on how to handle the situation. It is only when the family cannot agree or in a true emergency that the state intervenes, and, even then, family solutions must be given primacy. As a result of Family Group conferencing, the number of New Zealand children living in institutional settings and unrelated foster care has been sharply reduced.

A variation of Family Group Conferencing, called "Staffing", is being piloted in Hamilton County and elsewhere with funds from the Annie E. Casey Foundation. A "Staffing" is held after a referral is received from the child abuse/neglect hotline

and a decision must be made about whether to remove the child from his or her home. It is also held semiannually for every child in care and can be scheduled whenever there is a significant shift in the previous plan such as a change in custody or placement or reunification. The caseworker may invite lawyers, family members, community members, and other professionals to attend the conference, at which information relating to the protection and safety of the children and the overall functioning of the family is provided and a plan for the child and family developed.

- *Good information about children in care and their families.* Each site has excellent data regarding children in foster care and their families. Hamilton County is the only court with its own high quality data system, while the other two sites rely more on social service data. The Hamilton County system tracks children by social service needs and case activity. Data are used to provide monitoring reports, develop parent/child profiles, flag problem cases, and monitor referee decision-making.
- *Options in other jurisdictions.* One of the key initiatives for expanded permanency is the use of subsidized guardianship. We are following the use of subsidized guardianship through a waiver process begun in June 1995, in which 13 states were permitted to submit waiver requests to the U.S. Department of Health and Human Services for child welfare demonstration projects. Of the 13 states, three subsidized guardianship proposals were received from Delaware, Illinois and Maryland and have been approved by HHS. The three proposals are similar. Delaware and Illinois would allow for subsidies at the adoption subsidy rate. Maryland would pay a subsidy of up to \$300 per month, the maximum unearned income an individual in Maryland can receive and still qualify for Medicaid. In each program, the case would be closed and removed from the foster care roles after guardianship is transferred.

### **(C) Context**

A report tracing the history of the New York State Family Court since its inception provides a framework for understanding the child welfare system in New York State. Since the inception of the Children's Court at the turn of the century, there has been debate and confusion about its role. This debate has often centered on the tension between the court's exercise of discretion to rehabilitate children and the rights of individuals. In the report this tension is characterized as the basic question of whether the court plays a judicial or administrative role.

The early history of the court clearly indicated that it was to be different from traditional courts of law. At its heart was the belief that children should be treated differently from adults. This court was to provide "individualized justice," tailoring rehabilitative rather

than punitive remedies that recognized the individual needs of each child. To further the court's rehabilitative promise, court-administered services such as probation and mental health evaluations were established to provide judges with information with which to make judgements as well as oversee implementation of orders.

By the 1930's, Family Courts had paid probation staff and, often, court-annexed mental health evaluation services. Some courts actually provided direct, ongoing services, such as mental health treatment, though the development of such services was limited due to the power of voluntary sectarian child care agencies. In this period, a new service was developed in New York City, the Bureau of Adjustment, that sought to divert cases from the court and direct children to services that met their needs. Expansion of various court-annexed services further fueled the debate about the court's role, with reformers at different periods calling for location of these services in the public schools or other agencies outside of the court.

The continuing debate on the role of the court reached a crescendo in the 1950's when many questioned whether the judges' role should be limited to adjudication rather than disposition. During this period, a number of proposals were developed to delegate dispositional responsibility to other entities including a Foster Care Commission to review cases and an agency called the Family Court Social Adjustment Agency that would administer such services such as the investigation and supervision role of probation as well as provide counseling, treatment and other rehabilitative services. The development of non-judicial or administrative agencies to fulfill rehabilitative functions was consistent with innovation abroad, particularly in Great Britain and Norway.

By the early 1960's concern about due process re-framed the debate. The Family Court Act of 1962 embraced the view of the court as a court of law governed by due process and tacitly acknowledged the limitations of its original rehabilitative orientation. It also ended discussion of severing or delegating the court's functions. Over time, the court's role became more purely judicial, more passive and less able to fashion individual remedies. Ironically, over the next twenty years, this narrowing of the scope and nature of the court's review occurred at a time when state and federal law increased the jurisdiction of the court by requiring it to review virtually all cases of children in foster care. This gradual diminution of the court's role into a largely passive, supervisory body was coupled with a general disregard of court-connected services. The availability of services such as probation and mental health evaluation diminished. With the increased requirements of multiple reviews, even courts that sought to retain the original rehabilitative mission found it harder and harder to achieve that goal. As former judge Justine Wise Polier noted, the judges and the court became more and more "distant from the children and families," less able to shape and insure the provision of dispositional remedies.

## **Conclusion**

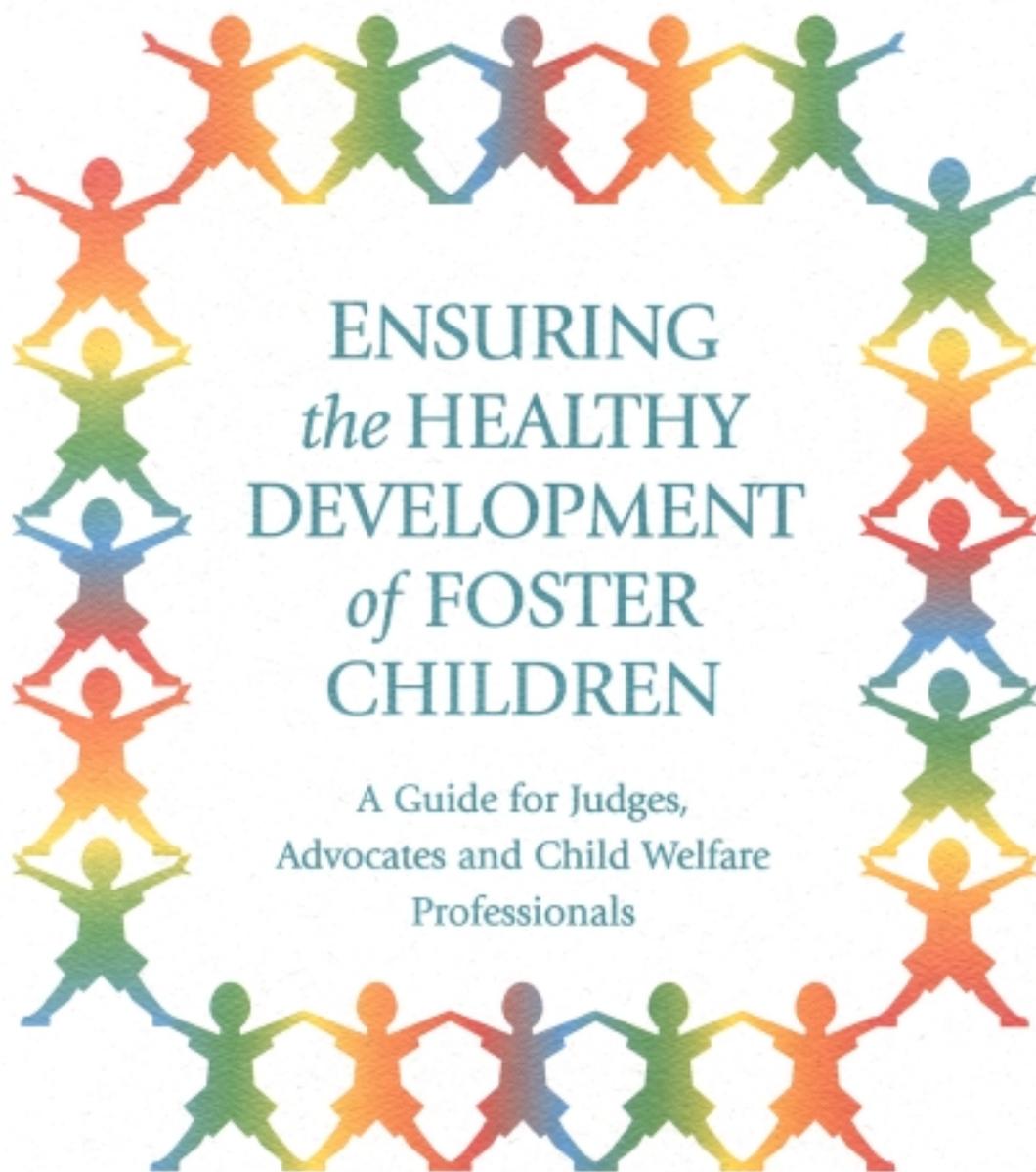
A review of the substantial body of research produced in connection with the Court Improvement Project presents an interesting picture. First, many of the problems the assessment identified are resolved by innovations developed by the benchmark courts.

Second, the benchmarks and context research are mirror images of each other in that the original goal of the Family Court — to provide “individualized justice” for children — is achieved in those reformed courts. The benchmark courts have a clear vision of an activist, not distant, court, fully engaged in insuring permanency for children. They accomplish this with several common elements that, taken together, address the critical problems of New York. By developing effective mechanisms for communication and cooperation between the courts and social services agencies and by assuming a leadership role for the court, they achieve several positive outcomes. Information about individual children is available enabling the court to shape individual orders, and information about community service needs facilitates the development of new and needed services. Both of these elements help to insure compliance with court orders.

In addition, the benchmark courts have developed non-adversarial alternative dispute resolution mechanisms. These non-judicial efforts have resulted in better communication among the parties and more timely resolution of cases, thereby addressing the enormous problem of delay as well as providing a forum for developing better plans or remedies. Finally, each of the benchmark courts has staff or other resources dedicated to assuring smooth court operations by facilitating the gathering of information and providing follow-up to assure compliance with court orders. This enables the court to achieve individualized justice for children.

In New York State, the role of the court has been blurred and the court has lost its historic mission. That mission, shaped at the turn of the century and refined by the Family Court Act, calls for individualized justice for children within the framework of due process. It is an activist court, not a passive one; it is a court unlike other courts of law. In the 21st century, the Family Court should recapture that historic mission by adopting and adapting the reform elements that the benchmark courts are testing.

## APPENDIX B



ENSURING  
*the* HEALTHY  
DEVELOPMENT  
*of* FOSTER  
CHILDREN

A Guide for Judges,  
Advocates and Child Welfare  
Professionals

New York State Permanent Judicial Commission on Justice for Children



Dear Reader,

The Permanent Judicial Commission on Justice for Children was established to address the problems of children whose lives and life chances are affected by New York State's courts. Our membership includes not only judges and advocates but also physicians, social workers, legislators, and state and local officials. During the past eight years, the Commission has undertaken several reform initiatives that have enhanced the lives of New York's children, including improving access to early intervention services for infants and toddlers with disabilities and establishing the nation's first statewide system of children's centers in the courts.

In 1994, the Court of Appeals designated the Commission to implement the State Court Improvement Project, a federally funded effort to improve outcomes in child welfare proceedings. As part of this initiative, the Commission found that many foster children had serious health needs that could compromise their healthy development and efforts to secure a permanent home, but that such issues were often neglected during child welfare proceedings.

I am pleased to share this booklet as part of our effort to ensure that at least one person involved in a child welfare case will ask questions about the foster child's basic health needs. While we do not suggest, or expect, that court appearances become medical inquiries, we hope that at some point an opportunity might be found to check these fundamental guideposts. By asking these questions, we can create a climate that spotlights the critical connection between foster





children's healthy development and their prospects for a permanent home. Hopefully the inquiry will ensure that needed services are provided. Where questions expose the inadequacy of resources available to meet the needs, we hope that judicial leadership can help spur new initiatives to ensure the healthy development of every foster child.

We want this booklet to serve as a useful working tool. We have therefore provided the reasons for asking each question, references to expert sources and even left blank back pages so that you can fill in telephone numbers and other information of special importance to you.

Whatever your role in the child welfare system, we hope this booklet helps you in your efforts to promote better outcomes for foster children and their families.

Judith S. Kaye

*Chief Judge of the State of New York*





**W**hether the result of parental neglect or abuse, poverty or other compromising circumstances, children in foster care are at particular risk for a number of chronic and acute medical problems. It is therefore particularly important that children in foster care have access to health care so their chances for healthy development, and their prospects for a stable and permanent home, are not diminished.

The nation's courts are at the front line for addressing the well-being of thousands of children in foster care. We would move closer to achieving the goal of healthy development for every foster child if at least one person involved in the court process—one judge, one lawyer, one law guardian, one Court Appointed Special Advocate (CASA)—asked questions to highlight that child's health needs and identify gaps in services. This booklet provides a checklist to assist judges, advocates and child welfare professionals in identifying foster children's health needs and the services that can address them.

### **The Scope of the Problem**

Study after study reveals that foster children have far more fragile health than other children and are far less likely to receive the health care that can improve their lives. Foster children have health needs similar to those of all children, requiring well-child health care, immunizations and treatment of childhood illnesses. But many foster children have additional health problems associated with poverty—low birthweight, increased risk of lead poisoning, malnutrition. Many foster children face further health risks specifically linked to parental neglect, including maternal substance abuse,



physical or sexual abuse and parental mental illness. Researchers have found that children with two or more identified risk factors are four times more likely than other children to develop social, educational and health problems. On average, foster children have more than fourteen risk factors. Not surprisingly, foster children have high rates of acute and chronic medical problems, developmental delays, educational difficulties and extensive behavioral and mental health problems.

While at high risk for health problems, foster children too often lack the most fundamental resource for assuring quality health care—a lasting relationship with a caring adult who has been able to observe their daily development over time, advocate on their behalf, and consent to evaluations and services. Bureaucratic obstacles can exacerbate the problem: multiple child welfare workers, multiple medical providers, incomplete documentation of services and lack of access to care.

The statistics paint a picture that cries out for a response. Approximately eighty percent of foster children have at least one chronic medical condition, with nearly one-quarter of these children having three or more chronic problems. Half of all children in the child welfare system—perhaps even more—have developmental delays and mental health problems severe enough to warrant clinical intervention. And yet, in a study of young foster children in three urban centers, the U.S. General Accounting Office found that twelve percent of the children received no routine health care, thirty-four percent received no immunizations and thirty-two percent continued to have at least one unmet health need after placement.



Lack of attention to foster children's health needs compromises their healthy development. It can also create additional stresses that may disrupt stable placements. Addressing foster children's health needs early on thus has a number of benefits: it can reverse bleak prognoses, strengthen families and enhance permanency.

### **A Checklist for the Healthy Development of Foster Children**

Every court proceeding presents an opportunity to inquire about a child's health needs. Judges can encourage advocates and child welfare professionals to spotlight a child's healthy development as an essential component of case review and permanency planning. The following are key questions that can elicit important information. Each question is accompanied by an explanation of its relevance to a foster child's healthy development.

The checklist is consistent with the national standards for health care for children as outlined in the federal Medicaid law through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions. The checklist also suggests questions based on more stringent standards of health care that specifically address foster children's unique health needs as mandated under New York State law and as recommended by the national American Academy of Pediatrics, the New York State (District II) American Academy of Pediatrics and the Child Welfare League of America.



## Checklist for the Healthy Development of Foster Children

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



## QUESTIONS *and* COMMENTARY

### 1. Has the child received a comprehensive health assessment since entering foster care?

Because children are likely to enter foster care as a result of abuse, neglect, homelessness, poverty and parental substance abuse or mental illness, all foster children should receive a comprehensive examination shortly after placement that addresses all aspects of a child's functioning. A comprehensive assessment can establish a child's health status baseline, enable the child to catch up on immunizations if necessary, and identify the need for further screening, treatment and referral to specialists. A pediatrician or family physician knowledgeable about the health care problems of foster children should perform the examination.

Ensuring the healthy development of foster children requires that they receive quality medical care. Quality health care for foster children includes comprehensive, coordinated, continuous, family-supportive care. Coordinated, continuous care requires that one person be identified as responsible for overseeing the child's care across systems—child welfare, early childhood, early intervention, education, medical, mental health. Family-supportive care requires sharing the child's health information with the child's caregivers and providing education and training programs to support families in their ongoing care of the child.

The Child Welfare League of America and the National and New York State (District II) American Academy of Pediatrics recommend a comprehensive developmental, educational, medical and mental health assessment for every child entering foster care to identify problems that might affect a child's placement. New York State administrative directive 90-ADM-21 includes standards from the federal EPSDT program, and also requires a comprehensive medical examination within thirty days of placement.



Medicaid covers health costs for foster children. But as children move in and out of the child welfare system, or are discharged from foster care, they may lose their Medicaid eligibility and thus their access to health care. Asking questions about a child's eligibility for Medicaid or the federally-funded State Children's Health Insurance Program (known in New York as "Child Health Plus") at this juncture can ensure continuous health coverage and care.

The New York State (District II) American Academy of Pediatrics recommends that every child in foster care have a "medical home" where health care is provided by a consistent practitioner knowledgeable about children in foster care.

## **2. Are the child's immunizations complete and up-to-date for his or her age?**

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

The American Academy of Pediatrics publishes an immunization schedule for all children and recommends that immunizations for Hepatitis B, Polio, Measles, Mumps, Rubella, Pertussis, Diphtheria, Tetanus, Haemophilus Influenzae Type B, Chicken pox and Rotavirus begin at two months of age, with follow-up at specific intervals thereafter.



### 3. Has the child received hearing and vision screening?

Undetected hearing loss during infancy and early childhood interferes with the development of speech and language skills and can have harmful effects on overall development.

Hearing loss during early childhood can result from childhood diseases, significant head trauma, environmental factors such as excessive noise exposure

and insufficient attention paid to health problems that may affect hearing. Studies reveal that seventy percent of children with hearing impairments are initially referred for assessment by their parents. Because foster children often lack a consistent caregiver who can observe their development, they should receive ongoing evaluation of hearing, speech and language development at routine child health visits.

Vision screening is an essential part of preventative health care for children. Early detection and treatment increase the likelihood that a child's vision will develop normally and, if necessary, that the child receive treatment and corrective devices.

The New York State (District II) American Academy of Pediatrics recommends ongoing surveillance throughout early childhood for hearing and language development.

The American Academy of Ophthalmology and the American Academy of Pediatrics recommend that children be screened for eye problems in the newborn nursery, at each well-baby visit during the first six months of life, at age three, then annually thereafter.

### 4. Has the child received screening for lead exposure?

Children who are young, low-income and have poor access to health care are particularly susceptible to the harmful effects of



lead poisoning. Ingested or inhaled lead can damage a child's brain, kidneys and blood-forming organs. Children who are lead-poisoned may have behavioral and developmental problems. According to the Centers for Disease Control and Prevention, however, lead poisoning is one of the most preventable pediatric health problems today. Screening is important to ensure that poisoned children are identified and treated and their home environment remediated.

The Centers for Disease Control and Prevention recommends universal lead poisoning screening beginning at nine months of age for children living in communities with high-risk lead exposure and targeted screening based on risk assessment during pediatric visits for all other children.

#### 5. Has the child received regular dental services?

Preventative dentistry means more than a beautiful smile for a child. Children with healthy mouths gain more nutrients from the

The American Academy of Pediatric Dentistry recommends that before the age of one, a child's basic dental care can be addressed during regular well-child visits with a primary care provider, with referral to a dentist as deemed medically necessary. For children older than one year of age, the Academy recommends a checkup at least twice a year with a dental professional. The American Academy of Pediatrics recommends that all children be referred to their first dental evaluation by age three.

foods they eat, learn to speak more easily, and have a better chance of achieving good health. Early dental care also prevents decay in primary teeth (baby teeth) which is currently at epidemic proportions in some U.S. populations and prevalent among foster children.



## 6. Has the child received screening for communicable diseases?

The circumstances associated with placement in foster care—such as prenatal drug exposure, poverty, poor housing conditions and inadequate access to health care—can increase a child’s risk of exposure to communicable diseases such as HIV/AIDS, congenital syphilis, hepatitis and tuberculosis. A General Accounting Office study found that seventy-eight percent of foster children were at high risk

The American Academy of Pediatrics recommends that all HIV-exposed infants be tested for HIV at birth, at one to two months of age, and again at four months. If these tests are negative, the child should be tested at twelve months of age or older to document the disappearance of HIV antibody. New York State regulations require universal newborn screening for HIV at birth and assessment of risk for HIV infection within five days of entry into foster care, at each case review and at each preventative health care visit.

for HIV, but only nine percent had been tested for the virus. Early identification of HIV is critical to enhance the lives of HIV-infected children, ensure that HIV-infected children receive modified immunizations to prevent adverse reactions and minimize their exposure to infectious illnesses such as measles and chicken pox. Adolescent foster children also require risk assessments for HIV exposure. Sexually active adolescents have the highest rates of reported sexually transmitted diseases, with increasing numbers of AIDS cases reported among young adults.

The American Academy of Pediatrics recommends assessment for risk of exposure to tuberculosis in high-risk areas and that all children with increased risk should receive tuberculin skin testing.

Tuberculosis is an airborne disease that primarily affects the lungs. Children become infected with tuberculosis mainly through exposure to infected adults in their home environment. One recent study of foster



children in San Francisco found that among foster children ages thirteen to eighteen, twelve percent had positive tuberculin skin tests. Tuberculosis in infants and children younger than four years of age is much more likely to spread through the bloodstream to the entire body, a dangerous condition that affects a child's central nervous system.

**7. Has the child received a developmental screening by a provider with experience in child development?**

Young foster children often exhibit substantial delays in cognition, language and behavior. A study conducted by the Center for Vulnerable Children in Oakland, California found that over eighty percent of all the foster children in the study exhibited developmental, emotional or behavioral problems, with over fifty percent

The American Academy of Pediatrics recommends that all infants and children be screened for developmental disabilities to identify those children who may need a more comprehensive evaluation. The New York State (District II) American Academy of Pediatrics recommends formal, comprehensive developmental and educational assessment for all children entering foster care.

of the children under age one having growth and motor delays and seventy-five percent of children ages three to five having significant delays in behavior, cognition and speech. Powerful new research tools confirm that early intervention is most effective during a child's first three years of life, when the brain develops the foundations for all developmental domains. Early identification of developmental health problems also can help caregivers better understand and address the child's needs. Developmental evaluations provide young children who have identified delays with access to two federal entitlement programs: the Early Intervention



Program for children under age three, and the Preschool Grants Program for children with disabilities between the ages of three to five.

Children from birth to age three who have a developmental delay or a condition with a high probability of resulting in developmental delay are eligible for early intervention services under Federal and State law. Early Intervention provides an array of services, including hearing and vision screening, occupational, speech and physical therapy and special instruction for the child as well as family support services to enable parents to enhance their child's development. The services are enumerated in an Individualized Family Services Plan developed collaboratively by the family, the evaluator and early intervention professionals.

Children three through five who have a disability in one or more domains—physical development, hearing and vision, learning, speech and language, social and emotional development, and self-help skills that affect their ability to learn—can receive special education and related services under the federal Preschool Grants Program. Children older than five may be evaluated for school-age special education services.

Foster children may be referred for early intervention and special education services by parents as well as health care and social service workers. Since these programs are premised on active parent involvement, they require parental consent for services. The law, however, provides a broad definition of "parent" that includes the birth or adoptive parent and a legal guardian or relative acting as a parent, or in some circumstances the foster parent with a long-term relationship with a child. Where no parent is willing or able to participate, the early intervention or local school district official may appoint a surrogate parent whose authority is limited to making educational decisions for the child.



## 8. Has the child received mental health screening?

Children enter foster care with adverse life experiences—family violence, neglect, exposure to parental substance abuse or serious mental illness, homelessness, chronic poverty. Once children are placed in foster care, they must cope with the separation and loss of their family members and the uncertainty of out-of-home care. The cumulative effects of these experiences can create emotional health issues that warrant an initial brief period of mental health counseling or further evaluation by a mental health professional.

Children exhibiting certain behaviors may also signal a need for a mental health assessment and neurological and educational evaluations. Many of the symptoms associated with child and adolescent emotional and behavioral health problems may be alleviated if addressed early. The American Academy of Child and Adolescent Psychiatry recommends assessments for infants who exhibit excessive fussiness, feeding and sleeping problems and failure to thrive. For toddlers and older children, the Academy recommends assessments for children exhibiting aggressive, defiant, impulsive and hyperactive behaviors, withdrawal,

The New York State (District II) American Academy of Pediatrics and the Child Welfare League of America recommend that every child in foster care receive a mental health assessment by a mental health professional shortly after placement in foster care and that children with identified problems be further evaluated for diagnosis and treatment.

extreme sadness and sleep or eating disorders. To promote and facilitate permanency, children identified with mental health problems should receive care from a mental health professional who can develop a treatment plan to strengthen the child's emotional and behavioral well-being and the child's relationship with caregivers. Services may include clinical intervention, home visiting, early care and education, early intervention services and



caregiver support for young children. Services for older children may include psychiatric consultation, clinical intervention, residential treatment and therapeutic foster care.

### **9. Is the young child enrolled in an early childhood program?**

Quality early childhood programs nurture children, protect their health and safety, and help to ensure that they are ready for school. Decades of research demonstrate that early education has a positive impact on school and life achievement. Early childhood programs also provide much needed support for caregivers. For many foster children, early childhood professionals may be the only adults, other than their caregivers, with daily opportunities to observe and impact their development.

In addition to the Early Intervention and Preschool Special Education Programs mentioned above, many foster children are eligible for early childhood programs such as Head Start and publicly funded pre-kindergarten programs for four-year-olds.

The American Academy of Pediatrics recommends universal access to good quality child care and education for children from birth to age five.

### **10. Has the adolescent child received information about healthy development?**

Adolescent foster children have high risk of unintended pregnancy, HIV exposure, sexually transmitted diseases and substance abuse.

Healthy development for adolescent foster children also requires that they receive information about mental health services, educational and vocational training opportunities, and programs that



The American Academy of Obstetrics and Gynecology and the American Academy of Pediatrics recommends that health care providers evaluate and counsel all adolescents on human reproduction and sexuality, high-risk behaviors and communicable diseases. New York law requires that all foster children older than age twelve be informed about the availability of family planning services.

teach daily living skills. For example, literacy experts and health care providers recognize that individuals with low literacy skills are at risk for developing health, learning and behavioral problems. Adolescent foster children with poor literacy skills may not understand materials distributed by health care providers to inform them about preventative health

measures and managing health problems. Additionally, older children entering the foster care system should receive a complete educational evaluation to identify undetected neurological damage and learning disabilities that can cause behavioral problems.

All adolescents who are discharged from foster care need information about continuous access to health coverage and care. Some adolescents may retain their Medicaid eligibility while adolescents who are under age nineteen and ineligible for Medicaid can apply for the federally-subsidized State Children's Health Insurance Program (such as New York's Child Health Plus).



Foster children deserve both a safe haven and the promise of healthy development. A child's time in the foster care system provides an opportunity to connect the child to programs established by Federal and State laws for enhancing healthy outcomes for foster children. By asking basic questions about foster children's health, judges, advocates and child welfare professionals can safeguard their right to health care and identify gaps in services that can enhance their well-being and strengthen their prospects for a stable and permanent home.



## PERMANENT JUDICIAL COMMISSION ON JUSTICE FOR CHILDREN

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## NOTES

## APPENDIX C

**Permanent Judicial Commission on Justice for Children**  
**Publications**

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

**“The Promise of Early Intervention for Foster Children and their Families,”**  
Interdisciplinary Report on At-Risk Children & Families, vol. 2, number 5 (November/December (1999)) Sheryl Dicker

**“Safeguarding Foster Children's Rights to Health Services,”** Children’s Rights Journal, vol. 20, number 2 (Summer (2000)) Sheryl Dicker & Elysa Gordon.

**“Harnessing the Hidden Influence of the Courts to Enhance the Healthy Development of Foster Children,”** Protecting Children, vol. 16, number 1 (2000) Sheryl Dicker & Elysa Gordon.

**“Connecting Healthy Development and Permanency: A Pivotal Role for Child Welfare Professionals,”** Permanency Planning Today (March (2000)) Sheryl Dicker & Elysa Gordon.

**“Early Intervention and Early Childhood Programs: Essential Tools For Child Welfare Advocacy,”** Clearinghouse Review (March/April (2001)) Sheryl Dicker & Elysa Gordon

**“Foster and Adoptive Parents: Essential Advocates for the Healthy Development of Children in foster Care,”** Coalition Voice, New York Citizen’s Coalition for Children (Spring (2001)) Sheryl Dicker & Elysa Gordon

**“Improving the Odds: Promoting Health, Developmental and Emotional Well-Being of Young Children in Foster Care,”** forthcoming publication, National Center on Children in Poverty (2001) Sheryl Dicker, Elysa Gordon & Jane Knitzer

## APPENDIX D

**Permanent Judicial Commission on Justice for Children**  
**Trainings**

- “Foster Children and Early Intervention” Westchester Foster Parents’ Association (3/01)
- “Ensuring the Healthy Development of Children in Foster Care: Challenge to the Medical and Legal Communities” Children's Hospital of Philadelphia Grand Rounds Presentation (2/01)
- “Promoting the Health and Development of Children in Foster Care” Dutchess County Legislature Citizen’s Advisory Committee on Foster Care and Adoption (1/01)
- “Connecting Children in Foster Care to Head Start and Early Childhood Programs: A Vital Link to Permanency” Head Start and Early Childhood Birth to Three Institute (1/01)
- “The Hidden Influence of the Court on the Healthy Development of Foster Children” National Conference, American Public Health Association (11/00)
- “Harnessing Early Intervention and Head Start Services to Meet the Needs of Young Foster Children and their Caregivers” NYS-CASA Cross-Systems Training Seminar Focusing on Children in Foster Care (10/00)
- “Integrating Best Practices and Facilitating Change” County-by-County, New York City Judicial Workshop sponsored by the Commission and the National Council of Juvenile and Family Court Judges (10/00)
- “The Health Status of Foster Children” U.S. Department of Health and Human Services Region II Hudson Valley Children’s Health Forum (9/00)
- “Strategies for Enhancing the Healthy Development of Foster Children” Arkansas Court Improvement Conference (9/00)
- “Ensuring the Healthy Development of Foster Children” Administration for Children and Families, Region II Child Welfare Conference (7/00)
- “Court Strategies for Enhancing the Healthy Development of Foster Children” New York Judges’ Seminar (7/00)
- Presentation by Dr. Judith Silver on the Special Health and Developmental Needs of Foster Children Aged Zero to Three, sponsored by the Commission for New York City Newly Appointed Judges (6/00)
- “Connecting the Healthy Development of Foster Children to Permanency” National Conference, Court Appointed Special Advocates (6/00).
- “New York’s Court Improvement Projects” New York State’s Citizen’s Coalition for Children Adoption 2000 Conference (5/00)
- Presentation by Margaret Burt on ASFA Implementation, sponsored by the Commission for the New York City Judges (5/00)
- “Ensuring the Healthy Development of Foster Children” Suffolk County Family Drug Treatment Court (4/00)
- “Fostering Permanency: A Spotlight on the Healthy Development of Foster Children” Children’s Defense Fund Annual National Conference (3/00)

- “Healthy Development Initiative” President's Committee on Mental Retardation Conference on Poverty and Disability (2/00)
- Court Appointed Special Advocates Training, New York City, Erie County, Westchester County and Annual Program Directors’ Meetings (2000-2001)
- “The Hidden Influence on the Healthy Development of Foster Children: Our Nation's Courts” National Training Institute, Zero to Three (12/99).
- “Ensuring Healthy Development for the County's Most Vulnerable Children: The Challenge and Promise of a Child-Centered Approach for Foster Children from Birth to Age 5 ” National Conference, National Association for the Education of Young Children (11/99)
- “Ten Questions: How Courts, CASAs, and Other Players Can Play a Role in Ensuring the Healthy Development of Foster Children” NYS-CASA Training Seminar (10/99)
- “New York Court Improvement Project” U.S. Department of Health and Human Services Region II Conference (9/99)
- “The Promise of Early Intervention for Foster Children and their Families” New York Public Welfare Association Summer Conference (7/99)
- “Advocating for the Health of Children in Foster Care” Practicing Law Institute’s Children’s Law Institute (7/99)
- Presentation to the New York State Legislative Women’s Caucus on the health status of foster children and New York’s Court Improvement Project (5/99)
- Court Improvement and Healthy Development of Foster Children New York City Model Court Site Visit, sponsored by the Commission and the National Council of Juvenile and Family Court Judges (4/99)
- “The New Face of Foster Care: Young Children with Developmental Delays” U.S. Department of Health and Human Services Conference on Child Welfare and Court Improvement (4/99)
- “Court Improvement Project: Phase II Implementation and Reform” New York Public Welfare Association 130<sup>th</sup> Annual Winter Conference (2/99)
- “Planning for ASFA Implementation” Panel Convened by Fordham University (2/99)
- “Quality Health Care for Foster Children: Problems and Potential” Hunter Lecture, Montefiore Medical Center (12/98).
- “Necessary Partners for Permanency: Early Intervention, Special Education and Developmental Disabilities” and related workshops, National Conference, Association of Interstate Adoption Compact Administrators (10/98).