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May 2011

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Who Are the Infants in Out-of-Home Care? An Epidemiological and Developmental Snapshot

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One of the many challenges of studying the population of children in out-of-home care is the fact that they are not a single, homogenous group of children. Rather, each child enters out-of-home care with a unique set of vulnerabilities and strengths. Perhaps no subset of the out-of-home care population is as distinct as the infant population. In this brief, we argue that from a policy perspective, infants represent a distinctive subset of the foster care population with service needs and developmental vulnerabilities and strengths that distinguish them from other children in out-of-home care.

Specifically, in this brief we examine five key domains in which infants in the out-of-home population differ from older children:

- 1) **Incidence of first-time out-of-home placements.** Infants are a disproportionately large percentage of first-time admissions to out-of-home care. In fact, almost 1 in 4 children admitted to care for the first time is under the age of 1 year.
- 2) **Duration in care.** Children who enter care as infants will, on average, spend more of their childhood in care than older children entering care.
- 3) **Experiences in care.** Infants spend more of their time in foster homes and less time in group homes than older children. Infants are also adopted at higher rates than older children, with 50 percent of children who enter care at less than 3 months of age leaving care with a new set of parents.
- 4) **Characteristics.** Infants who enter care differ from older children in terms of their own characteristics, characteristics of their birth families, and characteristics of the contexts in which they live.
- 5) **Vulnerability for delayed development.** Infants in care are particularly vulnerable to delays in emotional, social, and cognitive development. This may place them at particularly high risk for the negative outcomes commonly observed among foster children, including school failure, drug and alcohol abuse, and criminality.

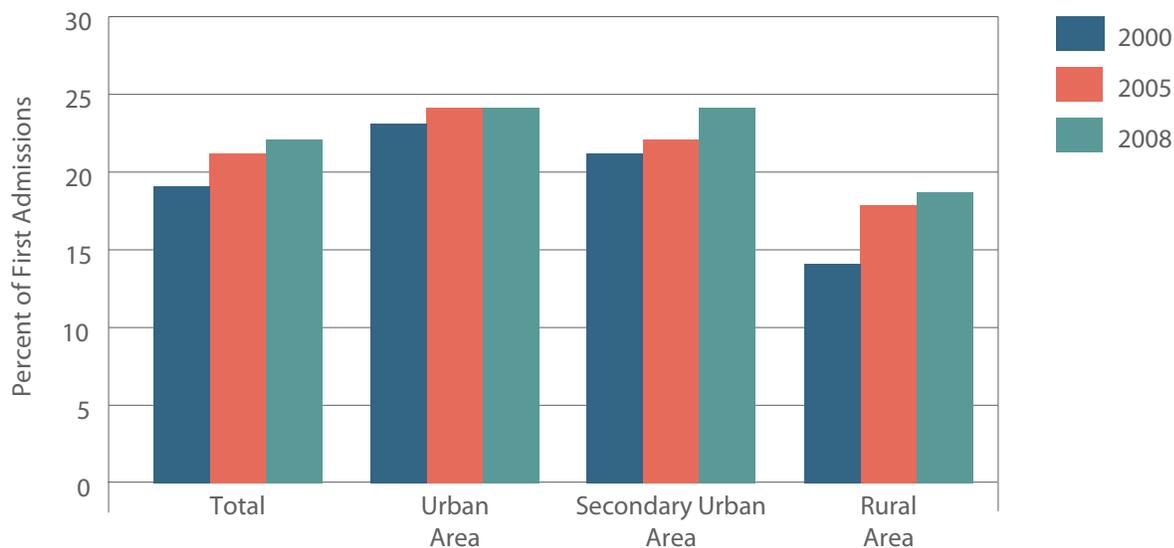
We examine the first three of these domains using the Multistate Foster Care Data Archive, which includes longitudinal placement data allowing us to analyze admissions to care as well as moves across placement settings, permanency outcomes, returns to care, and the length of time children spend in care. These analyses include data from 14 states, in all regions across the country, which provide information for the years spanning 2000 to 2008. These analyses utilize placement data for children placed for the first time between January 1, 2000 and December 31, 2008. We examine the fourth domain using weighted data from the National Survey of Child and Adolescent Well-Being (NSCAW). NSCAW is a nationally representative survey of over 5,500 children aged 0 to 14 who were investigated for child maltreatment in 93 designated areas (counties or child welfare jurisdictions) within a 15-month period starting in October 1999. Finally, as no data exist at the epidemiological level, we examine the fifth domain, developmental vulnerabilities, by summarizing the existing research on smaller samples of foster infants and toddlers.

Incidence

In 2008, 22 percent of children being admitted into out-of-home care for the first time were under the age of 1 year. This was an increase from 19 percent in the year 2000. (See Figure 1.) In urban areas, defined as the largest county in each state based on population, infants comprised 24 percent of first-time admissions. Secondary urban counties included all other counties with a large city and the remaining counties were defined as rural. In rural areas, infants were a smaller proportion of overall admissions; however, they were a more dramatically growing subset. Whereas in 2000, 14 percent of first-time admissions in rural areas were infants, this had risen to 19 percent in 2008.

Another way of conceptualizing the number of infants entering the foster care system relative to older children is by creating an incidence rate per 1,000 children. This is the number of children who are placed into care divided by the number of children in the risk set and then multiplying that number by 1,000.

Figure 1
Infants Are a Growing Proportion of First-Time Admissions to Care.



For the year 2000, the rate of placement for infants was 7.6 per 1,000. By 2008, this number had increased to 8.9. For older children, the rate of placement was 1.8 in 2000 and stayed the same in 2008. *Thus, the risk of placement for infants was four times greater than for older children in the year 2000, and this disparity actually increased by the year 2008.*

Duration

Infants are not only the largest group of children admitted into out-of-home care, they also are the group who spends the greatest amount of time in care once admitted. This is particularly true for the youngest infants. This long length of stay is partly due to the fact that infants are more likely to be adopted than older children and reunification must be ruled out in order for adoption to take place.

These data reveal two distinct patterns, as shown in Figure 2. First, children who enter care prior to the age of 3 months spend 33 percent more time in care than infants who enter care between the ages of 3 and 12 months, and they spend 50 percent more time in care

than older children. Second, the mean length of time in care fell by 2 months for the youngest infants while it increased slightly for infants who entered care between the ages of 3 and 12 months.

Placement Experience

Not only do infants enter care at higher rates than older children and stay in care longer but they also have different experiences once they are in care. Figure 3 identifies the placement setting where children spent 50 percent or more of their time. The most noticeable difference between infants and older children in care type is within the use of group care. Fewer than 6 percent of infants spend more than 50 percent of their time in out-of-home care in a group care setting. For infants, this is often a medical setting. For older children, the use of group care is much more common although it decreased for older children between 2000 and 2008.

Overall, the most common place for infants and older children to spend their time was in foster family care. At all three time points, over 60 percent of infants

Figure 2
Younger Infants Spend Longer Periods in Care.

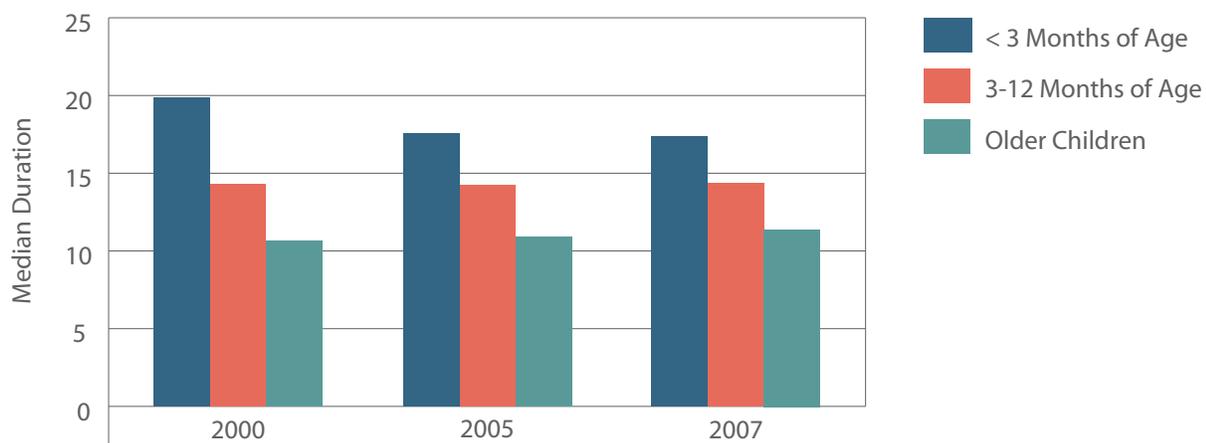
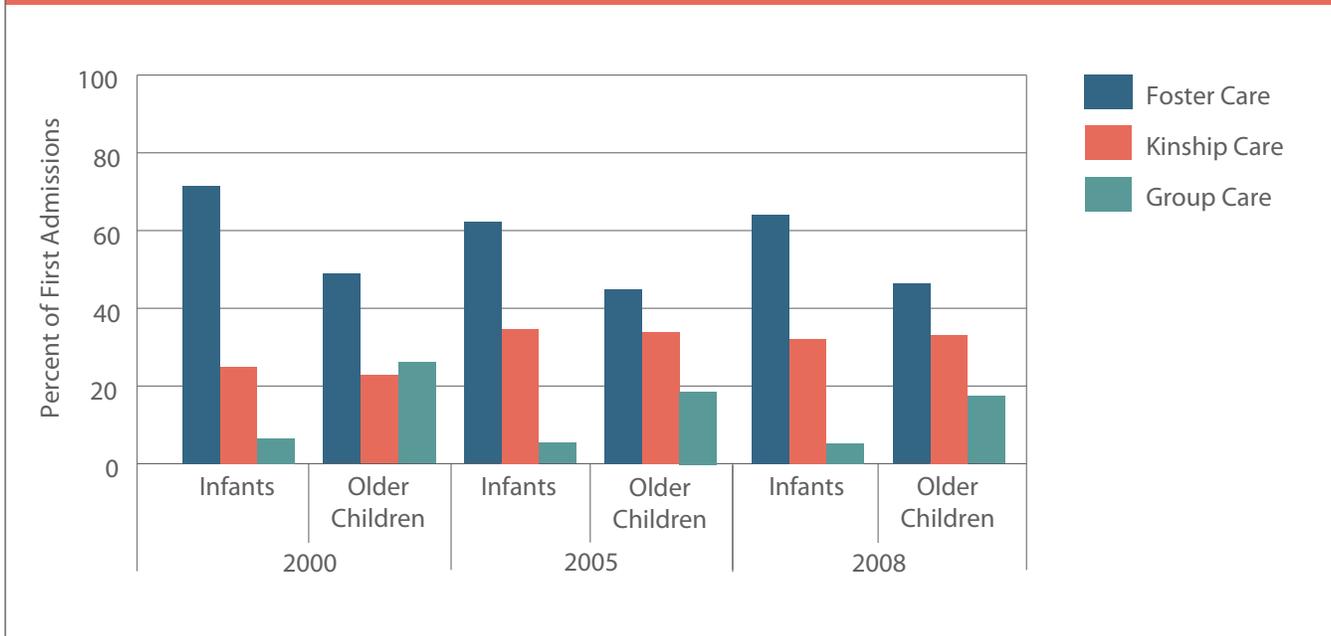


Figure 3
Infants Are More Likely to be Placed in Foster Family Care than Older Children.



spent most of their time in foster family care while for older children this number varied between 44 and 50 percent.

Child-placing agencies often attempt to find relatives to care for children entering care in an effort to provide familial continuity in the child’s life. Overall, the use of kinship care increased from about 20 percent in 2000 to just over a third in 2005 and 2008. Infants and older children appear to be almost equally likely to spend the majority of their time in kinship care.

Characteristics

Infants in care are unique in terms of their backgrounds and family characteristics. To examine specific characteristics of infants in care, we examined these children in the National Survey of Child and Adolescent Well-Being (NSCAW).

The Infants

Examining data from the NSCAW, we are able to create a composite “snapshot” of infants entering out-of-home care as shown in Table 1. We compare them to older children and find many differences and a few similarities.

Infants entering out-of-home care are most likely to be African American (39%) while older children are most likely to be white (48%). A slight majority of both infants and older children are female (53%).

When asked to categorize the most serious type of maltreatment reported, caseworkers selected physical neglect for 46% of the infants. This category included failure to provide as well as reports of unsanitary conditions and drug exposure prenatally. For older children, the most serious type of maltreatment was most often neglect, defined as a lack of supervision and including situations in which parents are arrested (28%).

Table 1
Comparing Characteristics of Infants and Older Children in Out-of-Home Care

	Number		Percent*	
	Infants	Children	Infants	Children
Race/Ethnicity				
White	12,283	108,827	30	48
Black	16,028	74,651	39	33
Hispanic	8,459	29,813	21	13
Other/Missing	3,985	14,690	10	6
Child Health Status				
Excellent	15,234	76,917	37	34
Very Good	9,030	88,497	22	39
Good	8,845	40,166	22	18
Fair/poor	7,645	22,401	19	10
Child Health Insurance				
Private, self-pay, other	2,061	47,863	5	21
Medicaid and state programs	38,694	180,119	95	79
Child Abuse Type				
Physical neglect – didn't provide	18,780	47,362	46	21
Neglect – no supervision, abandon	6,454	64,212	16	28
Emotional, sexual, moral maltreatment	2,136	37,353	5	16
Physical maltreatment	4,429	46,142	11	20
Gender				
Male	19,133	107,526	47	47
Female	21,622	120,455	53	53
Chronic Health Condition				
Yes	11,459	31,290	28	14
No	29,296	196,691	72	86

* Percents may not total 100 due to rounding and/or because missing data are included in the denominator.

As a group, infants admitted to care are less healthy than older children. Caregivers report that almost 19 percent of infants have fair or poor health with 28 percent of infants suffering from a chronic illness. This compares to only 10 percent of older children who are reported to have fair or poor health and only

14 percent of older children who are reported as having a chronic illness.

Infants are also more likely than older children to have their health insurance through Medicaid or a state program. Ninety-five percent of infants use

Medicaid or a state program; the remaining 5 percent have private health insurance or are self-paying or something else. The comparable numbers for older children are 79 and 21 percent, respectively.

The Birth Families

In the NSCAW, the investigative caseworkers conducted a risk assessment on each child’s family of origin. (See Tables 2 and 3.) This assessment

provides a glimpse into the birth families of the infants and children entering out-of-home care in the NSCAW sample.

According to caseworkers’ reports, 65 percent of families of infants had prior involvement with the child welfare system. This number was comparable to that of families of older children (66%). Caseworkers reported active alcohol and/or drug abuse by the primary caregiver, the secondary caregiver, or both,

Table 2 Characteristics of Families of Children in Out-of-Home Care				
	Number		Percent*	
	Infants	Children	Infants	Children
Prior Involvement with Child Welfare				
Yes	26,539	150,613	65	66
No	11,207	52,657	27	23
Caregiver Drug / Alcohol Abuse				
Yes	24,711	92,665	61	41
No	11,725	102,495	29	45
Prior/Active Domestic Violence				
Yes	18,655	83,591	46	37
No	16,332	114,754	40	50
Difficulty Paying Necessities				
Yes	23,269	88,209	57	39
No	12,504	112,980	31	50
Caregiver Recent Arrests				
Yes	16,870	54,172	41	24
No	17,992	118,194	44	52
Child with Special Needs/ Behavior Problem				
Yes	10,023	76,311	25	33
No	27,515	127,584	68	56
Caregiver Serious Mental Health Problem				
Yes	16,987	63,131	42	28
No	18,120	125,375	44	55

* Percents may not total 100 due to rounding and/or because missing data are included in the denominator.

for almost 41 percent of older children and almost 61 percent of infants. Families of infants were also more likely to have had a prior or active incident of domestic violence (46% of families of infants compared to 37% of families of older children). Recent arrests were reported for approximately 41 percent of primary caregivers of infants and for almost 24 percent of caregivers of older children.

Caseworkers indicated that over 79 percent of families of infants were experiencing high stress compared to 62 percent of families of older children. Financial stress was also more prevalent in the families of infants with caseworkers reporting that 57 percent of infants' families had difficulty paying for necessities but only 39 percent of the families of older children had difficulty paying for necessities.

Table 3 Comparing Characteristics of Infants' and Older Children's Caregivers				
	Number		Percent*	
	Infants	Children	Infants	Children
Caregiver Intelligent/Cognitive Impairment				
Yes	6,196	20,422	15	9
No	28,821	170,741	71	75
Caregiver Unrealistic Expectation of Child				
Yes	11,737	85,504	29	38
No	23,134	104,792	57	46
Caregiver Poor Parenting Skill				
Yes	28,533	156,365	70	69
No	7,136	42,440	18	19
Caregiver Excessive Discipline of Child				
Yes	5,189	58,934	13	26
No	30,552	136,551	75	60
Caregiver High Stress in Family				
Yes	32,336	141,800	79	62
No	4,013	59,679	10	26
Low Social Support				
Yes	18,606	105,072	46	46
No	18,186	94,570	45	42
Caregiver History of Child Abuse/Neglect				
Yes	19,635	64,604	48	28
No	16,937	128,213	42	56

* Percents may not total 100 due to rounding and/or because missing data are included in the denominator.

Caseworkers indicated that 42 percent of infants were being cared for by primary caregivers with a serious mental health or emotional problem compared to 28 percent of older children. They also indicated that intellectual or cognitive impairments were more common in the primary caregivers of infants (15%) than in the primary caregivers of older children (9%). Over 48 percent of infant caregivers and 28 percent of caregivers of older children—that is, primary caregivers, secondary caregivers, or both—had a history of abuse or neglect themselves.

In other ways, the families of infants and older children were similar. Many of these families, almost 46 percent, had low levels of social support. Caseworkers also reported that the great majority of primary caregivers had poor parenting skills (70% of primary caregivers of infants and almost 69% of primary caregivers of older children).

Caseworkers reported more special needs or behavior problems among older children (33%) than infants (25%); however, it is likely that the term *behavior*

problems was difficult to apply to the youngest infants. Caseworkers were more likely to report that caregivers of older children had unrealistic expectations of the child (38%) than were caregivers of infants (29%).

Caseworkers also indicated that in almost 13 percent of cases the primary caregiver, secondary caregiver, or both used excessive discipline of the child—a seemingly high number when considering that these children were under the age of 1 year. This number was higher for parents of older children at 26 percent.

Their Context

The NSCAW data concerning communities and home setting is derived from questions asked of current caregivers. As a result, these data reflect where the infants and children in care are living at the time they are in care rather than their family of origin. (See Table 4.)

Interestingly, infants and children are almost equally likely to come from a neighborhood that has *serious problems* as defined by the caregivers.

Table 4 Neighborhood Context and Placement Setting				
	Number		Percent	
	Infants	Children	Infants	Children
Neighborhood Quality				
No Serious Problem	36,676	199,987	90	88
Serious Problem	4,079	27,995	10	12
Urbanicity of PSU				
Non-urban	6,414	37,502	16	16
Urban	34,341	190,479	84	84
Child Service Setting				
Foster Home	21,484	82,139	53	36
Kin Care Setting	18,346	102,332	45	45
Group Home/ Res Program	513	22,881	1	10
Other OOHCArrangement	412	20,630	1	9

Twelve percent of the caregivers of older children and 10 percent of the caregivers of infants described their neighborhoods this way.

Infants are almost entirely in either foster homes (53%) or in kin care settings (45%). The majority of older children are also in either kin care settings (45%) or foster homes (36%); however, unlike the infants, a sizeable minority of older children is in group homes or residential programs (10%) as well as in other out-of-home care arrangements (9%).

Both infants and older children come from largely urban areas (84%).

Vulnerability for Delayed Development. Much of development during infancy and early childhood is dependent on sensitive and nurturing care from a primary caregiver. There is evidence that the absence of such care on a chronic basis creates a kind of “toxic stress,”¹ and that this stress has potential to compromise most areas of development, including emotions, behavior, cognitive functioning, and even health.² Why is this so? Humans (and indeed many other species) evolved with the capacity to tolerate relatively high levels of stress for short durations. We are equipped with a neuroendocrine system called the hypothalamic-pituitary-adrenal (HPA) axis, which produces the hormone cortisol. Cortisol, when released in response to stress, helps mobilize the

body’s stored energy by metabolizing fat into sugars, and also stimulates the immune system. In short, it helps us regulate stress. However, the HPA axis was not designed to be activated on a long-term basis. Under conditions of chronic stress, the system begins to break down, rendering the individual much more vulnerable to stress-related illnesses.³ This situation is exacerbated in infancy, when the infant is dependent on external support to reduce stress.⁴ For example, babies cannot feed themselves or change their own diapers, or soothe themselves when upset; this requires a parent or other caregiver both to identify the infant’s need and to address it. The absence of such care produces the type of chronic stress that the HPA axis is not well equipped to deal with, and the individual is thus vulnerable.

Based on the above profiles of foster infants, we know that the experience of neglect is extremely common, and that this is a very clear source of toxic stress. Such stress is compounded by abuse and trauma that the infant may have suffered prior to entering care.⁵ It is also made worse by another very common experience—caregiver transitions. Indeed, there is evidence that infants and children show dysregulated cortisol levels immediately following a move between foster homes, or even a positive move from foster care to a permanent placement (such as being reunified with biological parents or adopted).⁶

¹ Shonkoff, J. P., & Bales, S. N. (2011). Science does not speak for itself: Translating child development research for the public and its policymakers. *Child Development*, 82(1), 17-32. doi:10.1111/j.1467-8624.2010.01538.x

² Shonkoff, J. P., Boyce, W. T., & McEwen, B. S. (2009). Neuroscience, molecular biology, and the childhood roots of health disparities: Building a new framework for health promotion and disease prevention. *JAMA: Journal of the American Medical Association*, 301(21), 2252-2259. doi:10.1001/jama.2009.754

³ McEwen, B., & Lasley, E. N. (2007). Allostatic load: When protection gives way to damage. In A. Monat, R. S. Lazarus, & G. Reeve (Eds.), *The Praeger handbook on stress and coping* (Vol.1) (pp. 99-109). Westport, CT: Praeger/Greenwood.

McEwen, B. S., & Wingfield, J. C. (2010). What is in a name? Integrating homeostasis, allostasis and stress. *Hormones and Behavior*, 57(2), 105-111. doi:10.1016/j.yhbeh.2009.09.011

⁴ Bernard, K., & Dozier, M. (2010). Examining infants’ cortisol responses to laboratory tasks among children varying in attachment disorganization: Stress reactivity or return to baseline? *Developmental Psychology*, 46(6), 1771-1778. doi:10.1037/a0020660

⁵ Gunnar, M. R., Fisher, P. A., & The Early Experience, Stress, and Prevention Network. (2006). Bringing basic research on early experience and stress neurobiology to bear on preventive interventions for neglected and maltreated children. *Development and Psychopathology*, 18(3), 651-677. doi:10.1017/S0954579406060330

⁶ Fisher, P. A., Gunnar, M. R., Chamberlain, P., & Reid, J. B. (2000). Preventive intervention for maltreated preschool children: Impact on children’s behavior, neuroendocrine activity, and foster parent functioning. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39(11), 1356-1364. doi:10.1097/00004583-200011000-00009

Finally, an area that has received too little attention but that occurs with great frequency involves intrauterine exposure to drugs and alcohol. In addition to the well-documented neurotoxic effects of these substances, there is emerging evidence that prenatal stressors compound the effects of postnatal adversity on the development and functioning of the HPA axis and on other brain and biological systems affected by chronic stress.⁷ Although there are no precise estimates of the prevalence of intrauterine substance exposure, rates of drug and alcohol problems are extremely high among child welfare system-involved parents (as many as 80% of these individuals are substance abusers,⁸ and it is unlikely that many of them discontinue use during pregnancy). In short, many infants who end up in out-of-home care enter the world already affected by toxic stress and continue to be exposed throughout infancy to environments and events that render healthy development quite challenging.

It should not be surprising, therefore, that foster infants and toddlers typically exhibit disparities relative to their nonmaltreated peers across most domains of functioning. They achieve developmental milestones later (e.g., walking and talking), they are rated by caregivers as difficult to soothe, and they may even show signs of “failure to thrive,” a condition that includes small physical stature and reduced head

circumference. Thus, screening and early intervention are extremely important for this age group.

Notwithstanding the expected disparities that infants in out-of-home care exhibit as a group, some individuals do prove remarkably resilient in spite of chronically adverse prenatal and early environments.⁹ Indeed, in all studies of infants and young children in care, there is always a subgroup who appear developmentally on or ahead of schedule. A number of explanations have been offered for this phenomenon, including the possibility that these individuals are less sensitive to environmental influences (due to genetic or other constitutional variables) or certain aspects of their environments (e.g., the presence of a sufficient level of care even in the context of a maltreating parent to permit healthy development) that promote such resiliency.¹⁰ This is an area of developing, and quite important, knowledge.

What can be done to improve the odds of success once negative events have occurred? There is extremely promising evidence that a large amount of recovery is possible following exposure to early stress if adequate support is provided to parents, foster parents, or other caregivers, and if the proper therapeutic techniques are employed. Indeed, a number of studies have now shown that it is not only possible to promote developmental progress among foster infants and

⁷ Fisher, P. A., Kim, H. K., Bruce, J., & Pears, K. C. (in press). Cumulative effects of prenatal substance exposure and early adversity on foster children’s HPA axis reactivity during a psychosocial stressor. *International Journal of Behavioral Development*.
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⁸ Besinger, B., Garland, A., Litrownik, A., & Landsverk, J. (1999). Caretaker substance abuse among maltreated children placed in foster care. *Child Welfare*, 78, 221–239.

Young, N. K., Boles, S. M., & Otero, C. (2007). Parental substance use disorders and child maltreatment: Overlap, gaps, and

⁹ Houshyar, S., & Kaufman, J. (2005). Resiliency in maltreated children. In S. Goldstein & R. B. Brooks (Eds.), *Handbook of resilience in children* (pp. 181–200). doi:10.1007/0-306-48572-9_12

¹⁰ Kaufman, J. (2008). Genetic and environmental modifiers of risk and resiliency in maltreated children. In J. J. Hudziak (Ed.), *Developmental psychopathology and wellness: Genetic and environmental influences* (pp. 141–160). Arlington, VA: American Psychiatric Publishing.

young children, but that it may also be possible to mitigate toxic stress effects on specific brain and biological systems, producing more typical functioning in these systems.¹¹ It is important to recognize that the research in this area doesn't indicate that it is possible to completely "undo" the effects of what has occurred. It may be that foster infants, regardless of whether

environments subsequently improve, remain sensitive to future stress. It is not clear whether there is a limit to plasticity, and an amount of adversity past that makes recovery less likely. Clearly, more information is needed, and fortunately work is being conducted in this area at present.

¹¹ Fisher, P. A., & Stoolmiller, M. (2008). Intervention effects on foster parents stress: Associations with child cortisol levels. *Development and Psychopathology*, 20(3), 1003-1021. doi:10.1017/S0954579408000473
Dozier, M., Peloso, E., Lewis, E., Laurenceau, J.-P., & Levine, S. (2008). Effects of an attachment-based intervention of the cortisol production of infants and toddlers in foster care. *Development and Psychopathology* 20 (3), 845-859. doi: 10.1017/5095457 9408000400

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Recommended Citation

Wulczyn F., Ernst, M. & Fisher, P. (2011). *Who Are the Infants in Out-of-Home Care? An Epidemiological and Developmental Snapshot*. Chicago: Chapin Hall at the University of Chicago

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