This publication is designed in an 11x17 format viewed with a landscape orientation. In order to view it online, please scroll down. If you would like to print the tool, it must be printed on 11x17 paper.

Professionally printed copies are available from the ZERO TO THREE Policy Center by emailing policycenter@zerotothree.org with “Child Welfare Tool” in the subject line.

If you would like a Word version of the tool that can be filled out, please email policycenter@zerotothree.org and put “Child Welfare Tool Word Version” in the subject line. Thank you.
Acknowledgements

Many thanks to MaryLee Allen, Liany Arroyo, Sheri Brady, Hope Cooper, Kerry DeVooght, Lauren Hogan, Judy Langford, Arlene Lee, Judy Meltzer, John Sciamanna, and Fred Wulczyn for contributing their expertise and knowledge. Thank you to the authors of this planning tool: Jamie Colvard and Jaclyn Szrom. And special thanks to Lucy Hudson for her guidance and insight in developing the tool.

Several members of the ZERO TO THREE staff contributed time and expertise to this publication: Julie Cohen, Patty Cole, Barbara Gebhard, Erica Lurie-Hurwitz, and Debbie Rappaport. Thank you to the state representatives who provided feedback on the tool: Christin Harper, Pat Penning, Wendy Rickman, and Lori Woodruff. Many thanks to Austin Metze for his design of this publication and copyediting by Anne Brophy.

The development of this tool was made possible through a generous grant from the W.K. Kellogg Foundation.

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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. 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.

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).

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. Research shows that connecting babies to high-quality, research-based services that begin early can improve the odds of positive outcomes.

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

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<thead>
<tr>
<th>Recommended Policies and Practices</th>
<th>What policies and procedures do we have in place to ensure this occurs?</th>
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<th>What improvements can be made to current policies, procedures, and practices?</th>
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</table>
| 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. |
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<tr>
<td>5. When children are placed into foster care, efforts are made to ensure they stay with their pediatric medical home.</td>
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<td><strong>Note:</strong> 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.</td>
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<td>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.</td>
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<td><strong>Note:</strong> Children in foster care should receive in-person assessments within 30 days of entering care.</td>
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<td>7. Parents of young children known to the child welfare system are involved in evaluating their children’s health.</td>
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<td><strong>Note:</strong> 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.</td>
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<td>8. Temporary caregivers are informed of children’s health needs and developmental status.</td>
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<td>9. Young children with suspected health or developmental problems receive:</td>
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<td>a. Referrals to specialists.</td>
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<td>b. Follow-up.</td>
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<td>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.</td>
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<td><strong>Note:</strong> 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.</td>
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<tr>
<td>11. Infants and toddlers are successfully connected to the services needed to address identified developmental challenges.</td>
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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.

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

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<tr>
<td>1. There is a state-level memorandum of understanding (MOU) in place to ensure compliance with the CAPTA requirement for referral to Part C.</td>
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<td>2. Child welfare workers are made aware of the referral requirement as well as opportunities for developmental support under Part C.</td>
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| 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

<table>
<thead>
<tr>
<th>Policy/Practice</th>
<th>What policies and procedures do we have in place to ensure this occurs?</th>
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<tr>
<td>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.</td>
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**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.
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<tr>
<td>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. <strong>Note:</strong> 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.</td>
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<td>7. When appropriate, parents are connected to services in languages other than English, provided by culturally competent providers.</td>
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<td>8. When referrals for services are made, feedback is obtained on the services received and parents’ progress.</td>
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**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.

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<tbody>
<tr>
<td>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:</td>
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<td>a. Health services—pediatricians, dentists, American Academy of Pediatrics</td>
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<td>b. Mental health services</td>
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<td>c. Public assistance programs, including SNAP, WIC, CHIP, and LIHEAP</td>
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<td>d. <strong>Part C</strong></td>
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<td>e. Quality home visiting services</td>
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<td>f. Quality early learning and development programs such as EHS and high-quality child care</td>
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<td>g. Effective substance abuse treatment programs</td>
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<td>h. Domestic violence services</td>
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<td>i. Judicial system</td>
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<td>j. Law enforcement</td>
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<tr>
<td>k. Immigration and Customs Enforcement (ICE) <strong>Note:</strong> 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.</td>
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I. State/County Priorities

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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. 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

<table>
<thead>
<tr>
<th>1. Differential response (also referred to as dual track or alternative response) is used for infants and toddlers.</th>
<th>What policies and procedures do we have in place to ensure this occurs?</th>
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<tr>
<td><strong>Note:</strong> 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.</td>
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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

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| **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).³ | | |
| **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. | | |
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

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<td>e. Foster and adoptive families that reflect the culture and ethnicity of children are actively recruited, with support from community partners.</td>
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<td>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.</td>
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<td>4. Stable placements for young children are promoted.</td>
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</table>
| 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. |                                                                          |                                                      |                                                                          |

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.
**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

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<tr>
<th>Recommended Policies and Practices</th>
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<th>What improvements can be made to current policies, procedures, and practices?</th>
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</table>

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

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<tbody>
<tr>
<td>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. <strong>Note</strong>: For case reviews and hearings, it is important to have contingencies in place that address communicating with parents who are incarcerated or detained.</td>
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<td>2. The court holds monthly hearings while infants and toddlers are in foster care to assess progress and ensure that services are being provided.</td>
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<td>3. Permanency hearings are expedited for infants and toddlers. <strong>Note</strong>: It is important that permanency hearings be held no later than between 6 and 12 months after removal.</td>
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Researchers have found that approximately 82% of maltreated infants show disturbances in their attachment to their caregivers.

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

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<tbody>
<tr>
<td>1. Post-permanency plans are developed before and during the child’s reunification with birth parents and are regularly monitored. <strong>Note:</strong> 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.</td>
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<tr>
<td>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. <strong>Note:</strong> 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</td>
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<tr>
<td>3. Post-permanency plans are developed before and during a child’s adoption from foster care and are regularly monitored. <strong>Note:</strong> 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.</td>
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<tr>
<td>4. Post-permanency services and supports are provided to adoptive parents and guardians of infants and toddlers and are regularly monitored. <strong>Note:</strong> 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</td>
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<td>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.</td>
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<td>6. Children continue to receive services to meet their health, mental health, and developmental needs after permanency is achieved.</td>
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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)

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<tr>
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<tr>
<td>1. Child welfare workers are prepared to meet the needs of infants, toddlers, and their families through regular (monthly) training on:</td>
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<td>a. Developmentally appropriate and culturally relevant care of infants, toddlers, and their families.</td>
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<td>b. Concurrent planning for infants and toddlers.</td>
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<td>c. The protective factors that can help families involved in the child welfare system succeed, and how to strengthen these.</td>
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<td><strong>Note:</strong> 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. These protective factors can provide a framework for staff working with young families.</td>
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<td>d. The issues that parents involved with the child welfare system might be facing.</td>
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<td><strong>Note:</strong> Issues may include: underlying history of severe and often debilitating trauma, substance abuse issues, mental health issues, and poverty.</td>
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<td>2. Child welfare staff engages in trauma-informed care, trauma-informed supervision, and reflective supervision.</td>
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<td><strong>Note:</strong> These policies and procedures promote retention and professionalism.</td>
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### 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)

#### Table: Recommended Policies and Practices

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<tr>
<td>1. Training in developmentally approp</td>
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<td>2. Early care and education providers.</td>
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<td>3. Part C providers.</td>
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<td>4. Home visiting providers.</td>
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<td>5. Mental health providers.</td>
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#### III. State/County Priorities

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**Infants and toddlers constitute over one quarter (27%) of all abused and neglected children.**

## Action Planning

<table>
<thead>
<tr>
<th>Priority</th>
<th>Next Steps</th>
<th>Who is Taking the Lead</th>
<th>Timeline</th>
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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 that 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 examinations, preventive dental services, anticipatory guidance, and dental 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.1


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.17–21 Necessarily, these guidelines change as children grow and develop. The following 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/0-4yrsschedule-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.cf?n=CAPTA

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 – Seals to promote timely permanence for children in foster care by considering reunification and other permanency options at the earliest possible time.22 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 as fit and promote the child’s interest.23

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.24

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.19 In differential response, child protective services offer both traditional investigations and assessment and intervention strategies 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 refer them on to appropriate community-based resources.


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.25

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 health and well-being of very young children and their families. The mission of Early Head Start is to support healthy prenatals 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 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.us.hhs.gov/hcl/cntasystem/ihscarc/Early%20Head%20Start
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/famcenteredoverview/

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 decision meetings, family group conferencing, family team decision-making, family unity meetings, and team decision-making.

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

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 primary permanency options are being evaluated through concurrent two directions: adoption and family reunification. Foster families are typically trained as adoptive families who will work with the child during family reunification efforts but will adopt the child in the event that family reunification is not successful.


Kinship care refers to placements of children with relatives or, in some jurisdictions, close family friends (often referred to as fictive kin). Kinship-care placements are the preferred placement for children who must be removed from their birth family, 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 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.

Kinship – Kinship care refers to placements of children with relatives or, in some jurisdictions, close family friends (often referred to as fictive kin). Kinship-care placements are the preferred placement for children who must be removed from their birth family, 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

Low Income Home Energy Assistance Program (LIHEAP) – LIHEAP is a federally-funded program that helps assist low-income households, particularly those with the highest 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/lieheap/

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 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

http://www.acf.hhs.gov/programs/lieheap/

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 their ability to lead productive lives or to participate fully in the environment. Part C helps ensure that every young child’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 immediately initiated, 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.csp.org/reform/strengthening-families

Reactive 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 the “safe place” allows the supervisee to manage the stress the supervisee is likely to experience in the very sort of relationship that she is expected to provide for infants, toddlers, and families.


http://www.childwelfare.gov/famcenteredoverview/

http://www.acf.hhs.gov/programs/lieheap/

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

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


http://www.childwelfare.gov/famcenteredoverview/
Endnotes
8 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.
11 Children Maltreatment 2009
12 Formerly referred to as the Food Stamp Program, SNAP is the nation’s largest domestic food and nutrition assistance program for low-income Americans.
13 http://www.fns.usda.gov/snap/
14 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 families, caregivers, and children, improve outcomes for children in foster care, provide for Tribal foster care and adoption access, improve incentives for adoption, and for other purposes.
16 The Bureau of Citizenship and Immigration Services, U.S. Department of Homeland Security, is responsible for the adjudication of cases involving withholding of removal proceedings. See 8 CFR 1208.9 and 200.105. Immigration judges, who are administrative officers, determine whether withholding of removal and asylum are granted. Immigration judges are independent fact-finders in immigration proceedings.
17 Formerly referred to as the Food Stamp Program, SNAP is the nation’s largest domestic food and nutrition assistance program for low-income Americans.
18 http://www.fns.usda.gov/snap/
21 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 families, caregivers, and children, improve outcomes for children in foster care, provide for Tribal foster care and adoption access, improve incentives for adoption, and for other purposes.
22 Visits can include visits at any time of the day, including evenings and weekends. The type of visit will be determined by the parents, the child welfare worker (if the parent is a minor), and the court.
23 Visit coaching – Visit coaching is fundamentally different from supervisor 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 reestablishment of trust between the parents and children.
24 Formerly referred to as the Food Stamp Program, SNAP is the nation’s largest food assistance program for low-income Americans.
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