

Cohon, D., Fritz, D., Brady, M., Cooper, B. A., Needell, B. & Smith, K. 2001 "Specialized foster Care for Medically Complex, Drug-Exposed, HIV Positive Infants: The Baby Moms Program", *Children and Youth Services Review*. Vol. 23, No. 11, 831-863

Specialized Foster Care for Medically Complex, Drug-Exposed, HIV Positive Infants: The Baby Moms Program

J. Donald Cohon, Ph.D., Director
Institute for the Study of Community-Based Services
Edgewood Center for Children and Families
One Rhode Island Street
San Francisco, CA 94103

Diane Fritz, M.S.
Edgewood Center for Children and Families

Monica Brady, B.S.

Bruce A. Cooper, Ph.D.
California School of Professional Psychology/Alameda

Barbara Needell, MSW, Ph.D.
Center for Social Services Research
School of Social Welfare
University of California, Berkeley

Karen K. Smith, M.D.
University of California San Francisco
Baby Moms Unit

The findings and views presented in this paper are solely those of the authors and do not represent opinions of the San Francisco Department of Human Services, the City and County of San Francisco or Edgewood Center for Children and Families.

The analysis and preparation of this manuscript was supported primarily by project MCH-065080 from the Maternal and Child Health Bureau program, Health Resources and Services Administration, Department of Health and Human Services. Additional support came from The David and Lucile Packard Foundation, The Zellerbach Family Fund, and The California Endowment. The authors gratefully thank the staff, foster families and clients of the San Francisco Baby Moms program. Reprints may be obtained from J. Donald Cohon, Institute for the Study of Community-Based Services, Edgewood Center for Children and Families, 1 Rhode Island Street, San Francisco, CA 94103 [dcohon@itsa.ucsf.edu]

Published in Children & Youth Services Review (2001)

Abstract

The nineteen eighties saw a rise in the number of medically complex infants, some HIV positive, entering foster care. Nationally, a variety of programs were developed in response to this situation, many of them at private agencies. The forces of more than a decade ago that contributed to the increased placements of these babies in foster homes continue to affect families today. This paper describes San Francisco's Baby Moms program, a specialized foster care unit in the City's Department of Human Services. Federal support created an external private agency-based project to support Baby Moms, the Fragile Infant Special Care Program, forging a unique private-public partnership. In addition to explaining the program model, descriptive characteristics of infants and mothers are presented. Lastly, we discuss the relevant practice and policy lessons learned.

Background

Beginning in the early nineteen eighties, a confluence of factors led to an increase in the number of foster children, particularly infants, with complex medical needs. Published reports called attention to a “boarder” baby crisis, the crack cocaine epidemic, and the growing number of HIV positive infants (Feig 1990; U.S. General Accounting Office [GAO] 1990; Child Welfare League of America [CWLA] 1990; U.S. Department of Health and Human Services [DHHS] 1992a; Barth 1996). Advances in medical technology resulted in increased survival rates for infants born with life threatening conditions and very low birth weights (Hack & Fanaroff 1989; U. S. GAO 1989a; Kohrman 1991; Horbar & Lucey 1995; Bennett 1997). Due to extensive drug use, many parents could not adequately raise these newborns with special health care needs. Because some states viewed in utero drug exposure as child abuse, a large number of these children required foster care placement (Ruff, Blank & Barnett 1990).

Service Responses: When confronting a social problem of escalating magnitude, one federal government strategy is to appropriate funds through a competitive grant process to create demonstration projects in affected areas across the country (DHHS 1992b; U.S. GAO 1992). Each locale has unique demographics, preexisting agency relationships, and political considerations which influence choices about how best to provide services and produce different models including collaborative models, hospital-based services, and welfare agency-based units (Anderson 1990b; Besharov 1994; Hochstadt & Yost 1991).

Initially, medical centers developed programs to serve these affected families (Foster, Davis, Whitworth & Skinner 1982; Davis, Foster & Whitworth 1984; Lelyveld 1990; Boland 1990; Cabat 1990; Septimus 1990). Simultaneously, many child welfare agencies responded to the HIV crisis by contracting with private agencies to recruit, train, and support a unique cadre of specialized foster homes (Anderson 1990a). Hospital-based and foster agency programs developed partnerships reflecting particular aspects of their local contexts (Cabat 1990; Septimus 1990; Gurdin & Anderson 1987; Gurdin 1990; Rendon, Gurdin, Bassi & Weston 1989). Recognizing the multiple needs of these children and families, a number of these innovative programs promoted transagency coordination and multidisciplinary collaboration (Woodruff & Sterzin 1990; Boland 1990).

Some health care providers were critical of public welfare agencies, believing that “The foster care system was not designed to serve children’s long-term medical, emotional, and developmental needs nor is it prepared to respond effectively to major shifts in social and economic conditions such as increasing poverty and drug use.” (Klee, Soman and Halfon 1992:100) These authors advocate case management of infants and caregivers by a health care provider with support to child welfare workers and special training for foster parents. To address problems of fragmented services they implemented a hospital-based case management model to provide comprehensive health services to children in foster care (Halfon, Berkowitz & Klee 1993).

Another approach is the public welfare agency model. Deciding not to contract services to private organizations, Pennsylvania passed legislation to provide early intervention and training to drug-exposed infants and their families. They used existing public services, fostered collaboration between state-level agencies, assigned responsibility to the Public Welfare agency for infants zero to three, and then shifted them to the Department of Education from ages three to five (Antoniadis & Daulton 1992).

This paper describes an alternative welfare agency model. The Baby Moms program is a specialized foster care unit in the Family and Children’s Services Division (FCS) of San Francisco’s Department of Human Services (DHS). We first describe the program model, which for seven years received additional staffing and technical assistance from a federally funded

project at a private agency. This is followed by a discussion of characteristics of infants and their biological mothers. Finally, we discuss the lessons learned during the project period and make program and policy recommendations.

Baby Moms Unit and Fragile Infant Special Care Program

Background: Historically in San Francisco, foster children with complex medical needs or significant developmental delays were placed in special group home settings or in residential institutions. In the early eighties, the DHS implemented a Therapeutic Foster Homes program, creating a special unit for latency aged children with challenging behaviors. Foster parents with special skills to work with these children were recruited for this program, received ongoing training, and were paid a higher foster care board rate. Between 1983 and 1986, the number of drug-exposed infants with medical needs entering foster care increased alarmingly (San Francisco Department of Public Health [DPH] 1989). In 1987, DHS' Director of FCS conceived of a unit modeled after the Therapeutic Foster Homes program to care for these infants, some of who were HIV positive. A psychologist, who had consulted with FCS for ten years, was asked to help design and implement the program. DHS staff christened the program unit Baby Moms. The purpose of the program was twofold: 1) to provide severely medically compromised infants quality care in a home environment; and 2) to maintain infants in one placement until a permanency plan could be implemented or, in the case of terminally ill children, until death. Having the unit within FCS and contracting for medical support gave DHS staff the opportunity to monitor the psychosocial and medical status of these infants.

Funding: Initially, Federal Title IV-B and Medi-Cal funds were used to fund Baby Moms. In 1988 California passed SB 2076, which required the State Department of Social Services (SDSS) to establish one pilot project in California for foster parents of HIV positive and/or infants with AIDS. San Francisco's Baby Moms became the pilot project, and provided the following services: 1) Recruitment of foster parents willing to care for children two years of age and under who tested positive for antibodies to HIV or who were diagnosed with AIDS; 2) Training and education for each new foster parent; 3) Support for foster parents participating in the project, which included respite care and counseling.

SB 2076 funding began in 1989 and continued for two years. This enabled DHS to pay for a part-time program coordinator, a part-time pediatric nurse specialist, a consulting pediatrician, and a psychologist. DHS matched this special state grant with in-kind staff and other support services. As the program evolved, it was "adopted" by a home mortgage company's foundation, and, for at least five years, received small donations from an annual event.

The Maternal & Child Health Bureau's (MCHB) division for Children with Special Health Care Needs (CSHCN) awarded DHS' Baby Moms a grant beginning October 1, 1990. This funding permitted Baby Moms to develop a computerized database, pay for a consulting pediatrician and a psychologist, carry out developmental assessments of infants and begin data collection of qualitative and quantitative information describing the program and the foster parents. This MCHB project ended September 30, 1993. A second grant was requested from the MCHB, and the grant recipient was changed to Edgewood Center for Children and Families, a private nonprofit agency with extensive experience in working with children. Edgewood was awarded a four-year grant in October 1993 for the Fragile Infant Special Care Program to provide DHS' Baby Moms unit medical consultation, developmental assessments and non-didactic developmental guidance for infants, foster parent support, data collection and analyses. This federally funded project at a private nonprofit organization was unique because it worked in partnership specifically to support a public agency's foster care unit, independent of DHS administrative control.

Fragile Infant Special Care Program (FISCP): FISCP staff were located at Edgewood and participated in weekly Baby Moms staff meetings at the DHS, monthly foster parent meetings, and social outings of the Baby Moms foster families. FISCP staff each contributed particular expertise to DHS staff and these foster families. Project personnel included a pediatrician, developmental specialist, project coordinator, and project director, who was also a psychologist.

FIGURE 1 ABOUT HERE

The FISCP pediatrician was employed part-time and provided regular medical reviews of Baby Moms infants, following their progress at weekly meetings and recommending changes to levels of care. The pediatrician gave DHS staff detailed medical information as needed and also conducted periodic training for caregivers on specific topics. Another important role that the pediatrician played was as liaison between DHS staff and a child's physician or surgeon.

FISCP's developmental specialist conducted periodic developmental assessments of infants. Based on these assessment findings and observation during home visits, the developmental specialist provided foster and kin families with non-didactic developmental guidance and support. These developmental assessments were shared with other medical and school personnel involved in the care of these babies. The developmental specialist also worked with some families after infants were discharged into their permanent placements. The developmental specialist was responsible for scheduling developmental assessments and maintaining contact with Baby Moms graduates.

FISCP's project coordinator worked with DHS staff to develop and implement a targeted recruitment program for minority foster families and also to revise and carry out a comprehensive training curriculum. Baby Moms staff grew to rely on the project coordinator to supply administrative and organizational support that was not available within the DHS.

The FISCP project director was employed half time. The project director, a clinical psychologist, worked with staff to design a database for recording infant demographic information and results of the developmental assessments, and he consulted with a statistician to analyze data to produce reports. The project director was available to support Baby Moms foster parents. He met privately (ensuring professional confidentiality) to hear their personal reactions to caregiving and sometimes served as an ombudsman providing a resource outside the DHS system for caregivers who wanted to discuss conflicts with the public bureaucracy. The project director consulted with Baby Moms staff to resolve issues with caregivers that involved enforcing public laws and regulations or questionable caregiving and also to address program design and policy matters. The project director also assessed new applicants to Baby Moms. In summary, Edgewood's FISCP regularly provided direct support and specific feedback to the DHS staff and caregivers to assist with the care of these children.

Baby Moms Program Model: The description of any service delivery model includes the dynamics and skills used in a helping process from the opening to the closing of a case for an identified population (Jackson 1996:585). The Baby Moms model involves processes that encompass foster parent selection, infant placement, HIV testing, referral, care levels, carrying, and permanency components. These processes are described below.

Foster parent selection: The foster parent is the primary provider of care for these challenging infants and children. Selection processes and personal qualities for foster parents caring for HIV infected infants have been described elsewhere (Gurdin 1987; Boland 1990; Feig.1990), as have the challenges in this undertaking (Chamberlain, Moreland & Reid 1992; U.S.GAO 1989b; U. S. GAO 1989c). Cohon & Cooper (1993) discuss the use of psychometric assessment in selecting

Baby Moms' foster parents. For this DHS unit, applicants with little or no prior baby care or pediatric medical experience are first required to provide care to infants in the DHS Medically Fragile Infant (MFI) shelter program for no less than six months. Children in MFI placement are at risk, but do not have medical needs so severe as to qualify them for Baby Moms. The length of time an applicant remains a MFI foster parent is determined on a case-by-case basis to provide enough time for mutual evaluation between the DHS and foster parent prior to placing a more challenging Baby Moms infant in that home. Once the MFI experience has been successfully completed, the individual begins other training for specific skills and subjects. These include: 1) HIV/AIDS (medication/drugs); 2) Intrauterine drug exposure, withdrawal, at risk infants—practical lessons and parent survival skills; 3) Fetal Alcohol Syndrome and Effects; 4) Prematurity; chronic lung disease; 5) Normal infant development; 6) What constitutes a major concern and when to call for help? Applicants with adequate pediatric medical or extensive foster care experience may not be required to provide care to MFIs, but they must attend the skills training.

Prior to discharging an infant, each hospital is responsible to adequately train the child's Baby Moms caregiver to carry out whichever of these specialized procedures may be required: 1) Tracheotomy care (including suctioning); 2) Use of apnea monitor; 3) Supplemental oxygen delivery; 4) Naso-gastric feeding and gastrostomy care; 5) Central line management; 6) Seizure management; 7) Infant and child CPR; 8) Administration of medications; and Dressing changes; Hospital training and certification particular to the needs of the baby takes place each time an infant is discharged to Baby Moms, regardless of how many times a caregiver has been trained.

As the number of children in kinship placements in California's foster care system has increased in the past decade (Barth, Courtney, Berrick & Albert 1994), Baby Moms placements have followed a similar pattern. In part, this growth of relative placements reflects the decline in the number of available foster homes, especially those with skills and commitment to care for ill infants requiring 24-hour observation (GAO 1998). The shift is also consistent with recommendations to provide home-based services to biological families with HIV on a voluntary basis, or to use kinship placements with appropriate supports (Gruendel and Anderson 1995). This change from foster to kinship placement has been accompanied by applying a slightly different standard for relatives accepted into the Baby Moms unit. Kin families are not required to have extensive prior experience with infants or to have a period of time caring for an infant in a MFI home. But DHS recognizes that specialized care for these medically complex infants is of paramount concern and requires that hospital staff provide training and determine if the relative caregiver is capable of meeting each infant's unique needs. As of December 1998, five of twelve (42%) active Baby Moms foster homes were kinship placements, reflecting a significant rise in the use of relative placements within the past year. This percentage of kinship homes is consistent with California Department of Social Services figures as of August 1998 showing 46% of children in the foster care system statewide reside in relative placements (CDSS 1998).

Infant placement criteria: The severity of the medical problem(s) determines whether the infant or child is placed in Baby Moms (greater severity) or designated medically fragile and assigned to a MFI home. Infants and children who have been exposed to drugs and/or alcohol in utero leading to significant irritability, who are HIV positive, who have AIDS, or who have a serious medical condition as determined by the program's pediatrician and pediatric nurse specialist, are eligible for the Baby Moms program. Most asymptomatic HIV positive infants, all HIV positive symptomatic, and all technologically dependent infants are placed in Baby Moms.

HIV Testing: The Perinatal Coordinator of the Department of Public Health (DPH) stipulates that all infants who are at "high risk" for HIV infection are to be tested as soon after

birth as possible. Consent for testing is obtained from the infant's parent. If the parent is absent or refuses consent, the Juvenile Court Judge is requested to sign a Minute Order giving consent. In the case of an infant placed in Baby Moms whose HIV status is unknown, precautions are taken by foster and kinship parents, until HIV test results are known.

Referral procedure: Baby Moms has a countywide referral and triage system that links staff of newborn nurseries at local hospitals with the program. Typically, hospital nursery staff identify potential referrals and contact the DHS' Emergency Response Unit (ERU) to assess the need for filing a dependency petition. If dependency is indicated and the infant's medical condition warrants, the infant is referred to Baby Moms. Hospital staff, or in some instances the DHS worker who is carrying the family's case, may simultaneously make referrals to the ERU, the Baby Moms' unit supervisor, and pediatric nurse specialist.

Once accepted, all staff discuss that particular infant's needs, considering the status of the biological parents and potential for reunification, and identify the most appropriate available home. At the time of placement, two medical folders are made: one for the DHS file and one for the Baby Moms home. Each file contains physician and dental reports, medical history reports, monthly foster parent reports and any specialty clinic evaluations. The duplicate file at the foster home is used in case of medical emergency if the child's regular physician is not available. This file accompanies the baby into its permanent placement.

For kinship placements, this placement process is more flexible. For example, infants have been placed directly with a relative after hospital staff have certified the kin caregiver's ability to meet the child's medical needs. Some kin families have been assigned initially to a DHS unit other than Baby Moms. After that unit's CWW determined the extent of the child's medical needs, the worker transferred the kin family to Baby Moms.

Care levels: All children in Baby Moms require specialized home care. There are three levels of care, examples of which are: a) LEVEL I—Developing premature babies; Chronic medical conditions that have stabilized; HIV exposed and without symptoms; At risk infant whose care level has decreased from II or III; b) LEVEL II—Adjustment for a chronic intensive care nursery baby with moderate problems (e.g. special tube feedings, apnea monitor, oxygen); HIV infected child with stable disease; and c) LEVEL III—Complicated medical needs for a child with AIDS; Ventilator management; Chronic disease in agonal stages; Multiple complex procedures/management.

Placement at different levels is determined after review by DHS based on the child's medical and social needs, acuity of current conditions, medical reports, Baby Moms' staff visits and home observation. Levels of care are reassessed and changed quarterly by the consulting pediatrician, pediatric nurse specialist, and other Baby Moms personnel. Each level of care is paid at the basic board rate of \$365 per month to which is added a special care supplemental rate that increases as more is required of the Baby Moms foster parent: The total rate for Level I is \$1,366 per month; Level II is \$1,589 per month; and Level III is \$1,923 per month.

Kinship placements are also reimbursed, but the board rates paid to kinship homes differ from those paid to regular Baby Moms foster homes. Including the basic rate, these levels for relatives are as follows: Level I \$735, Level II \$885, and Level III \$1035, which is \$900 less than the foster parent rate. If a child placed with a relative is evaluated and determined eligible for Regional Center services, the kin family receives an increase in their rate that is closer to that of Baby Moms foster parents.

Carrying/Ongoing Care: Once in placement, the foster parents assume the major tasks of caring for the infants with support from program staff. The average Baby Moms' CWW caseload size is between 20-25 infants and children. The CWW and/or pediatric nurse specialist see the infant and foster parent at a monthly face-to-face visit, and more frequently for ill infants. The

frequency of these visits varies depending upon children's and caregivers' needs, caseload size, and paperwork requirements of the staff. The CWW monitors services that the infant may receive from therapists and at specialty medical clinics. Efforts are made to engage and involve the biological parents with their child. Staff meet weekly to discuss programmatic issues related to foster parents and kin caregivers, infants, biological parents, discharge plans, monthly training, legal and legislative developments, community networking, recruitment and selection of new foster parents, research and evaluation, and special events.

Foster parents attend monthly meetings, and kinship caregivers are invited to come as well. These sessions provide opportunities for didactic training, supportive interaction and networking. When requested by foster parents, Edgewood's FISCOP psychologist convened problem-focused groups. The purpose of these groups was often to address communication issues between foster parents and Baby Moms staff or to deal with foster parents' feelings of loss and stress related to caregiving.

Because of round-the-clock demands, caregivers are required to take 50 hours of respite per month. Respite hours must be used each month and cannot be accrued. This requirement gives caregiver families a chance to rest and, hopefully, avoid burnout. Baby Moms may select and employ their own respite care workers, who must meet standard DHS agency requirements. A predominant concern has been the difficulty to find and maintain medically skilled respite workers. Caregivers with a large circle of family and friends did not express feelings of frustration around respite care issues, tending to employ family members for respite support.

Discharge and Permanent Plan or Child's Death: Baby Moms discharge policy assumes that moving an infant disrupts continuity of caregiving and is potentially harmful to the infant both physically and psychologically. For this reason an infant is discharged only after two requirements are met: 1) the infant's medical problems no longer require specialized care, or an appropriate placement is found that can meet the child's long-term medical needs, and 2) a permanent plan is in place for the infant.

The CWW develops a permanent plan that involves reunification with the biological parent(s), placement with a relative, foster-adopt/adoption, or long-term placement. Whenever possible, biological parents are invited to join foster parents in training and support meetings to facilitate reunification efforts. Even though it is the primary goal of staff to reunify the infant with his/her parents, this is a challenging task because of the difficulties these families face (especially regarding drugs). One of the more important factors in the reunification process is the foster parents' attitude. Caregivers are often active advocates for reunification, taking the initiative to arrange visits with biological parents or other permanent placement settings. In most cases these plans involve careful transitions with multiple visits by the family to familiarize the child with these new caregivers and the home environment. In some instances, Baby Moms caregivers who have not been included in permanency planning from the beginning have disputed DHS permanency efforts.

When a child with a life-threatening condition is placed into a Baby Mom's home, DHS provides the foster parent with a written statement indicating that this child is at risk of dying due to severe medical problems. The foster parent may show this document to the medical team and police if death occurs. The letter alerts authorities that the death was expected, asks them immediately to contact DHS' Special Investigator and may influence their treatment of the Baby Moms caregiver. When death is immanent and quality of life is marginal, children with terminal illnesses may have "Do Not Resuscitate" orders placed in their files. This step is taken only after extensive consultation with medical personnel and review by the DHS and court.

Infant and Maternal Characteristics

Since beginning Baby Moms in 1987, staff collected data about infants, but until the MCHB grant in 1990, there were no resources for developing a database and systematically recording and analyzing information. After the grant, it became possible to store detailed information about infants and their biological mothers. Thus, because several years passed before systematic data collection began, the descriptive information reported is incomplete for all variables. Nevertheless, the picture that emerges is of a group of newborns having below normal measurements with multiple medical problems associated with maternal drug use and lack of prenatal care.

Baby Moms Infants: One hundred seventy-three infants and children were served between 1987 and 1997. When these analyses were performed in 1998, 19 infants were active (one child living with a biological parent), and 154 were no longer in the program. Of the total number served, 80 (46%) were female and 93 (54%) were male. Ethnically, the infants were described as follows: 86 (50%) African-American; 29 (17%) Caucasian; 8 (5%) Hispanic; 7 (4%) Native American; 7 (4%) Asian/Pacific Islander; and 36 (21%) Multiracial.

Medical records for 25 of the babies noted they were small for their gestational age (SGA), and the median gestational age reported in weeks for 129 infants was 35, with a range from 21 to 42. Separately, Ballard exams performed with 76 babies resulted in a median gestational age of 33 weeks. For 130 babies, median Apgar scores at one minute were reported at 6, and for 131 infants, their five-minute Apgar median was 8. There were a small number of infants with very low Apgars at five minutes. Head circumference at birth reported for 109 infants ranged from 20 centimeters (cm) to 49 cm for a child with macrocephaly. Seven infants were reported as microcephalic. The median head circumference for all Baby Moms infants was 32 cm (12.6 inches), and their Mean head circumference of 31.3 cm is consistent with the Mean for typical infants born between 34 and 35 weeks (Hall, Froster-Iskenius & Allanson 1989).

The median birth weight for 154 infants was 2,282 grams, which is below the 2,500 grams figure (5 pounds 8 ounces), usually accepted as the marker for low birth weight (LBW). The infants' weight ranged from 567 to 4,139 grams, roughly one pound four ounces to eight pounds 14 ounces. Fifty-nine infants (38%) weighed over 2,500 grams; 50 (32%) are LBW, defined as less than 2,500 grams; 30 (20%) were very low birth weight (VLBW) defined as less than 1,500 grams; and 15 infants (10%) were extremely low birth weight (ELBW) defined as less than 800 grams.

Medical and social service records indicated that 136 (79%) of these children were born to a drug-abusing mother. For the total number of infants served, 80 (46%) had positive toxicology screens at birth. Although there are multiple drugs appearing in the toxicology panels of these newborns, cocaine was the most frequently occurring substance found in 56 (64%) of the 80 tested infants. Records show that 85 (63%) of these infants were affected by drugs at birth, demonstrating jittery motor movements with high pitched crying (noted as a type of withdrawal), and 32 (38%) of the 85 warranted severity ratings of moderate to severe.

Infants' HIV status during the time of the study showed that 18 (10%) were HIV infected; 31 (18%) sero-converted, that is they were born HIV positive but converted to negative during infancy; 84 (49%) were negative and 40 (23%) had unknown HIV status. Between 1987 and October 1993, 45 children were re-hospitalized after entering a Baby Moms foster home. Data recording the number of days these children stayed in the hospital were reported for 38 of the infants as follows: HIV negative (n=4) spent a Mean number of 26.8 days; HIV sero-converted (n= 5) spent a Mean number of 4.3 days; HIV positive/AIDS infants (n=5) spent a

Mean number of 33.4 days, and HIV status unknown (n=24) spent a Mean number of 15.9 days in hospital.

These 173 children presented with a variety of unique medical conditions, often seen in combination with other problems. Intra-ventricular hemorrhage was reported in 24 infants—fourteen Grade I, four Grade II and six Grade III. Twenty-six (15%) of all newborns received blood transfusions. Fourteen (8%) underwent surgical procedures following birth. For 17 infants (10%), hospital staff recorded the presence of Fetal Alcohol Syndrome (FAS) ranging from mild to severe. Seventeen babies (10%) required parenteral alimentation (e.g. nutritional support). Asphyxia was recorded for 19 infants (11%). Twelve of the babies (7%) experienced seizures while hospitalized. Of the total 173 infants served, five were positive for Hepatitis B at birth. Forty-eight infants (28%) had respiratory assistance in hospital, and 22 (13%) had chronic lung disease, broncho-pulmonary dysplasia, noted from mild to severe (n=12/7%). Forty-three of these infants (25%) received oxygen for a median number of six days. Sixty infants (35%) received antibiotics for a median number of seven days while in the hospital. Ninety-nine newborns (57%) were discharged from hospital into the Baby Moms program with cardio respiratory monitors, fifteen (9%) with oxygen and one required a ventilator in the foster placement.

The median number of post-delivery days in hospital reported for 140 (81%) infants was 22, ranging from 2 to 354. The median number of days spent in the Baby Moms program for 152 (88%) children was 370, ranging from a very short stay of 11 days, in the case of a child that was transferred to a skilled care facility, to a maximum of 1949 days for an HIV positive child who died while in the program. Infants' birth weight and the presence of HIV infection influenced the length of time in the Baby Moms program. Not surprisingly, the relationship of birth weight to number of days was generally inverse, increasing length of stay as infants' weight decreased. For infants with no HIV infection, those weighing more than 2500 gm (n=20/12%) were in Baby Moms a median number of 264 days. For LBW (n=19/11%) this rose to 397 days, for VLBW babies (n=16/9%) the stay was 500 days and for ELBW, less than 800 gm (n=10/6%) the number of Baby Moms' days was 483. For all HIV positive children regardless of weight, the median length of time in Baby Moms was 1041 days. A small number of infants placed at birth are now eight years of age and continue to live in Baby Moms homes, but were not included in the figures reported above, which describes cases that are no longer active.

At their time of discharge from Baby Moms, 154 children were placed in the following settings: Twenty-five infants (16%) had been reunified with biological parent(s); 32 (21%) were living with relatives; one was adopted directly from the program; 65 (42%) had been placed into foster-adopt (which is long-term foster care with the intention of eventual adoption); five infants (3%) were living with legal guardians; 10 (6%) were in long-term placement; 15 (10%) died while still in the program; and one had been transferred out of county. At follow-up in December 1997, these initial discharge placements had changed for 46 (30%) children. Twenty-three children (15%) were now with biological parents; 30 (19%) were living with a relative; 27 (18%) remained in foster-adopt, 37 (24%) had been adopted; two (1%) remained living with legal guardians; 15 (10%) were now in long-term placement; 19 (12%) were now deceased; and one remained out of county. Of the 25 (16%) children reunified with a parent, only 2 had re-entered the foster care system at follow-up.

TABLE 1 ABOUT HERE

Comparison of Baby Moms with other San Francisco Foster Infants: The FISCP shared Baby Moms data on 153 infants with the Center for Social Services Research (CSSR) at the University

of California Berkeley's School of Social Welfare for purposes of conducting comparative analyses with data drawn from the state Foster Care Information System (FCIS). The analysis was restricted to children who entered foster care from 1988 to 1994, and who were no more than seven months old at entry to care. Of these, 109 Baby Moms identification numbers were successfully matched to their FCIS records. These cases were compared to 1458 other infants no more than seven months old at entry to foster care from 1988 to 1994 in San Francisco. Vital Statistics data were matched for 59 of the 109 Baby Moms cases and approximately two-thirds of the control group. Data in the Baby Moms file that were not otherwise available due to unmatched birth data (e.g., birth weight, prenatal care) were included in the analysis dataset.

We found no significant differences on a number of variables: Ethnicity; Rates of re-entry to foster care after reunification (18% for Baby Moms and 20% for San Francisco); Number of placements; and Year of entry to foster care. However, Baby Moms infants were less likely than all San Francisco infants to enter foster care in their first month following birth, probably due to longer hospital stays for this medically involved group (Baby Moms was 48% versus 71% for San Francisco). Baby Moms infants were more likely to be LBW or VLBW: Only 34% of Baby Moms were normal birth weight compared to 68% for other San Francisco foster infants; Baby Moms had 34% LBW compared with 28% for San Francisco and 6% for a random sample of California infants (Needell & Barth 1998); and 33% of Baby Moms infants were VLBW compared with only 4% of the San Francisco group. The mothers in the Baby Moms group were less likely to have had prenatal care, with 43% of the newborns having no care in comparison with 20% of the San Francisco foster infants.

Examining their first stay in placement, a smaller proportion (20%) of Baby Moms infants were reunified with biological parents, and a higher proportion (28%) were adopted than the San Francisco foster infant group, (reunification 37% and adoptions at 19% respectively).

Two types of predictive models were constructed, one using logistic regression for 1988-1991 cohorts, modeling adoption/in care and reunification/in care at four years after entry, and the second a competing risks proportional hazards regression modeling hazard of adoption and reunification for all entries. Both types of models show an increased likelihood of adoption and a decreased likelihood of reunification for Baby Moms infants, controlling for ethnicity, birth weight, and prenatal care.

Maternal Characteristics: Because five women gave birth to twins and eight others had more than one child who entered the program between 1987 and 1997, there are data recorded for 160 mothers of the 173 infants. For 158 mothers for whom age is reported, the median age is 28, ranging from a girl of 13 to a 44 year old woman, with four of these ages 16 or younger. The ethnic breakdown for these women is 85 (53%) African-American; 47 (29%) Caucasian; 8 (5%) Latino; 6 (4%) Native American; 10 (6%) Asian/Pacific Islander; and 5 (3%) Multiracial. Maternal HIV status shows that 44 (28%) were HIV positive; 77 (48%) HIV negative; and 39 (24%) were Unknown.

As reported in hospital records and social services history files, 130 (81%) of these mothers used drugs during their pregnancy, and 71 (44%) tested positive to a toxicology screen performed after delivery. Results of the screening found that 51 women out of 71 (72%) tested positive for the presence of cocaine. These test results indicated that drug use often involved more than one substance. Other substances found in these tests included alcohol, heroin/opiates, amphetamines, PCP, marijuana, methadone and nicotine. Since the effects of different drugs in the system act both additively and synergistically, multiple use makes it extremely difficult to "partial out" the effects of one toxin on the newborn. Environmental influences such as poor prenatal care and nutrition during pregnancy further complicate the relationship between drug

and effect. As noted in birth records, 29 mothers used drugs prior to delivery, and 23 of these had used within the previous 48 hours, primarily cocaine.

For these 160 mothers, 70 had no prenatal care, 25 had some and data are not recorded for 65. Thirty-six (23%) delivered their babies via cesarean section. Records show a median number of 4 pregnancies (gravida) for 118 moms ranging from one to 22, an unusually high figure, with four of these women having more than ten pregnancies. There are a median number of two deliveries (parity) for 116 of the group ranging up to nine. Seventeen of these women had one or more (up to four) spontaneous miscarriages, and 26 had one or more (up to 14) therapeutic abortions.

Review of birth and social services records show that at least one third of these women had prior contact with the foster care system and, as a group, have multiple social and personal problems. Fifty-one women (32%) had a child previously placed in foster care, and of these 19 were drug-exposed. Twenty-one (13%) had a prior history of psychiatric problems. At some time during the pregnancy, 47 women (29%) were homeless, and 16 (10%) report a history of family violence. In this group, 25 (16%) were incarcerated during their pregnancy.

Discussion

The events that contributed to increased foster care placements of medically complex infants in the nineteen eighties have continued into the nineties (Behrman 1995; Lewis & Bendersky 1995; Cole, Barth, Crocker & Moss 1996; Lester, LaGasse & Bigsby 1998). Although from 1996 to 1997 the number of children under 13 years of age who were diagnosed with AIDS declined 40% reflecting the use of zidovudine (AZT) therapy for pregnant HIV infected women and infants, vertical transmission of HIV to infants continues (Centers for Disease Control and Prevention [CDC] 1998). The Centers for Disease Control and Prevention notes that of 8,086 pediatric AIDS cases reported in 1997, 91% (7,335) were born to mothers with or at risk of HIV infection (CDC 1997:13). As newer treatments have been introduced, the response to AIDS has shifted from a terminal illness to a chronic disease model requiring long-term support services (Taylor-Brown 1991). In addition to these new trends in HIV and AIDS, nationally the incidence of substantiated child maltreatment in the past decade has increased, with slightly more than one million children identified as victims of substantiated or indicated abuse or neglect in 1997 (Wang & Daro 1998; U. S. DHHS 1998; Sedlak & Broadhurst 1996). Another significant change in the nation's child welfare system in the past decade has been the increase in the number of children in kinship placements (Goerge, Wulczyn & Harden 1994; Berrick, Barth & Needell 1994).

A majority of the programs that began a decade ago described by Anderson (1990a) continue to serve this population of infants and families. During the course of the FISCIP-Baby Moms private-public partnership, lessons were learned that may inform other practitioners whether in private or public agency models. These issues involve agency relations, policies and personnel.

Interagency issues: Although private agencies manage many of the foster care programs for this population, Baby Moms remains within San Francisco City and County's DHS. Retaining the program within a public welfare agency produced what may be unique interagency issues. As privatization of human services has spread in the past twenty years, many nonprofit agencies are poised to respond and seek contracts from the public sector (U. S.GAO 1997a; U. S. GAO 1997b). When the Baby Moms was starting, representatives from private agencies went before the San Francisco City and County's Human Services Commission to criticize DHS, complaining that services to infants and families were not being delivered effectively. DHS was repeatedly admonished by individuals from the African American community for not having a sufficient number of minority Baby Moms foster homes and for having a staff that did not racially match

clients. These frictions continued for several years before private agencies and community groups accepted this DHS program.

The complexity of delivering services to multiproblem families continues to challenge providers. Coordination of services has proved difficult, especially when attempting to forge alliances between different public systems with varied federal and state funding mandates (Boyd-Franklin & Boland 1995; Children's Research Institute of California [CRIC] 1989). Child welfare professionals repeat the often-heard call that providers "must develop community-based models of collaboration" (Groze, Haines-Simeon & Barth 1994:80). Increasingly, parent-led organizations are advocating that families share in program planning, policy formation, and evaluation for health, education and human services (Parents Helping Parents 1998). Family-centered care adds an essential perspective to service provision, but further complicates the collaborative enterprise (Institute for Family-Centered Care 1998). Ten years after repeated efforts at collaboration, a recent qualitative study of social workers who serve family members caring for AIDS orphans once again identifies communication and coordination between agencies as an important tool and recommends centralizing different services in one location, suggesting that the problem of successful collaboration persists (Paige & Johnson 1997). For the Baby Moms unit, having medical personnel on staff reduced conflicts with local health care providers, but multi-agency collaboration remained a challenge. Financial reimbursement issues and payment responsibility for these infants were also topics of heated discussions and some conflict between agencies.

Permanency planning: The Baby Moms program has a standard of care to keep an infant in their initial foster home placement until a permanent plan for the child is in place. Although there was no significant difference in the number of placements between Baby Moms infants and a comparison group of San Francisco babies in foster care, the data suggest that maintaining infants in one home prior to moving them to permanency may increase the likelihood of adoption as the path to permanence. This greater potential for adoption was found in spite of the serious medical conditions in this population.

Effective planning for medically complex infants requires a commitment of staff and resources to focus on smaller caseloads permitting regular, consistent contact between the CWWs and babies, biological families and foster families in the program. The FISCP-Baby Moms partnership evidenced the public agency's commitment to openly collaborate with a federally funded project and to make use of data and recommendations to improve the quality of the service delivery system. It also requires an administrative commitment to maintaining infants and children in one foster home until an appropriate permanent plan is developed, a plan that involved careful transitioning of the infant to their permanent setting.

Baby Moms foster parents played a central role in promoting the transition to permanence, transporting infants to the new placement and encouraging visits from families in their own homes. A photo album, familiar toys, and developmental history written by the Baby Moms foster parent often accompany the infant into their permanent home. Staff and foster parents usually work together to achieve a gradual move to permanence with the goal of maintaining some contact between the children and the primary Baby Moms caregiver. However, in some instances the Baby Moms foster parents form negative opinions of the adoptive placement or reunification plans, and they have attempted to thwart placements. These foster parents feel deeply that they know the infant's needs better than DHS staff. Underlying tensions raise doubts in the minds of the adoptive or long-term placement families and may lead to a rupture in the continuity of relationship between the Baby Moms foster parents and the infants following placement. This has not been a frequent occurrence, but has happened enough that others should be aware of the potential for this to occur.

Another issue surrounding the move to permanence is that a number of homes have not been adequately prepared for the difficulties of raising these medically involved children. While most families have had some preparation for the challenges ahead, others report having received little or no information about the medical or drug exposure history of the infant. Several families describe being “dropped” by the system once they had taken children from Baby Moms into care. Support and medical services were not readily available from previous providers, and families had to re-create the supportive services needed to maintain these infants. One way to address this situation is to involve local community-based Family Resource Centers or similar parent-directed organizations with these infants, ideally when they are in the care of the DHS foster parents. Providing these infants and foster parents with parent advocacy while the babies are still in the DHS can build a link with a service system that can provide ongoing support for families once infants leave the public sector. Of course, it also adds another perspective to the planning process; potentially further complicating collaboration between agency personnel and families.

Kinship homes: An important development for Baby Moms in the past year has been to place infants with members of their extended families. Accompanying this change has been a lessening of eligibility criteria to become a Baby Moms kinship home. The major requirement is that kin families are capable of providing for the medical needs of the infant as determined by hospital staff. There are no additional specific Baby Moms requirements other than the criterion necessary for anyone wanting to become a DHS foster parent, which should ensure that these kin placements adequately meet standards of care for foster children. As of December 1998, five of twelve active Baby Moms homes (42%) were kinship homes. This represents a trend within the foster care system nationally, which, in the past decade, has witnessed almost a 50% increase in the use of kinship or relative homes. It is vital to delivering family-centered services to this population that this shift to kin placements continues without compromising care for these vulnerable infants.

These relative placements do not receive parity in board rates paid by DHS. A recently completed focus group of social workers about caregivers for AIDS orphans identified lower compensation for kin as a barrier to assisting these families (Paige & Johnson 1997). Differential funding may be illustrative of another issue for relative caregivers, lack of mutual trust. Most DHS Baby Moms CWWs have worked in the foster care system many years. Their experience with children from different generations of one family may contribute to a skepticism about the potential for families to genuinely engage with the system. This view by child welfare workers that family pathology is intergenerational has been noted in the literature (Katz 1971; Shapiro 1976). Conversely, kin families have a historical mistrust of a system that removes their children and places them in foster homes.

In Baby Moms, another factor that sometimes contributed to tensions between relatives and the public welfare agency stemmed from the foster parents feelings. FISC staff observed a number of Baby Moms foster parents who harbored resentment for the families of the babies, blaming them for the plight of the child. The following comment from foster parents was heard on more than one occasion: “The authorities should prosecute people like this who know and still compromise their children.” Baby Moms has a core group of foster families, who have worked together with DHS for many years. As kinship homes continue to enter Baby Moms, these relative families not only may confront typical challenges of being a newcomer to an established group but also significant feelings and attitudes from foster parents and DHS staff. Other practitioners have found that providing a support group for foster families to discuss their feelings, especially about the biological parents of the infants, is useful to reducing negative emotions (Boyd-Franklin & Boland 1995:209).

As use of kinship homes grows, there may be a reduction in the rates of adoption reported as the permanent plan for Baby Moms infants. Several factors may lower the number of children adopted. First, the literature suggests that kin families are reluctant to adopt, not wanting to terminate parental rights for the biological parent(s), believing that these children are “already family” (Needell & Gilbert 1997:93; Courtney & Needell 1997:140). Secondly, if kin families did adopt, they would experience a significant reduction in their monthly board rate. On the other hand, new Federal (P. L. 105-89, Adoption and Safe Families Act of 1997) and state (AB1901 McPherson) legislation may influence reimbursement rates in the Baby Moms program, especially for relatives, who in California will be eligible for special kin guardianship board rates.

Financial reimbursement for caregiving: Another of the challenges to implementing a program that links levels of care to foster home reimbursement rates is how to reward caregivers for working to improve the health of the infants. Financial incentives to families reward caring for infants with more serious medical, developmental, and behavioral problems that require more intense care (e.g. Level 3 receives a higher rate than Level 1). While everyone acknowledges that caregivers want an infant’s health and developmental status to improve, the system rewards foster parents who have a sicker infant in their home. Understandably, financial considerations are one of the motives for entering Baby Moms or similar programs, and it is inevitable that foster parents want to receive what they view as fair. Some foster families regularly disagreed with DHS decisions to lower an infant’s care level. This sometimes created harsh feelings among those foster parents who believed that they knew the infants’ problems more intimately than the DHS staff. Additionally, Baby Moms shared information with one another about children’s care levels, which occasionally contributed to feelings between them when one family believed another’s reimbursement rate was too high for a particular child. The problem is not unique to Baby Moms, and has been identified by others who are implementing similar programs (Foster, Davis, Whitworth, & Skinner 1982).

Numbers of infants per home: California social services regulations limit the number of medically fragile infants to no more than two per home. FISC staff have seen that caring for infants with these serious medical conditions places significant stress on the primary caregivers, as well as all support staff. FISC staff also recognized that financial reimbursement schedules when caring for very ill children acted as an incentive for foster parents to take more children into care. This was not viewed as a negative motivation for undertaking this role, but as a realistic factor contributing to foster parents’ interest in caregiving. Establishing a limit on the number of very ill children permitted in a home not only serves the best interests of the child but also the caregiver.

FISC and Baby Moms: A goal of Edgewood’s FISC was to obtain local funding support to continue key federal project staff positions when MCHB funding ended. This was only partially achieved. San Francisco’s Department of Public Health is now paying for the Baby Moms pediatrician, increasing her time on the project. Because the majority of these infants begin their contact with the public system in hospitals, it is critical that agencies working with this population have a pediatrician on staff. This increases the continuity of care that is being provided regularly by specialty clinics, AIDS programs, and the children’s physician. Medical personnel, regardless of agency affiliation, share taxonomy for describing infants’ health status that enhances collaboration. The Baby Moms pediatrician continues to work with the pediatric nurse specialist to monitor infants, to train and consult with foster and kinship parents, and to add to the database of descriptive data. The pediatric nurse specialist position is of vital importance to Baby Moms because this person is in daily or weekly contact with families, monitoring the status of infants and providing feedback to CWWs and, when necessary, the pediatrician. Any program unable to fund a pediatrician or a pediatric nurse specialist, must

establish strong working relationships with local hospitals, clinics and doctors, striving to overcome disciplinary biases.

The FISCSP developmental specialist provided an important function for the Baby Moms program, but local funding to continue this job was not forthcoming. Having a developmental specialist periodically evaluate and provide non-didactic parenting guidance to foster and biological families brings a needed dimension to the specialized foster care experience for these infants and their families. While foster parents may have superior medical skills in handling these children, most of them indicated that they place high regard on the home visits of the developmental specialist, who assessed the infant and provided feedback. Although some foster parents were defensive about utilizing developmental guidance, viewing themselves as expert caregivers, the majority of these families indicated that developmental assessments were especially useful. Home visits and developmental feedback encouraged them to think differently about the infants and to sometimes see these children more positively. Having reliable baseline developmental information about these infants allows for more appropriate interventions to begin early in their lives and theoretically will reduce the need for services as these children mature. The obstacle to public welfare agencies having a developmental specialist is primarily financial.

DHS workers quickly grew to value Edgewood's FISCSP project coordinator. The coordinator had responsibility for providing ancillary administrative services such as targeted recruitment and implementing the monthly foster parent training, tasks that the regular DHS staff did not have time to carry out because of their caseload responsibilities. Although it was widely recognized that this position was of significant value, the DHS was not able to support it after MCHB funding ended. Since 1997, DHS recruitment and training functions have waxed and waned in degree of coverage, as DHS staff take responsibility for them depending on availability. If the number of kinship homes continues to rise, the issue of targeted recruitment may become less relevant, but at present there is an effort to recruit more San Francisco foster homes.

The FISCSP psychologist was available to meet with Baby Moms foster parents for support and these sessions, either individual or group, were confidential. Foster parents now have quarterly group meetings with a consultant child psychiatrist to alleviate stress and air issues of concern. The FISCSP psychologist also used psychometric assessment to screen foster parent applicants, but this position was not continued. Using a consultant psychologist to interview applicants, administering a brief battery of psychometric instruments, provided staff information about families to assist in deciding whether to accept them as Baby Moms foster parents. The costs for a single assessment and a write-up will vary with professional fees, but shouldn't exceed \$300-\$400 per individual family member. This role and its impact on the program are more fully discussed elsewhere (Cohon & Cooper 1993).

Edgewood's FISCSP staff also gathered vital demographic and medical data, which have been entered into a database. This repository provides a baseline of information describing this San Francisco population. This database has been turned over to the Baby Moms pediatrician, and reports should be available periodically to practitioners and policy makers.

Staff emotional state: Applicants for Baby Moms foster parents were found to be somewhat idiosyncratic, unique individuals who do not fall into the normative range on standardized psychological measures (Cohon & Cooper 1993). This should not be construed negatively, because volunteering to care for medically fragile babies, some HIV positive, some who may die, is not likely to attract persons who might be described as typical. The exceptional nature of this group challenges program managers to find staff that are flexible and relate easily and effectively with a variety of individuals. Working intensely with a smaller caseload of high risk infants, families, and foster parents increases the potential for CWWs to develop close positive personal

relationships and also to experience strong interpersonal conflicts. Both the DHS and FISC staff members directly involved with services to children and families were affected. Some DHS staff became cynical about particular foster parents and had difficulty working effectively with them. In part this response reflects individual personality characteristics that did not “fit” well with the foster parents. Matching staff from one unit with clients is a daunting challenge to programs in which there are only a limited number of available foster homes. It is realistic to expect occasional poor “fit” between workers and foster parents and to develop a mechanism for addressing this. In Baby Moms, having the FISC psychologist as an external resource proved useful in mediating some situations.

Since Baby Moms is part of a large public bureaucracy already facing significant challenges, it is difficult to attribute effects on staff solely to their role in this specialized program. It may be that the social services agency environment in itself can have a negative impact on people. Nevertheless, the serious medical conditions of these infants and the life circumstances of their families that include drugs, crime, and poverty weighed heavily on staff. Large agencies sometimes have difficulty responding to individual staff members’ needs and burnout is a very real factor. Several Baby Moms workers who had stress-related problems during their tenure in the program were transferred. Just as foster parents are required to take 50 hours of monthly respite, there should be regular respite for staff, trying to avoid the aura of elitism or favoritism that could lead to intra-agency jealousy. We recommend that all staff in this type of unit be rotated after three to four years of service. Such a regular change of staff may have negative implications for continuity of care and familiarity with the children and foster parents. Also the need to learn specialized medical terms and procedures as well as dealing with very complicated medical conditions is beyond the typical training of most social workers. Regular rotation and training needs imply that new staff will require more time to become acclimated in this type of specialized program.

Foster parent goodness-of-fit with infant and need for developmental guidance: Where there was not a good fit between the infant and the foster parent, children were not treated with respect and love. While most of the foster parents had an enduring kindness and patience for the mundane tasks of parenting, a number had difficulty maintaining respect for the unique character, learning style and temperament of each child. Developmental assessment and guidance is invaluable in these situations to assist the foster parent in recognizing and working to overcome negative feelings for a child.

Infants and Mothers: The 21% of children whose ethnicity is multiracial reflects San Francisco’s unique demographics, where rates for multiracial youth are reported in the 20-25% range for many youth service programs (San Francisco Mayor’s Office of Children Youth and Families [MOCYF] 1998). The medical status of the infants in Baby Moms is highly compromised. They have characteristics that resemble those reported in the literature describing LBW, VLBW, premature, drug-exposed babies (Chasnoff, Griffith, Freier & Murray 1992; Field 1995; Leeds 1997; Bennett 1997; Singer, Arendt, Song, Warshawsky & Kliegman 1994), and more closely resembling infants described as medically fragile (Boyce, Smith, Immel, Casto & Escobar 1993; Saylor, Casto & Huntington 1996). The severity of medical conditions of Baby Moms infants is greater than those of babies reported in other research, which noted low prevalence of adverse medical complications in a substance-exposed sample (Lester 1998).

Records show that the majority of Baby Moms infants were born to a drug-abusing mother with cocaine as the most frequently occurring substance noted among the multiple substances to which they were exposed. For 152 infants the median length of stay in a Baby Moms placement was 370 days, and this was generally inversely related to birth weight increasing

as weight decreased. Prior to being discharged into the program, these newborns spent a median of 22 days hospitalized.

Concerning HIV status, 10% of the Baby Moms infants were HIV positive, and close to one third (31%) sero-converted to HIV negative during infancy. This rate is 50% lower than the expectable 65% expected sero-conversion rate for infants whose mothers were not treated with zidovudine (AZT) during pregnancy (CDC 1992). The low conversion rate for Baby Moms infants may be due to the fact that mothers were further advanced in their illness; were homeless and had poor nutrition and little prenatal care. Currently, the risk of HIV transmission to newborns is lowered from 25-30% to 8% if mothers are identified and receive AZT treatment for more than six weeks prior to and at time of delivery (Connor & Mofenson 1995). Forty-five children were re-hospitalized between 1987 and 1993. Not surprisingly, the HIV positive infants spent the longest time re-hospitalized. It is likely that the short number of days back in the hospital for the sero-converted infants results from the reason for their initial placement in Baby Moms—HIV positive status, without other medical complications. Once this HIV status resolved, there were no medical reasons for re-hospitalizing this group. Conversely, HIV negative infants entered Baby Moms with serious medical conditions and, after the HIV positive group, spent the longest time re-hospitalized. Although universal testing recommendations for pregnant women have been made, not all nurseries are testing mothers and newborns for HIV (CDC 1988). Baby Moms strongly urges HIV testing of mothers and/or the infant in the nursery to promote optimal care and appropriate placements.

Mothers' characteristics resemble findings from other studies showing high rates of drug abuse, a large percentage of African Americans, a median number of four pregnancies and median of two prior births (Lester et al 1998; Leeds 1997; Woods, Behnke, Eyler, Conlon & Wobie 1995).

Conclusion

Baby Moms has successfully demonstrated that a public social services program can select, train and support a group of caregivers to provide for the medical needs of infants with a variety of serious medical conditions. Having a specialized unit available for foster placements probably contributed to reducing the length of initial hospital stays for these infants. In addition to child welfare personnel, optimal staffing of this program would include a developmental specialist, a part-time project coordinator, a pediatric nurse specialist, and consultant pediatrician. Medical personnel are necessary to bridge the important links between hospitals, specialty medical clinics, and physicians. Baby Moms increasingly uses kinship homes in lieu of foster placements. This is a positive move, but to ensure appropriate care and safety for these children, relative families must be provided training, support, respite and adequate financial reimbursement commensurate with that given to foster parents. Matching program staff to foster or kin caregivers and caregivers to infants can optimize program operations and enhance positive developmental caregiving for the babies. The need for optimal "fit" between staff and foster parents and foster parents and infants strongly suggests that individuals, and not models, produce positive programs. Respite and periodic rotation is essential for agency staff and caregivers to reduce negative emotional effects stemming from this extremely challenging work. Challenges to successful collaboration may result because of the numerous agencies involved in serving these infants and families. Furthermore, children's care may also be compromised at the service level by the conflicting opinions of biological parents, the county juvenile court acting in loco parentis, child welfare workers, foster parents, and extended family.

Edgewood's FISCIP assistance to Baby Moms ended in September 1997. The DHS Baby Moms staff consists of a part-time unit supervisor, two full-time child welfare workers (CWW), a pediatric nurse specialist, a part-time pediatrician consultant, and part-time clerk typist. DHS and

San Francisco Department of Public Health (DPH) pay the pediatrician, initially supported with MCHB funds. No other FISCIP staff were incorporated into the present Baby Moms program.

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Figure 1.

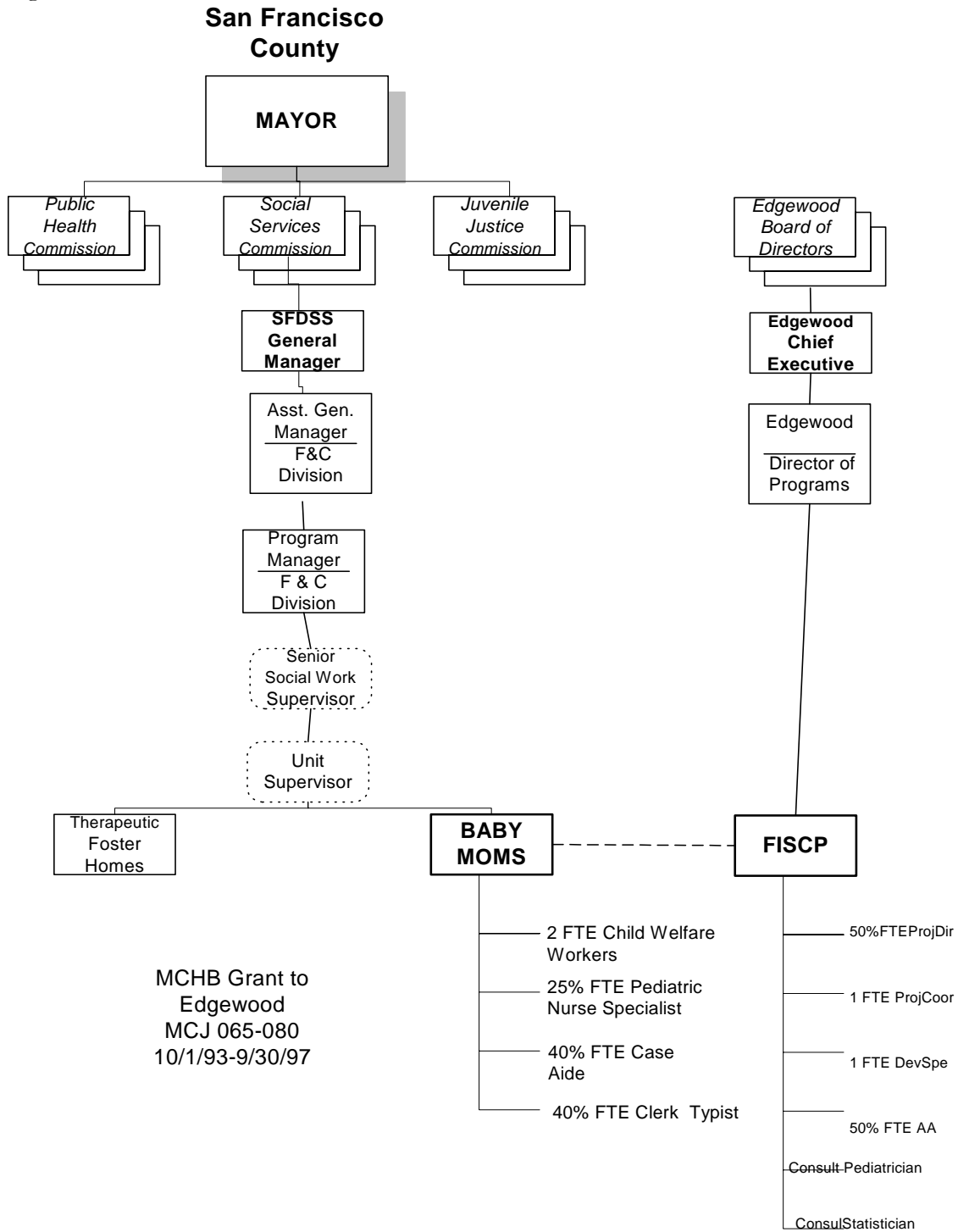


Table 1:

DISPOSITIONS OF 154 BABY MOMS CHILDREN	AT DISCHARGE FROM BABY MOMS	AT FOLLOW-UP
REUNIFIED WITH BIOLOGICAL PARENTS	25 (16%)	23 (15%)
PLACED WITH OTHER RELATIVE	32 (21%)	30 (19% 0)
ADOPTED (CHILD FREED)	1 (1%)	37 (24%)
FOST-ADOPT (NOT FREED)	65 (42%)	27 (18%)
GUARDIANSHIP	5 (3%)	2 (1%)
LONG-TERM PLACEMENT	10 (6%)	15 (10%)
DECEASED	15 (10%)	19 (12%)
OTHER	1 (1%)	1 (1%)