Zero to Three: Critical Issues for the Juvenile and Family Court

BY JULIE COHEN AND VICTORIA YOUCHA

ABSTRACT

Infants are the fastest growing population in foster care. Without intervention they are at great risk of poor developmental outcomes. Juvenile and family courts have a unique opportunity to make a positive difference in the lives of the babies in their care. This article outlines six critical issues that impact the development of very young children in the child welfare system and recommends strategies that juvenile and family courts can use to address the needs of this most vulnerable population.

INTRODUCTION

A child's first years of life set the stage for all that follows. Future development in key domains—social, emotional, and cognitive—is based on the experiences and relationships formed during these critical years. During these early years, the cognitive, social, and emotional domains of development are "inextricably linked," and the brain undergoes its most dramatic development as children rapidly acquire the ability to think, speak, learn, and reason (Shonkoff & Phillips, 2000). In fact, by age three, roughly 85% of the brain's core structure is formed (Bruner, Goldberg, & Kot, 1999). Relationships and experiences with biological parents, foster parents, caregivers, and teachers during these early years "form the foundation and scaffold on which cognitive, linguistic, emotional, social, and moral development unfold" (Shonkoff & Phillips, 2000, p. 349).

"Neuroscientific research on early brain development says that young children warranting the greatest concern are those growing up in environments, starting before birth, that expose them to abusive and neglectful care" (Shonkoff & Phillips, 2000, p. 217). The developmental impact of child abuse is greatest among the very young. Infants and toddlers are extremely vulnerable to the effects of maltreatment. Its impact on their emotional, developmental, and physical health can have life-long implications if not properly addressed.

These risks become particularly worrisome when coupled with the fact that infants are the fastest growing category of children entering foster care in the United States (Dicker, Gordon, & Knitzer, 2001). They comprise the largest cohort of young children in care—accounting for one in five admissions (Dicker et al., 2001). Once they have been removed from their homes and placed in foster care, infants and toddlers are more likely than older children to be abused and neglected and to stay longer in foster care (Wulczyn & Hislop, 2002). Half of all babies who enter foster care before they are three months old spend 31 months or longer in placement (Wulczyn & Hislop, 2002), and they are less likely to be reunified with their parents. Thirty-six percent of infants who enter care between birth and three months of age are reunified with their parents compared to 56% of infants who enter care at 10-12 months of age (Wulczyn & Hislop, 2002).

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FAST FACTS:
INFANTS, TODDLERS, AND THE SCIENCE OF EARLY CHILD DEVELOPMENT

- There are 11,416,676 infants and toddlers living in the United States, representing 4% of the entire population (Oser & Cohen, 2003a).
- Development in the first years of life proceeds at a pace exceeding that of any subsequent stage of life (Shonkoff & Phillips, 2000).
- Relationships and experiences with parents, caregivers, and preschool teachers during these early years "form the foundation and scaffold on which cognitive, linguistic, emotional, social and moral development unfold" (Shonkoff & Phillips, 2000, p. 349).
- By age three, roughly 85% of the brain's core structure is formed (Bruner, Goldberg, & Kot, 1999).
- Neuroscience evidence from animal research is pointing to the experiences of neglect, stress, and trauma within the caregiving environment as a source of compromised brain development (Shonkoff & Phillips, 2000).

According to one longitudinal study, being abused or neglected as a child increases the likelihood of arrest as a juvenile by 59%, as an adult by 28%, and for a violent crime by 30% (Widom & Maxfield, 2001). Abused and neglected children are also more likely to have mental health concerns (suicide attempts and posttraumatic stress disorder); educational problems (extremely low IQ scores and reading ability); occupational difficulties (high rates of unemployment and employment in low-level service jobs); and public health and safety issues (prostitution in males and females and alcohol problems in females) (Widom & Maxfield, 2001). However, research confirms that the early years present an unparalleled opportunity to effectively intervene with at-risk children. The experiences these babies have while in foster care will largely determine whether they succeed in school and in life or whether they begin another generation of failure and dependence on the public welfare systems.

The caring professionals in the juvenile and family court system can make a positive difference in the lives of these most vulnerable children and can help to ensure that the priorities of the Adoption and Safe Families Act (ASFA)—safety, permanence, and well-being—are carried out. The following six critical issues provide a framework for meeting the needs of infants and toddlers involved in the juvenile justice system.

Critical Issue #1: Multiple Placements

Separation from parents, sometimes sudden and usually traumatic, coupled with the difficult experiences that have precipitated placement, can leave infants and toddlers dramatically impaired in their emotional, social, educational, and physical development. Multiple foster care placements present a host of other traumas for very young children. When a baby faces a change in placement, fragile new relationships with foster parents are severed, reinforcing feelings of abandonment and distrust. Even young babies are capable of grief when their relationships are disrupted, and this sadness adversely affects their development. Early secure attachments with a stable primary caregiver play a central role in a young child's social, emotional, and cognitive development. Children who have experienced abuse or neglect have an even greater need for sensitive, caring, and stable relationships. Placement decisions should focus on promoting security and continuity for infants and toddlers in out-of-home care.

What the Research Says

We know from the science of early childhood development that early relationships and attachments to a primary caregiver are the most consistent and enduring influence on social and emotional development for young children (Shonkoff & Phillips, 2000). Children form strong attachments and rely on their

parents for security and comfort. Infants and toddlers who are able to develop secure attachments are observed to be more mature and positive in their interactions with adults and peers than children who lack secure attachments (Shonkoff & Phillips, 2000). They may also have a better self-concept, more advanced memory processes, and a better understanding of emotions (Shonkoff & Phillips, 2000). Those who do not have an opportunity to form an attachment with a trusted adult (i.e., infants and toddlers who experience multiple foster homes) suffer, and their development can deteriorate, resulting in delays in cognition and learning, relationship dysfunction, and difficulty expressing emotions. Separations occurring between six months and about three years of age are more likely to result in subsequent emotional disturbances, especially due to the typical anxiety a child has around strangers and the normal limitations of language abilities at this age (American Academy of Pediatrics, 2000). Having at least one adult who is devoted to and loves a child unconditionally, who is prepared to value and care for that child for a long time, is key to helping a child overcome the stress and trauma of having been abused or neglected (American Academy of Pediatrics, 2000).

Recommendations

There are several strategies that can help prevent multiple placements. However, these recommendations may involve a change in the operations of the local child welfare system.

- Make the first out-of-home placement with a view toward permanency. Whenever possible, assure that the foster family is also a potential adoptive home.
- Develop a transition plan for any change in placement. Arrange for the sending and receiving caregivers to exchange information and spend time together with the infant or toddler. Make the change in placement gradually as the baby's behavior is monitored.
- Provide training and support for foster parents and child welfare staff to help them understand and mitigate the distress experienced by a baby when a change in placement occurs.

Critical Issue #2: Evidence-based Prevention and Treatment Models

Abuse and neglect during the early years can have serious consequences on later developmental out-

FAST FACTS: INFANTS AND TODDLERS IN CHILD WELFARE

- 39,060 children under age one entered foster care in 2000 (U.S. Department of Health and Human Services, 2002; Oser & Cohen, 2003a).
- 21% of all children in foster care were admitted prior to their first birthday (Wulczyn, Hislop, & Harden, 2002; Oser & Cohen, 2003a).
- 45% of all infant placements occurred within 30 days of the child's birth (Wulczyn et al., 2002; Oser & Cohen, 2003a).
- 36% of infants between birth and three months of life are reunified with their parents compared to 56% of infants who enter care at 10-12 months of age (Wulczyn & Hislop, 2002; Oser & Cohen, 2003a).
- 77% of all children who died from abuse and neglect were younger than four years of age (U.S. Department of Health and Human Services, 2002; Oser & Cohen, 2003a).
- 40% of young children in foster care are born low birthweight and/or premature (Dicker et al., 2001).
- More than half of the young children in foster care experience developmental delays—four to five times the rate found among children in the general population (Dicker et al., 2001; Oser & Cohen, 2003a).

comes. Research shows that young children who have experienced physical abuse have lower social competence, show less empathy for others, have difficulty recognizing others' emotions, are more likely to be insecurely attached to their parents, and have elevated rates of aggression, apparent even in toddlers (Shonkoff & Phillips, 2000). They have been found to have deficits in IQ scores, language ability, and school performance (Shonkoff & Phillips, 2000). In addition, young children who are victims of physical abuse may experience psychosomatic disorders, anxiety, fears, sleep disruption, excessive crying, and school problems (Lederman, Osofsky & Katz, 2001). By the time these children reach school age, they will be at risk for social problems and early learning deficits. Compounding the problem, one-third of the individuals who were abused and neglected as children, without intervention, can be expected to abuse their own children (National Research Council, 1993). Research on model programs reveals that well-designed services with explicitly defined goals can be effective in changing parenting practices and influencing parent-child interactions (Shonkoff & Phillips, 2000). It is clear, therefore, that prevention and early treatment are critical strategies for protecting at-risk babies and their families.

What the Research Says

One prevention strategy with a significant amount of evidence is home visiting. The Task Force on Community Prevention Services conducted a systematic review of scientific evidence concerning the effectiveness of early childhood home visitation for preventing various forms of violence. The Task Force found that quality early childhood home visitation is highly effective in preventing child abuse and neglect. Compared with the control group, the median effect size of home visitation programs was a reduction of approximately 40% in child abuse and neglect (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2003). In addition, Healthy Families America, a home visitation model, has been found to reduce the incidence of child abuse and neglect. For example, in Arizona, only 3.3% of program participants versus 8.5% of comparison group members had substantiated reports of abuse (Healthy Families America, 2002). In Hawai'i, families receiving program services had significantly fewer substantiated cases of abuse or neglect (3.3%) compared to 6.8% from the control group (Healthy Families America, 2002).

There is limited research documenting the effectiveness of many interventions used in the treatment of child abuse and neglect. Of particular concern are some of the therapeutic approaches used to treat disorders of attachment in very young children. The American Psychiatric Association's Position Statement on Reactive Attachment Disorder cautions that this disorder affects a small number of children and requires a comprehensive psychiatric assessment for accurate diagnosis. Further, they state that there is no scientific evidence to support the effectiveness of some specific therapies used to treat this disorder such as coercive holding and/or "rebirthing techniques" (American Psychiatric Association, 2002).

The American Psychological Association and the American Psychological Society support the use of evidence-based, scientifically grounded treatment strategies (Goode, 2004). One way to ensure this occurs is to hire mental health professionals who are credentialed by their professional organization and have specialized training in working with very young children.

Other issues related to the provision of mental health services for infants and toddlers are addressed in the following section.

Recommendations

It is important to seek documentation of effectiveness for both prevention and treatment strategies. As you look at the available prevention and intervention strategies available in your community, ask about the models these strategies are based on and whether there is documentation of their effectiveness.

- Develop a list of evidence-based prevention and treatment programs in the community.
- Request available data on program effectiveness and staff qualifications.
- Assure that mental health providers use evidence-based treatment approaches that are appropriate for infants and toddlers.

Critical Issue #3: Comprehensive, Developmentally Appropriate Physical and Mental Health Care

Nearly 40% of young children in foster care are born low birthweight, premature, or both, two factors that increase their likelihood of medical problems and developmental delay (Halfon, Mendonca, & Berkowitz, 1995). Being born either low birthweight or premature increases the risk for both chronic health problems and disabilities. In addition, these babies are far less likely to receive services that address their special needs (Dicker et al., 2001; Oser & Cohen, 2003b). More than half of these children suffer from serious health problems, including elevated lead blood levels, and chronic diseases such as asthma (Halfon et al., 1995). Sadly, a significant percentage of children in foster care do not receive even basic health care, such as immunizations, dental services, hearing and vision screening, and testing for exposure to lead and communicable diseases.

In addition, infants and toddlers entering the foster care system have mental health needs that are frequently overlooked. Early childhood mental health is the capacity of the child from birth to age five to experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn. Because maltreatment and repeated and often traumatic separation from caregivers may place infants and toddlers in foster care at risk for mental health disorders, mental health supports for babies in foster care, their birth families, and their foster care families is critical. Untreated mental health disorders in early childhood can have disastrous effects on children's functioning and future outcomes.

There is an enormous disconnect between what we know about very young children and their mental health, and what we do for very young children in the child welfare system. Over the past 20 years, much has been learned about the mental health of young children in foster care and how to provide early childhood mental health services. Early childhood mental health services should be integrated and delivered via family-centered learning experiences at home and in center-based programs.

It is critical that early childhood providers understand not only the unique needs of infants and toddlers, but also the unique needs of very young children who have been victims of abuse/neglect and who have been separated from their families. In addition to improving the mental health aspects of the child welfare system, there must be training for mental health and other early childhood providers.

Federal and state policy must support early identification, screening, and evaluation of emotional development; improve the service array for diagnosis, treatment, and prevention of early mental health problems; and increase mental health supports for parents and foster parents in the existing child welfare system and other systems that serve these children.

What the Research Says

Findings from a U.S. General Accounting Office report examining young children in foster care in three urban areas found:

- 12% received no routine health care.
- 34% received no immunizations.
- 32% continued to have at least one unmet health need after placement.
- Less than 10% received services for developmental delays.
- More than half suffered from serious physical health problems.
- More than half experienced developmental delays (U.S. General Accounting Office, 1995).

Infants and toddlers in the child welfare system are disproportionately exposed to early trauma and other developmental risk factors that can result in a variety of mental health disorders. Many of these children exhibit signs of traumatic stress, including withdrawn behavior, fearfulness, anxiety, aggression, disorganization, and sadness (Lederman et al., 2001).

The 2001 and 2002 federal Child and Family Service Reviews (CFSR) revealed that 31 of 32 states failed to achieve positive ratings on the indicator that addresses the provision of physical and mental health services.The reviews also indicated a scarcity of mental health services for children, questionable quality of mental health services, and lack of routine mental health assessments (National Child Welfare Resource Center for Family-Centered Practice, 2004).

One of the greatest barriers to young children

receiving mental health care is access. The Summer 2003 issue of *Best Practice/Next Practice* states that access is especially difficult for low-income, minority families who are supposed to receive coverage under Medicaid in the child welfare system. The report notes, "The services are often unavailable, inaccessible, and inappropriate. Waiting lists are often very long" (National Child Welfare Resource Center for Family-Centered Practice, 2003, p. 6).

Additional barriers to adequate comprehensive physical and mental health care for these children include insufficient funding, lack of access, inadequate community-based medical and mental health services, lack of coordination of services, and poor communication among health and child welfare professionals (Simms, Dubowitz, & Szilagyi, 2000; U.S. General Accounting Office, 1995). Although the Child Welfare League of America and the American Academy of Pediatrics have published standards of care, many child welfare agencies lack specific policies for children's physical and mental health services (Schorr, 1981).

Recommendations

The following recommendations can assist courts in assuring that comprehensive physical and mental health services are provided to all infants and toddlers under their jurisdiction.

- Develop liaisons with the local health department to assure continuity of care and comprehensive and coordinated treatment.
- Establish a system that allows all parties involved in the child's health care to communicate effectively with each other.
- Complete a health screening evaluation on all children entering foster care before or shortly after placement.
- Perform a comprehensive physical and mental health assessment within one month of placement.
- Monitor the child's physical, developmental, and mental health status frequently.
- Develop systems to ensure that the efficient transfer of physical and mental health information are in place including models such as the "medical passport" and/or "medical home."

Critical Issue #4: Early Intervention—Part C of the Individuals with Disabilities Education Act

Infants and toddlers in foster care are more likely to have fragile health and disabilities and are far less likely to receive services that address their needs (Dicker et al., 2001). They may show signs of significant delays in language, cognition, and behavior. In fact, they have rates of developmental delay approximately four to five times higher than children in the general population (Dicker et al., 2001). Therefore, there must be a strong connection between the child welfare/child protection systems and Part C of the Individuals with Disabilities Education Act to ensure early access to services. Part C of the Individuals with Disabilities Education Act is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for infants and toddlers with developmental delays or disabilities, ages birth through two years (the third birthday), and their families. Nine states also fund programs serving infants and toddlers who are at risk for delays. The National Research Council/Institute of Medicine recommends that infants and toddlers who are referred to a protective services agency for evaluation of suspected abuse or neglect be automatically referred for a developmental-behavioral screening under Part C (Shonkoff & Phillips, 2000). A new provision of the Keeping Children and Families Safe Act of 2003 that amended the Child Abuse Prevention and Treatment Act (CAPTA) (P.L. 108-36) requires that each state develop "provisions and procedures for referral of a child under the age of three who is involved in a substantiated case of child abuse or neglect to early intervention services funded under Part C of the Individuals with Disabilities Education Act (IDEA) (§106(b)(2)(A)(xxi))."

Infants and toddlers coming into foster care need a comprehensive assessment of their physical, behavioral, emotional, cognitive, and relational domains before placement, if possible, and at least within 30 days of placement (Child Welfare League of America, 1988).

What the Research Says

Children in foster care are substantially overrepresented among those in early intervention (U.S. Department of Education, 2001). It has been estimated that up to 60% of children in foster care experience

some type of developmental delay, including language delays, cognitive problems, gross motor difficulties, and growth problems (Silver et al., 1999; Simms & Halfon, 1994). Of the babies and toddlers entering Part C programs for children with disabilities and developmental delays, 7% were in foster care at the time of entry, about 10 times the rate of children in the general population (Hebbeler et al., 2001). Although foster children are disproportionately represented in Part C because of their high rates of developmental disabilities and delays, most eligible foster children are still not receiving services. The most vulnerable children are those with multiple risk factors—it is the combined impact of both environmental risk and biological risk that poses the greatest threat to young children (Oser & Cohen, 2003b; Shonkoff & Phillips, 2000). Model programs that deliver carefully designed interventions with well-defined goals can affect both parenting behavior and the developmental trajectories of infants and toddlers whose life course is threatened by family disruption (Shonkoff & Phillips, 2000).

Without formal intervention, there is a general decline in performance on developmental measures for children with a variety of cognitive disabilities, such as Down syndrome, across the first five years of life (Shonkoff & Phillips, 2000). In addition, infants and toddlers who score in the "at-risk" range of developmental functioning (i.e., below the mean of national norms) and do not receive services frequently move into the lowest functioning at-risk group (i.e., mental retardation) as they get older (U.S. Department of Health and Human Services, 2002).

Recommendations

The following strategies can assure that all infants and toddlers in juvenile and family court receive the developmental supports they so critically need.

- Identify a contact person for Part C referrals and services who will work closely with the juvenile and family court.
- Refer all infants and toddlers for a Part C screening at their first court contact.
- Monitor all eligible infants and toddlers to ensure they receive early intervention services in a timely manner.

Critical Issue #5: Quality Early Care and Learning Experiences

Infancy and toddlerhood are times of intense growth and development in all areas, including rapid changes in motor development, cognition, and emotions (Shonkoff & Phillips, 2000). All babies and toddlers need positive early learning experiences to foster their intellectual, social, and emotional development and to lay the foundation for later school success. Abused or neglected infants and toddlers are at increased risk for adverse outcomes and need additional supports to promote their healthy growth and development. Quality early learning experiences can provide very young children in foster care the opportunity to form secure attachments with teachers and child care providers who can provide consistent, positive environments. These early relationships are associated with adaptive social development (Shonkoff & Phillips, 2000). High quality early care and education programs can also support foster, kinship, and biological parents by directing them to other support systems, providing information, and connecting them with other parents who they may turn to for advice and support (Dicker et al., 2001).

What the Research Says

Cognitive, linguistic, social, and emotional competencies—the foundations of school readiness and literacy—begin to develop from the earliest moments of life. We know from the science of early childhood development that high quality early care and education programs have lasting impacts on infants and toddlers. Intensive, high quality, center-based interventions that provide learning experiences directly to the young child have a positive effect on early learning, cognitive and language development, and school achievement (Shonkoff & Phillips, 2000). The strongest effects of high quality care are found for children under the greatest stress (Shonkoff & Phillips, 2000). In addition, a secure relationship with a teacher or child care provider can help safeguard infants and toddlers against the development of serious behavior problems and relationship challenges later in life.

Unfortunately, many preschool and child care programs are not high quality. Researchers affiliated with the National Institute of Child Health and Human Development's (NICHD) study of early child care report

that, in general, day care in the United States is "fair," but not outstanding. This study, initiated by the NICHD and conducted by investigators at the NICHD and 14 universities around the country, has enrolled more than 1,216 children and their families from 10 locations throughout the United States. It has also found that children attending child care centers that meet professional standards for quality score higher on school readiness and language tests and have fewer behavioral problems than their peers in centers not meeting such standards (NICHD Early Child Care Research Network, 1999).

One example of a high quality early learning program with proven results is Early Head Start, a program designed to support healthy prenatal outcomes and enhance intellectual, social, and emotional development of infants and toddlers. A three-way partnership between Early Head Start, the Children's Bureau, and the child welfare system was created last year to meet the critical needs of infants and toddlers in the child welfare system. Through the Early Head Start/Child Welfare Services Initiative, infants, toddlers, and parents are able to access more health, mental health, nutritional, child development, and parent education services. The National Evaluation of Early Head Start concluded that Early Head Start is making a positive difference in areas associated with children's success in school, family self-sufficiency, and parental support of child development. Early Head Start produced statistically significant, positive impacts on standardized measures of children's cognitive and language development (U.S. Department of Health and Human Services, 2002). Programs such as Early Head Start can provide the foundation that very young children need to enter school ready to learn and can serve as a wonderful resource for infants and toddlers in foster care. Yet, there are not nearly enough programs to serve the majority of eligible children—Early Head Start currently serves only 3% of eligible children.

Recommendations

The following recommendations can help assure that infants and toddlers who have experienced abuse and neglect receive the benefits quality early care and education programs can provide.

- Identify a liaison with the local Early Head Start and Head Start programs.
- Develop and maintain a list of local early childhood programs accredited by the National Association for the Education of Young Children (NAEYC) with current contact information. NAEYC maintains a listing of programs that have voluntarily met high standards.
- Routinely refer all infants and toddlers to either an Early Head Start program or an NAEYC-accredited early childhood program.

Critical Issue #6: Visitation Practices

Current visitation practices usually consist of brief encounters that occur anywhere from once a month to once or twice a week. For very young children, infrequent visits are not enough to establish and maintain a healthy parent-child relationship. Infants and toddlers build strong attachments to their biological parents through frequent and extended contact. One month in the life of a baby is an eternity. Visits should occur frequently, in a safe setting that is comfortable for both parent and child, and should last long enough for a positive relationship to develop and strengthen. Visits are often used to evaluate parenting skills. This adds another stress for the parent and can impede the development of a comfortable parent-child relationship. If parenting skills are to be evaluated, additional separate visits should be scheduled for this purpose.

What the Research Says

There is not much research available about visitation for very young children. However, there does seem to be consensus that one of the best predictors of reunification is frequency of visits (Hess & Proch, 1993). Haight et al. (2002) examined the perspectives of mothers, foster mothers, and child welfare workers to learn how parent visits with very young children might be improved. Their study revealed how emotionally difficult visits can be for mothers, foster mothers, and child welfare workers. They recommend that goals for visits be reevaluated and simplified. "If the primary goal of visits is to strengthen the development of the parent-child relationship, then other contexts may be required to achieve secondary goals that might otherwise undermine natural and spontaneous parent-child interaction during visits, for example, parenting skills might be

assessed in special sessions of parenting sessions that include children" (p.27).

Haight et al. (2002) also described specific components of visitation that impact mothers, foster mothers, child welfare workers, and children. These include the initial separation and accompanying feelings, preparation for the visit, the context of the visit including physical location, duration, interactions and activities, and the post-visit including reactions to the visit and support provided. Each of these components represents an opportunity to provide support and coaching to improve visits for all involved.

Recommendations

Courts can promote and support psychologically meaningful relationships between parents and their babies by examining and revising their visitation policies and practices.

- Provide training, support, and supervision to parents, foster parents, and child welfare workers so they are prepared to address the psychological complexities of each component of visitation—separation, visit preparation, visit context, and post-visit.
- Determine the frequency, location, and duration of visits based on the needs of the individual infant or toddler.
- Expand visitation options by enlisting the support and cooperation of child care centers, family day care homes, doctors, relatives, foster families, and other locations that might provide options for safe visits.

A New Approach to Promoting the Health and Well-Being of Infants and Toddlers—Infant-Toddler Court Teams

Given the fiscal and time constraints on juvenile courts, how realistic are these recommendations? Following is one approach that offers promise by building on the existing collaborative approach of the National Council of Juvenile and Family Court Judges' Model Courts and the expertise of ZERO TO THREE: National Center for Infants, Toddlers and Families in translating the science of early childhood into resources for parents, professionals, and policy-makers. Multidisciplinary Court Teams, with a specific focus on the needs of infants and toddlers, could be a vehicle for implementing these recommendations. By partnering legal expertise with the science of early childhood development, these Court Teams could work to raise awareness, increase knowledge and skills, and change practice and policy regarding the needs of infants, toddlers, and their families involved in the judicial system.

This model envisions Court Teams co-led by a judge and an infant mental health/child development expert in partnership with key community stakeholders who serve the very youngest children, including community leaders, Court Appointed Special Advocates, and guardians *ad litem*. By bringing together the knowledge and skills from the judicial system with the training and expertise of the child development field, this collaborative, coordinated model has the potential to promote child well-being by improving systems, services, and funding.

This Infant-Toddler Court Team model is based on the pioneering work of Judge Cindy Lederman and Dr. Joy Osofsky who have been collaborating on the development of an Infant Mental Health Court in Miami-Dade, Florida, since the late 1990s. In the Miami-Dade Juvenile Court, all infants, toddlers, and their mothers receive screening and assessment services. All babies are screened for developmental delays and referred for services. An Early Head Start program connected to the court is the first designed specifically to meet the needs of maltreated children. A parent-infant psychotherapy intervention is available to a select number of mothers. These mothers and their babies receive 25 therapeutic sessions that focus on building a positive parent-infant relationship. For the families who completed the 25 sessions, preliminary data show substantial gains in improving parental sensitivity, child and parent interaction, and behavioral and emotional parental and child responsiveness. In addition, there have been no new instances of founded abuse or neglect. The children showed significant improvements in enthusiasm, persistence, and positive affect and a reduction of depression, anger, withdrawal, and irritability. Further, there was reunification with the family or permanent placement for all children who completed the intervention and who were not in parental custody at the beginning of the project. While the Miami-Dade model is unique, collaborative court initiatives exist in many communities that might be modified to focus on this population.

Another challenge to the development of Infant-Toddler Court Teams is a shortage of knowledge and resources about the developmental needs of infants and toddlers in many areas of the country. This model would enlist the expertise of ZERO TO THREE and the National Council of Juvenile and Family Court Judges to provide training, technical assistance, and materials to communities seeking to start these Court Teams. Over time, these Court Teams would mentor new communities. While we continue to seek support for this initiative, we have taken a first step by launching the "babyjudge listserve." This is an e-mail group of juvenile and family court judges and other professionals interested in exploring ways to better meet the needs of infants, toddlers, and their families who are involved in the judicial system.

Conclusion

Although the challenges for infants and toddlers in foster care are great, their needs are even greater. We must continue to seek support for new initiatives while at the same time developing new collaborations and sharing increasingly scarce resources. The juvenile court has a unique opportunity to help infants and toddlers in the child welfare system. We know from the science of early childhood development what infants and toddlers need for healthy social, emotional, and cognitive development. We also know that infants and toddlers in the child welfare system are at great risk for poor outcomes.

The amazing growth that takes place in the first three years of life creates vulnerability and promise for *all* children. The science tells us that babies can't wait. The juvenile court has the opportunity to translate this knowledge into decisions that promote and improve the emotional, social, cognitive, and physical health and development of our nation's youngest and most vulnerable children.

As individuals who make critical decisions for these children, we can and must do more to help families and communities do the best by their babies. "One day we will all need them as much as they need us now. Our destinies are intertwined. Our future is their future. Our babies are waiting" (Oser & Cohen, 2003a, p. ix).

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ADDITIONAL RESOURCES

- The Pew Commission on Children in Foster Care—http://www.pewfostercare.org/
- Future Unlimited—http://www.futureunlimited.org
- Miami Safe Start Initiative—http://www.miamisafestart.org
- New York State Permanent Judicial Commission on Justice for Children—http://www.courts.state.ny.us/ip/justiceforchildren/index.shtml
- Babyjudge listserve: To subscribe to the listserve, send an e-mail to: ldi_babyjudge@lists.zerotothree.org

For more information on preventing multiple placements:

- The American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care section on adoption and foster care—http://www.aap.org/sections/adoption/resources.htm
- ZERO TO THREE, journal articles on attachment research and findings from *Neurons to Neighborhoods*—http://www.zerotothree.org/ztt_journal.html

For more information on evidence-based models to prevent and treat child abuse and neglect:

- Healthy Families America—http://www.healthyfamiliesamerica.org
- U.S. Department of Health and Human Services, Centers for Disease Control and Prevention—http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5214a1.htm
- American Psychiatric Association, Position Statement on Reactive Attachment Disorder—http://www.psych.org/edu/other_res/lib_archives/archives/200205.pdf

For more information on assuring appropriate physical and mental health care:

- American Academy of Pediatrics—http://www.aap.org
- American Academy of Pediatrics—http://www.medicalhomeinfo.org/resources/foster.html
- Caring Communities for Children in Foster Care—http://www.peatc.org/FosterCare/index.htm
- Child Welfare League of America—http://www.cwla.org
- California Institute of Mental Health, Mental health screening tool for children birth to five years—http://www.cimh.org/index.php?ptype=products&menuid=9&pid=90
- Best Practice/Next Practice: Family-Centered Child Welfare. A publication of the National Child Welfare Resource Center for Family-Centered Practice, a service of the Children's Bureau—http://www.cwresource.org/Online%20publications/RC%20Bulletin.pdf

For more information on ensuring access to Part C:

- ZERO TO THREE Policy Center brief on IDEA Part C Reauthorization—http://www.zero tothree.org/policy/
- Find the Part C coordinator in your state—http://www.ectac.org/search/confinder.asp

For more information on ensuring access to quality early care and learning experiences:

- Early Head Start National Resource Center at ZERO TO THREE—http://www.ehsnrc.org
- Early Head Start research reports–www.acf.dhhs.gov/programs/core/ongoing_research/ehs/ehs_reports.html
- National Association for the Education of Young Children: List of accredited programs—http://www.naeyc.org/accreditation/center_search.asp

For more information on Developing Visitation Practices:

- Children and Family Research Center, School of Social Work, University of Illinois at Urbana-Champaign—http://cfrcwww.social.uiuc.edu/

REFERENCES

American Academy of Pediatrics, Committee on Early Childhood, Adoption and Dependent Care. (2000). Developmental issues for young children in foster care (Policy Statement). *Pediatrics, 106*(5), 1145-1150.

American Psychiatric Association (2002). Reactive Attachment Disorder Statement. APA Document Reference No. 200205. Retrieved online from http://www.psych.org/edu/other_res/lib_archives/archives/200205.pdf.

Bruner, C., Goldberg, J., & Kot, V. (1999). *The ABC's of early childhood: Trends, information and evidence for use in developing an early childhood system of care and education.* A joint publication of Iowa Kids Count and the Iowa Forum for Children and Families.

Child Welfare League of America (1988). *Standards for health care services for children in out-of-home care.* Washington, DC: Child Welfare League of America.

Dicker, S., Gordon, E., & Knitzer, J. (2001). *Improving the odds for the healthy development of young children in foster care.* New York: National Center for Children in Poverty.

Goode, E. (2004, March 9). Defying psychiatric wisdom, these skeptics say "prove it." *The New York Times*.

Haight, W. L., Black, J., Mangelsdorf, S., Giorgio, G., Tata, L., Schoppe, S., & Szewczyk, M. (2002). Making visits better: The perspectives of parents, foster parents, and child welfare workers. *Child Welfare, 81*(2), 173-202.

Halfon, N., Mendonca, A., & Berkowitz, G. (1995). Health status of children in foster care: The experience of the center for the vulnerable child. *Archives of Pediatric and Adolescent Medicine, 149*(4), 386-391.

Healthy Families America, (2002). Healthy Families America reduces child maltreatment. Retrieved Jan. 10, 2004 from http://www.healthyfamiliesamerica.org/downloads/hfa_fact_a.pdf.

Hebbeler, K., Wagner, M., Spiker, D., Scarborough, A., Simeonsson, R., & Collier, M. (2001). *National early intervention longitudinal study: A first look at the characteristics of children and families entering early intervention services*. Menlo Park, CA: SRI International.

Hess, P., & Proch, K. (1993). Visiting: The heart of reunification. In B. Pine, R. Warsh, & A. Maluccio (Eds.) *Together again: Family reunification in foster care.* Washington, DC: Child Welfare League of America.

Lederman, C., Osofsky, J., & Katz, L. (2001). When the bough breaks the cradle will fall: Promoting the health and well being of infants and toddlers in juvenile court. *Juvenile and Family Court Journal, 52*(4), 33-38.

National Child Welfare Resource Center of Family-Centered Practice (2003, Summer). Best Practice/Next Practice: Mental Health Issues in the Child Welfare System. Available online at: http://www.cwresource.org/publications.htm.

National Child Welfare Resource Center of Family-Centered Practice (2004, Winter). Best Practice/Next Practice: Mental Health in Child Welfare: A focus on caregivers. Available online at: http://www. cwresource.org/publications.htm.

NICHD Early Child Care Research Network (1999). Child outcomes when child care center classes meet recommended standards for quality. *American Journal of Public Health, 89*.

National Research Council. (1993). *Understanding child abuse and neglect.* p. 223.

Oser, C., & Cohen, J. (2003a). *America's babies: The ZERO TO THREE Policy Center data book.* Washington, DC: ZERO TO THREE Press.

Oser, C., & Cohen, J. (2003b). Improving early intervention: Using what we know about infants and toddlers with disabilities to reauthorize Part C of IDEA. Washington, DC: ZERO TO THREE Policy Center.

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

Schorr, E. (1981). Health care supervision of foster children. *Child Welfare, 60*, 313-319.

Silver, J., DiLorenzo, P., Zukoski, M., Ross, P. E., Amster, B. J., & Schlegel, D. (1999). Starting young: Improving the health and developmental outcomes of infants and toddlers in the child welfare system. *Child Welfare, 78*(1), 148-165.

Simms, M. D., Dubowitz, H., & Szilagyi, M.A. (2000). Health care needs of children in the foster care system. *Pediatrics, 106,* 909-918.

Simms, M.D., & Halfon, N. (1994). The health care needs of children in foster care: A research agenda. *Child Welfare, 73*(5), 505-524.

U.S. Department of Education. (2001). *23rd annual report to Congress on the implementation of the Individuals with Disabilities Education Act.* Washington, DC: Author.

U.S. Department of Health and Human Services, Administration for Children and Families (2002). *Making a difference in the lives of infants and toddlers and their families: The impacts of Early Head Start.* Washington, DC.

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (2003, Oct. 3). First reports

REFERENCES

evaluating the effectiveness of strategies for preventing violence: Early childhood home visitation and firearms laws. *Morbidity and Mortality Weekly Report, 52*(RR-14).

U.S. General Accounting Office (1995). *Foster care: Health needs of many young children are unknown and unmet* (GAO/HEHS 9a5-114). Washington, DC: U.S. General Accounting Office.

Widom, C., & Maxfield, M. (2001). An update on the "Cycle of Violence." *Research in Brief,* Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

Wulczyn, F., & Hislop, K. (2002) Babies in foster care: The numbers call for attention. *Zero to Three Journal, 22*(4), 14-15.

Wulczyn, F., Hislop, K., & Harden, B (2002). The placement of infants in foster care. *Infant Mental Health Journal, 23*(5), 454-475.