A R T I C L E

CHILDREN BIRTH TO THREE ENTERING THE STATE'S CUSTODY

REDMOND REAMS
Children's Assessment Service, Morrison Center

ABSTRACT: Children entering the state's legal custody are a high-risk group. They have experienced, not only maltreatment of some form and usually separation from attachment figures, but often have also witnessed domestic violence, been exposed prenatally to alcohol and/or drugs, or been in attachment relationships with substance-abusing and/or mentally ill parents. This paper presents data on the developmental and mental health status of these children, including diagnoses using the Diagnostic Classification: 0–3. Over half the children received referrals for additiional needed developmental or mental health services. The importance of assessing these children early in their time in foster care is emphasized.

RESUMEN: Los niños que entran bajo la custodia legal del estado son un grupo de alto riesgo. Ellos han experimentado, no sólo maltrato o negligencia y usualmente la separación de las figuras que representan para ellos la unión afectiva, sino que a menudo también han presenciado violencia doméstica, han estado expuestos al alcohol y/o a las drogans antes de nacer, o han estado en relaciones afectivas con padres que usan sustancias o que están mentalmente enfermos. Este ensayo presenta información sobre la condición de salud mental y de desarrollo de estos niños, incluyendo diagnósticos usando la Clasificación de Diagnósticos: 0–3. Más de la mitad de los niños fueron referidos para recibir los servicios adicionales de salud mental y de desarrollo que necesitaban. Se enfatiza la importancia de evaluar estos niños muy pronto después de que han entrado al cuidado de otras familias.

RÉSUMÉ: Les enfants entrant sous la garde légale de l'état sont un groupe à haut risque. Ils ont connu non seulement la maltraitance ou la négligence et la plupart du temps la séparation de figures d'attachement, mais aussi ont aussi souvent été témoins de violence domestique, été exposés avant la naissance à l'alcool et/ou à des drogues, ou été dans des relations d'attachement avec des parents se drogant ou bien des parents mentalement malades. Cet article présente des données sur le développement et le statut de santé mentale de ces enfants, y compris des diagnostics utilisant la Classification Diagnostic: 0–3. Plus de la moitié des enfants ont été envoyés en consultation pour de l'aide supplémentaire nécessaire pour leur développement ou leur santé mentale. L'importance qu'il y a à évaluer ces enfants tôt après leur entrée à DASS est mise en valeur.

ZUSAMMENFASSUNG: Kinder, die in staatliche Obsorge übernommen werden sind eine Hochrisikogruppe. Sie erfuhren nicht nur falsche Behandlung, oder Vernachlässigung und üblicherweise Trennung von Bezugspersonen, sondern waren oft noch Zeugen von Häuslicher Gewalt, wurden vorgeburtlich Alkohol

An earlier version of this paper was presented at the Twelfth National Training Institute of the National Center for Infants, Families, and Toddlers. The Children's Assessment Service is supported by grants and in-kind services from the Robert Wood Johnson Foundation, the Meyer Memorial Trust, and Multnomah County, Oregon. Direct correspondence to the author at Children's Assessment Services, 3355 S.E. Powell Blvd., Portland, OR 97202.

INFANT MENTAL HEALTH JOURNAL, Vol. 20(2), 166–174 (1999)
© 1999 Michigan Association for Infant Mental Health
CCC 0163-9641/99/020166-09

oder Drogen ausgesetzt, oder waren in primären Beziehungen mit drogenabhängigen und/oder geisteskranken Eltern. Diese Arbeit präsentiert Ergebnisse zu dem entwicklungsmäßigen und geistigen Zustand dieser Kinder unter Verwendung der Diagnosen, wie sie in der diagnostischen Klassifikation: 0–3 Jahre angeboten werden. Mehr als die Hälfte der Kinder wurden zu zusätzlichen entwicklungspsychologischen, oder anderen Betreuungseinrichtungen überwiesen. Die Bedeutung der Untersuchung bald nach ihrem Eintritt in die Fremdpflege wird hervorgehoben.

抄録：州の法的な保護に入る子どもは、ハイ・リスク・グループである。彼らは虐待あるいは放置（ネグレクト）および通常愛着対象からの分離を経験しているばかりでなく、しばしば家庭内暴力を目撃し、胎内でアルコールや麻薬にさらされ、あるいは物質乱用のや精神的に病気の親と愛着関係にあった。この論文は、これらの子どもたちの発達およびメンタルヘルスの現状についての、0-3 診断分類 the Diagnostic Classification: 0-3 を用いた診断を含む、データを提供する。半分以上の子どもたちは、更に発達及びメンタルヘルスサービスが必要として、専門家へ紹介を受けた。これらの子どもたちを、里親の養育に入った後早期に評価する重要性が、強調される。

* * *

Across the developmental spectrum, children entering the state's legal custody are at high risk for medical, developmental, and mental health concerns (Chernoff, Combs-Orme, Risley-Curtiss, & Heisler, 1994; Dale, Kendall, & Stein-Schultz, 1996; Hochstadt, Jaudes, Zimo, & Schachter, 1987; Kendall, Dale, & Plakitsis, 1995; State of Oregon, 1993; Urquiza, Wirtz, Peterson, & Singer, 1994). Most recent estimates place 450,000 children in the foster care system in the United States (GAO, 1995a) and children under the age of three are the fastest growing segment of that population (GAO, 1995b; Wulczyn, Harden, & Goerge, 1997).

Yet data has been reported only sporadically about infants and toddlers entering the state's legal custody. GAO (1995b) reported that 58% of foster children 0–3 had serious physical health problems in three urban areas. Dale, Kendall, and Stein-Schultz (1996) reported that 51% of children birth through 5 years of age were found to be at risk on a developmental screening. Chernoff et al. (1994) reported that children under 3 years of age were at or below the 5th percentile for weight and head circumference three times as often as expected and five times more likely to be at or under the 5th percentile for height. Hochstadt et al. (1987) reported that 57% of children entering foster care birth to three were felt to need an infant stimulation program. Urquiza et al. (1994) found that 27% of children less than 2 1/2 years old were two standard deviations or more below age expectations on the Bayley Scales of Infant Development and that 39% of children under 4 years of age scored in the clinical range of Internalizing domain of the Achenbach Child Behavior Checklist. Klee (1997) reported that 16% of foster children birth through 3 years of age score in the significantly delayed range on the Bayley Scales of Infant Development.

None of the above studies has used the Diagnostic Classification: 0–3 (Zero to Three, 1994) to look at infant mental health diagnostic issues. This research has also not used the new assessment instruments such as the Test of Sensory Functions in Infancy (DeGangi & Greenspan, 1989) or the Infant/Toddler Symptom Checklist (DeGangi, Poisson, Sickel, & Wiener, 1995) that have been developed to more systematically measure sensory integration issues among infants and toddlers. The intent of the current study is to look at the mental health/developmental issues and risk factors present for children under the age of four entering the state's legal custody.

METHOD

Participants

All children under 48 months of age who were evaluated by the Children's Assessment Service of the Morrison Center were included as subjects. One hundred and forty-four children met this age criteria. Because of age restrictions on certain assessment measures and missing data from foster parents or the child welfare agency, the *N*s for various analyses may be less.

The Children's Assessment Service (CAS) works to ensure that children birth through 13 years of age receive medical, developmental, and mental health assessment and any recommended follow-up services for children newly entering foster care in Multnomah County, Oregon (the county containing the city of Portland). All children entering the state's legal custody are eligible for referral to CAS and 72% of children listed on court dockets are actually referred by local child welfare agency staff. Children's Assessment Service attempts to balance comprehensiveness of assessment with the quantity of assesssments to be done. The mandate of CAS is to assess potentially every child birth through 13 that enters the state's custody in this county. We do not turn away referrals, are not to maintain a waiting list, and there is no need for identified preexisting problems to qualify for the evaluation. Over 500 assessments are performed annually. Given this volume, we do not perform an in-depth comprehensive evaluation; rather, we work to determine if further evaluation or services are needed.

The children's average age is 23 months; 10% were newborns. There were 53% male and 47% female children. Their ethnic breakdown is 59% European-American, 25% Multiracial, 11% African-American, 3% Native American, and 1% each Hispanic and Asian-American. The confirmed maltreatment suffered by these children includes 80% of the children being neglected, 19% being physically abused, and 3% being sexually abused. Children were placed in a foster home 75% of the time, in a shelter 10% of the time, and 15% of the children were living with birth parent(s) after being taken into the state's legal custody. Of the foster parents, 13% were relatives and 87% were not. Forty-nine percent of the foster parents had not had previous experience with foster children birth to three before the placement of this child. There was a mean of 4.8 children in the foster home. Children were assessed an average of 69 days after placement into the state's custody. Children were not assessed for difficulties in areas in which they were already receiving services, for example, early intervention or psychotherapy.

Measures

The following is the current standard assessment protocol for children birth to three evaluated by the Children's Assessment Service with relevant age parameters in parentheses:

- Test of Sensory Functions in Infancy (4–18 months; DeGangi & Greenspan, 1989),
- a parent–child play interaction,
- an interview of the current caretaker and sometimes an interview of a previous caretaker,
- the Achenbach Child Behavior Checklist for 2–3 year olds (24–47 months; Achenbach, 1992),
- the Battelle Developmental Inventory Screening Test (4–47 months; Newborg, Stock, & Wnek, 1988),
- the Social Skills Rating Schedule (36–47 months; Gresham & Elliott, 1990), and
- the Infant/Toddler Symptom Checklist (DeGangi et al., 1995).

The last two measures have recently been added to the battery and so there were insufficient numbers of subjects for the analyses on these measures. The Parenting Stress Index Short Form (Abidin, 1995) is not currently in the battery although it has been used in the past with sufficient frequency that it will be included in some of the analyses.

Assessments are conducted by Master's level staff in a 1½- to 2-hr time period at agency offices. Before the date of evaluation, the staff person usually has some child welfare records available that will document the immediate reason the child was placed into the state's custody and will give some information on home environment (e.g., drug use by parents, domestic violence, unsanitary conditions) and possible prenatal drug exposure. When the child and caretaker first arrive the purpose of the evaluation is reviewed with the caretaker (a foster parent in 85% of the cases) and any questions or concerns are discussed. A 20-min play interaction is the first part of the evaluation. Caretakers are instructed to play with the child as they would at home. Developmentally appropriate toys are available. Children are observed for eye contact, attachment behaviors, responsiveness to overtures, affect expression, adaptiveness, compliance, and motor skills. The TSFI and Battelle are then administered. After these are completed, the caretaker is interviewed about the child's current behaviors and history to the extent known. Finally, the evaluator will play with the child while the caretaker completes either the ITSC or the Achenbach checklist depending on the age of the child. Birth parents are not present at the evaluation in the vast majority of cases. When feasible, the birth parent is interviewed over the phone.

After the assessment, the master's level staff writes up a draft of the report, including diagnosis. This report is reviewed in conjuction with all of the testing by a doctoral psychologist experienced in infant/toddler mental health issues. Findings and recommendations are reviewed with caseworkers and caretakers 2–3 weeks after the assessment. Because the assessments do not evaluate the parents, they generally are not used forensically by the child welfare agency. Staff have been called to testify in fewer than 3% of the cases evaluated.

RESULTS

Risk Factors

Children aged birth to three are clearly a high-risk population. This risk is manifest given the maltreatment already described and that most are removed from daily contact from their primary attachment figures. In addition, as can be seen in Table 1, these children have also been

TABLE 1. *Risk Factor Frequency for Children Aged 0–3 Entering the State's Legal Custody*

Risk Factor	*Percentage of Children (%)*
Had previously lived in poverty	78
Exposed to domestic violence	60
Born to teenage mother	22
Lived in a family with 3 or more other children	31
Exposed to drugs in utero	32
Parental history of criminal arrest	52
Parental history of chronic substance abuse	73
Parental history of psychiatric hospitalization	9

TABLE 2. *Developmental Findings for Children Aged 0–3 Entering the State's Legal Custody (*N *= 84)*

Battelle Domain	*Developmental Age Based on Testing (months)*	*Percentage of Children 2 or More Standard Deviations Behind (%)*
Personal-Social	19.3	14
Adaptive	20.6	17
Gross Motor	20.8	4
Fine Motor	20.4	4
Receptive language	21.5	8
Expressive language	20.9	15
Cognitive	21.0	23

exposed to many other risk factors. Taking all this information into account, the prototypical child birth to three taken into state's custody in Multnomah County, Oregon has been neglected and has parents who are poor, domestically violent, and substance-abusing.

Developmental Findings

Although the average age delay on the Battelle is not substantial (3–5 months), the percentages of children delayed more than two standard deviations is concerning. Only 2–3% of children in a normal population group would be expected to score two standard deviations below the mean. The percentages are much higher in this group of children taken into the state's legal custody (see Table 2). Motor skills and receptive language abilities appear to be the least often delayed areas. Cognitive, personal-social, adaptive, and expressive language areas have the most concerning frequencies of substantial delays.

Overall, on the total score on the Test of Sensory Functions In Infancy (DeGangi & Greenspan, 1989), 23% of the children were placed in the deficient range, 14% in the at-risk range, and 63% in the normal range with regard to sensory integration development. In examining subtest scores (see Table 3), it is clear that Reactivity to Tactile Deep Pressure and Adaptive Motor Functions are contributing the most to the problematic scores. The Reactivity to Tactile Deep Pressure subtest assesses tactile defensiveness, while the Adaptive Motor Functions taps into motor planning, tactile discrimination, and visual-spatial integration skill areas.

TABLE 3. *Sensory Integration Findings for Children Aged 0–3 Entering the State's Legal Custody (*N *= 35–37)*

TSFI Subtest	*Normal (%)*	*At Risk (%)*	*Deficient (%)*
Reactivity to tactile deep pressure	58	13	29
Adaptive motor functions	62	11	27
Visual-tactile integration	84	8	8
Ocular-motor control	86	8	6
Reactivity to vestibular stimulation	81	3	16
Total test	63	14	23

TABLE 4. *Rates of Children 0–3 Entering the State's Legal Custody with Clinically Significant Behavior Problems on the Achenbach*

Achenbach Scale or Domain	*Percentage of Children Scoring at a Clinically Significant Level (%)*
Anxiety	13
Withdrawal	28
Sleep problems	13
Somatic concerns	5
Aggression	15
Destructiveness	13
Internalizing	34
Externalizing	25

Mental Health Findings

The manual for the Achenbach Child Behavior Checklist defines cutoffs for clinically significant levels for each subtest (*T* score $>$ 70 or $>$ 2 standard deviations) and for the two broad internalizing and externalizing domains (T score $>$ 63 or $>$ 1.5 standard deviations) (Achenbach, 1992). Using these criteria, 1 in 3 children had clinically significant levels of behavior problems as reported by caretakers in the broad internalizing domain, which measures symptoms such as anxiety, depression, withdrawal, etc. One in four children had clinically significant levels of behavior problems as reported by caretakers in the externalizing domain, which measures symptoms such as oppositionalism, aggression, destructiveness, etc. On more specific subscales, the highest level of problems was reported on the Withdrawal subscale (28% of children at clinically significant levels), which has items such as "Shows little affection toward people" or "Uncooperative." Achenbach findings are presented in Table 4.

Two diagnostic systems were used in conceptualizing these young children's mental health issues. The *Diagnostic Classification: 0–3* (National Center for Clinical Infant Programs, 1994) was used in addition to the *DSM-IV*. Sixty-one percent of children received a 0–3 diagnosis, with adjustment and regulatory disorders being the most often used (see Table 5). *DSM-IV* diagnoses were given to 65.5% of the children. Adjustment disorders (40%), language disorders (21%), reactive attachment disorder (15%), and posttraumatic stress disorders (6.5%) were the most commonly occurring diagnoses. The mean Children's Global Assessment Scale score was 61.

TABLE 5. *0–3 Diagnoses for Children Entering the State's Legal Custody*

Diagnosis	*Percentage (%)*
Adjustment disorder	23
Regulatory disorder	22
Reactive attachment disorder	7
Traumatic stress disorder	2
Multisensory developmental disorder	2
Other diagnoses	19
No diagnosis	39

TABLE 6. *Referrals Made for Services for Children 0–3 Entering the State's Legal Custody*

Type of Referral	*Percentage of Children Receiving This Referral (%)*
Medical	60
Primary physician	44
Specialist	10
Dental	17
Developmental	76
Early intervention evaluation	42
Other further developmental evaluation	25
Head Start enrollment	16
Mental health	33
Outpatient treatment	22
Day treatment	3
Other mental health treatment	8
Any type	83

Referrals Made for Services

The vast majority (83%) of children assessed received referrals for needed services (see Table 6). The referrals can be broken down into three major areas: medical, developmental, and mental health. Sixty percent of these children were referred for medical services, usually to their primary health-care provider for needed follow-up on subacute conditions noted at the exam. Developmental services, usually further evaluation, were recommended for 76% of the children. Mental health services, most often outpatient psychotherapy for the child or caretaker–child dyad, were recommended for 33% of the children. It should be remembered that children already receiving services were usually screened out of being assessed in that area of need. Thus, the actual need for developmental services is probably higher for all children 0–3 entering the state's legal custody than the percentage reported from these referral data.

DISCUSSION

Clearly, these young children entering the state's legal custody are a high-risk, high-need population. In addition to the maltreatment these children were exposed to, there are many other factors that could affect their development:

- prenatal exposure to substances,
- domestic violence,
- poverty,
- substance abuse in the home,
- placement in foster care homes with many children, or
- placement with caretakers without prior experience with foster children in this age range.

These risks are clearly manifesting themselves in high needs as indicated by the percent-

ages of children above clinical cutoffs on developmental and mental health assessments. Referrals were made for the vast majority of children. Six-month follow-up phone calls are under way to track the implementation of these referrals.

Assessment of these youngest foster children is clearly important. Birth parents can be unreliable sources of information about their children's needs. Unlike older children, there are few reporters, in the form of teachers or the children themselves, of past history and problems to provide historical context for present functioning. It takes a skilled assessment to tease out the competing explanations of a test result of delay. It could be a temporary regression in response to placement or it could be a delay based on neglect that is easily remedied in an enriched environment or it could be a delay that needs professional intervention as soon as possible. Foster parents and caseworkers have neither the training, the time, nor often the awareness of the need to conduct such an assessment. It is clear much advancement is needed in research and policy to ensure that these youngest foster children have their needs identified and met. Because foster children are such a high-risk group, the mission of this program was to be available to assess *every* child entering the state's legal custody. Already existing in the community was an in-depth, comprehensive diagnostic service affiliated with a medical center which usually had a substantial waiting list. More widely available and used were 10–15 min well-child examinations done by a pediatrician. Our goal was to do an intermediate level of evaluation that could be done with large numbers of children in a timely fashion within the fiscal constraints of the program. We wanted this evaluation to be able to responsibly state whether the child needed further evaluation that was more in-depth or whether particular services should be provided.

By designing the evaluation to occur in only one appointment, we have clearly not followed recommendations for evaluations of young children (e.g., Greenspan, 1992; Greenspan & Meisels, 1996). Given that our evaluation is not comprehensive and definitive, we still assert that it is adequate for the purpose of identifying children from a high-risk population for further services. However, the data from this study should be replicated using more in-depth evaluations before making generalizations about young children in foster care.

REFERENCES

Abidin, R. (1995). Parenting Stress Index (3rd ed.). Odessa, FL: Psychological Assessment Resources.

Achenbach, T.M. (1992). Manual for the Child Behavior Checklist/2–3 and 1992 Profile. Burlington, VT: University of Vermont Department of Psychiatry.

Chernoff, R., Combs-Orme, T., Risley-Curtiss, C., & Heisler, A. (1994). Assessing the health status of children entering foster care. Pediatrics, 93, 594–601.

Dale, G., Kendall, J., & Stein-Schultz, J. (1996, June). Refining screening protocols of "at-risk" children entering foster care. Poster session presented at the APSAC's 4th National Colloquim.

DeGangi, G., & Greenspan, S. (1989). Test of Sensory Functions in Infants (TSFI). Los Angeles: Western Psychological Services.

DeGangi, G., Poisson, S., Sickel, R., & Wiener, A. (1995). Infant/Toddler Symptom Checklist: A screening tool for parents. Tucson, AZ: Psychological Corporation.

GAO (1995a). Complex needs strain capacity to provide services. (GAO/HEHS-95-208). Washington, DC: Author.

GAO (1995b). Foster care: Health needs of many young children are unknown and unmet. (GAO/HEHS-95-114). Washington, DC: Author.

Greenspan, S. (1992). Infancy and early childhood: The practice of clinical assessment and intervention with emotional and developmental challenges. Madison, CT: International Universities Press.

Greenspan, S., & Meisels, S. (1996). Toward a new vision for the developmental assessment of infants and young children. In S. Meisels & E. Fenichel (Eds.), New visions for the developmental assessment of infants and young children (pp. 11–26). Washington, DC: Zero to Three: National Center for Infants, Toddlers, and Families.

Gresham, F., & Elliott, S. (1990). Social Skills Rating System Manual. Circle Pines, MN: American Guidance Service.

Hochstadt, N., Jaudes, P., Zimo, D., & Schachter, J. (1987). The medical and psychosocial needs of children entering foster care. Child Abuse and Neglect, 11, 53–62.

Kendall, J., Dale, G., & Plakitsis, S. (1995). The mental health needs of children entering the child welfare system: A guide for caseworkers. The APSAC Advisor, 8, 10–13.

Klee, L. (1997). Foster care's youngest. American Journal of Orthopsychiatry, 67, 290–299.

National Center on Clinical Infant Programs (1994). Diagnostic Classification: 0–3. Arlington, VA: Author.

Newborg, J., Stock, J., & Wnek, L. (1988). Battelle Developmental Inventory Screening Test. Chicago: Riverside Publishing Co.

State of Oregon (1993). The cohort study—children entering out-of-home care. Report One: A description of children and families. Salem, OR: Author.

Urquiza, A., Wirtz, S., Peterson, M., & Singer, V. (1994). Screening and evaluating abused and neglected children entering protective custody. Child Welfare, 73, 155–171.

Wulczyn, F., Harden, A., & Goerge, R. (1997). An update from the multistate foster care data archive: Foster care dynamics 1983–1994. Chicago: Chapin Hall Center for Children.

Zero to Three. (1994). Diagnostic Classification: 0–3. Washington, D.C.: Author.

Copyright of Infant Mental Health Journal is the property of Michigan Association of Infant Mental Health and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.