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A Developmental Approach to Child Welfare Services for Infants, Toddlers, and Their Families

A Self-Assessment Tool for States and Counties Administering Child Welfare Services

ZERO TO THREE
in collaboration with:
Center for the Study of Social Policy
Child Trends
Children's Defense Fund
National Black Child Development Institute
National Council of La Raza
Voices for America's Children

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INTRODUCTION

Infants and toddlers are the age group most vulnerable to maltreatment and its aftermath. Early and sustained exposure to risk factors such as abuse and neglect can influence the physical architecture of the brain, preventing infants and toddlers from fully developing the neural connections that facilitate later learning.[1] Although this time of life is one of great vulnerability, it is a time of great potential to intervene early and effectively to prevent or minimize negative effects that may prove to be irreversible later in life. It is crucial that child welfare systems infuse guiding principles for infant and toddler development into policies and practices. The September 2011 passage of the *Child and Family Services Improvement and Innovation Act*, which instituted a new requirement for states to describe in their child welfare state plans how they promote permanency for and address the developmental needs of young children in their care, offers an opportunity for states to be more intentional in their efforts to meet the unique needs of infants, toddlers, and their families.

For more information about terms formatted in *italics* throughout the text, see the Glossary section at the end of this tool.

This self-assessment tool stems from the collective vision of leading child welfare and early childhood development organizations on the important steps that can and should be taken in policies, programs, and practices to address the needs of vulnerable infants and toddlers *known to the child welfare system* contained in *A Call to Action on Behalf of Maltreated Infants and Toddlers* (www.zerotothree.org/acalltoaction).[2]

This tool is designed to help states and counties both prepare to meet these new federal requirements and conduct ongoing assessment and quality improvement efforts. It will help states and counties to:

- Assess how well their child welfare policies and practices address the developmental needs of infants, toddlers, and their families.
- Identify where and how policies and practices can be improved.
- Engage partners in taking constructive action.

For the purposes of this tool, "infants, toddlers, and their families known to the child welfare system" includes both those who have an open case with the child welfare agency for family support, in-home, or family preservation services, and children who are in foster care (both traditional foster care and *kinship* care). This does not include those who are referred to the child welfare agency but do not receive an investigation or assessment through *differential response*.

TIPS FOR USING THIS TOOL

- **Involve a diverse group of stakeholders.** While the child welfare agency has primary responsibility for managing cases and addressing the needs of the children in its care, many other agencies and community organizations provide services or have an interest in ensuring the well-being of young children. Therefore, this tool is most useful when completed by and shared with a diverse group of stakeholders, such as representatives from mental health, health, court, early care and education, *home visiting*, and *Part C of the Individuals with Disabilities Education Act (Part C)*. Please visit www.zerotothree.org/cwstakeholders to download a list of suggested stakeholders to include.
- **Make it data driven.** Before beginning to use this tool, it is important to have an understanding of the population it addresses. A good place to start is looking at the number and percentage of maltreated children in your state or county who are under age 3 and the number and percentage of these children entering foster care for the first time. Throughout this tool, we have identified examples of data that will be useful for completing each section. Sources for the data may include: the statewide automated child welfare information system (SACWIS), *Part C* data, and Medicaid data. Disaggregating data by age, geography, race, ethnicity, and reason for entry can help provide a clearer picture of system strengths and gaps while also focusing attention on disparities and disproportionalities, with the goal of reducing and ultimately eliminating them.
- **Use the tool as a way to frame a discussion.** This tool describes policies and procedures that are based on sound developmental practice for young children involved in the child welfare system. It is meant to guide you through a discussion of how your state or county currently meets the needs of young children, what barriers exist to implementing a developmental approach, and what improvements to practices and policies you want to undertake. Many of the statements provide additional guidance on why the recommended policy or practice is important for young children and the process by which it should be implemented.
- **Act on the results.** This tool is designed to be action oriented. Each section provides space to identify priorities for improving your system to better meet the needs of infants and toddlers. At the end of the tool is a table to help you develop action plans for each of your top priorities, with areas to identify next steps, who is taking the lead, and the timeline for action.

After your state or county uses this self-assessment tool, ZERO TO THREE would appreciate your feedback. If you would like to share your experience, please contact Patricia Cole at PCole@zerotothree.org.

I. Assessing and Addressing The Needs of Infants, Toddlers, and Their Families Who Become Known to the Child Welfare System

A. Assessing and Addressing Children's Health, Mental Health, and Developmental Needs

While assessing the safety and placement options for young children has historically been a focus in child welfare, it is equally important that the child welfare system take steps to ensure that young children's health, mental health, and developmental needs are regularly assessed and addressed. Doing so can help identify problems that may jeopardize a child's healthy development and ensure that the child is connected to the appropriate services. Half of maltreated infants exhibit some form of cognitive delay.[3] Research shows that connecting babies to high-quality, research-based services that begin early can improve the odds of positive outcomes.[4]

Review available data on infants, toddlers, and their families known to the child welfare system, such as:

- ✓ Children's health insurance status (Medicaid/*Children's Health Insurance Program (CHIP)*, private, other)
- ✓ How often children receive regular health care and dental visits
- ✓ Number/percentage of children who have a pediatric *medical home*
- ✓ When, how, and by whom children are screened for health and developmental problems
- ✓ Number/percentage of children referred to specialists for follow-up care in response to screening results
- ✓ Number/percentage of children referred who receive the recommended services
- ✓ Average length of time between when a referral is made and when services begin
- ✓ Accessibility of different services by geographic area

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
1. Young children known to the child welfare system receive regular health care visits per the *American Academy of Pediatrics' (AAP's) recommended schedule for preventive pediatric health care*. **Note:** The AAP recommends that children receive preventive pediatric health care visits prenatally, at birth, within 5 days of birth, and at ages 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, 3 years, and annually thereafter.			
2. Health care visits regularly include screenings for developmental, hearing, vision, behavioral, motor, language, social, cognitive, and emotional skills using reliable tools that are age and culturally appropriate. **Note:** Screenings should begin at birth and be repeated regularly (the AAP notes when different screenings should occur) so that problems can be identified and addressed early. Connecting infants and toddlers to services early can minimize the long-term effects of developmental delays and other health problems. Screening for the possibility of prenatal alcohol exposure is critical in this population.			
3. Young children known to the child welfare system receive oral health care per the *American Academy of Pediatric Dentistry recommendations*.			
4. Young children known to the child welfare system have pediatric *medical homes*. **Note:** Research shows that children with special health care needs in particular receive more timely and thorough care when they are connected to a *medical home*.[5]			

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
5. When children are placed into foster care, efforts are made to ensure they stay with their pediatric *medical home*. **Note:** It is important in all aspects of the lives of infants and toddlers in foster care to provide continuity of relationships. Their health care provider is an important example of this.			
6. Young children known to the child welfare system who are eligible for Medicaid receive comprehensive physical and mental health assessments using the *Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT)* framework. **Note:** Children in foster care should receive in-person assessments within 30 days of entering care.			
7. Parents of young children known to the child welfare system are involved in evaluating their children's health. **Note:** For example, the *Ages and Stages Questionnaires (ASQ)* can be used with parents to track children's development and to help parents understand what is developmentally normal at various ages. It is important to provide guidance to parents about what is developmentally appropriate for the child's behavior and to offer them coping strategies to help them stay ahead of the child's exploration.			
8. Temporary caregivers are informed of children's health needs and developmental status.			
9. Young children with suspected health or developmental problems receive:			
a. Referrals to specialists.			
b. Follow-up.			
10. Services are available to young children known to the child welfare system for the full range of developmental challenges a child might face, including social-emotional issues and *fetal alcohol spectrum disorders*. **Note:** These services include providers of physical and occupational therapy and mental health clinicians capable of providing a range of family, group, play, and *dyadic therapies*.			
11. Infants and toddlers are successfully connected to the services needed to address identified developmental challenges.			

Intervening in the early years can lead to significant cost savings over time through reductions in child abuse and neglect, criminal behavior, welfare dependence, and substance abuse.

Julie Cohen, Patricia Cole, and Jaclyn Szrom, *A Call to Action on Behalf of Maltreated Infants and Toddlers*. American Humane Association, Center for the Study of Social Policy, Child Welfare League of America, Children's Defense Fund and ZERO TO THREE, 2011, www.zerotothree.org/acalltoaction.

B. Complying with the Child Abuse Prevention and Treatment Act (CAPTA) Requirement for Referral to Part C of IDEA

CAPTA requires that states refer children under age 3 who have a substantiated case of child abuse or neglect for screening for early intervention services funded by *Part C*. Ensuring that these provisions of *CAPTA* are being implemented is essential for the well-being of young children involved in the child welfare system.

Review available data on infants, toddlers, and their families known to the child welfare system, such as:

- ✓ Number/percentage of children under 3 referred to *Part C*
- ✓ Number/percentage of referred children who receive a complete *Part C* evaluation
- ✓ Number/percentage of referred children who are eligible for *Part C* services
- ✓ Number/percentage of children found in need of services
- ✓ Number/percentage of children who are referred to services
- ✓ Number/percentage of referred children who receive services
- ✓ Number/percentage of *Part C* staff who attend training specific to children known to the child welfare system

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
1. There is a state-level memorandum of understanding (MOU) in place to ensure compliance with the *CAPTA* requirement for referral to *Part C*.			
2. Child welfare workers are made aware of the referral requirement as well as opportunities for developmental support under *Part C*.			
3. There are policies and procedures between child welfare and early intervention and education agencies at the local level to ensure compliance with the *CAPTA* requirements. **Note:** This could include joint training for *Part C* and child welfare staff or procedures requiring that *Part C* provide information about other programs and services *(e.g., Early Head Start (EHS), home visiting programs,* private therapists) to families of children who are referred but found not eligible for *Part C*.			
4. The roles of caseworkers and *Part C* early intervention staff are made clear. **Note:** For example, it should be clear who is responsible for such functions as ongoing and systematic developmental screening, referral, eligibility determination, assessment, and intervention planning.			
5. Training is provided to *Part C* staff to better equip them to address the unique needs of very young children in the child welfare system. **Note:** Training should cover such topics as: understanding the impact of trauma on child development, recognizing developmental delay, and supporting and engaging families.			
6. Barriers to implementing the *CAPTA* requirement for referral to *Part C* have been identified and systematic solutions to addressing them are being employed. **Note:** Potential barriers include: lack of cross-training, limited capacity to handle referrals, inconsistency of implementation, and children not being referred to *Part C* or not being deemed eligible for *Part C* if referred.			
7. The service needs of young children who have developmental delays but do not meet *Part C* eligibility criteria are being met.			

C. Assessing and Addressing the Needs of Parents Who Become Known to the Child Welfare System

Parents of abused and neglected children often face a plethora of challenges that inhibit their capacity to care for their children. It is critical that the child welfare system work with parents from day one to understand the challenges they are facing and connect parents to supports that will help them address their problems. It is equally important that a family-centered approach be used to identify families' strengths and build on them to achieve optimal outcomes.

Review available data on infants, toddlers, and their families known to the child welfare system, such as:

- ✓ Number/percentage of children who are known to the child welfare system due to a parent being detained because of legal status
- ✓ Number/percentage of parents who receive complete physical and mental health assessments
- ✓ Number/percentage of parents assessed who are referred for services
- ✓ Number/percentage of parents referred who receive services by service types (substance abuse treatment, mental health treatment, health treatment, etc.)
- ✓ Number/percentage of parents who are referred to appropriate services and who receive services
- ✓ Average length of time between referral and receipt of services
- ✓ Number/percentage of parents found in need of various supports (housing, education/job training, food, child care, transportation, etc.)
- ✓ Capacity of local programs to serve this population (waiting lists, accessibility, etc.)

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
1. Parents of abused and neglected children understand how the child welfare process works and what is expected of them, whether their child is remaining in the home or being removed from the home. **Note:** It is very important that parents understand the time limits that dictate how long they have to make progress in addressing the issues that prompted the case being opened, and the consequences of not meeting them.			
2. *Family-centered practice* is used when working with parents of abused and neglected children to enhance their capacity to care for and protect their young children. **Note:** *Family-centered practice* recognizes the strengths of family relationships and builds on them to achieve optimal outcomes.			
3. Parents of abused and neglected children are given complete physical and mental health exams to determine any underlying problems that might contribute to maltreatment. **Note:** Parents' capacity in a range of skills necessary for successful parenting (such as daily living skills, verbal memory, and receptive communication skills) should also be assessed. Assessment results and identified treatment needs should be incorporated into parents' case plans.			
4. Parents of abused and neglected children are screened for substance abuse.			
5. Parents of abused and neglected children who have a substance abuse problem are referred to comprehensive family-based treatment programs when possible or other treatment programs that can provide evidence of their success in helping clients to: address the problems that led to their substance abuse, complete treatment, and stay sober over an extended period of time. **Note:** Underlying problems that could lead to substance abuse include child sexual abuse, other history of childhood and adult trauma, and neurodevelopmental disorders associated with their mothers' use of alcohol during pregnancy.			

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
6. Parents of abused and neglected children are connected to services and supports to address their identified problems. This includes identifying service providers, such as community resources, to support parents who do not qualify for public assistance programs due to legal status. **Note:** Services and supports may include: health services, mental health services, public assistance programs (e.g., the *Supplemental Nutrition Assistance Program (SNAP)*, the *Special Supplemental Nutrition Program for Women, Infants, and Children (WIC),* public housing, food banks, *CHIP,* the *Low Income Home Energy Assistance Program (LIHEAP)*), quality *home visiting services, quality early learning and development programs,* domestic violence services, and other community resources that help families build informal support systems.			
7. When appropriate, parents are connected to services in languages other than English, provided by culturally competent providers.			
8. When referrals for services are made, feedback is obtained on the services received and parents' progress.			

D. Creating Linkages and Utilizing Community Resources

Supporting at-risk families with infants and toddlers requires a comprehensive approach that utilizes community-based networks of social service supports. Regular communication between child welfare and other community services can create a web of concrete services for infants, toddlers, and their families. More formal linkages can be established through MOUs, special referral processes, reserved slots, intensified treatment requirements, and single point of entry. To ensure that the needs of young children are met, it is essential that child welfare staff have strong working relationships with other entities working with families known to the child welfare system.

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
1. Strong linkages and/or formal partnerships are in place to refer infants, toddlers, and their families to culturally-appropriate, quality resources and to support the work of the child welfare system in addressing the unique needs of infants, toddlers, and their families. These include:			
a. Health services—pediatricians, dentists, American Academy of Pediatrics			
b. Mental health services			
c. Public assistance programs, including *SNAP, WIC, CHIP*, and *LIHEAP*			
d. *Part C*			
e. Quality *home visiting services*			
f. *Quality early learning and development programs* such as *EHS* and high-quality child care			
g. Effective substance abuse treatment programs			
h. Domestic violence services			
i. Judicial system			
j. Law enforcement			
k. Immigration and Customs Enforcement (ICE) **Note:** It is important that the child welfare agency maintain relationships with ICE to help ensure that separated children who encounter the child welfare system receive appropriate care and that the child welfare agency is able to locate parents to determine best next steps.			

I. State/County Priorities
1.
2.
3.
4.
5.

II. Creating Foster Care That Promotes Attachment and Permanency

A. Using Concurrent Planning, Planned Transitions, and Placement Stability to Promote Secure Attachments

For very young children, early development occurs in the context of relationships—infants and toddlers rely on their closest caregivers for security and comfort. Children with *secure attachments* exhibit a greater capacity for self-regulation, effective social interactions, positive self-representations, self-reliance, and adaptive coping skills.[6] It is very disruptive for a young child to be separated from his or her parent or caregiver and placed in out-of-home care. Thus, whenever possible, it is incumbent on child welfare professionals to do all that they can to promote and protect infants' and toddlers' ability to develop and sustain *secure attachments*.

Review available data on infants, toddlers, and their families known to the child welfare system, such as:

- ✓ Number/percentage of families who come to the attention of the child welfare system and are referred for *differential response*
- ✓ Legal status of infants, toddlers, and parents known to the child welfare system
- ✓ Number/percentage of families engaged in *pre-removal conferences*
- ✓ When *concurrent planning* begins for each child (from date of first removal from home)
- ✓ Number/percentage of foster placements that qualify as *foster-adopt*
- ✓ Number/percentage of children in different types of care (traditional foster care, *kinship* care, group homes, and *shared family care*)
- ✓ Number/percentage of children remaining in home with parents while family receives services
- ✓ Number/percentage of children who remain in their first placement throughout their tenure in foster care
- ✓ Average number of placements that children experience within 3 months of the initial removal from their home, 6 months of the initial removal from their home, and 1 year of the initial removal from their home

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
1. *Differential response* (also referred to as dual track or alternative response) is used for infants and toddlers. **Note:** With *differential response*, reports that are assessed as low- or moderate-risk cases with no immediate safety concerns are handled by conducting a family assessment to gauge a family's needs and strengths and refer them to appropriate community-based resources. High-risk cases still receive a full investigation. Research in several states has found that *differential response* can lower the rate of removals, lower the rate of subsequent reporting, and increase the frequency with which families are connected to mental health services.[7]			
2. Procedures and approaches are in place to prepare for the infant's or toddler's removal from home, ease the transition for the child, and begin the permanency planning process.			
a. *Pre-removal conferences* or *family group decision-making* is used in the 24 hours before removal to engage families and identify resources (e.g., relatives and close family friends). **Note:** *Pre-removal conferences* should be initiated by and held at the child welfare agency with parents and members of their support system.			

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
b. Notification of adult relatives is expedited for infants and toddlers who are removed from their parents' care. **Note:** The *Fostering Connections to Success and Increasing Adoptions Act* requires that the state exercise due diligence to identify and provide notice to all adult grandparents and other adult relatives within 30 days of a child's removal from his or her parents' custody.			
c. *Kinship* guardians are identified and supported as the preferred placement for infants and toddlers when appropriate. **Note:** Placing young children with people they already have relationships with can be less disruptive and have beneficial effects when contrasted with placement with nonrelated caregivers. Research shows that children in *kinship* care tend to experience more stability (that is, fewer placement disruptions).[8]			
d. Steps are taken to place infants and toddlers in the least restrictive setting appropriate to the children's special needs, restricting the use of congregate or group care. **Note:** For very young children, placement in foster and *kinship* homes is important to their healthy development, as opposed to group homes or other congregate care settings with rotating staff and lack of nurturing relationships that can negatively affect young children's development.			
3. *Concurrent planning* supports the developmental needs of infants and toddlers.			
a. *Concurrent planning* is undertaken, in which child welfare staff work equally diligently with birth and foster parents at the same time toward securing a permanent family for infants and toddlers. **Note:** *Concurrent planning* can reduce the time to permanency and minimize the number of moves children experience. This is especially important for infants and toddlers, who need a stable placement that allows them to develop the strong and caring relationships that are essential for healthy development.			
b. *Concurrent planning* begins immediately after an infant or toddler is removed from his or her home. **Note:** It is essential that consideration of reunification and other permanency options begin at the earliest possible point so that permanency can be achieved as soon as possible for young children. Even short time spans are a large proportion of an infant's or toddler's life.			
c. A systematic approach is used for considering alternatives to foster care that promote attachment. **Note:** An example is *shared family care* in which the child and parent are placed together in a foster or *kinship* home, allowing for ongoing and consistent modeling of good parenting interactions.			
d. *Foster-adopt* families are recruited and used, specifically those who commit to mentoring the infant's or toddler's birth parents to help them move toward reunification while at the same time agreeing that they will adopt the infant or toddler if reunification is not possible. **Note:** In either type of permanency, both birth and foster parents would continue to be loving members of the child's extended family. It is important to ensure that foster parents are committed to providing for the child's emotional needs and supporting birth parents in healing their relationship with their children. *Foster-adopt* parents are typically trained in infant and toddler development, in addressing the trauma involved in a baby's removal from a primary caregiver, and in promoting stability for the child.			

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
e. Foster and adoptive families that reflect the culture and ethnicity of children are actively recruited, with support from community partners.			
f. In the case of young children who speak or are familiar with a language other than English, foster and adoptive families who speak that language are actively recruited.			
4. Stable placements for young children are promoted.			
a. Infants and toddlers remain in their first out-of-home placement throughout their tenure in foster care. **Note:** It is essential that young children have stable placements that allow them to form a *secure attachment* with at least one trusted adult.			
b. Infants and toddlers are not moved in foster care unless there is a higher level review and reassessment of the child to determine the effects of the moves on the child's development and well-being.			
c. When it is necessary to move an infant or toddler to a new placement, planning is done to ensure continuity of relationships with the infant's or toddler's caregiver(s). **Note:** When transitions are necessary, it is important for there to be a period of time (3 weeks at least) when the child spends time with both caregivers together and then for short periods with the new caregiver alone, always mindful of how well the infant or toddler tolerates the new situation. After the transition is complete, visits with the former caregiver should continue to be part of the child's life.			

B. Training and Supporting Foster Parents

Ensuring the healthy development of infants and toddlers in foster care requires that foster parents, including *kinship* guardians, have the level of knowledge and skills necessary to respond effectively to the needs of abused and neglected children and other at-risk young children.

Review available data on infants, toddlers, and their families known to the child welfare system, such as:

- ✓ Number/percentage of foster homes trained to care specifically for infants and toddlers
- ✓ Frequency of foster parent training, both pre- and in-service, for foster parents of infants and toddlers
- ✓ Elements/components of the trainings
- ✓ Number/percentage of foster homes that have cared for infants and toddlers, including how many different children they have fostered
- ✓ Number/percentage of *foster-adopt* homes available for infants and toddlers
- ✓ List of comprehensive services available to foster parents and *kinship* guardians of infants and toddlers (support groups, *respite care*, benefits, etc.)
- ✓ Number/percentage of foster parents and *kinship* guardians receiving these services

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
1. Foster parents and *kinship* guardians are prepared to care for infants and toddlers through training in child development and strategies to create and sustain an optimal environment for young children. **Note:** Training requirements should include pre- and in-service training on a regular basis. Training topics should include: infant-toddler development, understanding and addressing the impact of trauma on child development and school readiness, recognizing developmental delays, supporting and engaging families of infants and toddlers, *cultural competence*, language courses, and promoting stability for the child.			

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
2. Foster parents and *kinship* guardians of infants and toddlers are provided access to supports. **Note:** Supports may include: structured support groups; *respite care*; benefits (e.g., health insurance, stipends); public assistance programs (e.g., *SNAP, WIC, CHIP*); quality early care and education, including *EHS*; and overall support from social workers.			
3. Birth parents have the opportunity to provide the relative or foster parent caring for their infant or toddler with information about the child's special needs and routines.			
4. Support is provided to foster parents to help them promote thoughtful interaction between the child and the child's birth parents or other family members.			

C. Promoting Frequent and Appropriate Parent–Child Contact

It is important to ensure frequent contact (as close to daily as possible) between the infant or toddler, parents, and siblings in home-like settings, individualized for each family to meet their needs. Visitation for the youngest children in foster care is a crucial support in the achievement of the family's permanency planning goal.

Review available data on infants, toddlers, and their families known to the child welfare system, such as:

- ✓ State/county guidelines for visitation
- ✓ Frequency of parent–child visits per week/month per infant/toddler
- ✓ Locations for visitation provided by the state child welfare agency
- ✓ Number of parent–child visits at which *visit coaching* (or similar technique) is used; proportion of total infant/toddler caseload receiving these services
- ✓ Frequency of sibling visits per week/month per infant/toddler

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
1. Parents have face-to-face visitation with their infants and toddlers on a frequent basis, as close to daily as possible.			
2. Parent–child contact occurs in locations and times that work for birth parents, foster parents, and the infants and toddlers.			
3. Birth parents' healthy parenting practices and relationship-building capacities are supported during visits. **Note:** This can be achieved by having *visit coaches* model play activities for birth parents to help them understand how to support their children's healthy development or by making early childhood mental health specialists available to help parents understand their children's needs.			
4. Parent involvement in normal family activities—such as doctor's appointments and birthday celebrations—is promoted.			
5. Face-to-face visitation occurs between infants and toddlers and their siblings (if they have been separated) on a frequent basis, as close to daily as possible.			

D. Establishing a Process for Regular Case Reviews

Monthly case reviews (preferably in court) can help keep everyone involved on track and making progress. Ideally, these meetings would involve a team of service providers, attorneys, and the child welfare agency staff to review the family's progress. This monthly monitoring process can be crucial in preventing very young children and their birth families from falling through the cracks and in helping to ensure that the services they are receiving are in fact addressing their identified needs. Expedited permanency hearings are also important in ensuring that very young children achieve a stable and appropriate permanent placement as quickly as possible.

Review available data on infants, toddlers, and their families known to the child welfare system, such as:

- ✓ Requirements for the timeframe for establishing the initial case plan (from date of removal from home) and for identifying who is involved in the development of the plan
- ✓ Frequency of case reviews for infants and toddlers over a 12-month period
- ✓ Frequency of court hearings for infants and toddlers in foster care
- ✓ Requirement for timeframe of permanency hearings for infants and toddlers (from date of removal from home)
- ✓ Persons who are entitled to receive notice of and attend hearings (e.g., child and parent, foster parent, pre-adoptive parent, etc.)
- ✓ Number/percentage of cases with infants and toddlers in foster care for between 6 and 12 months that have been the subject of expedited permanency hearings

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
1. Monthly case reviews, which involve birth and foster parents, social workers, attorneys, and service providers, are conducted in order to assess progress made, ensure that services are being provided, and establish goals for the next review period. **Note:** For case reviews and hearings, it is important to have contingencies in place that address communicating with parents who are incarcerated or detained.			
2. The court holds monthly hearings while infants and toddlers are in foster care to assess progress and ensure that services are being provided.			
3. Permanency hearings are expedited for infants and toddlers. **Note:** It is important that permanency hearings be held no later than between 6 and 12 months after removal.			

Researchers have found that approximately 82% of maltreated infants show disturbances in their attachment to their caregivers.

Douglas Goldsmith, David Oppenheim, and Janine Wanlass, "Separation and Reunification: Using Attachment Theory and Research to Inform Decisions Affecting the Placements of Children in Foster Care." *Juvenile and Family Court Journal* 55, no. 2 (2004): 1–13.

E. Meeting Needs After Permanency

A child has reached a permanent home when the child has been discharged from foster care due to one of the following reasons: (1) reunified with parents or primary caretakers, (2) legally adopted, or (3) living with a legal guardian. Infants are particularly vulnerable to reentry into care after reunification. Appropriate post-permanency supports can help avoid reentries. Research suggests that post-permanency services should include services that enhance parenting skills necessary for caring for very young children, provide social support, connect families to basic resources, and address the developmental needs of infants and toddlers.[9]

Review available data on infants, toddlers, and their families known to the child welfare system, such as:

- ✓ Record of specific permanency outcomes for each infant and toddler
- ✓ Time to permanency (date of first removal from home and date of permanency placement)
- ✓ Number/percentage of infants and toddlers achieving permanency that had post-permanency plans
- ✓ Tracking of infants and toddlers once in new permanency placement
- ✓ Number/percentage of infants and toddlers reunified with parents whose family receives services
- ✓ Guidelines for services provided to birth parents after reunification with infant/toddler
- ✓ Number/percentage of infants and toddlers who are adopted from foster care whose families receive services
- ✓ Number/percentage of adoptions of infants and toddlers from foster care that result in open relationships with birth parents
- ✓ Number/percentage of infants and toddlers who had achieved permanency and later return to the child welfare system

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
1. Post-permanency plans are developed before and during the child's reunification with birth parents and are regularly monitored. **Note:** Post-permanency plans should: identify barriers to successful reunification, provide supports to address and overcome reunification barriers, and develop safety plans to help parents cope with parenting stressors.			
2. Post-permanency services and supports are provided to birth parents who are reunified with their infant or toddler and are regularly monitored, regardless of parents' legal status. **Note:** Birth parents need many of the same supports that are often available to adoptive parents and other permanent caregivers, as well as supports for addressing the needs that brought the child to the attention of the child welfare system. Post-permanency services may include mental health services; financial services such as income support, job training, health care, or housing assistance; and support networks including *respite care*, peer support groups, and linkages with community-based services.[10]			
3. Post-permanency plans are developed before and during a child's adoption from foster care and are regularly monitored. **Note:** This should include family-focused, long-term support. When the adoptive family is different from the foster parents, foster parents should be encouraged to continue as resources to the adoptive families once permanency has been achieved.			
4. Post-permanency services and supports are provided to adoptive parents and guardians of infants and toddlers and are regularly monitored. **Note:** Common post-permanency services include *respite care*, support groups for adoptive parents and children, services for young children with developmental delays, early care and education services, and counseling.[11]			
5. Birth parents, adoptive parents, foster parents, and *kinship* guardians have agreements certifying open relationships with the infant or toddler that continue when permanency has been achieved.			
6. Children continue to receive services to meet their health, mental health, and developmental needs after permanency is achieved.			

II. State/County Priorities
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III. Training and Supporting Child Welfare Staff and Other Professionals Involved in the Child Welfare System

A. Training and Retaining Child Welfare Workers

Social/case workers with training in early childhood development should be recruited for front-line and supervisory staff positions. Ongoing training should occur on such topics as: infant-toddler development, understanding and addressing the impact of trauma on child development and school readiness, recognizing developmental delays, supporting and engaging families of infants and toddlers, *cultural competence*, and promoting stability for the child. Training should include education and guidance on reducing disproportionality and disparate treatment in the child welfare system.

Review available data on infants, toddlers, and their families known to the child welfare system, such as:

- ✓ Data monitoring on caseworker progress on infant and toddler cases (performance data)
- ✓ Number/percentage of trainings for caseworkers of infants and toddlers (both pre- and in-service)
- ✓ Elements/components of caseworker training on infants and toddlers (e.g., development of young children, the role of attachment, techniques for working with birth and foster parents to support early development, applying knowledge of early development to case decision-making)

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
1. Child welfare workers are prepared to meet the needs of infants, toddlers, and their families through regular (monthly) training on:			
a. Developmentally appropriate and culturally relevant care of infants, toddlers, and their families.			
b. *Concurrent planning* for infants and toddlers.			
c. The *protective factors* that can help families involved in the child welfare system succeed, and how to strengthen these. **Note:** The Center for the Study of Social Policy has identified five *protective factors* that can ameliorate the risk of child abuse and neglect: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and the social and emotional competence of children.[12] These *protective factors* can provide a framework for staff working with young families.			
d. The issues that parents involved with the child welfare system might be facing. **Note:** Issues may include: underlying history of severe and often debilitating trauma, substance abuse issues, mental health issues, and poverty.			
2. Child welfare staff engages in *trauma-informed care*, *trauma-informed supervision*, and *reflective supervision*. **Note:** These policies and procedures promote retention and professionalism.			

B. Training Other Professionals Involved in the Child Welfare System

It is important that all professionals involved with infants and toddlers in the child welfare system have an understanding of the cumulative effect of early adverse experiences on infants and toddlers, and their resulting developmental needs. Ongoing training should include topics such as: infant-toddler development, understanding and addressing the impact of trauma on child development and school readiness, recognizing developmental delays, supporting and engaging families of infants and toddlers, *cultural competence*, and promoting stability for the child. Training should include education and guidance on reducing disproportionality and disparate treatment in the child welfare system.

Review available data on infants, toddlers, and their families known to the child welfare system, such as:

- ✓ Which professionals receive training on developmentally appropriate and culturally relevant practices for infants and toddlers
- ✓ Number of trainings
- ✓ Frequency of trainings
- ✓ Elements/components of training for each of the different parties involved (e.g., development of young children, the role of attachment, techniques for working with birth and foster parents to support early development, applying knowledge of early development to case decision-making)

Recommended Policies and Practices	What policies and procedures do we have in place to ensure this occurs?	What barriers exist and/or what resources are lacking?	What improvements can be made to current policies, procedures, and practices?
1. Training in developmentally appropriate and culturally relevant practices for infants and toddlers is provided to:			
a. Attorneys, judges, and other court staff.			
b. Early care and education providers.			
c. *Part C* providers.			
d. *Home visiting* providers.			
e. Pediatricians. **Note:** Training should include the use of developmental screening tools for infants and toddlers.			
f. Mental health providers.			
III. State/County Priorities			
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Infants and toddlers constitute over one quarter (27%) of all abused and neglected children.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Child Maltreatment 2010. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2011, http://www.acf.hhs.gov/programs/cb/pubs/cm10/cm10.pdf.

Action Planning

Priority	Next Steps	Who is Taking the Lead	Timeline

GLOSSARY

A Call to Action on Behalf of Maltreated Infants and Toddlers – *A Call to Action* represents the collective vision of leading child welfare and early childhood development organizations on the important steps that can and should be taken in policies, programs, and practices to address the needs of vulnerable infants and toddlers who come to the attention of the child welfare system. The policy agenda is intended to provide a starting point for policymakers at all levels of government in creating a response to these special needs. It first presents the compelling evidence for addressing the needs of infants and toddlers in the child welfare system and then suggests key elements of a developmental approach for this vulnerable population. Organizations joining with ZERO TO THREE to create the policy agenda and urge action include the American Humane Association, Center for the Study of Social Policy, Child Welfare League of America, and Children's Defense Fund.

http://www.zerotothree.org/acalltoaction

Ages and Stages Questionnaires (ASQ) – The ASQ Third Edition *(ASQ-3)* and ASQ-Social Emotional *(ASQ:SE)* are developmental screening tools appropriate for screening children from 1 month to 5 ½ years of age. The tools are based on research and are both reliable and valid. The *ASQ-3* uses drawings and simple directions to help parents elicit and indicate children's language, personal-social, motor, and cognition skills. The *ASQ:SE* helps screen for emotional and behavioral problems. Both tools are available in English and Spanish.

http://agesandstages.com/

American Academy of Pediatric Dentistry recommendations for oral health care – The American Academy of Pediatric Dentistry provides recommendations for periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment for children ages 6 to 12 months, 12 to 24 months (all children should have established a dental home by 12 months), 2 to 6 years, 6 to 12 years, and 12 years and older.[13]

http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf

American Academy of Pediatrics' (AAP's) recommended schedule for preventive pediatric health care – The AAP has developed recommendations for preventive pediatric health care. The guidelines represent a consensus by the AAP and Bright Futures. They are intended for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. The AAP stresses that additional visits may become necessary if circumstances suggest variations from normal. The AAP schedule recommends that children receive preventive pediatric health care visits prenatally, at birth, within 5 days of birth, and at ages 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months, 3 years, and annually thereafter. The AAP, Advisory Committee on Immunization Practices, and the American Academy of Family Physicians have also approved a new version of the recommended immunization schedule for persons ages 0 - 6 years.

http://www.aap.org (American Academy of Pediatrics)

http://www.cdc.gov/vaccines/recs/schedules/downloads/child/0-6yrs-schedule-pr.pdf (Schedule of immunizations)

Child Abuse Prevention and Treatment Act (CAPTA) – CAPTA is the key federal legislation addressing child abuse and neglect. It provides federal funding to states in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations, including Indian Tribes and Tribal organizations, for demonstration programs and projects. Additionally, CAPTA identifies the federal role in supporting research, evaluation, technical assistance, and data collection activities. CAPTA also sets forth a minimum definition of child abuse and neglect. CAPTA requires state early intervention and child welfare systems to establish coordinated procedures for the referral of substantiated cases of abused, neglected, or illegal drug–exposed infants and toddlers to *Part C* services.

http://www.childwelfare.gov/search/search_results.cfm?q=CAPTA

Child and Family Services Improvement and Innovation Act – The Child and Family Services Improvement and Innovation Act instituted a new requirement for states to describe in their child welfare plans how they promote permanency for, and address the developmental needs of, young children in their care. Specifically, state plans must "include a description of the activities that the State has undertaken to reduce the length of time children who have not attained 5 years of age without a permanent family, and the activities the State undertakes to address the developmental needs of such children who receive benefits under this part or part E."[14] The Act also requires states to outline how emotional trauma associated with a child's maltreatment and removal from home will be monitored and treated, and to design services and activities that facilitate contact between young children and their parents and siblings as a component of time-limited family reunification services. These new requirements offer an opportunity for states to be more intentional in their efforts to meet the unique needs of infants, toddlers, and their families known to the child welfare system.

http://www.gpo.gov/fdsys/pkg/PLAW-112publ34/pdf/PLAW-112publ34.pdf

Children's Health Insurance Program (CHIP) – The Children's Health Insurance Program (CHIP) provides health coverage to nearly 8 million children in families with incomes too high to qualify for Medicaid, but who can't afford private coverage. Signed into law in 1997, CHIP provides federal matching funds to states to provide this coverage.

www.medicaid.gov

Concurrent planning – Seeks to promote timely permanence for children in foster care by considering reunification and other permanency options at the earliest possible point after a child's entry into foster care. The process includes: systems that institutionalize the approach, clarity and services for birth parents, training and support for caseworkers, processes for recruiting and training families to foster children in concurrent planning cases and adopt if that is the outcome, and active promotion by the court.

http://www.childwelfare.gov/permanency/overview/concurrent.cfm

Cultural competence – An individual's or family's culture can affect the kinds of services needed, as well as the optimal place, time, and method of delivering services and supports. Addressing issues of culture, race, class, and ethnic background increases the likelihood of family engagement and a positive intervention. By working to understand the cultural needs of the families within systems of care, service providers convey the importance of respect, dignity, nondiscrimination, and self-determination to all participants.[15]

Differential response – In traditional child protective service systems without differential response, there is only one response to all reports. Child welfare workers investigate the allegation with a resulting formal disposition indicating whether maltreatment occurred. Research indicates that this single approach is not effective in all types of reports of maltreatment.[16] In differential response, child protective services offer both traditional investigations and assessment alternatives to families reported for child abuse and neglect, depending on the severity of the allegation and other considerations. The introduction of differential response has been driven by the desire to be more flexible in responding to child abuse and neglect reports, recognize that an adversarial focus is neither needed nor helpful for all cases, understand better the family issues that lie beneath maltreatment reports, and engage parents more effectively to use services that address their specific needs. For high-risk reports, an investigation generally ensues. For low- and moderate-risk cases with no immediate safety concerns, a family assessment is conducted to gauge the family's needs and strengths and refers them on to appropriate community-based resources.

http://www.childwelfare.gov/pubs/issue_briefs/differential_response/

Dyadic therapy – Dyadic therapy is an intervention approach provided to infants and young children with symptoms of emotional disorders. Therapy includes the child and the parent and focuses on rebuilding a healthy and secure relationship between them. Research suggests that this type of therapy is useful in helping the parent and child to regain trust, develop a *secure attachment,* work through trauma and fears, and improve parenting skills.[17]

Early Head Start (EHS) – Early Head Start is the only federal program specifically designed to ensure that all young children have the same opportunities by improving the early education experiences of low-income infants and toddlers. The mission of Early Head Start is to support healthy prenatal outcomes and enhance the intellectual, social, and emotional development of infants and toddlers to promote later success in school and life. It does so by offering opportunities for early learning experiences, parent support, home visitation, and access to medical, mental health, and early intervention services. This comprehensive approach supports the whole child—physically, socially, emotionally, and cognitively—within the context of the family, the home, and other child-serving settings.

http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/Early%20Head%20Start

GLOSSARY

Family-centered practice – Family-centered practice is a way of working with families, both formally and informally, across service systems to enhance their capacity to care for and protect their children. It focuses on the needs and welfare of children within the context of their families and communities. Family-centered practice recognizes the strengths of family relationships and builds on these strengths to achieve optimal outcomes. Family is defined broadly to include birth, blended, *kinship,* and foster and adoptive families.

http://www.childwelfare.gov/famcentered/overview/

Family group decision-making – Refers to a collection of family intervention approaches in which family members come together to make decisions about caring for their children and to develop a plan for services. This type of intervention also is referred to as family team conferencing, family team meetings, family group conferencing, family team decision-making, family unity meetings, and team decision-making.

http://www.childwelfare.gov/systemwide/assessment/approaches/family.cfm

Fetal alcohol spectrum disorders (FASDs) – FASDs are a group of conditions that can occur in a person whose mother drank alcohol during pregnancy. These effects can include physical problems and problems with behavior and learning. Often, a person with an FASD has a mix of these problems. FASDs are a leading known cause of intellectual disability and birth defects.

http://www.cdc.gov/ncbddd/fasd/facts.html

Foster-adopt home placements (also called legal risk placements) – When a child is placed with a foster-adopt family, typically the child's permanency options are being evaluated through *concurrent planning* in two directions: adoption and family reunification. The child is placed in the home of a specially trained prospective adoptive family, who will work with the child during family reunification efforts but will adopt the child in the event that family reunification is not successful.

Home visiting services – Home visiting can be an effective method of supporting families, particularly as part of a comprehensive and coordinated system of high-quality, affordable early care and education, health and mental health, and family support services for families prenatally through pre-kindergarten. These voluntary programs tailor services to meet the needs of individual families, and they offer information, guidance, and support directly in the home environment. The 2010 Patient Protection and Affordable Care Act allocated significant funds to states to expand evidence-based home visiting programs in at-risk communities through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Information on the models for which states can use MIECHV funding can be obtained at:

http://homvee.acf.hhs.gov/Default.aspx

Kinship – Kinship care refers to placements of children with relatives or, in some jurisdictions, close family friends (often referred to as fictive kin). Relatives are the preferred placement for children who must be removed from their birth parents, as this kind of placement maintains the children's connections with their families. Kinship care is often considered a type of family preservation service.

http://www.childwelfare.gov/outofhome/types/kinship.cfm

Known to the child welfare system – For the purposes of this tool, "infants, toddlers, and their families known to the child welfare system" includes both those who have an open case with the child welfare agency for family support, in-home, or family preservation services and children who are in foster care (both traditional foster care and *kinship* care). This does not include those who are referred to the child welfare agency but do not receive an investigation or assessment through *differential response*.

Low Income Home Energy Assistance Program (LIHEAP) – LIHEAP is a federally-funded program that helps assist low-income households, particularly those with the lowest incomes that pay a high proportion of household income for home energy, primarily in meeting their immediate home energy needs.

http://www.acf.hhs.gov/programs/ocs/liheap/

Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) framework – The EPSDT is a comprehensive medical treatment and prevention service available to Medicaid-eligible children younger than 21 years, managed by Medicaid at the Centers for Medicare & Medicaid Services. The EPSDT guidance for screening includes physical examinations, lab tests (e.g., lead screening), developmental questionnaires, hearing and vision, and child and family history.

Medical home – When children have a medical home, all aspects of pediatric care can be managed by one consistent pediatrician who knows a child's family and their medical history. This includes well-child visits; immunizations; screenings and assessments; patient and parent counseling about health, nutrition, safety, and mental health; and supervision of care. In addition, when appropriate, a pediatrician can also refer a child to specialized health care providers and early intervention services while coordinating care with other early childhood programs and services. The AAP has identified seven desirable characteristics of a medical home: accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.[18]

http://www.medicalhomeinfo.org/

Part C of the Individuals with Disabilities Education Act (Part C) – Part C is the Early Intervention Program for Infants and Toddlers with Disabilities. It is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for children from birth to 2 years old who have developmental delays or who are at risk of developing a delay or special need that may affect their development or impede their education, and their families. Part C can help ensure that very young children's developmental needs are met through services such as occupational and speech therapies, counseling, nursing services, transportation, and more.

http://idea.ed.gov/part-c/search/new

Pre-removal conference – Pre-removal conferences are initiated by and held at the child welfare agency. At these meetings, mediated by a trained facilitator, the investigative social worker and the worker who will take the case after the investigation talk with the parent(s) about the reasons for removal, the family's strengths and challenges, the services that could be initiated immediately, and the special needs of the child(ren). This allows parents to be seen as the experts about their child(ren) and to know that the child welfare workers are in their corner. Relatives and other members of the parents' support system are also invited to participate.

Protective factors – The Center for the Study of Social Policy has identified five protective factors that can ameliorate risk of child abuse and neglect:

- Parental resilience – the capacity to cope with all types of challenges.
- Social connections – positive relationships with friends, family members, neighbors, and others who can provide concrete and emotional supports to parents.
- Knowledge of parenting and child development – accurate information about raising children and appropriate expectations for their behaviors.
- Concrete support in times of need – financial security and access to informal and formal supports.
- Social and emotional competence of children – the ability of children to interact positively and articulate their feelings.

http://www.cssp.org/reform/strengthening-families

Quality early learning and development programs – Quality early learning programs offer the promise of a solid future by providing our youngest children with nurturance, support for early learning and language development, preparation for school, and the opportunity for all infants and toddlers to reach their full potential. The quality of care for infants and toddlers in an early learning program ultimately boils down to the quality of the relationship between the care provider and the child: skilled and stable providers promote positive development. A secure relationship between the infant and the caregiver can complement the relationship between parents and young children and facilitate early learning and social development. Young children whose caregivers provide ample verbal and cognitive stimulation, who are sensitive and responsive, and who give them generous amounts of attention and support are more likely to be advanced in all aspects of development compared with children who fail to receive these important inputs.

http://www.zerotothree.org/public-policy/policy-toolkit/child_caremar5singles.pdf

Reflective supervision – Reflective supervision is a practice commonly used with professionals who work with infants, toddlers, and their families. There are three building blocks of reflective supervision: reflection, collaboration, and regularity. Reflective supervision is the process of examining, with someone else, the experiences, thoughts, feelings, actions, and reactions evoked in the course of working closely with young children and their families. Working through complex emotions in a "safe place" allows the supervisee to manage the stress she experiences on the job and also allows the staff person to experience the very sort of relationship that she is expected to provide for infants, toddlers, and families.

http://www.zerotothree.org/about-us/areas-of-expertise/reflective-practice-program-development/three-building-blocks-of-reflective-supervision.html

GLOSSARY

Respite care – Respite care provides parents and other caregivers with short-term child care services that offer temporary relief, improve family stability, and reduce the risk of abuse or neglect. Respite can be planned or offered during emergencies or times of crisis. Respite may be available to foster, *kinship*, and adoptive families, as well as birth families in need of support.

http://www.childwelfare.gov/systemwide/service_array/respite/

Secure attachment – Research demonstrates that forming secure attachments to a few caring and responsive adults is a primary developmental milestone for babies in the first year of life. Infants and toddlers who are able to develop secure attachments are observed to be more mature and positive in their interactions with adults and peers than children who lack secure attachments.[19]

Shared family care – Parents and children are placed together in the home of a host family who is trained to mentor and support the parents as they develop the skills necessary to care for their children independently. It can be used to prevent out-of-home placement, to provide a safe environment for the reunification of a family that has been separated, or to help parents consider other permanency options, including relinquishment of parental rights.

http://www.childwelfare.gov/outofhome/types/shared.cfm

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) – WIC provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age 5 who are found to be at nutritional risk.

http://www.fns.usda.gov/wic/

Supplemental Nutrition Assistance Program (SNAP) – Formerly referred to as the Food Stamp Program, SNAP is the nation's largest domestic food and nutrition assistance program for low-income Americans.

http://www.fns.usda.gov/snap/

The Fostering Connections to Success and Increasing Adoptions Act – The Fostering Connections to Success and Increasing Adoptions Act was signed into law on October 7, 2008, as Public Law 110-351. The Act amended Parts B and E of Title IV of the Social Security Act to connect and support relative caregivers, improve outcomes for children in foster care, provide for Tribal foster care and adoption access, improve incentives for adoption, and for other purposes.

http://www.childwelfare.gov/systemwide/laws_policies/federal/index.cfm?event=federalLegislation.viewLegis&id=121

Trauma-informed care – Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may aggravate.

http://www.samhsa.gov/nctic/trauma.asp

Trauma-informed supervision – The key to making child- and youth-serving systems more trauma-informed is professionals who understand the impact of trauma on child development and can address trauma and minimize any additional negative effects. In doing so, it is important that practitioners are provided with the opportunity to talk through their own personal reactions to very troubling family trauma and learn how to cope and manage professional and personal stress, often called vicarious or secondary trauma. Trauma-informed supervision provides a concrete way for supporting child welfare professionals.

http://www.childwelfare.gov/pubs/braindevtrauma.pdf

Visit coaching – Visit coaching is fundamentally different from supervised visits. Instead of merely watching the family, the coach is actively involved in supporting them to demonstrate their best parenting skills and make each visit fun for the children; the coach's intention is to facilitate safe reunification by helping parents demonstrate their skills at meeting their children's needs. Visit coaching can be effective immediately after removal and/or as an aftercare practice as children begin extended visits prior to case closing. Visit coaching includes: helping parents articulate their children's needs to be met in visits; preparing parents for their children's emotional reactions and behaviors in visits; helping parents plan to give their children their full attention at each visit; appreciating parents' strengths in responding to their children and coaching them to improve their skills; supportively reminding parents immediately before and during the visit of how they plan to meet their children's needs; and helping parents cope with their feelings in order to (a) visit consistently and (b) keep their anger and depression out of the visits.[20]

Endnotes

1 U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, *Child Maltreatment 2009*. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2011, www.acf.hhs.gov/programs/cb/pubs/cm09.

2 Julie Cohen, Patricia Cole, and Jaclyn Szrom, *A Call to Action on Behalf of Maltreated Infants and Toddlers*. American Humane Association, Center for the Study of Social Policy, Child Welfare League of America, Children's Defense Fund and ZERO TO THREE, 2011, www.zerotothree.org/acalltoaction.

3 Brenda Jones Harden, *Infants in the Child Welfare System: A Developmental Framework for Policy and Practice*. Washington, DC: ZERO TO THREE, 2007.

4 National Research Council and Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Jack Shonkoff and Deborah A. Phillips, eds., Washington, DC: National Academy Press, 2000.

5 Christine Johnson-Staub, *Charting Progress for Babies in Child Care Project: Promote Access to Early, Regular, and Comprehensive Screening*. Center for Law and Social Policy, 2012, http://www.clasp.org/babiesinchildcare/recommendations?id=0011.

6 Douglas F. Goldsmith, David Oppenheim, and Janine Wanlass, "Separation and Reunification: Using Attachment Theory and Research to Inform Decisions Affecting the Placements of Child in Foster Care." *Juvenile and Family Court Journal* 55, no. 2 (Spring 2004): 1-13.

7 Cohen, Cole, and Szrom, *A Call to Action on Behalf of Maltreated Infants and Toddlers*.

8 Brenda Jones Harden, "Safety and Stability for Foster Children: A Developmental Perspective." *The Future of Children*, 14, no. 1, (Winter, 2004): 31-47.

9 Child Welfare Information Gateway, *Family Reunification: What the Evidence Shows*. Child Welfare Information Gateway, June 2006, www.childwelfare.gov.

10 Susan Dougherty, "Promising Practices in Reunification." National Resource Center for Foster Care & Permanency Planning, April 2004, http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/promising-practices-in-reunification.pdf.

11 Mark F. Testa. "When Children Cannot Return Home: Adoption and Guardianship." *Children, Families, and Foster Care,* 14, no. 1 (Winter 2004): 115-129.

12 http://www.cssp.org/reform/strengthening-families/the-basics/protective-factors.

13 American Academy of Pediatric Dentistry, "Guideline on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents." *Reference Manual*, 33, no. 6 (2010-2011): 102-108.

14 Child and Family Services Improvement and Innovation Act of 2011, 112th Cong., H.R. 2883, http://www.gpo.gov/fdsys/pkg/PLAW-112publ34/pdf/PLAW-112publ34.pdf.

15 Child Welfare Information Gateway, "Systems of Care." Child Welfare Information Gateway, February 2008, http://www.childwelfare.gov/pubs/soc/soc.pdf.

16 Cohen, Cole, and Szrom, *A Call to Action on Behalf of Maltreated Infants and Toddlers*.

17 Julie Cohen, Cindy Oser, and Kelsey Quigley, *Making It Happen: Overcoming Barriers to Providing Infant-Early Childhood Mental Health*. ZERO TO THREE, 2012, www.zerotothree.org.

18 American Academy of Pediatrics, "The Medical Home." Pediatrics 110, no. 1 (2002): 184–186, http://pediatrics.aappublications.org/content/110/1/184.full.

19 National Research Council and Institute of Medicine, *From Neurons to Neighborhoods*.

20 Marty Beyer, "Visit Coaching: Building on Family Strengths to Meet Children's Needs." *Juvenile and Family Court Journal* 59, no.1 (2008): 47–60.

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