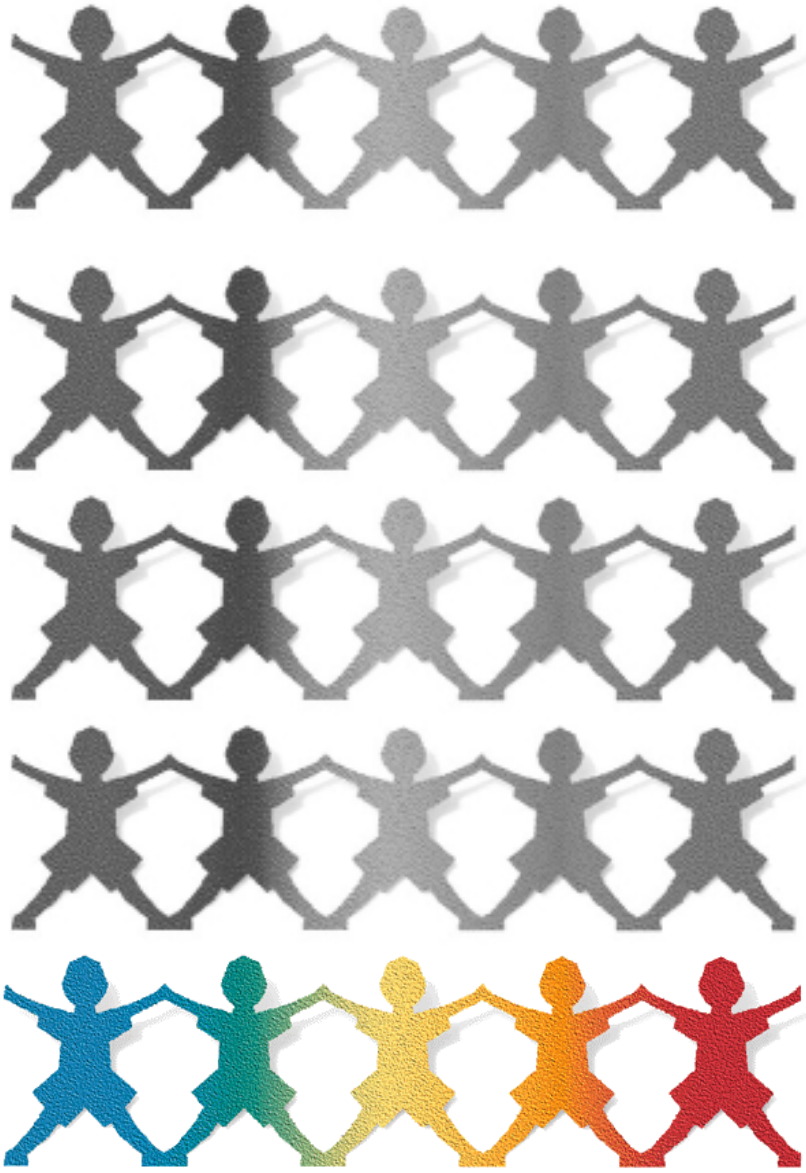

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The Permanent Judicial Commission on Justice for Children

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Our nation's courts are at the front line for addressing the well-being of the over 150,000 children under age five who spend days, weeks, or more likely, years in foster care. All of these children are placed in foster care by court order due to allegations of abuse or neglect. While research nationwide reveals that the vast majority of foster children have serious health conditions and disability, courts rarely receive information about these problems and there exists little understanding of the court's power and potential for enhancing foster children's health and development. As the central decisionmaker in every child protective case, the court requires information about a child's health, defined broadly to include their physical, developmental, and emotional needs, and the parent's capacity to meet those needs. This article spotlights the hidden influence in the lives of foster children exerted by our nation's courts and describes strategies developed by the Permanent Judicial Commission on Justice for Children to harness the power of the court by focusing attention on the healthy development of foster children.

The Role of the Court

All foster children in the United States have a court order approving placement in foster care. The court must review the child's needs and the parent's ability to meet those needs at every child protective hearing. This critical role was established by Congress in 1980 by the passage of the Adoption Assistance and Child Welfare Act (PL 96-272) and reinforced by the Adoption and Safe Families Act of 1997 (ASFA).

PL 96-272 was premised on the notion that many children were being placed in care unnecessarily and that most children could avoid placement in foster care or return home safely with appropriate family support and services. The law was designed to preserve families and to promote permanency planning. It required States to develop preventive and reunification programs, necessitated the development of case plans for services for children and parents and required child welfare agencies to exercise "reasonable efforts" by providing services initially to prevent placment and after placment to reunify families. Most significantly, the law defined the role of the court as the central decisionmaker and monitor by requiring courts to approve all foster care placements, to find "reasonable efforts" at every court proceeding and to review cases within 18 months of placement.

While the foster care caseload declined by half in the early eighties following the passage of PL 96-272, the foster care population more than doubled from the mid-eighties to the nineties due to the epidemics of AIDS, crack and increased poverty. Very young children comprised a large share of the new admissions to foster care. The sheer volume of cases coupled with the complex needs of these children and their families resulted in children, particularly the youngest children, spending their childhood in foster care. This new reality made the task of ensuring "reasonable efforts" toward reunification more challenging.

In 1997, Congress passed ASFA and signaled a pendulum swing away from the emphasis on family preservation and towards permanency and adoption (P.L. 105-89). ASFA strengthened the court's role as central and ultimate decisionmaker in child welfare proceedings. ASFA also makes clear that a child's health and safety is a

paramount consideration in every child protective proceeding and that courts have broad authority to address health needs. ASFA allows the court to find that "reasonable efforts" toward reunification are not necessary in a specific situations such as where the parent has subjected the child to aggravated circumstances including abandonment, torture, chronic abuse and sexual abuse or where the parent has committed murder, voluntary manslaughter or felony assault that resulted in serious injury to the child or if the parental rights of the parent to a sibling have been terminated voluntarily. ASFA tightens the timeframes for decisionmaking, requiring permanency planning hearings 12 months after placement and within 30 days of placement where the court determines that reasonable efforts to reunify are not required. ASFA also requires that termination of parental rights petitions be filed when a child is in care for 15 out of 22 months unless compelling reasons exist such as placement with a relative, an adolescent who objects to adoption or failure to provide timely services to parents as enumerated in the case plan. As a result, courts must keep a tighter rein on cases and have access to information that can identify a child and family's needs and barriers to permanency more quickly. Finally, ASFA provides fiscal incentives for states to increase adoptions.

The newly issued federal ASFA regulations specifically hold States accountable for providing services to address the "safety, permanency and well-being of children and families." (45 C.F.R. Part 1357 §1355.33 b (2)) States must ensure that:

- "families have enhanced capacity to provide for their children's needs;
- children receive appropriate services to meet their educational needs; and
- children receive adequate services to meet their physical and mental health needs." (45 C.F.R. Part 1357 §1355.34 b(1)(iii))

The Court Process

The process for removing a child from home and into foster care underscores the court's role as central decisionmaker and highlights the critical junctures where information about a child's well-being can be brought to the attention of the court. When child protective services (CPS) receives a report alleging abuse or neglect, typically they will investigate the allegation within 24 to 72 hours to determine whether the child is at imminent risk of harm. If CPS determines that the child is at imminent risk, they can remove the child with an emergency court approval, or in some circumstances with court approval after the removal. In all instances, a court order must be obtained for the child to remain in foster care. The court will consider whether the child can be returned home safely and the types of supports needed by the family. If the court determines that the child cannot return home, it can order that the child be placed with a relative if available, order supervised visitation with the parents and order assessments, evaluations or reports of the child and family to be provided to the court by the next hearing date. This next court appearance often does not occur for 30 to 60 days during which time the child remains in foster care.

The next step is the adjudication hearing where the court determines the merits of the abuse and neglect allegations. Often, adjudication is delayed due to lack of information. If the court finds that the allegations are true or if the parent admits the abuse or neglect, the court generally holds an initial disposition hearing thirty days thereafter. At the disposition hearing, the court reviews case service plans, reviews

visitation arrangements and orders services. By this time, a child may be in foster care for ninety days and often longer. The disposition hearing is a critical juncture for the court to receive and consider information about the health and development needs of the child and the biological and foster parent's ability to meet those needs. In addition to the disposition hearing, courts are required to conduct periodic reviews of the placement and the parties' compliance with court orders. At every hearing, the court must make a "reasonable efforts" finding and every court review is an additional opportunity for court actors and other professionals to bring vital information about the child's well-being to the attention of the court.

Under ASFA, if a child has been in foster care for 15 out of the most recent 22 months, state agencies must file petitions to terminate parental rights (TPR) unless compelling circumstances exist. The standard for proving termination is the high "by clear and convincing evidence" standard and the grounds on which a court can terminate parental rights are narrow. Examples of circumstances that can terminate parental rights include abandonment, parental mental incapacity, severe or repeated child abuse or permanent neglect. While ASFA requires that a petition must be filed at a specific point, it does not require a specific timeframe for holding the TPR hearing. Often, the petition is contested and even appealed and the process can span years of a child's time in foster care. Once a court order is final for the termination of parental rights, the child is freed for adoption and a petition for adoption can be filed. All too often, the adoption hearing is delayed as the child remains in foster care. Again, it is essential that the court receive ongoing information about the child's health needs throughout the child's time in foster

care. Courts also need information about the child's access to health services after discharge from foster care.

The Permanent Judicial Commission on Justice for Children

The Permanent Judicial Commission on Justice for Children, a multidisciplinary Commission chaired by New York State's Chief Judge Judith Kaye and the nation's only children's commission based in the judiciary, since 1991 has focused its attention on the needs of young children whose lives and life chances are affected by the court system. In order to identify specific doable tasks to address the problems of young children who pass through the courts, the Commission embarked on a series of key informant interviews of experts around our state and nation. The informants identified children spending idle time waiting in our state's courthouses precluding parents from participating in court proceedings, impeding efficient administration of justice and jeopardizing the well-being of the children. The informants also reported that the children involved in court proceedings were not only getting younger, they were showing greater signs of developmental delays, particularly among the young children in foster care. Thus, the Commission's agenda was set for the next decade - - to make the environment of the courthouse more hospitable to children and to address the needs of young foster children in court proceedings.

The Children's Centers Program

The Children's Centers program provides a safe haven for children in our courthouses where they can be constructively engaged in a quality early childhood program while their caregivers attend to court business. The Centers are also a site to connect children and families to vital services such as Head Start, WIC and Child Health Plus. For many families, the Centers are the only place to connect children with these

services until a child begins school. Twenty-six Centers operate in New York's courts and served over 40,000 children last year.

The Court Improvement Project

In 1994, the Commission was given the opportunity to tackle the challenging problem of addressing the needs of foster children. The Commission was designated by New York's Court of Appeals, New York's highest state court, to spearhead the federal State Court Improvement Project (CIP). The CIP's mandate is to assess and improve proceedings related to foster care, termination of parental rights and adoption. During the first phase of this project, the Commission conducted a series of research endeavors. First, we reviewed all available social sciences and court data to construct a profile of New York State's foster care population. Our research found that the foster care population was disproportionately young -- almost 40 percent of the admissions were children under age five and 25 percent were under age two. These young children were likely to enter foster care and remain in care longer than older children. Our findings were consistent with national data revealing that 40 percent of foster children admitted to care are under age five and one-third are under age two.

The identification of the disproportionate number of very young children entering foster care shaped our next research effort -- a targeted project that conducted both court observations and reviewed case files for over 400 foster children in five counties in New York State, 300 of whom entered foster care in the first year of life. Through this research, we found ample evidence that scant attention was paid to the health and developmental needs of children, particularly young foster children, in court proceedings and that court orders seldom contained specifications for services to young children. All

too often, those involved in the court process focused on children's safety, overlooking the critical link between safety, healthy development and permanency. The Commission responded to these grim findings by developing the Health Care for Foster Children Initiative as an integral component of its court improvement strategies.

The Health Profile of Foster Children

Our research findings were alarming to us because we knew the national research that paints a particularly grim picture of the health profile of young foster children:

- Approximately 80 percent of foster children have at least one chronic medical illness and 25 percent have three or more chronic medical conditions. (Silver 1999; Halfon 1995)

- Studies nationwide find that at least half of young foster children exhibit developmental delay -- approximately four to five times the rate of developmental delay found among children in the general population. (Jaudes & Shapiro 1999; Takayama 1998)

- Nearly 80 percent of foster children are at-risk for a wide range of physical and developmental health problems related to prenatal exposure to maternal substance abuse. (Halfon 1995)

- Infants and toddlers enter foster care at high risk of prenatal exposure to HIV and tuberculosis. (Rosenfeld 1997)

- Foster children have asthma three times the national average and growth problems twice that found in the general pediatric population. (Blatt & Simms 1997; Halfon 1995)

- Nearly half—perhaps even more—of all children in the child welfare system have mental health problems severe enough to warrant clinical intervention.(Jaudes & Shapiro 1999; Halfon 1995)

- Many young foster children do not receive basic services to enhance their health and development once they are placed in foster care. In a 1995 study of young foster children in three urban centers – Los Angeles, New York City and Philadelphia – the U.S. General Accounting Office (GAO) found that 12 percent of the children received no routine health care, 34 percent received no immunizations and 32 percent continued to have at least unmet health need after placement. The GAO found that 78 percent of the children were at high risk for HIV, but only nine percent had been tested for the virus. (GAO 1995)

- There was no national information on how many foster children were receiving the critical federal entitlement Early Intervention program for infants and toddlers with disabilities.

The Legal Right of Foster Children to Receive Health Services

The Commission found the lack of attention to the health needs of foster children and the gaps in services disturbing because foster children have a legal entitlement to receive health care under federal law and many are eligible to participate in early intervention and early childhood programs. Existing federal and state laws and programs provide a pathway to enhance the healthy development of foster children and to assist their families.

- Medicaid and EPSDT

In all states, foster children are eligible for Medicaid. All children under the age of twenty-one enrolled in Medicaid are entitled under federal law to receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services (42 U.S.C.A. §1396). EPSDT is a comprehensive benefits package that requires medical, vision, hearing and dental screens to be performed at distinct intervals that meet current standards of pediatric and adolescent medical and dental care. The medical screen must include at least five components: a comprehensive health and developmental history assessing both physical and mental health; a comprehensive unclothed physical exam; immunizations; laboratory tests including testing for high-risk exposure to lead; and health education. EPSDT requires state Medicaid agencies to assure the provision of necessary treatment for both physical and mental health conditions to the extent required by the needs of an individual child.

- Early Intervention

Children from birth to age three who have a developmental delay or a condition with a high probability of resulting in developmental delay are entitled to early intervention services under Federal and State law (34 C.F.R. 303). Early Intervention provides an array of services, including hearing and vision screening, occupational, speech and physical therapy and special instruction for the child. The early intervention program is premised on a large body of research that demonstrates the importance of providing services to the family to enhance the child's development. These services include parent training and counseling, respite care, home visits and service coordination. Both biological and foster parents can benefit from Early Intervention services which are enumerated in an Individualized Family Services Plan (IFSP) developed collaboratively by the family, the evaluator and early intervention professionals.

- Special Education

Children age 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 (34 C.F.R. Parts 300 and 301).

- Early Childhood Programs

High quality early care and education programs can enhance healthy development for foster children, offer families information and direct services to assist with the problems of parenting and create an additional opportunity for the child to establish a stable relationship with an adult caregiver. Head Start is a federal program that provides comprehensive and developmentally appropriate preschool services for children from low-income families (45 C.F.R. 1304). Like Early Intervention, Head Start is child-focused and family-supportive, making the program a rich resource for foster children and their caregivers. Quality early childhood programs also have a two-generational approach—providing early childhood education for the child and support for the parents. Other federal programs provide funding streams for day care to low-income children including Temporary Assistance to Needy Families, the Social Services Block Grant (Title XX) and the Child Care Development Block Grant.

The Connection Between Healthy Development and Permanency

Additionally, the Commission understood the critical connection between the healthy development of foster children and their prospects for a stable, permanent home. We knew that failing to address their health needs could undermine permanency by thwarting reunification of biological families as well as recruitment and retention of adoptive parents. Research confirms that a caregiver's ability to parent can be undermined by the stress associated with caring for a child with a medical condition or disability. The National Center on Child Abuse and Neglect found that children with disabilities were maltreated twice as often as children without disabilities. The same study reveals that children with disabilities are emotionally neglected three times as often and physically abused and neglected and sexually abused twice as often as maltreated children without disabilities. (National Center on Child Abuse and Neglect 1994)

Parenting a child with health problems or a disability can drain the emotional, financial and physical resources of even the most stable families. For families involved in court proceedings, many who struggle with substance abuse, mental illness and poverty, the presence of medical conditions or disability can compound the stress in their lives. For example, a parent who is abusing drugs may be unable to appropriately cope with the demands of an infant born premature or low birthweight who may be irritable and difficult to calm. The strain of meeting such demands on these fragile families can make it more difficult to manage the daily challenges of parenting, increasing the risk of abuse and neglect, family dissolution or failed placement.

The Kelso case and its subsequent media coverage highlights the stress involved in parenting a child who needs round-the-clock care, even for the most financially stable families. In December 1999, the parents of a severely disabled ten year old were charged with child abandonment after leaving him at a hospital with a note saying they could no longer care for him. The father was the CEO of a multimillion dollar company and the mother was a member of a Pennsylvania state advisory council on developmental disabilities.

While inattention to a foster child's health needs can jeopardize his or her prospects for permanency, early identification and intervention can increase the likelihood of healthy development and family stability. New research on the brain and early childhood experiences reveals that a child's earliest years form the foundation of healthy development. Also emerging from this research is a greater understanding of the influence of the early caregiving and physical environments on the child's development and the impact of the child's behavior on the functioning of the family. To achieve permanency, foster children and their families need services at the earliest possible juncture to enhance the child's healthy development and to support caregivers in their parenting efforts.

Commission Strategies

The Permanent Judicial Commission on Justice for Children developed a multi-pronged initiative to assist courts in identifying the health needs of foster children, to improve the delivery of services to foster children and to highlight the connection between healthy development and permanency. The centerpiece of this strategy is to focus all those involved in the court process on the health and development of foster children. In addition, the Commission is working to educate all professionals working with vulnerable children about foster children's needs and the child welfare and court systems. The Commission has published a booklet, *Ensuring the Healthy Development of Foster Children: A Guide for Judges, Advocates and Child Welfare Professionals*, that provides ten questions to identify a foster child's health needs and gaps in services. Each question in the booklet is consistent with national standards for health care for children as outlined in the federal Medicaid law and EPSDT and as recommended by the American Academy of Pediatrics and the Child Welfare League of America. Additionally, the checklist is a tool to assist states and localities in meeting ASFA requirements to provide services to meet foster children's educational, physical and mental health needs.

Through a broad dissemination strategy, the checklist has been shared with the Court Improvement Projects in all states, all model courts of the National Council of Juvenile and Family Court Judges, all Family Court Judges in New York State, all local Social Services and Health Commissioners, relevant State Commissioners, state legislators, all Early Intervention Officials, all Public Health Nurse Directors, advocates, law guardians, parents' attorneys and child and family services providers. We hope at least one person involved in the court process- - the judge, the lawyer for the child, the lawyer for the parent, the caseworker, the lawyer for the agency, the Court Appointed

Special Advocate volunteer -- in every case asks the following basic questions about the child's health and development:

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?

In most cases the answer to these questions will either be yes or somebody will be impelled to address that basic need. In some instances, if the answer is no, the court will need to order services for the child. Under federal law, the judge has been vested with protecting the health and safety of all foster children and it is his/her job to oversee case plans and their implementation. Furthermore, in almost every state, judges have very broad authority to protect the well-being of children and to issue orders for the services addressed by this checklist. There may be instances where the judge orders the services and they do not exist. Capturing that information is critical too, because it can be the basis for an advocacy strategy on a local or state level to compel the creation of needed services. Additionally, the court's use of the checklist can be a tool to assist States and localities in complying with the new federal ASFA regulations that require States to provide services to meet foster children's educational, physical and mental health needs.

Focusing on the health care needs of foster children in New York has already enhanced child development and bolstered permanency efforts. Judges, lawyers and Court Appointed Special Advocate (CASA) volunteers throughout New York State are

using the checklist at the earliest possible point, even in abandonment proceedings, to identify the needs of young foster children and to shape permanency planning. The Commission has trained all the state CASA directors and they have trained their local volunteers. In Erie and Westchester Counties, CASAs have been specifically assigned to cases of young children in abuse and neglect proceedings. The CASA volunteers are keeping data on the use of the checklist and we are beginning to get information on their use. The initial results have been very encouraging.

- In Westchester, CASAs discovered that a five year old who had been diagnosed by the health care provider as having high blood pressure had not been referred for follow-up diagnosis and treatment. As a result of CASA's efforts, the Westchester Judge entered an order for the child to be seen by a cardiac specialist who is now treating the problem.

- In Erie County, CASAs attended health care visits with a young child who was severely burned. As a result, CASAs were able to share specific information with the court that was incorporated into a court order related to the level of care required by the child and training needed for the child's mother to meet the child's daily medical and emotional needs.

In addition to CASA, the Commission's initiative has uncovered resources throughout the state that can assist courts in obtaining and interpreting information related to the health and development of foster children. In Suffolk County, for example, public health nurses do assessments of all the young children under age three assigned to the Suffolk County Drug Treatment Court. The nurses meet with the Drug Court team on a monthly basis and their involvement has resulted in many referrals for Early Intervention services for these children. The Suffolk County Public Health Nurse Bureau also has developed a program where public health nurses do home visits twice a year to foster children from birth to age 14 to provide physical and developmental screens. In other states, including California and Utah, public health nurses work with local

Departments of Social Services to provide direct services and care coordination to foster children.

Like public health nurses, Early Intervention professionals can be invaluable resources in assisting courts to ensure that young foster children actually obtain needed services. In New York State, for example, all counties are required by public health law to appoint a public official as their Early Intervention official. This person is responsible for making sure eligible children have an evaluation, appointing an initial service coordinator to assist families in understanding their child's multidisciplinary evaluation and developing their IFSP and ensuring that children and their caregivers get the early intervention services listed in their IFSPs. In addition to the initial service coordinator, families choose an ongoing service coordinator to help them obtain the services in the IFSP and coordinate early intervention services with other services needed by the child and family. Some judges in New York State routinely order that every foster children under age three be screened for developmental delays, providing eligible children with vital services and their caregivers with care coordinators.

Conclusion

Courts can be a gateway to services for young foster children. Yet, harnessing the court's power to ensure that young foster children actually obtain services that can enhance their healthy development requires court actors to ask questions about their health needs. At the same time, professionals providing services to foster children in health care, early intervention and early childhood settings must bring the information they have about a foster child to the attention of the court. In doing so, the court can

reach its potential to enhance not only the a foster child's healthy development, but his or her prospects for a stable, permanent home.

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