Mental Health Assessment of Infants in Foster Care

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Infants placed in foster care are at high risk for emotional and behavioral problems. Assessment of their mental health must account for their often-adverse life experiences prior to placement and the involvement of multiple systems that shape their lives in lieu of parents' authority. This article presents practice guidelines for infant mental health evaluations with consideration of legal requirements and the unique issues conferred by foster care.

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Early childhood presents an unparalleled opportunity to improve the mental health and developmental outcomes of high-risk infants[1] (Shonkoff & Phillips, 2000). Much of what is published on early childhood assessment has focused on child-care settings or early intervention programs for infants with developmental delays and disabilities (Knitzer, 2000; Shonkoff & Meisels, 2000). The vast majority of these children reside with their parents. However, infants who experience maltreatment and placement in foster care[2] face the greatest risk for emotional and behavioral problems.

This paper is intended to inform the professional practice of those involved in the mental health assessment of infants in foster care. It briefly summarizes existing guidelines for infant mental health assessment and recommends practice modifications based on legal requirements and other distinctive issues associated with foster care. Mental health evaluations of these infants must address the complexity contributed by their atypical life experiences and the involvement of multiple systems that shape children's lives in lieu of parents' authority. In 2003, the Child Welfare League of America and the American Academy of Child and Adolescent Psychiatry (AACAP) collaborated to develop guidelines addressing the mental health needs of children in foster care. The authors, a clinical child psychologist and a child welfare/disability attorney, participated in and developed recommendations for assessment based on work with court-involved infants (Dicker & Gordon, 2004; Silver, DiLorenzo, Zukoski, Ross, Amster, & Schlegel, 1999a).

Why Assess Infants?

Infants in foster care experience longer placements, higher rates of reentry into foster care (experiencing recurrent maltreatment and disruption of family bonds), and high rates of behavior problems,

[1] In this article, the term "infant" refers to children under the age of 3.

[2] In this article, the term "foster care" is inclusive of infants placed with relatives in kinship care.

developmental delays, and health problems (Blatt, Saletsky, Meguid, Church, O'Hara, & Haller-Peck, 1997; Goerge & Wulczyn, 1999; National Survey of Child and Adolescent Well-Being, 2005; Silver et al., 1999a). Because of these risk factors, mental health assessment is critical.

Infants are exquisitely sensitive to the emotional tone of their environments. When confronted with episodes of abuse, domestic violence, and volatile adults, their brains respond by secreting atypical levels of stress hormones (Dozier, Manni, Gordon, Peloso, Gunar, & Stovall-McClough, 2006; Gunnar & Barr, 1998). Similarly, severe neglect, which leaves the infant isolated, hungry, and in pain and discomfort, also results in high levels of stress (Dozier et al., 2006; Gunnar & Barr, 1998). Infants experience heightened physiological arousal, manifested in symptoms of intense anxiety, such as exaggerated startle responses, sleep and feeding disorders, fearfulness, and irritability (Scheeringa & Gaensbauer, 2000). Infants also experience grief and depression in response to losing beloved family members due to foster placement, a parent's incarceration, death, or child abandonment (Zero to Three, 2005).

Infants express emotional distress in several ways. They may demonstrate physiological dysregulation (for example, intense irritability, heightened arousal, limited ability to self-soothe, feeding and sleep disorders). Often, toddlers also present with behavioral disturbances (for example, aggression, defiance, impulsivity, overactivity, or sexualized behavior). Toddlers may exhibit intense fears and anxiety related to situations associated with past trauma (for example, bathing, being left alone in a room, diaper changes) (Heller, Smyke, & Boris, 2002).

Emotional and behavioral issues among infants in foster care may present in dramatic ways:

- A 17-month-old compulsively inserts toys into her vagina during her bath and cries hysterically when men visit her foster home.

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- A 30-month-old eats insatiably, shoves food in his mouth even when choking, and takes food off others' plates.
- A 12-month-old screams when asleep, has nightmares, and cries whenever her foster parent leaves the room.

The behaviors of these infants can be challenging for their caregivers, often leading to stress in the household and failed placements.

A comprehensive infant mental health evaluation can identify previously unknown and unmet emotional and developmental needs and clarify differential diagnoses (Blatt, Saletsky, Meguid, Church, O'Hara, & Haller-Peck, 1997; Silver, Haecker, & Forkey, 1999b); identify the infant's developmental and mental health status, including relative strengths and weaknesses; provide the foster parent, caseworker, and court with guidance on where to refer infants for services (Dicker & Gordon, 2004; Dicker, Gordon, & Knitzer, 2001); help caregivers better understand difficult behaviors and care needs; and recommend interventions to improve the infant's functioning and outcomes. The evaluation also may provide information pertinent to permanency decisions (Dicker & Gordon, 2004), identifying strengths, weaknesses, and areas of conflict in the family or environment of the proposed placement change, reunification, or permanency plan (American Academy of Pediatrics [AAP], 2001).

Mental Health Assessment of Infants

The infant mental health evaluation differs from that of older children. Professionally recognized tools and methodology for infants, such as Practice Parameters for the Psychiatric Assessment of Infants and Toddlers (0–36 Months) (American Academy of Child and Adolescent Psychiatry [AACAP], 1997), and the Diag-

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nostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised Edition (DC: 0-3R) (Zero to Three, 2005), are available. When assessing infant mental health, three issues are paramount: a dynamic, developmental perspective is essential (AACAP, 1997; AAP, 2000), assessment should include interdisciplinary input, and assessment should occur in the presence of the infant's parent or foster parent (AACAP, 1997; Zero to Three, 2005).

Developmental Perspective Is Essential

The most rapid period of development occurs during the first three years of life. The infant's functioning is moderated by the differential pace of development of various domains, such as speech/language, cognitive, and social skills. During this time certain experiences must be present or later outcomes may be compromised during sensitive periods. An infant's opportunity to form a secure attachment to a primary caregiver can impact early development of emotional self-regulation (Dozier et al., 2006), and multiple placement changes may interfere with this process.

Interdisciplinary Assessment Is Crucial

Infants require interdisciplinary evaluation because of the intricate interface among health, developmental, and reactive mental health conditions. For this preverbal population, it is often difficult to differentiate between conditions acquired as a result of the infant's life experiences and those potentially congenital (Morrison, Frank, Holland, & Kates, 1999).

- A foster mother reports the 27-month-old doesn't chew his food, has difficulty swallowing, stuffs food into his mouth even when choking, and eats beyond satiety. Although many infants with histories of neglect and hunger may present with some of these behaviors, he is diagnosed with Williams Syndrome, a rare genetic condition that includes problems in cardiovascular and musculoskeletal systems, feeding problems, and growth delay.

- A newly placed 9-month-old is irritable and difficult to comfort. Feeding is extremely trying as she arches her back, rejects her bottle, and spits up formula. Although many of these symptoms may be associated with difficulty adjusting to a new placement, she suffers from gastroesophageal reflux, which interferes with her ability to feed and enjoy mealtimes. If untreated, she may experience intense pain as her esophagus becomes inflamed. The caregiver-infant relationship may become impaired by her irritability.

In these cases, medical and reactive emotional conditions show similar behavioral presentations. Thus, the mental health professional should work collaboratively and even evaluate jointly with pediatric and allied health professionals so that the mental health evaluation is informed by their findings (Horwitz, Owens, & Simms, 2000).

Assess in the Presence of the Infant's Primary Caregiver

It is essential to evaluate infants in the presence of a familiar caregiver. Infants experience distress as a state of physiological arousal and internalized feelings. They are easily overwhelmed and stressed by encounters with unknown adults. Both physiological and behavioral regulations are facilitated when the infant is with a familiar adult who knows effective ways to soothe him (Schuder & Lyons-Ruth, 2004). The evaluator is more likely to obtain valid assessments when infants have been in foster care for approximately a month and both the infant and caregiver are familiar with each other.

Special Issues in the Assessment of Infants in Foster Care

Absence of History

When infants enter foster care, information about their current medical needs, past medical history, family history of medical con-

ditions, and important information on birth history typically are unavailable. When conducting an assessment, the evaluator should seek as much history as possible, including birth history, length of gestation/prematurity, newborn health status ratings, health and immunization records, early intervention assessments, and related Individual Family Service Plans (IFSPs) or Individualized Education Plans (IEPs) (Silver et al., 1999b). Establishing agreements for release of records to the evaluator prior to the evaluation is helpful. Often, certain records are essential to conduct a valid evaluation. For example, with premature infants younger than 24 months, the evaluator must take into account the length of gestation in weeks to determine whether current functioning is appropriate or delayed.

Multiple Sources

In obtaining information about the infant's presenting problems and pertinent family history (including key events that occur during this and prior placements), the evaluator should rely on multiple sources, including the child's current foster parent, caseworker, and birthparent whenever possible (AACAP, 1997).

Establishment of an Alliance with the Family

In general, the evaluator needs to establish an alliance with the infant's family to encourage the exchange of information both during and following the evaluation (AACAP, 1997). For infants in foster care, this situation is complicated by the biological parents' availability to the evaluator and possible concerns about the adversarial nature of the child welfare and court systems. Parents may be reluctant to speak to the evaluator, fearing this discussion will prevent their child's return. Alternatively, foster parents may feel undermined by their lack of standing in court despite their devotion to the infant. The evaluator must be sensitive to these dynamics and be strongly encouraged to reach out both to the infant's biological and foster parents for information.

Legal Issues

The court is the central decision maker in foster care cases, approving all placements and reviewing all case plans. The court can order release of records, an assessment of the infant, or the sharing of the assessment report with the child welfare agency, foster parent, primary care physician, early intervention provider, mental health provider, attorneys, or Court Appointed Special Advocate.

Although the court order granting custody to the child welfare agency includes the authority to consent to emergency and routine medical care, if reunification is the goal it is good practice to keep the biological parents involved in these matters. Efforts should be made to obtain consent from the biological parents to release birth medical discharge records as well as pertinent health, early intervention, and mental health records. Parental consent to the infant's mental health assessment and to release its report also should be sought (Dicker & Gordon, 2001). If parental rights have been terminated, this consent must be obtained from the court. Table 1 describes critical legal information the evaluator should consider.

When Should Assessments Occur?

High-risk infants, such as those placed in foster care, require multiple points of assessment over the first three years of life because of the dynamic nature of development during these years. The interplay of frequent maturational changes, the often-uneven emergence of skills in different developmental domains, and infants' unique vulnerabilities to stress and deprivation warrant ongoing examination (AACAP, 1997).

Within 30 days of entering placement, all children should receive a comprehensive pediatric evaluation, with pediatric follow-up according to guidelines of the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) schedule (AAP, 2000; AAP, 2001; Child Welfare League of America, 2007). Children under three should then receive an interdisciplinary developmental evaluation that includes the use of standardized measures between 30 and 60

TABLE 1

Critical Legal Information

Stage of the Case:

– Has the court:
  - ordered removal of the child from the biological home?
  - held an adjudication hearing to determine if the child was maltreated?
  - issued a dispositional order including placement, visitation, and services for the chid and the parents?
  - held a permanency hearing? What permanency goals were ordered (i.e., adoption, return home, placement with relatives)?
  - entered an order terminating parental rights?
  - set adoption as a goal and scheduled a hearing?

Permanency Status:

– With whom is the child placed?
– What are the visitation orders?
– Have parental rights been terminated?
– What is the permanency goal?

Consent Issues:

– Has the biological parent:
  - signed a release of information? Has the court issued an order for the release of information?
  - granted consent to referral, evaluations, and services? Has the court issued an order for referral, evaluations, and services?

Contact Information:

– Child's attorney and CASA
– Child welfare caseworker
– Child welfare private provider agency caseworker
– Primary health care provider
– Parent's attorney
– Foster parents and biological parents

Contents of Court Orders:

– Permanency goal
– Information-sharing
– Placement
– Visitation
– Services for child and parents (EI /Preschool Special Education Program, Early Head Start or Head Start)

days in placement. The mental health evaluation should occur at the same time or shortly following the developmental evaluation.

Initial developmental and mental health evaluations are best conducted after the infant has had a month to adjust to the new caregiver(s). Prior to this period the infant may still be acutely reacting to the loss of the primary caregiver due to entering placement. This initial assessment provides a baseline of developmental and mental health status against which to compare the infant's growth and progress in the future. Ideally, reevaluations should take place every six months until the infant is 36 months old, with annual mental health/developmental evaluations thereafter, or as needed. This frequency is suggested due both to the distinctive nature of this stage of life, when specific disorders emerge, and because of problems regarding continuity of care inherent in the child welfare system. During this stage of life we see the emergence of developmental disorders (such as autistic spectrum disorders), developmental delays (when an infant functions significantly below their chronological age in one or more areas of development), and relational disorders (such as attachment disorders), all warranting intervention to address the condition and improve the infant's functioning. Many conditions emerging in early childhood present differently at subsequent stages of development, thus serial evaluations are needed to monitor the infant over time.

Another trigger for the mental health evaluation for an infant is when a parent, foster parent, caseworker, teacher, or health care professional expresses concern about the infant's emotional or behavioral functioning. A comprehensive, interdisciplinary evaluation is urgently needed when infants appear to be losing previously acquired developmental skills. The infant should first be seen by the primary health care provider (PCP) to identify whether the behavior changes and loss of skills may be due to medical conditions, such as the onset of neurological disorders (for example, seizure disorders, tuberous sclerosis, and postnatal exposure to toxins like lead) and other conditions. The PCP may be able to rule out a medical problem or may decide that referral to a specialist is war-

ranted to further evaluate for physical etiologies. The developmental and mental health evaluations should follow the PCP appointment but may be conducted during the time the infant is waiting to see the specialist. The developmental and mental health evaluation(s) aim to identify whether the infant's deterioration is a function of the emergence of an autistic spectrum disorder, or an emotional reactive condition (for example, depression following separation from family), or due to an adverse environment (for example, exposure to violence, neglect or abuse), which can result in posttraumatic stress and other anxiety disorders. The evaluator must also consider whether the quality of the current foster home plays a role in the infant's deterioration. Finally, comprehensive evaluations should be conducted when the infant changes placement or prior to reunification or adoption (Blatt et al., 1997). This evaluation provides a baseline for monitoring the infant's adaptation after the transition.

Components of the Evaluation

Review of the Results of Recent Pediatric Assessment and Treatment Plan

Highlight any medical conditions, recommendations for additional medical specialty evaluations, or tests.

Developmental Assessment

Assess with standardized measures to determine an infant's developmental status. This information may be obtained from other sources, including the infant's most recent EPSDT screen from a pediatric well-child visit or a multidisciplinary developmental evaluation for early intervention or special education services. Recent legislation (Keeping Children and Families Safe Act, 2003; Individuals with Disabilities Education Improvement Act [IDEA], 2004) mandate that all children under three involved with a substantiated case of maltreatment must be referred to Part C early intervention services. Although this mandate only involves

one evaluation, we strongly recommend that infants who do not qualify for early intervention services receive reevaluations biannually until 3 years of age due to concerns about both the discontinuities inherent in the child welfare system (for example, changes in placements and, by extension, the PCP, compounded by the high turnover of caseworkers) and the rapid pace of development. New caregivers may not recognize emerging developmental delays or disorders when these infants change foster homes or if their caseworker has changed.

Mental Health Assessment

Reason for referral. This is used to record caseworkers', foster caregivers', and biological parents' reports of concerning behaviors and exposure to adverse experiences. It is "essential to gather information from those who are most familiar with the child's current and past functioning" (AACAP, 1997). Thus, the evaluator should not rely exclusively upon the caseworker's report, but should obtain information from the infant's multiple caregivers. The evaluator should consider reasons for placement, family and foster family life events, and traumatic experiences (including exposure to violence).

Family relational history. The nature of the relationship between infant and parent is critical due to infants' profound dependence upon parents (AACAP, 1997). Yet when an infant is placed in foster care, the evaluator should inquire about the foster caregiver's perceptions, attitudes, and expectations of the infant, including whether they are age- and developmentally appropriate. Some foster parents misinterpret infants' rejecting behaviors as meaning that they do not need nurturing when they are hurt or upset. Paradoxically, the infants' off-putting behaviors often are symptoms of attachment problems (Stovall & Dozier, 2000). As a corollary, note the number of prior placements and reasons for placement disruptions.

Infant's social relatedness. This includes notably the infant's interest in household members (adults and children) and tendency to imitate

others. Social relatedness involves the infant's ability to initiate, manage, and communicate in social interactions (Morrison et al., 1999). Does she turn to the foster parents for comfort when feeling threatened? Is she able to rely on them for emotional support when anxious or does she routinely fail to seek comfort whenever hurt or upset? Social relatedness is fundamentally impacted by the infant's previous experiences with caregivers who provided physical and emotional care for a prolonged period, notably biological parents and foster parents (including those from previous placements) (Howes, 1999).

Infants' social relatedness also is influenced by the behaviors and emotional attunement of their current caregivers. For example, during an evaluation a 20-month-old made no vocalizations, and her affect was flat. Obviously anxious, she did not cry in protest nor turn to her foster mother for support who, in turn, did not attend to her needs. When the toddler started to fall from her chair the foster mother watched passively, without trying to prevent her fall. Despite words to the contrary, the foster mother's actions implied indifference. Subsequently, the toddler was removed from that home and placed in a preadoptive foster home. Six months later she appeared transformed. The toddler demonstrated a wide range of affect, was socially responsive, and celebrated her achievements on test items, turning to her new, attentive foster mother with obvious pride, which was reciprocated.

In contrast to children whose deficits in social relatedness are due to experiences of unempathic, unresponsive caregiver relationships, some children are predisposed to atypical social relatedness due to genetic or biological congenital factors and may have autism or other related Pervasive Developmental Disorders (PDD). The primary deficits in this spectrum of disorders include impaired communication and social-emotional development (Robins, Fein, Barton, & Green, 2001). If autism/PDD is suspected, referral to a specialist is warranted.

The evaluator may have difficulty in determining this diagnosis when a toddler has experienced severe neglect and poor quality attachment relationships (Morrison et al., 1999), as he may present

with symptoms similar to those seen in children on the autism spectrum. However, when these children are placed in a nurturing foster home their autistic symptoms usually abate (Hoksbergen, ter Laak, Rijk, van Dijkum, & Stoutjeskijk, 2005).

Relationships with other children. For example, those living in the household, including the caregivers' biological children and the new arrivals and departures of other foster children. Inquire about episodes of aggression, biting, or being bullied by others.

Infant's contact with the biological family. This includes parental and sibling visitation or lack thereof and its impact upon the infant.

Assessment of the infant's behavioral organization. Inquire about the infant's temperament. How does the infant regulate his physiological state, alertness, and activity patterns? How persistent is he with goal-directed activities? How distractible? How does the toddler regulate his emotions and calm himself? How does he adapt to new situations? What situations set him off, what does he do during a tantrum, what is their duration, and what soothes him? It is important to consider whether this behavior is age-typical, a function of delayed language development, or symptomatic of intense distress.

Assessment of the infant's response to stress. How does the infant deal with feeding, sleeping, toileting, bathing, diapering, separation, and frustration/distress? Observe how she copes with the stress of the evaluation, and makes use of her caregiver for emotional support.

Assessment of the toddler's quality of play. Play should be considered in terms of the insights it provides into the infant's preoccupations, emotional tone, and developmental status. Play themes can be revealing, such as traumatic play in which a toddler repeats episodes of violence or abuse (for example, adult dolls repeatedly hitting each other) or sexualized play (for example, two dolls simulating sexual intercourse) (S. Chinitz, personal communication, October 17, 2006). The toddler's emotional expression during play

should be noted. The examiner should also become familiar with developmental milestones associated with play (Gitlin-Weiner, Sandgrund, & Schaefer, 2000).

Assessment of the infant's strengths. This includes the caregiver's, parent's, and caseworker's reports, as well as evaluator observations. Ask the parent and foster parent what they like about the child.

Assessment for signs and symptoms of maltreatment. This includes neglect and physical, sexual, and emotional abuse (AAP, 2001). The evaluator should observe the infant's appearance, such as the presence of bruises, burn marks, sparse hair, circles under the eyes, and whether the infant or toddler appears thin. Behaviorally, infants may cringe or arch their backs when the evaluator benignly approaches or lifts his or her hand (S. Chinitz, personal communication, October 17, 2006). They may seem hypervigilant, presenting a wary watchfulness and serious demeanor, as if on "high alert."

Assessment for risks of placement disruption (AAP, 2001). This includes caregiver burnout, ambivalence or indifference, or escalation of the infant's behavior problems.

Diagnostic and clinical formulation. The mental health assessment of an infant in foster care aims to improve understanding of the infant's developmental and interpersonal strengths and weaknesses relative to others the same age; identify symptoms; and formulate a diagnosis (when warranted) and intervention plan providing guidance about what caregivers should do to enhance the infant's social-emotional functioning and well-being. This plan should conceptualize the infant's symptoms within the context of psychosocial stressors and the infant's functional, emotional, and developmental capacities. The DC: 0-3R is the preferred diagnostic classification approach because of its attention to developmental process and its emphasis on the primacy of infant-caregiver relationships.

Report Guidelines

The evaluation report should address issues inherent in foster care, such as emotional/behavioral indicators of neglect or abuse, attachment issues, and, when warranted, how infants may be affected by visitation, reunification, or change in placement. The report should highlight whether the infant presents significant caregiving challenges, such as developmental delays, a chronic illness, or behavior problems.

It is critical that the report also address the infant's strengths and family strengths (both foster parents' and biological parents'). It should note whether any support systems are in place or need strengthening. If the infant has special needs, it should be determined whether the adults are able to provide for that child, such as following-up with doctor and specialist appointments and advocating for special education services (Dicker & Gordon, 2004).

The evaluation report should highlight both positive attributes and problematic conditions and alert the court and child welfare authority to consider these factors in devising a realistic permanency plan to prevent failed reunifications and later reentry into foster care.

Collaboration with the Child Welfare System

Child welfare professionals may receive limited training on child development, health, and early childhood mental health, which may then affect decision making regarding removal, placement, and permanency. They need to know what questions to ask to help them identify risks to infants' healthy development and understand how infants' developmental and emotional needs impact a caregiver's capacity to parent that child (Dicker & Gordon, 2004). They also require a broad knowledge of programs that assess and serve infants and their families, including early intervention, Early Head Start and Head Start preschool programs, and infant mental health programs. Evaluations should be written in accessible language, avoiding professional jargon and clearly

connecting infants' developmental and mental health needs to the issues of placement, services, visitation, and permanency (Dicker, Gordon, & Knitzer, 2001).

Collaboration with the Early Intervention and Preschool Special Education Service Systems

One of the richest entitlements for infants in foster care and their families is through Part C of the Individuals with Disabilities Education Improvement Act (P.L. 108-446, 2004; IDEA). Part C early intervention provides an entitlement for children under age 3 who experience developmental delays or have physical or mental conditions with a high probability of resulting in delay. Part C early intervention is an entitlement for both infant and parent; infants receive specialized assessments and services, and their caregivers receive services to improve their ability to enhance their infant's development. Legal parents (biological and adoptive) and foster parents may receive services, including parent training, counseling, support groups, and respite under the Part C program. The Individualized Family Service Plan (IFSP), the blueprint for services under Part C, enumerates those services. Part C early intervention programs are administered by lead state agencies (for example, Departments of Health, Children's Services, or Developmental Disabilities). Unlike other health-related services, the child welfare agency is prohibited from consenting to the early intervention evaluation, IFSP, or services. The parent, guardian, or foster parents, if permitted under state law, must consent. If no parent is available, the lead agency or the court must appoint an educational "surrogate parent" (Dicker & Gordon, 2001; Dicker & Gordon, 2002).

Under the Keeping Children and Families Safe Act of 2003, amending the Child Abuse Prevention and Treatment Act, state child protection agencies must have "provisions and procedures for referral of a child under age 3 involved in a substantiated case of child abuse or neglect to early intervention services funded under Part C of the Individuals with Disabilities Education Act

(P.L. 108-36)." A parallel provision was enacted in the 2004 reauthorized Individuals with Disabilities Education Improvement Act (P.L. 108-446). Thus, infants in foster care increasingly should receive this vital service.

Although some states may continue Part C early intervention services for children up to age 5, most 3- to 5-year-old children with delays receive services under the IDEA Preschool Special Education Grants Program (P.L. 108-446), which is administered by local school districts and provides special education and related services for children who have a specific, diagnosed disability that affects their ability to learn. Unlike EI, this is not a family-centered program. The blueprint for services is the Individualized Education Plan (IEP), not the IFSP. Mental health evaluators can assist the early intervention programs and child welfare and court systems by helping to link the infant's IFSP/IEP plan to the permanency plan.

Conclusion

Infant well-being is impacted both by biological and psychosocial factors. Infants placed in foster care are extremely vulnerable on both accounts. Mental health evaluations must take into account the infants' atypical life experiences and the complexity imparted by the wide variety of stakeholders, including parents, foster parents, child welfare professionals, attorneys, and judges. Mental health assessment should link the infant to prevention and intervention services and contribute to permanency planning.

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